Public Document Pack

JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

4.00 pm	Tuesday 18 July 2017	Barking Town Hall, Council Chamber

COUNCILLORS:

LONDON BOROUGH OF BARKING & DAGENHAM

Councillor Peter Chand (Chairman)
Councillor Jane Jones
Councillor Adegboyega Oluwole

LONDON BOROUGH OF WALTHAM FOREST

Councillor Chris Pond
Councillor Richard Sweden
Councillor Geoff Walker

LONDON BOROUGH OF HAVERING

Councillor Dilip Patel
Councillor Michael White
Councillor Nic Dodin

ESSEX COUNTY COUNCIL

Councillor Chris Pond

LONDON BOROUGH OF REDBRIDGE

Councillor Stuart Bellwood
Councillor Suzanne Nolan/Councillor Hugh Cleaver
Councillor Neil Zammett

EPPING FOREST DISTRICT COUNCIL

Councillor Aniket Patel (Observer Member)

CO-OPTED MEMBERS:

Ian Buckmaster, Healthwatch Havering
Mike New, Healthwatch Redbridge
Richard Vann, Healthwatch Barking & Dagenham
Vacant, Healthwatch Waltham Forest

For information about the meeting please contact:
Anthony Clements
anthony.clements@oneSource.co.uk 01708 433065

Protocol for members of the public wishing to report on meetings of the London Borough of Havering

Members of the public are entitled to report on meetings of Council, Committees and Cabinet, except in circumstances where the public have been excluded as permitted by law.

Reporting means:-

- filming, photographing or making an audio recording of the proceedings of the meeting;
- using any other means for enabling persons not present to see or hear proceedings at a meeting as it takes place or later; or
- reporting or providing commentary on proceedings at a meeting, orally or in writing, so that the report or commentary is available as the meeting takes place or later if the person is not present.

Anyone present at a meeting as it takes place is not permitted to carry out an oral commentary or report. This is to prevent the business of the meeting being disrupted.

Anyone attending a meeting is asked to advise Democratic Services staff on 01708 433076 that they wish to report on the meeting and how they wish to do so. This is to enable employees to guide anyone choosing to report on proceedings to an appropriate place from which to be able to report effectively.

Members of the public are asked to remain seated throughout the meeting as standing up and walking around could distract from the business in hand.

Essex County Council

Waltham Forest

Havering LONDON BOROUGH

London Borough of Redbridge

London Borough of Barking & Dagenham lbbd.gov.uk

NOTES ABOUT THE MEETING

1. HEALTH AND SAFETY

The Joint Committee is committed to protecting the health and safety of everyone who attends its meetings.

At the beginning of the meeting, there will be an announcement about what you should do if there is an emergency during its course. **For your own safety and that of others at the meeting, please comply with any instructions given to you about evacuation of the building, or any other safety related matters.**

2. CONDUCT AT THE MEETING

Although members of the public are welcome to attend meetings of the Joint Committee, they have no right to speak at them. Seating for the public is, however, limited and the Joint Committee cannot guarantee that everyone who wants to be present in the meeting room can be accommodated. When it is known in advance that there is likely to be particular public interest in an item the Joint Committee will endeavour to provide an overspill room in which, by use of television links, members of the public will be able to see and hear most of the proceedings.

The Chairman of the meeting has discretion, however, to invite members of the public to ask questions or to respond to points raised by Members. Those who wish to do that may find it helpful to advise the Clerk before the meeting so that the Chairman is aware that someone wishes to ask a question.

PLEASE REMEMBER THAT THE CHAIRMAN MAY REQUIRE ANYONE WHO ACTS IN A DISRUPTIVE MANNER TO LEAVE THE MEETING AND THAT THE MEETING MAY BE ADJOURNED IF NECESSARY WHILE THAT IS ARRANGED.

If you need to leave the meeting before its end, please remember that others present have the right to listen to the proceedings without disruption. Please leave quietly and do not engage others in conversation until you have left the meeting room.

AGENDA ITEMS

1 CHAIRMAN'S ANNOUNCEMENTS (Pages 1 - 4)

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

Directions and parking information for the venue are attached.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.

Apologies have been received from Councillors Mark Rusling and Geoff Walker, London Borough of Waltham Forest. Apologies have also been received from Richard Vann, Healthwatch Barking & Dagenham and Ian Buckmaster, Healthwatch Havering.

3 DISCLOSURE OF INTERESTS

Members are invited to disclose any interests in any of the items on the agenda at this point of the meeting. Members may still disclose an interest in an item at any point prior to the consideration of the matter.

4 MINUTES OF PREVIOUS MEETING (Pages 5 - 12)

To agree as a correct record the minutes of the meeting of the Joint Committee held on 18 April 2017 (attached).

5 BHRUT - UPDATE ON SAFETY OF SERVICES (Pages 13 - 24)

Covering report and presentation attached.

6 NELFT FUTURE PLANS (PROVISIONAL ITEM) (Pages 25 - 86)

Provisional Item: North East London NHS Foundation Trust officers will summarise their future plans in response to the inspection report by the Care Quality Commission (attached).

7 HEALTHWATCH HAVERING REPORTS (Pages 87 - 152)

An officer from Healthwatch Havering will present details of the organisation's reports into Meals at Queen's Hospital and the NELFT Mental Health Street Triage Service (attached).

8 COMMITTEE'S WORK PLAN (Pages 153 - 156)

Attached.

9 NEXT MEETING

To note that the next meeting of the Joint Committee will be on Thursday 10 October 2017 at 4 pm at Redbridge Town Hall, Ilford.

10 URGENT BUSINESS

To consider any items of which the Chairman is of the opinion, by means of special circumstances which shall be specified in the minutes, that the item be considered as a matter of urgency.

Anthony Clements
Clerk to the Joint Committee

If you are driving to the JHOSC meeting at Barking Town Hall on 18 July, there is car parking available at the London Road Multi-storey Car Park (Post code IG11 8AJ).

Please click here for a map of where the Car Park is located.

Please do not park on the ground and first floors (levels 1 and 2), as these floors are reserved for season ticket holders only. There are signs on levels 1 and 2 stipulating this. Parking on these floors may result in you being issued with a ticket.

You may park on level 3 onwards. **Please read all of the below before your journey.**

London Road Multi-storey Car Park

Customers are able to make pay for parking via RingGo. From 1 April 2017 all payments must **be made by debit, credit or contactless payment card.**

Either pay by phone: 0203 046 0010 or via the RingGo app on your smartphone.

(RingGo Code 7005)

RingGo code	7005
Up to 2 hours	£2.00
Up to 4 hours	£3.50
Up to 6 hours	£5.50
Up to 8 hours	£9.00
Up to 12 hours	£16.00
Overnight parking (8pm - 8am)	£5.50

The attached map shows walking directions from the Car Park to the Town Hall. It is about a 5 minute walk.

For anyone using the underground, from the attached you can see how to get to the Town Hall from Barking Station.

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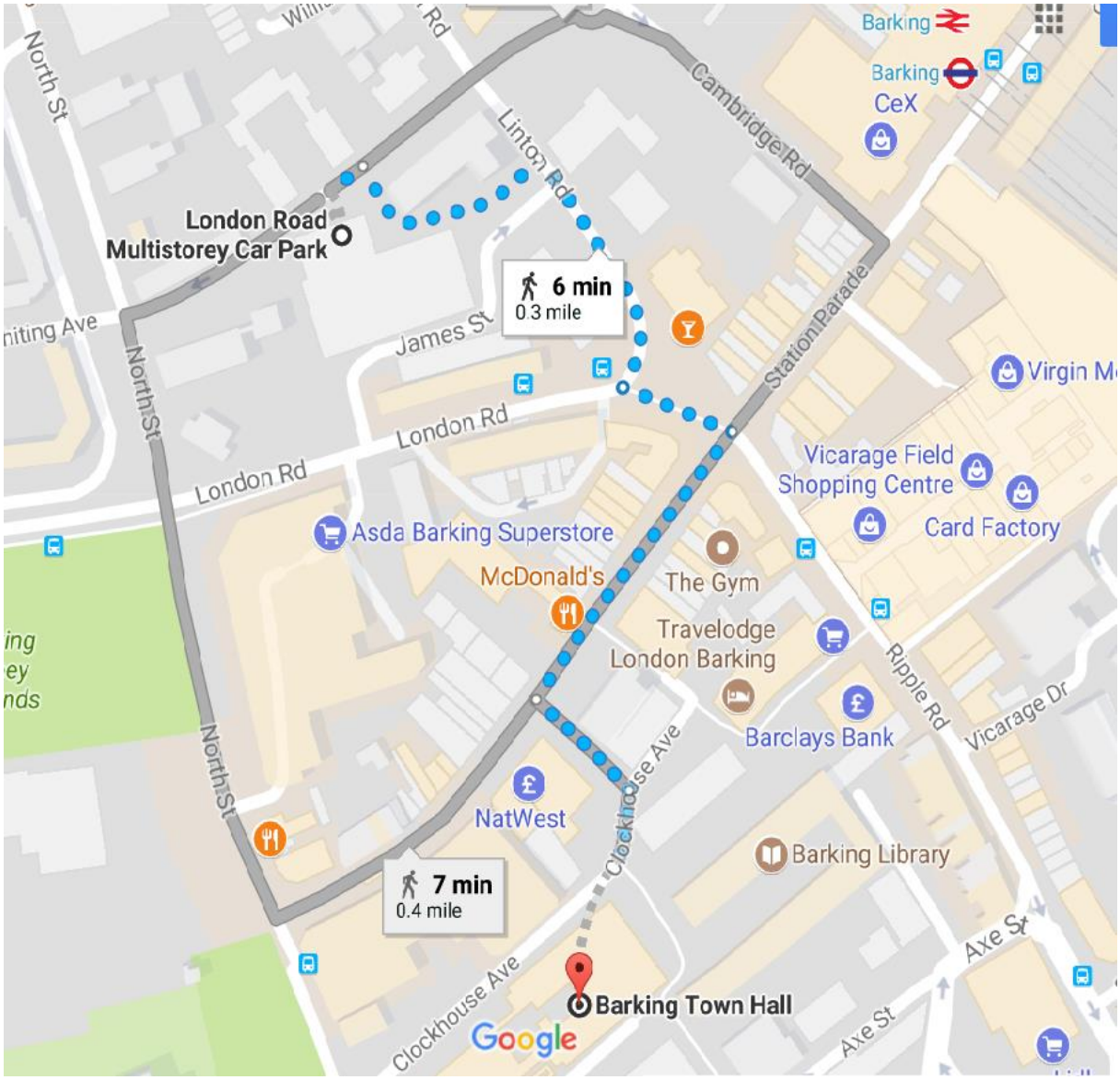
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Virgin M
Vicarage Field
Shopping Centre
Card Factory
Asda Barking Superstore
McDonald's
The Gym
Travelodge
London Barking
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NatWest
Clockhouse Ave
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MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Waltham Forest Town Hall
18 April 2017 (4.00 - 6.15 pm)

Present:

COUNCILLORS

London Borough of Barking & Dagenham	Jane Jones
London Borough of Havering	Dilip Patel, Michael White and June Alexander
London Borough of Redbridge	Stuart Bellwood and Neil Zammett
London Borough of Waltham Forest	Richard Sweden (Chairman) and Paul Douglas (substituting for Councillor Anna Mbachu)
Co-opted Members	Ian Buckmaster (Healthwatch Havering) and Mike New (Healthwatch Redbridge)

All decisions were taken with no votes against.

Also present:

Enrico Panizzo, Senior Commissioning Manager, Waltham Forest Clinical Commissioning Group (CCG)
Melissa Hoskins, Communications and Engagement Manager, BHR Clinical Commissioning Groups
James Avery, Deputy Chief Nurse, Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT)
Louise Perman, Deputy Lead Officer, PMS contract review
Louise Mitchell, Director, Planned Care Transformation Programme, BHR CCGs
Dr Anju Gupta, Clinical Lead
Dr Ravi Goriparthi, Clinical Lead

Approximately 20 members of the public were in attendance.

34 CHAIRMAN'S ANNOUNCEMENTS

The Chairman gave details of arrangements in case of fire or other event that might rwquire the evacuation of the building.

35 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.

Apologies were received from Councillors Peter Chand (Barking & Dagenham) Suzanne Nolan (Redbridge) Chris Pond (Esex) and Anna Mbachu (Waltham Forest – Councillor Paul Douglas substituting).

Apologies were also received from Richard Vann, Healthwatch Barking & Dagenham.

36 DISCLOSURE OF INTERESTS

There were no disclosures of interest.

37 MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on on 17 January 2017 were agreed as a correct record and signed by the Chairman.

38 STATEMENTS BY MEMBERS OF THE PUBLIC

The Committee was addressed by the Honorary Secretary of the City & Hackney branch of the British Medical Association. Concerns were raised by the speaker over who would be accountable for planning and commissioning local health and social care services under the Sustainability and Transformation Plan (STP). It was felt there was a danger that Councils may lose their power to scrutinise and influence local health and social care services and it was asked how Councils would raise these concerns.

The Chairman of the meeting noted the concerns raised and suggested these could be responded to at a future meeting. The Chairman further suggested that these concerns should also be raised at the forthcoming meeting of the equivalent committee covering Inner North East London.

The Committee was also addressed by a representative of the Save Our NHS campaign. Concerns were raised by the speaker about the decision by BHRUT to only hold their Board meetings in public on a bi-monthly rather than monthly basis. It was felt that issues such as the loss of beds at Queen’s or a report on excess pneumonia deaths at the Trust were not being discussed in public and that greater transparency should be provided.

The Chairman asked the Clerk to the Committee to seek to ascertain an explanation from BHRUT for this change in policy.

39 INTEGRATED URGENT CARE AND NHS 111 PROCUREMENT UPDATE

Officers explained that urgent care services including the NHS 111 service were currently in the process of being reprocured across the seven North East London boroughs. It was planned for the new service to meet national standards and for NHS 111 to be the first point of contact for urgent care needs.

The formal procurement process would commence by 21 April and the procurement documents would be made available on-line. Changes under the new service would include GPs and other clinicians being based within the NHS 111 service itself. Engagement had taken place with clinicians and was now under way with patient reference groups and other public representatives. A total of 170 surveys had been completed as part of the public engagement although overall numbers engaged with had been higher than this.

Clinical assessments at NHS 111 would be prioritised for babies and for callers over 75 years of age. All existing out of hours health phone numbers for North East London would be combined within NHS 111 although this was already the situation in Outer North East London. A patient sub-group fed into the procurement process and patients were also represented on the relevant Programme Board.

The new provider of the NHS 111 service would be expected to work with GP practices in order to obtain appointment slots that could be made available via NHS 111. It was anticipated that 2-3 appointments per day at each GP practice could be made available via NHS 111 for urgent patients. It was also hoped that NHS 111 could assist self-care by directing patients to pharmacies etc. It was also planned to have an on-line NHS 111 service in due course.

Whilst the precise value of the urgent care contract was confidential at this stage, the contract was expected to be of a large value. Fewer calls were now referred from NHS 111 to ambulances with calls being retriaged by clinicians if necessary. It was hoped that the new NHS 111 service would establish better connections with GPs, pharmacies and mental health services etc which would reduce the numbers of people attending A & E. It was also hoped that repeat prescriptions would be able to be issued via the service. It was also anticipated that IT connections between GP practices and NHS 111 would be established within this financial year.

It was hoped that consortia of bidders would apply for the contract, including smaller, local organisations.

The Joint Committee AGREED that the not for profit sector should be involved in the NHS 111 contract and otherwise noted the position.

40 OUTCOME OF BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS' NHS TRUST CARE QUALITY COMMISSION INSPECTION

The Deputy Chief Nurse for BHRUT confirmed that, following the recent CQC inspection, the Trust had exited special measures. The inspection had been targeted on certain services including paediatrics, outpatients and accident & emergency. The most recent inspection report had given better ratings to the Trust but it was accepted that further work still needed to be undertaken. Three of the Trust's core services were now rated as 'good' with none being rated 'inadequate'.

Several areas of outstanding practice had been noted in the Trust's children's services as well as in services for dementia which had seen a lot of improvement. Staff feedback on the Trust's services was now more positive and an operational plan for the next two years had been developed. The Trust's full operational plan and strategy could also be supplied to the Committee.

It was accepted that the Trust needed to work more closely with the NHS 111 service. Waits for treatment had improved and there were now only three people who had waited more than a year for treatment at the Trust. Patient feedback at the Trust was above the London average and a new patient experience strategy had recently been launched.

A lot of overseas recruitment of nurses had taken place but it had proved difficult to keep recruits in post long term. The Trust was therefore looking to further develop its nursing associates scheme whereby healthcare assistants could train to move into nursing. From January 2018, the Trust would also begin training its own nurses in partnership with the University of East London.

Whilst the Trust aimed to received 'good' and 'outstanding' ratings for all services assessed, officers accepted that a lot of work remained in order for this to be achieved. Trends in performance were shown on the Trust's Integrated Quality Dashboard and this could potentially be brought to a future meeting of the Committee.

The decision to close A & E at King George Hospital had been taken in 2011 and broader planning around this was currently being reviewed. The lower ratings received for 'being safe' domains at Queen's were primarily due to a lack of hand washing by staff. These areas were now being monitored on a monthly basis. Members felt it would be useful for the Committee to receive a further update on progress with the safety of services at the Trust.

The decision to only have public Board meetings on a bi-monthly basis allowed more time to be spent on delivering improvements but officers would report back to the Trust the Committee's concerns that a greater degree of transparency was required. The Clerk to the Committee would also contact the Trust re this issue.

Officers also agreed to share information on the number of deaths in A & E at the Trust over the last two years.

Subject to the actions listed above, the Committee NOTED the position.

41 PRIMARY MEDICAL SERVICES CONTRACT UPDATE

The review of the Primary Medical Services (PMS) contract for GPs had been initiated by NHS England in 2014. Following a pause, CCGs had been asked by NHS England to restart the review in November 2016, on the basis of only a local offer with no London-wide offer. Any agreement reached would not be to the detriment of patients. Governance of the contract negotiations was the responsibility of the Primary Care Commissioning Committee which included representation from local Councils.

Around one third of Practices across Barking & Dagenham, Havering and Redbridge were subject to the PMS contract. Any proposals by the CCGs needed to be affordable and existing PMS contracts were being investigated to see if any further revenue could be derived from them. Discussions would be held shortly with NHS England in order to establish the best option in terms of affordability. The new contract was required to be in place by the end of October 2017 and officers accepted this was a tight timescale.

All local GP Practices had now been inspected by the CQC although the outcomes of inspections were still awaited for approximately 25% of cases. Six local GP practices had been placed in special measures with around 30 receiving a rating of 'requires improvement'. All Practices in this position were offered support to revise procedures as well as on-line training being made available for Practice staff.

GP networks were being established across Barking & Dagenham, Havering and Redbridge which would be vehicles for collaborative working between Practices. Work between Practices on areas such as quality improvement for diabetes services was already under way.

Some sanctions were available for poorly performing Practices. Officers would consider the position if the Practice of a member of the CCG governing body was itself placed in special measures. Officers accepted that there were significant problems facing primary care in North East London including workforce issues and concerns that there would not be sufficient capacity to cope with the rising population in the area.

The review did not specifically cover the issue of health inequalities but it was anticipated that this would be covered by the work of the GP networks. The Committee agreed that health inequalities should be covered by the PMS review, as should workforce and capacity issues.

Whilst there was a small positive correlation nationally between GP list size and quality, it was accepted that single practices often also recorded better scores for patient experience. GP practices were encouraged to share services such as Practice nurses and back office functions although Practices remained private businesses. Several Members added that GPs were now often reluctant to become partners due to the added workload and preferred to stay as salaried GPs or locums.

It was AGREED that a letter should be sent on behalf of the Committee summarising its concerns that issues such as workforce, capacity and health inequalities should be included within the PMS contract review.

42 SPENDING NHS MONEY WISELY CONSULTATION

It was noted that the effect of the recently announced General Election and associated restrictions on publicity on the consultation was currently being considered by officers.

It was accepted by officers that local health services faced a financial challenge with £55 million in savings having to be found across the Barking & Dagenham, Havering and Redbridge CCGs. Essential services such as cancer, emergency services and mental health services would be protected. Some savings had already been made by, for example, keeping to the CCGs' policy on funding of Procedures of Limited Clinical Effectiveness.

The current consultation, which was due to run until 18 May 2017, sought the views of stakeholders and the public on reducing or stopping funding of services such as IVF, cosmetic procedures, over the counter medicines, bariatric weight loss surgery and sterilisation. The proposals suggested options for decreasing the number of IVF cycles that were funded. Over the counter services that it was proposed would no longer be funded included the prescribing of gluten free food and vitamins. It was also proposed that travel vaccinations would no longer be funded. It was clarified that the ceasing of cosmetic procedures would not apply to cases of post-cancer reconstruction, trauma or severe burns. For services such as mole or cyst removal, exceptions could still be made if for example a clinician felt these had a significant impact on an individual and/or there was a clinical need for removal.

It was emphasised that no decisions had been made as yet. The consultation document had been widely distributed to GPs, Councils,

community groups etc. Drop-in sessions had also taken place in each borough.

A Member raised the issue of the impact of the proposals on financially disadvantaged groups and officers agreed that this would be fed back as a response to the consultation. The proposed service changes had not been set by NHS England and similar reductions in other geographic areas had been looked at by the project team. It was possible, given the financial context, that other savings areas may be proposed but only these areas had been identified at present.

For services such as mole and cyst removal, exceptions could still be made if for example a clinician felt these were unsightly. Some bariatric surgery would also still be available if agreed clinical criteria were met.

Final decisions on the proposals would be taken by the CCG governing bodies towards the end of June and Equality Impact Assessments would be completed for all changes proposed. Members felt that more explicit guarantees were needed and that each of the proposed changes needed a thorough Equalities Impact Assessment in order to assure that there was no disproportionate effect on those least able to cope with the changes. It was AGREED that these comments, together with the need for clinically approved procedures to still be available as required, should form the Committee's response to the consultation.

43 DATES OF FUTURE MEETINGS

It was AGREED that the Committee's meetings for the 2017/18 municipal year should be arranged for the following dates and venues. All meetings were due to start at 4 pm.

Tuesday 18 July 2007, Barking & Dagenham
Tuesday 10 October 2017, Redbridge
Tuesday 16 January 2018, Havering
Tuesday 3 April 2018, Waltham Forest

44 URGENT BUSINESS

There was no urgent business raised.

Chairman

Havering
LONDON BOROUGH

OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 18 JULY 2017

Subject Heading:	BHRUT Integrated Quality Dashboard
Report Author and contact details:	**Anthony Clements, Principal Democratic Services Officer, London Borough of Havering**
Policy context:	**The attached presentation gives details of incident reporting procedures at Barking, Havering ad Redbridge University Hospitals' NHS Trust (BHRUT).**
Financial summary:	**No impact of presenting of information itself.**

SUMMARY

The attached presentation gives details of incident reporting and associated safety procedures at BHRUT.

RECOMMENDATIONS

1. That the Joint Committee considers the information presented on quality and safety procedures and takes any action it considers appropriate.

REPORT DETAIL

Officers will present and summarise the main features of incident reporting procedures at the Trust.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

INTEGRATED QUALITY AND SAFETY REPORT

Annual Review
May 2016 – May 2017

Kathryn Halford
Chief Nurse

TAKING PRIDE IN OUR CARE

Barking, Havering and Redbridge University Hospitals NHS Trust

WHAT IS AN INCIDENT?

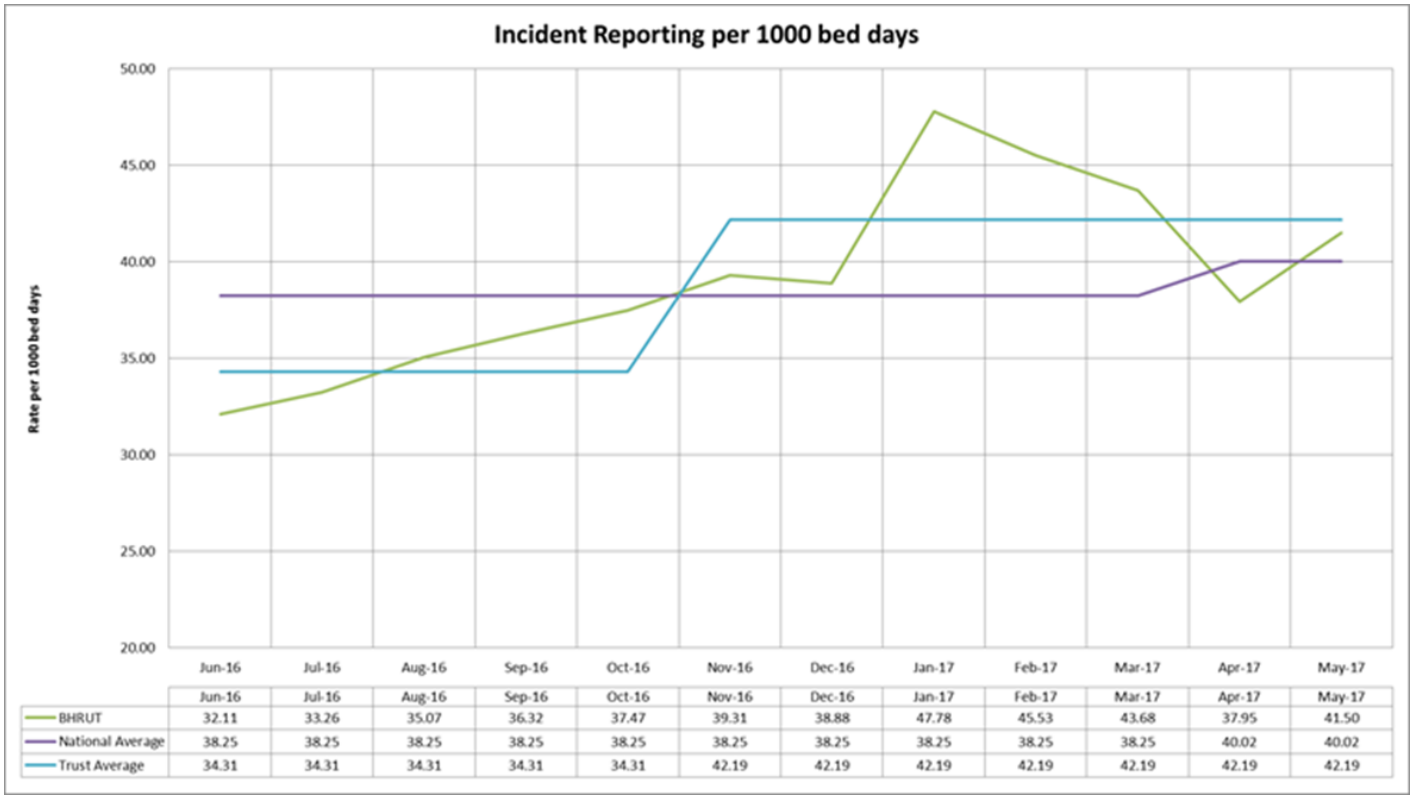
'An incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care' ***National Patient Safety Agency***

Examples of incidents could include:

- An expired drug being administered
- Failure to act on test results
- Equipment breaking down
- Hospital acquired pressure ulcers
- Not recognising a deteriorating patient
- Slips, trips or falls

INCIDENT REPORTING

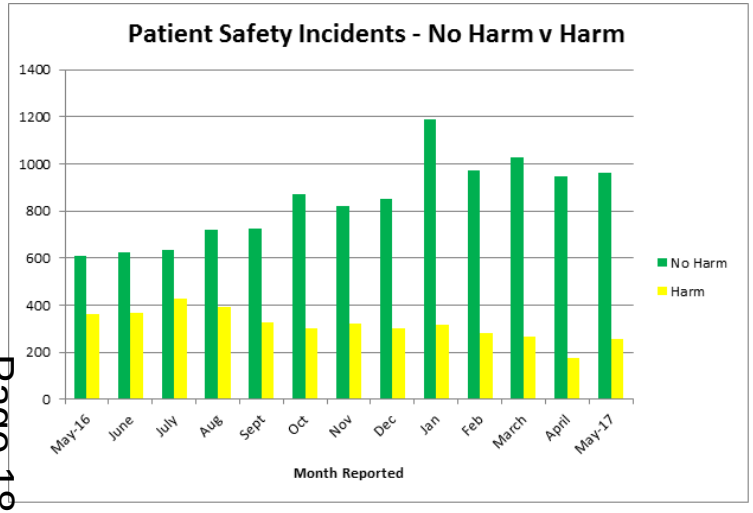
High incident reporting rates point towards an organisation with a good safety culture where staff feel confident to report concerns in order to improve patient safety through learning from incidents. At Barking, Havering and Redbridge University Hospitals (BHRUT) we actively encourage staff to report not only incidents which have occurred, but also concerns relating to potential 'near misses' which allow us to identify potential for harm before harm occurs.



	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
BHRUT	32.11	33.26	35.07	36.32	37.47	39.31	38.88	47.78	45.53	43.68	37.95	41.50
National Average	38.25	38.25	38.25	38.25	38.25	38.25	38.25	38.25	38.25	38.25	40.02	40.02
Trust Average	34.31	34.31	34.31	34.31	34.31	42.19	42.19	42.19	42.19	42.19	42.19	42.19

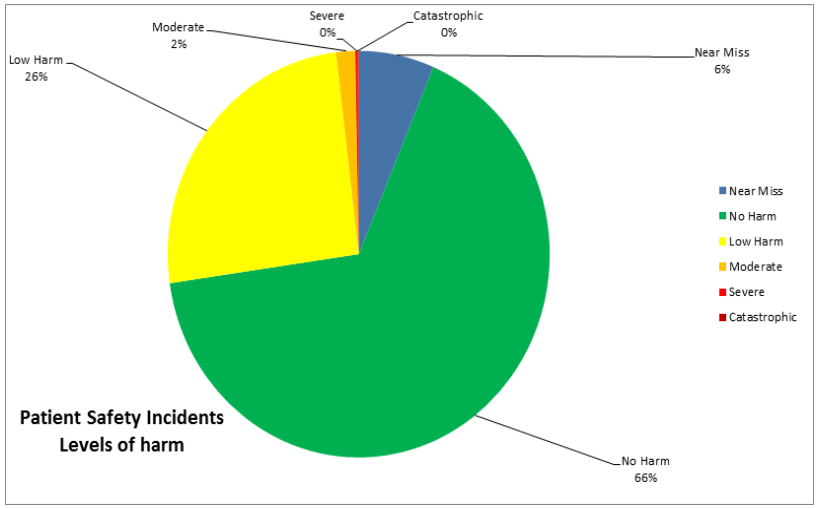
Over the past year our incident reporting figures have been on an upwards trajectory and we have achieved figures above the national average every month since November 2016 except for a slight dip in April 2017.

PROVIDING ASSURANCE OF IMPROVING PATIENT SAFETY



No harm	Incidents where no harm has been caused to the patient, including near misses where an incident is reported with the potential to harm patient but no harm has occurred
Harm	Incidents where the patient has sustained harm (low – catastrophic harm groups)

	Near Miss	Potential to cause harm
	No Harm	No injury caused
	Low Harm	Minor injury requiring minor intervention
	Moderate	Injury requiring professional intervention over a short term period
	Severe	Major injury leading to long term injury
	Catastrophic	Leading to death



TOP FIVE INCIDENT GROUPS

Of the 22,564 incidents were reported in the past year, 15,003 were related to patients' safety and were reported to the National Reporting and Learning Service. The remaining 7,561 incidents were non-patient related incidents e.g. staff accidents.

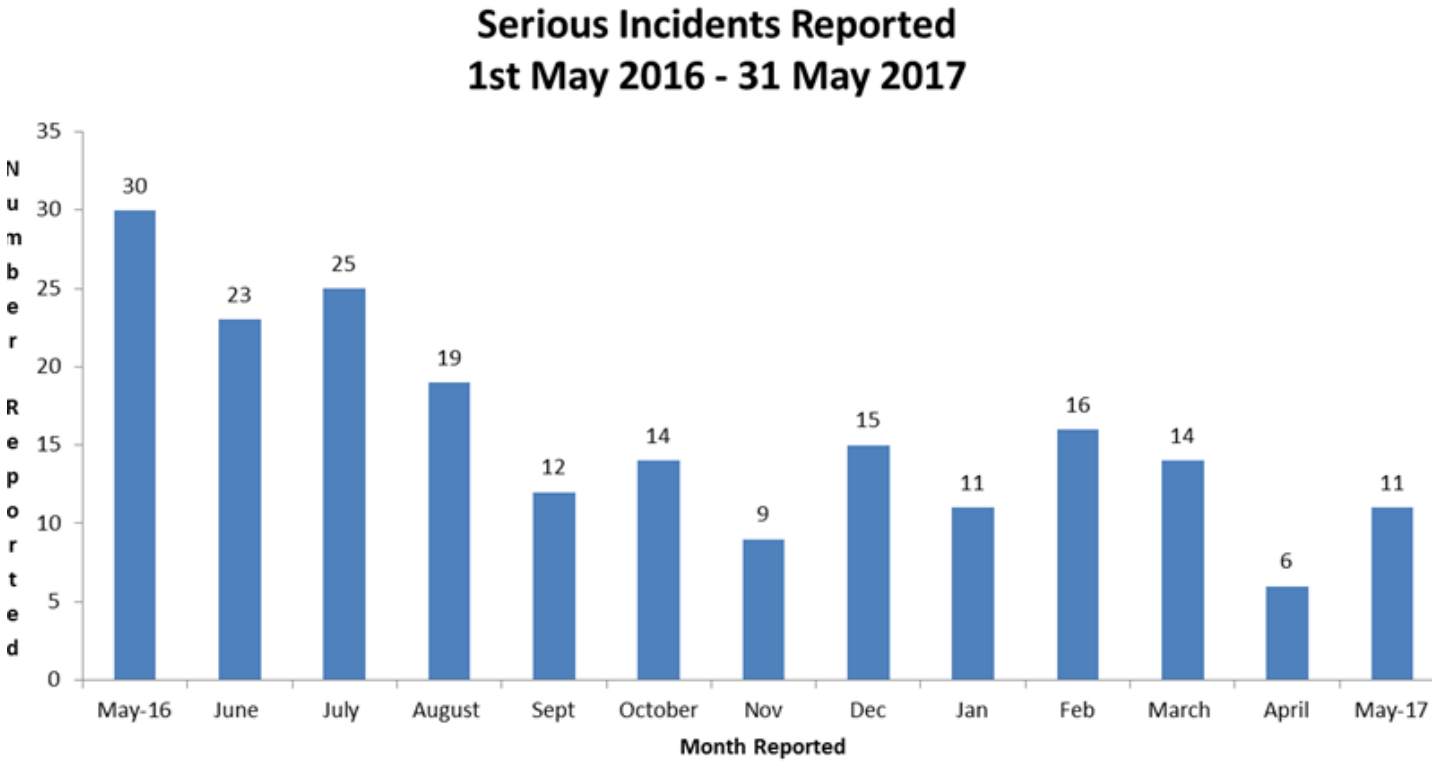
Incidents are grouped in order to identify areas of concern, allowing the trust to consider additional strategies to tackle areas where improvement may be required.

1. **Inherited pressure ulcers**. Staff complete an incident report for any patient who attends our hospitals with a pressure ulcer. These incidents are notified immediately to the Tissue Viability Team who endeavour to assess the patient whilst in our care.
2. **Treatment failure and delay.** The majority of incidents within this category relate to surgical delays or cancellations. These can include minor delays such as late running of theatre lists due to clinical complications or requirement to cancel surgery for a variety of reasons
3. **Slips, Trips and Falls.** We have seen a decrease in the numbers of falls overall, both without and with harm. For the financial year of 2016-2017 72% of all falls resulted in no physical harm.
4. **Medication.** Medication incidents can include supply, administration and prescription errors with various levels of harm: 85% of these incidents fall into the 'near miss' or 'no harm' categories.
5. **Obstetrics.** Our Maternity team deliver around 8,000 babies per year. This category can include incidents relating to ante natal care, unexpected complications during delivery requiring transfer to Labour Ward from the Birthing Centre, and unexpected admissions to neonatal intensive care unit.

REDUCING SERIOUS INCIDENTS

Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. *NHS England Serious Incident Framework (2015)*

Over the past twelve months we have noted a reduction in the number of incidents per month which have met the criteria as a Serious Incident, largely as a result of ongoing learning.

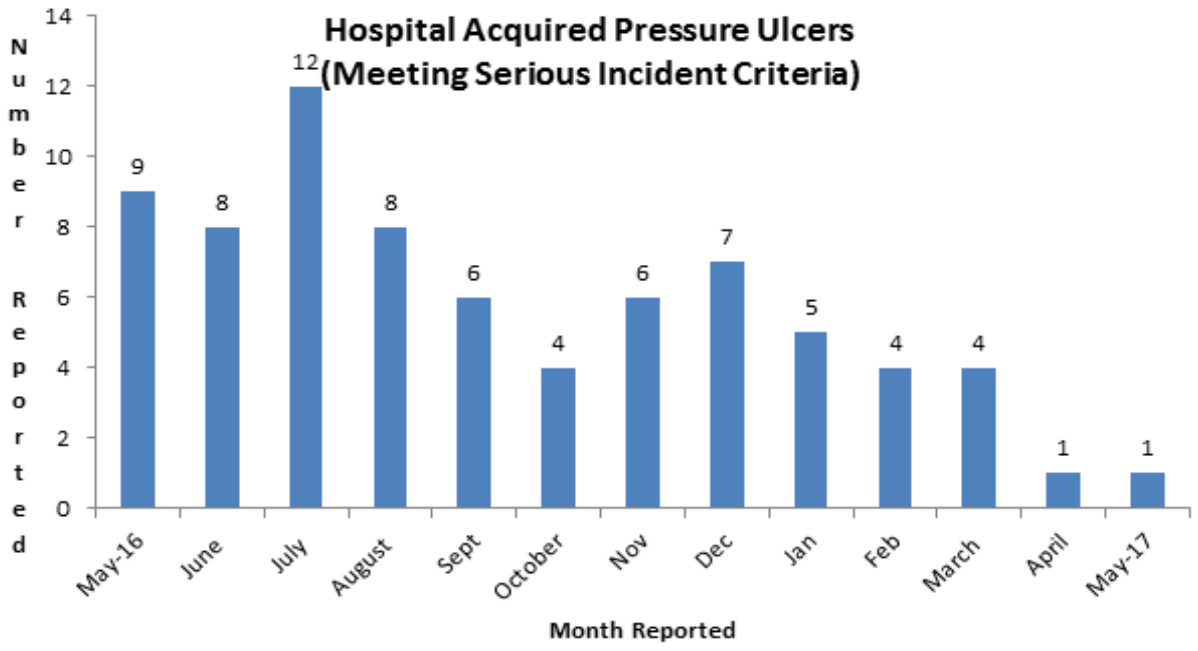


LEARNING FROM SERIOUS INCIDENTS

Over the past year the incidence of hospital-acquired pressure ulcers reportable as serious incidents has steadily reduced, indicating great progress with identification of pressure damage and early intervention to reduce the potential for skin breakdown.

The Trust is actively working to reduce these wounds, holding monthly review panels for all hospital-acquired wounds that explore how they occur and identify issues to be addressed. These panels have been instrumental in reducing the number of wounds reported and the Trust is now reporting the lowest numbers since May 2015.

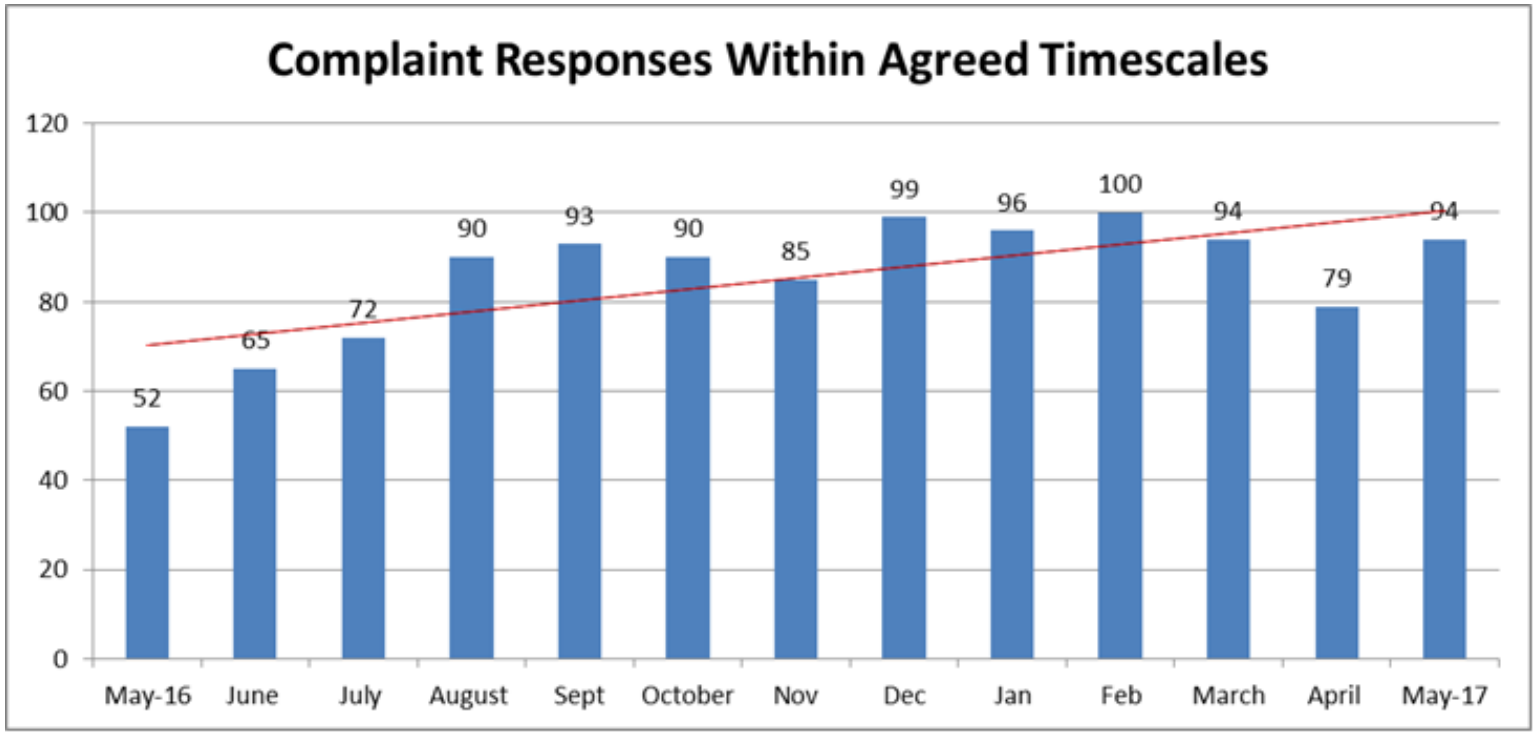
A trend was identified earlier in the year that showed that heel damage was problematic area. To address these issues mirrors were distributed to the ward staff to use to help check the heels more easily. Additional education was provided to ward staff to help them find alternatives to heel protectors when this equipment is not viable.



COMPLAINTS

We value all feedback from service users as an indicator of the quality of care we provide. Complaints are a vital part of this feedback and we aim to provide a robust response to concerns which have been raised.

We have a target of acknowledging formal complaints received within three working days and a 85% target of responding to complaints within the agreed timescales. Complaint responses within agreed timescales have improved dramatically from 52% in May 2016 to 94% in May 2017.



LITIGATION AND CLAIMS

Our legal department provided assistance in 87 inquests between May 2016 and May 2017. During this period we received one Regulation 28 report advising on required changes to practice.

Regulation 28

During March the first regulation 28 Report in 18 months was issued against the Trust in relation to a case where a patient died following a liver biopsy on 8 June 2016.

Action taken in response to the Regulation 28 is that the Trust has created a new care and has developed a standard operating procedure (SOP) for the clinical area. There has been an increase in staffing within radiology to ensure that a patient has a nurse in attendance until such time as they are returned to the ward and consideration of a dedicated recovery area within Radiology is in the planning stages.

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OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 18 JULY 2017

Subject Heading:	North East London NHS Foundation Trust – Plans to improve Care Quality Commission rating
Report Author and contact details:	**Anthony Clements, Principal Democratic Services Officer, London Borough of Havering**
Policy context:	**Plans to seek to improve the Care Quality Commission rating of the Trust will be presented to the Joint Committee.**
Financial summary:	**No impact of presenting of information itself.**

SUMMARY

North East London NHS Foundation Trust (NELFT) officers will summarise the findings of the most recent Care Quality Commission report on the Trust and plans to improve the rating given.

RECOMMENDATIONS

1. The Joint Committee to review the plans put forward by NELFT and make any appropriate recommendations.

REPORT DETAIL

Attached is the most recent report by the Care Quality Commission on the services provided by NELFT. This gave the Trust an overall rating of 'Requires Improvement'.

NELFT officers will summarise the Trust's plans to seek to improve this rating by the Trust is next inspected by the Care Quality Commission.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

North East London NHS Foundation Trust

Quality Report

Trust Head Office
Goodmayes Hospital
157 Barley Lane
Ilford
G3 8XJ
Tel: 0300 555 1200
Website: www.nelft.nhs.uk

Date of inspection visit: 4 – 8 and 14 April 2016
Date of publication: 27/09/2016

Core services inspected	CQC registered location	CQC location ID
Community Health Services for Adults	Trust Headquarters	RAT
Long stay/rehabilitation mental health wards for working age adults	Sunflowers Court	RATY1
Acute wards for adults of working age and psychiatric intensive care unit	Sunflowers Court	RATY1
Wards for older people with mental health problems	Sunflowers Court Woodbury Court	RATY1 RATWD
Community-based mental health services for adults of working age	Trust Head Office	RAT
Mental Health crisis services and health based places of safety	Sunflowers Court	RATY1
Community mental health services for people with learning disabilities	Trust Head Office	RAT
Specialist community mental health services for children and young people	Phoenix House Trust Head Office	RATX8 RAT
Wards for people with a learning disability or autism	Sunflowers Court	RATY1

Summary of findings

Child and adolescent mental health wards	Brookside Unit	RATRK
Forensic inpatient/secure wards (low secure)	Sunflowers Court Brookside	RATY1 RATRK
Community health services for adults	Trust Head Office	RAT
Community health services for children, young people and families	Trust Head Office	RAT
Community inpatient services	Foxglove Ward Mayflower Community Hospital Ainslie Rehabilitation Unit, Waltham Forest Rehabilitation Services Alistair Farquharson Centre, Thurrock Community Hospital	 RATFG RATDK RATY2 RATX4

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for services at this Provider	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

Contents

Summary of findings

Overall summary

We rated North East London NHS Foundation Trust as requires improvement for the following reasons:

- The child and adolescent mental health wards were a particular of concern, where we identified concerns in relation to a number of areas including staffing, restrictive practices, lack of incident reporting and lack of recovery orientated care planning. On this ward, and that of the acute wards for adults of working age and older people mental health wards risks were not always mitigated in relation to the needs of the patients. The environment of the acute wards for adults of working age and older people mental health wards were not safe as the trust had failed to ensure that the risks to patients from ligature anchor points were identified, assessed and appropriate works to address them scheduled. We served a Warning Notice on the trust in relation to these areas.
- In the community health services there were major staffing shortages and recruitment challenges across all staff groups and localities. There were high caseloads for staff, high use of agency and bank staff, all which had an impact on the delivery of the services.
- The trust had not demonstrated appropriate learning from incidents and not taken appropriate steps across all of the mental health services to ensure that risks to patients from ligature anchor points had been taken to minimise the risks these might pose to patients.
- Training in the Mental Health Act was not part of the mandatory training for staff in the mental health services which could lead to staff not working effectively with patients at risk of harm to themselves or others.
- There was a lack of consistent recording of patient risk across the services to ensure these were captured and plans made to minimise risks.
- Improvements were needed in the rate of supervision and appraisals of staff across the trust.
- Improvements were needed in the capturing of information about people who use the services as diversity information was not routinely recorded across services.
- The trust did not have a Patient Advice and Liaison Service (PALS) and so this advice was not available to people. This meant that patients and users of the service had to contact the service directly and go through complaints procedures without the additional support of an advice and liaison service. This might deter people from raising concerns or complaints.
- The board did not have assurance that all clinical risks, including those linked to regulatory compliance had been addressed. The trust governance structures had not been fully embedded and did not ensure consistency across services.
- The trust quality assurance processes had not identified if learning from incidents were implemented or that services were deteriorating.
- The trust did not meet the fit and proper persons' requirement for directors and was not compliant with the law. Also, there was a lack of robust induction or training for the trust governors, which meant they might not be as effective as they could be in their role.

However:

- The trust had good overall systems and processes for managing safeguarding children and adults at risk.
- There was good access to physical healthcare across the services and this was kept under regular review.
- Directors and managers demonstrated commitment and enthusiasm to the trust and spoke passionately of the work being undertaken to develop services.
- The trust had taken positive action in response to the recent NHS staff survey to involve and engage staff more in the development of the trust.
- There was a well-established patient experience partnership group with direct links to the board to enable strategic developments for people using services.
- Staff well-being, particularly through the black and minority ethnic network has worked to address inequalities, which has been recognised at a national level. The workforce race equality standards have been met.

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as requires improvement for the following reasons:

- The trust had not demonstrated appropriate learning from incidents and taken appropriate steps across all of the mental health services to ensure that risks from ligature anchor points had been taken to minimise risks to patients.
- Patients were put at risk where they could not always summon assistance when needed. There was a lack of call alarms on Cook older people mental health ward. The alarms at Brookside child and adolescent mental health unit did not activate in the education area.
- In the community health services there were major staffing shortages and recruitment challenges across all staff groups and localities. There was a high use of agency and bank staff across these services which impacted on the services provided. For example, within the community health inpatient wards this had led to a basic provision of service. Across the community health services for adults this had resulted in high and unsustainable caseloads for staff. Staffing levels on Brookside child and adolescent unit were not always maintained at safe levels.
- Equipment within the community health inpatient services had not always been appropriately maintained or checked to ensure it was safe for use. On some mental health wards there were not always records to demonstrate that the environment had been regularly cleaned. In particular the child and adolescent mental health wards at Brookside were not clean, with dirty and stained floors and a lack of completed cleaning schedules.
- The trust had not implemented a reduction strategy to reduce the use of restraint and prone restraint.
- Training in the Mental Health Act was not part of the mandatory training for staff in the mental health services which could lead to staff not working effectively with patients at risk of harm to themselves or others.
- At Brookside child and adolescent mental health unit there was evidence that patients' may have been secluded without proper safeguards in place.
- There was a lack of consistent recording of patient risk across the services to ensure risks were captured. There was an ineffective system to assess risks to young people awaiting assessment or treatment for the child and adolescent

community mental health services. Patients in the community health adult services who had been flagged as a risk at referral had not continued to be flagged as this on the trust electronic recording system, the rust referred to this as electronic patient records.

- Blanket restrictions and restrictive practices were in place throughout the child and adolescent mental health wards. Internal doors were locked and patients had to ask permission to move from one area of the unit to another at all times. Staff searched young people on returning to the ward despite a lack of policy or procedure for this.

However:

- With the exception of some inpatient mental health wards and some community service bases, the accommodation was generally well maintained across the trust sites.
- Where there were mixed gender wards, these were managed in accordance with Department of Health guidance on same sex accommodation.
- The trust had good overall systems and processes for managing safeguarding children and adults at risk.
- There was generally good medicines management practice across the trust sites inspected.

Are services effective?

Requires improvement

We rated effective as requires improvement for the following reasons:

- Care plans had not been developed for all children and young people using the community mental health teams. Care plans were not recovery-orientated in the child and adolescent mental health wards.
- Access to psychological therapies for people with mental health problems was not consistently provided across the trust.
- There was inconsistent measurement and analysis of patient outcomes across the community health services for adults and community health services for children, young people and families. Whilst some services and localities had very clear patient outcome measures, others had limited evidence of measuring and monitoring patient outcomes. There was also a large backlog of incomplete outcomes in the community health services for adults.
- There was a lack of robust induction or training for the trust governors which meant they might not be as effective as they could be in their role.

- Improvements were needed in the rate of supervision and appraisals of staff across the trust.
- Training in the Mental Health Act was not part of the mandatory training for staff in the mental health services which could lead to staff not working effectively with patients at risk of harm to themselves or others.
- Staff on the mental health wards could not access the original documentation where patients were detained under the Mental Health Act as these were held in the central office. This meant that should a patient need to be transferred out of hours to another unit no papers would be available for staff to enable this.
- Consideration of Gillick competence and application of the Mental Capacity Act on the child and adolescent mental health wards did not take place. Staff in the community adult services did not carry out capacity assessments despite having been trained to do so.

However:

- Where in place, the quality of care planning was generally good, holistic and kept under regular review. Inspectors who observed home visits observed best practice being implemented.
- There was good access to physical healthcare across the services and this was kept under regular review. The trust had developed a robust process for managing and treating pressure ulcers across the services which had resulted in a decrease in the number and severity of pressure ulcers reported.
- The trust used a number of nationally recognised tools and audits to measure and improve the outcomes of patients and people using their services.
- The teams across the trust had of a range of experienced staff in different disciplines including nurses, social workers, occupational therapists, doctors and recovery support workers and there was good multi-disciplinary working.
- All new staff received a trust induction and local induction to their service.

Are services caring?

Good

We rated caring as good for the following reasons:

- Caring was good across the majority of core services where we found that people were treated with compassion, kindness and respect.

Summary of findings

- We observed many examples of positive interactions where staff communicated with people in a calm and professional manner.
- The trust incorporated national initiatives undertaken to seek feedback about people's experience of the care they received.
- The trust had an active patient experience group with direct links to the board to enable strategic developments for people using services.

However:

- Patients of the child and adolescent and older people inpatient wards were not always treated with dignity and respect by the staff. Within the child and adolescent wards we rated this domain as inadequate, due to the lack of dignity and respect towards the young people.
- Survey results for the 'staff friends and family test' were 13% below the national average for recommending the trust as a place to receive care.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement for the following reasons:

- The diversity information of patients and people using services was not routinely recorded across services.
- Within the community health services for adults there was a lot of variation in referral to treatment times for accessing specialist nursing services. The trust did not have a system in place for monitoring referral times to treatment in district nursing. Within the community health services for children, young people and families services where there were challenges with long wait times and waiting list breaches for referrals to therapy and diagnostic services.
- The trust was moving towards a more integrated care model and standardised practice across the different localities; however, community health service teams were often unaware of what similar teams were doing in other parts of the trust which meant there was inconsistency across services.
- The older people mental health and child and adolescent mental health wards did not always promote the dignity of patients, where their bedrooms were kept locked during the day and patients had to ask staff to unlock these.
- The trust did not have a Patient Advice and Liaison Service (PALS) and so this advice was not available to people. This

meant that patients and users of the service had to contact the service directly and go through complaints procedures without the additional support of an advice and liaison service. This might deter people from raising concerns or complaints.

However:

- The trust worked collaboratively with commissioners and other NHS trusts in East London and Essex to plan and meet the needs of local populations. In the community health services the trust worked effectively with a number of local acute trusts in meeting the needs of patients.
- The trust worked to make the access to services as straightforward as possible. Children's services across the trust had a single point of access
- Patients were rarely moved between the wards after admission unless this was for clinical reasons.
- Between 1 May 2015 and 31 October 2015 the average bed occupancy rate was 84% across all 22 wards. This meant that demand for beds was high, but a bed could generally be available when needed.

Are services well-led?

Requires improvement

We rated well-led as requires improvement for the following reasons:

- The board did not have assurance that all clinical risks, including those linked to regulatory compliance had been addressed.
- There were insufficient governance structures to monitor the completion of care plans and risk assessments across services. This meant that there was the potential for patients to be placed at risk of avoidable harm.
- The trust governance structures did not ensure that learning from incidents was implemented across inpatient mental health services to keep people safe.
- There was a lack of clarity across the children, young person and families services of how they were represented at board level.
- The governance structures and quality assurance processes did not identify that services were deteriorating.
- The trust governance systems did not ensure there was consistency across the trust's services in rates of staff mandatory training, staff appraisal and supervision.
- The trust did not meet the fit and proper persons' requirement for directors and was not compliant with the law.

Summary of findings

- There was a lack of robust induction or training for the trust governors which meant they might not be as effective as they could be in their role.

However:

- Staff knew and agreed with the trust values and felt that objectives reflected the trust's vision. Staff spoke about how the values of putting the patient first worked well the trust.
- Directors and managers demonstrated commitment and enthusiasm to the trust and spoke passionately of the work being undertaken to develop services.
- The trust had taken positive steps in response to the recent NHS staff survey to involve and engage staff more in the development of the trust.
- There was a well-established patient experience partnership group who worked closely with the board to improve patient experience.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Helen MacKenzie, Executive Director of Nursing, Berkshire Healthcare NHS Foundation Trust

Team Leader: Natasha Sloman, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Managers: Louise Phillips, Inspection Manager mental health hospitals, CQC; Max Geraghty, Inspection Manager acute hospitals, CQC

The team included four inspection managers; 16 inspectors; two Mental Health Act reviewers; a pharmacy inspector; six experts by experience; support staff and a variety of specialists. The specialists included senior managers, consultant psychiatrists, health visitors, a school nurse, community health nurses, specialist nurses in mental health and learning disabilities, psychologists, occupational therapists and social workers.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

When we inspect, we always ask the following five questions of every service and provider:

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

Before the inspection visit the inspection team:

- Requested information from the trust and reviewed the information we received.
- Asked a range of other organisations for information including NHS Improvement , NHS England, clinical commissioning groups, HealthWatch, Royal College of Psychiatrists, other professional bodies and user and carer groups.
- Sought feedback from patients and carers through attending two user and carer meetings.
- Received information from patients, carers and other groups through our website.
- Held focus groups with the trust governors and non-executive directors, union representatives, clinical commissioning groups and local authorities.
- Observed a board meeting and a quality and safety committee meeting.

During the announced inspection visit from the 4 – 8 April, and unannounced inspection on the 14 April 2016 the inspection team:

- Visited 62 wards, teams and clinics.
- Spoke with 265 patients and people using services or their relatives and carers, either in person or by phone.
- Looked at the care and treatment records of more than 258 patients.
- Collected feedback from 339 patients, carers and staff using comment cards.
- Joined 6 patient meetings/ groups.
- Spoke with 32 ward and team managers and more than 468 staff members.
- Attended and observed 43 multi-disciplinary meetings, including care reviews, handovers and risk meetings.
- Held 18 focus groups attended by 74 staff.
- Interviewed 15 senior staff and board members.
- Joined care professionals for seven home visits and clinic appointments.
- Carried out a specific check of the medication management across a sample of wards and teams.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

- Requested and analysed further information from the trust to clarify what was found during the site visits.
- Observed a strategic patient experience meeting.
- Had a tour of the premises at each location.

We visited all of the trust's hospital locations and a sample of community health services. We inspected all wards across the trust including adult acute services, the psychiatric intensive care unit, community hospitals, the forensic ward, health centres and older peoples wards. We looked at the trust health based place of safety under section 136 of the Mental Health Act. We visited a sample of adult community mental health, crisis, learning disability, children and young people community mental services, child development centres and older people's community services.

Information about the provider

North East London NHS Foundation Trust provides community health and mental health services in Essex and across the North East London Boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest. With an annual budget of £330 million, the trust provides care and treatment for a population of about 1.75million whilst employing around 6,000 staff.

The trust provides the following 11 mental health core services:

- Acute wards for adults of working age and psychiatric intensive care units (PICUs)
- Child and adolescent mental health ward
- Forensic inpatient/secure wards (low secure)
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems
- Wards for people with a learning disability or autism
- Mental health crisis and health-based places of safety
- Community-based mental health services for adults of working age
- Community-based mental health services for older adults
- Community-based mental health services for people with a learning disability or autism
- Specialist community mental health services for children and young people

It also provides five community health core services:

- Community dental services
- Community end of life care
- Community health services for adults
- Community health services for children, young people and families
- Community inpatient services

We did not inspect the eating disorder, perinatal, community dental or community end of life care services provided by the trust. Despite this, an overall rating has been given for the trust. If we inspect these services at a later date then we will consider amending the overall trust rating, if relevant

North East London NHS Foundation Trust became a foundation trust in 2008. It has a total of 11 registered locations: Brentwood Community Hospital, Grays Court Community Hospital, Mayflower Community Hospital, Thurrock Community Hospital, Brookside, Foxglove ward, Phoenix House, Sunflowers Court, Trust Head Office, Waltham Forest Rehabilitation Services and Woodbury Unit.

The Care Quality Commission has inspected North East London NHS Foundation Trust 17 times since registration. The most recent focused inspection took place in October 2015 at Sunflowers Court (specifically Ogura, Titian and Stage wards). There have also been five joint inspections with Ofsted looking at children's services at Thurrock, Barking and Dagenham, Havering, Waltham Forest and Redbridge. Of the services we have inspected, Sunflowers Court had outstanding areas of non-compliance in the acute wards for adults of working age and psychiatric intensive care units. This was in relation to the trust not ensuring that risks to patients from ligature anchor points were identified, assessed and appropriate works to address them scheduled. The trust had also not ensured that appropriate steps were taken to address the potential ligature risks posed by the use of plastic bin bags in communal areas of the ward.

There were four Mental Health Act reviewer visits between 15 January 2015 and 28 January 2016, all of which were

Summary of findings

unannounced. There were 22 issues in total that were followed up as part of this inspection. The issues include lack of involvement of patients in care planning, respect and restrictive practice.

What people who use the provider's services say

Before the inspection took place we met with two different groups of patients, carers and other user representatives:

- Disability Rights UK.
- Redbridge User Network User Pressure Group service user network.

Through these groups we heard from patients and carers. We also received feedback from two independent mental health advocacy services and two HealthWatch teams who provided us with general feedback and details of their 'enter and view' visits.

We received feedback from people using the service of the trust via 339 comment cards. Of these, 274 comments (81%) were positive in their feedback 23 (7%) were negative and 42 (12%) were mixed in nature.

During the inspection the teams spoke with 265 patients and people using services or their relatives and carers, either in person or by phone. Most of the feedback we received was positive and patients found the staff were committed, caring and respectful. Patients on the forensic mental health ward were very complimentary about the service and the positive role of staff in their recovery and that they were actively involved in the planning of their care. Parents of children using the community health services for children, young people and families gave us universally positive feedback and highlighted the encouragement and support of health visitors in clinics and home visits. The staff working across this service continued to engage with people, even after discharge and maintained contact with families after the death of a child.

However, improvements were needed in the child and adolescent mental health wards where patients gave mixed views of the unit. We were told regular staff members were nice and respectful but that not all agency staff introduced themselves to the young people and were sometimes rude. Feedback from patients of the older people mental health wards was that some staff ignored them or seemed disinterested and they did not always feel involved in their care. Improvement were also needed on the acute wards for adults and psychiatric intensive care unit, where whilst patients were generally treated with respect, staff sometimes entered patients bedrooms without knocking on the bedroom door. On these wards some patients did not feel safe due to the actions of other patients on the wards.

Good practice

- The trust had a positive approach to equality and diversity amongst its workforce. Their work on this agenda led to the trust winning the inclusive networks award. The trust had been nominated for the Diverse Company of the Year award at the National Diversity Awards 2016 and had been cited as one of the top ten global black and minority ethnic networks by The Economist in February 2016.
- All memory services were accredited in the Memory Service National Accreditation Programme run by the Royal College of Psychiatrists.
- The child and adolescent mental health community teams had joined the children and young people improving access to psychological therapies programme. This was a national service transformation programme delivered by NHS England to improve mental health services for children and young people. Redbridge child and adolescent mental health community team were involved in the 'puzzled out' national survey of children and young people improving access to psychological therapies programme.
- The diabetes team in Essex community health adults service had developed a number of initiatives to meet the needs of the local population more effectively. The team provided Skype appointments and telephone

assessments depending on patient needs, and texted blood results to patients to spare them an appointment. The team had two articles published in diabetes journals in the past three years.
- All of the older people mental health wards took part in the Butterfly scheme, a UK wide hospital scheme designed to improve patient safety and wellbeing in hospital, its focus enables staff to respond appropriately to people with memory impairment or dementia.
- The older people mental health wards offered 'Namaste Care' which is a sensory based programme designed for use with people who have advanced dementia. Namaste is a Hindu greeting that means 'to honour the spirit within'. It is a dementia friendly approach to patient care that combines nursing care with additional sensory experiences like touch and sound to create a soothing peaceful environment for patients who cannot engage in other mainstream activities.

Areas for improvement

Action the provider MUST take to improve

Provider:

- The trust must ensure there is a reduction strategy implemented to reduce the use of restraint and prone restraint.
- The trust must ensure that Mental Health Act training is mandatory for mental health staff, as this may lead to staff not having essential knowledge to work effectively with people at risk to themselves or others.
- The trust must ensure a consistent access to psychological therapies for people with mental health problems across the trust.
- The trust must ensure there are sufficient governance structures to monitor the clinical risk in services and that learning from incidents has been implemented. The lack of this means the potential for patients to be placed at risk of avoidable harm.
- The trust must have appropriate policies and procedures to carry out checks of directors in regard to the fit and proper person requirement.

We issued a Warning Notice to the provider in respect of the following:

The trust must ensure the risks to the health, safety and welfare of patients using services are completed or mitigated. This is because the care and treatment was not always provided in a safe way for patients:

- The trust must ensure that risk assessments and care plans on the acute wards for adults of working age and older people or child and adolescent mental health wards are completed and risks mitigated. There was a lack of a robust call bell system on the older people mental health wards.
- The trust must ensure there are sufficient staffing levels on the child and adolescent mental health wards.
- The trust must ensure there are no restrictive practices throughout the child and adolescent mental health wards on Brookside unit.
- The trust must ensure there is evidence of capacity and consent to treatment at Brookside unit.
- The trust must ensure the care plans at Brookside unit are recovery orientated and reflect patient preferences, goals and views.
- The trust must ensure that patients at Brookside unit are not secluded without proper safeguards in place.
- The trust must ensure that there are effective systems or processes in place to ensure that they provide care and treatment for patients using services in a safe environment.
- The trust must ensure that searching of patients at Brookside unit is carried out in accordance with a clear policy.
- The trust must ensure that all incidents at Brookside unit are being reported on the computerised incident reporting system.
- The trust must ensure there are effective systems or processes in place to provide care and treatment for patients using services in a safe environment:

Summary of findings

- The trust must ensure that on the acute wards for adults of working age and older people that the risks to patients from ligature anchor points are identified, assessed and appropriate works to address them scheduled.
- The trust must ensure that the environment of the child and adolescent mental health wards at Brookside unit is comfortable and therapeutic for the patients, with broken furniture made good.
- The trust must ensure that the cleanliness at Brookside unit is of a good standard at all times.

Core services:

Community health services for adults:

- The trust must ensure that staff consistently record medicines administration in case notes so that it is clear what medication has been given to a patient.
- The trust must implement a system for monitoring and frequently auditing the completion of risk assessments in patient records across community health services for adults.
- The trust must ensure community services for adults are meeting minimum targets for supervision and appraisals for all staff.
- The trust must develop an effective system of governance for adult community health services, which includes means for measuring and comparing quality or performance across services through audit. This to include the quality and completion of patient records across the services and referral to treatment (RTT) times for universal and specialist services across all localities.

Community mental health services for people with learning disabilities:

- The trust must ensure that teams monitor data for waiting times from referral to assessment for people who use the services.

Community health inpatient services:

- The trust must ensure that equipment at the Alistair Farquharson Centre is appropriately stored and therapy equipment properly maintained.
- The trust must ensure that equipment such as blood pressure machines, beds and bed pan macerators were are properly maintained.
- The trust must ensure that there are suitably qualified staff to meet the needs of the rehabilitation service at Mayflower Hospital and the Alistair Farquharson Centre.

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

- The trust must ensure that all people, who have been assessed to have a mental disorder, have their social situations assessed by an approved mental health professional before being discharged home.

Community-based mental health services for older people:

- The trust must ensure that the premises used by staff and patients are safe.
- The trust must ensure safety alarms work and are present in interview rooms.

Wards for older people with mental health problems:

- The trust must improve upon the prevention and management of falls on wards for older people with mental health problems.
- The trust must ensure that patient dignity and privacy is maintained by reviewing the viewing hatches on patient bedroom doors and enable access to their bedrooms in the day.
- The trust must ensure that any changes that are made to ward procedure as a result of learning from a serious incident is applied consistently across the wards.
- The trust must ensure that there is an adequate alarm system in place in all patient bedrooms and en-suite shower rooms so that patients can alert staff in the event of an emergency or urgent need.
- The trust must ensure that the ligature risk assessment clearly specifies when the work to remove ligatures will be completed by.
- The trust must ensure that all staff have Mental Health Act (MHA 1983) training.

Community-based mental health services for adults of working age:

- The trust must address the standards of the assessing and recording of the risks of people who use the services of the community recovery teams. Accurate and complete risk assessments were not in place for each person, including risk formulation, nor was there evidence in all risk assessments of risks being updated regularly or after any significant event.

Specialist community mental health services for children and young people:

- The trust must ensure all children and young people have a care and/or treatment plan.

Community health services for children, young people and families:

- The trust must ensure that sensitive personal information is kept securely and not recorded in paper diaries.

Child and adolescent mental health wards:

- The trust must ensure there are sufficient numbers of, and suitably skilled, staff deployed at the unit.
- The trust must review the restrictive practices and blanket restrictions in operation throughout Brookside unit.
- The trust must review the capacity and consent to treatment of all patients at Brookside unit. No record of parental consent to admission to hospital was recorded for any patient records we reviewed or whether the patients were competent (if under 16 years of age) or consent (if over 16 years of age) to their own hospital admission. We found no evidence of assessment of capacity to consent to treatment in patient notes and no evidence of the use of Gillick competence (for those under 16 years of age).
- The trust must review patient care plans and ensure they are holistic and recovery orientated.
- The trust must develop a policy to support staff when searching patients.
- The trust must undertake maintenance works on Willows ward in the dining area.
- The trust must review the cleanliness of the Brookside unit.
- The trust must ensure that staff include all risks that they identify, when making a risk assessment of a patient, in the patient's care plan.
- The trust must ensure food choices are available to meet the needs of cultural and religious beliefs.
- The trust must ensure all incidents and safeguarding are recorded on Datix.
- The trust must ensure staff receive regular supervision.
- The trust must ensure staff receive regular appraisals.

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

- The trust must ensure risk assessments are completed and consider all patient risks.
- The trust must ensure ligature assessments and action plans identify all ligature points and how to mitigate the risk to patients.
- The trust must ensure care plans are recovery orientated and reflect the personal views and preferences of patients.
- The trust must ensure out of date medications are not being used and are destroyed and recorded appropriately.
- The trust must ensure medical equipment is calibrated and within review dates.
- The trust must ensure maintenance issues are rectified on all wards.

The trust must ensure all staff are up to date with mandatory training.

Action the provider SHOULD take to improve

Community health services for adults:

- The trust should provide agency nursing staff working in the community with a means of completing patient records and outcomes from their patient visits.
- The trust should review how services report the results from pressure ulcers assessments to ensure the data can be compared across services.
- The trust should take steps to ensure safeguarding practices and performance are frequently audited in line with trust safeguarding policies.

Summary of findings

- The trust should provide staff with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS) to meet the minimum trust targets for training in these areas.
- The trust should review the lone working policy for staff and ensure the implementation of the policy is standardised across the trust.
- The trust should take steps to improve the information sharing process between different disciplines working in integrated care teams.
- The trust should improve opportunities for staff to share information with similar teams working in different localities across the trust.
- The trust should develop a clear strategic vision for community health services with clear shared for the directorate and individual goals for services.
- The trust should take steps to ensure actions identified in audits, incidents and complaints are completed within deadlines.

Forensic inpatient/secure wards:

- The trust should consider inviting advocacy services to hold dedicated, regular drop in clinics for patients.
- The trust should consider a plan of action to ensure staff receive training on the Mental Health Act.

Community mental health services for people with learning disabilities:

- The trust should ensure that teams undertake mandatory training to ensure they meet the trust's
- The trust should ensure that the teams use outcome measures when supporting people. Teams did not use outcome measures to monitor and evidence people's progress while receiving support.
- The provider should ensure safety alarms work and are present in interview rooms.
- The trust should ensure that all risks to the health and safety of people who use the service receiving care and treatment is assessed to manage any such risks. There must be an effective system in place to assess the risks to people who use services while they were waiting for assessment or treatment.
- The trust should address the standards of assessing and recording of the risks of people who used the learning disabilities community recovery teams. Risks should be re-assessed following incidents relating to people who use the services.
- The trust should ensure that the Waltham Forest team provide a range of easy read resources in the waiting area for people who use their service.
- The trust should ensure that the teams receive Mental Health Act training. Lack of this training may lead to staff not having essential knowledge to work effectively with people with learning disabilities regarding their rights under the Act.
- The trust should ensure that all members of the Cranbrook and Loxford team are provided with mobile phones and personal alarms in line with the trust's lone working policy to promote their safety when working in the community.
- The trust should ensure the environment at Waltham Forest is dementia friendly for people who used the services who have a learning disability and dementia.

Community health inpatient services:

- The trust should consider whether the layout of the premises and the environment of the Alistair Farquharson Centre is suitable for modern needs.
- The trust should ensure that the staff rota on Alistair Farquharson reflects the actual time staff started work. For instance, staff were starting their shifts at 7.15am when the rota said 8.15am.
- The trust should ensure that at Mayflower Hospital there are sufficient groups such as exercise groups and activities of daily living groups.

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

- The trust should review whether all staff are aware of their responsibilities around incident reporting.
- The trust should address ligature points and provision of a bed in the health-based place of safety.
- The trust should consider introducing a system to standardise how staff record progress notes.
- The trust should adopt a system that flags people on caseloads with a learning disability.

Summary of findings

- The trust should make information on how to complain more readily available.
- The trust should make it easier for people to give feedback on the service.

Wards for people with learning disabilities or autism:

- The trust should ensure that all staff receive mandatory training in each of the specified topics.
- The trust should seek to reduce (or eliminate) the use of restraint in the prone position and the use of rapid tranquilisation.
- The trust should consider increasing the amount of specialist speech and language therapy input available to the ward.
- The trust should ensure that meal arrangements are flexible to accommodate the needs and wishes of all patients.
- The trust should ensure that patients have access to hot drinks at any time of day.
- The trust should look to actively encourage patients to personalise their bedrooms.
- The trust should seek to improve ease of access to the ward garden for patients with restricted mobility.

Community-based mental health services for older people:

- The trust should ensure risk assessments are monitored and updated when needed.
- The trust should ensure that team managers have access to information systems to support their management of the team.
- The trust should ensure care plans in the Barking and Dagenham team have a focus on recovery.
- The trust should ensure the environment at Barking and Dagenham is dementia friendly.
- The trust should ensure managers had sufficient authority and resources to make decisions about their service.

Wards for older people with mental health problems:

- The trust should follow the National Institute for Health and Care Excellence quality statement which recommends that anyone over 65 should automatically be considered at risk of falls.
- The trust should consider the use of assistive technology in the care for patients over the age of 65, such as motion sensor equipment.
- The trust should ensure that all staff that care for people with dementia receive training in dementia, as recommended by the National Institute for Health and Care Excellence.
- The trust should ensure that all staff have access to training in the Mental Capacity Act 2005 and not just the qualified staff.
- The trust should ensure that all approved mental health professionals reports are present in Mental Health Act paperwork.
- The trust should consider making the wards a more dementia friendly environment.
- The trust should ensure that care plans include patient views and that patients are involved in their care.
- The trust should ensure that psychology screening is implemented before commencing or discontinuing pharmacology as a treatment for patients. Patients should also have access to a National Institute for Health and Care Excellence recommended therapy while on the wards.

Community-based mental health services for adults of working age:

- The trust should address the standards of care plans in the community recovery teams. Some care plans we saw did not include the involvement of the person using the service in the creation of the plans, nor did they evidence a broad range of recovery focused goals for each person.
- The trust should ensure that an accessible system for recording and resolving of complaints is in place for each team. The complaint log for complaints resolved informally at each of the three community recovery teams could not be accessed by managers at the time of our visit.
- The trust should ensure that all people being supported by the access assessment and brief intervention teams are aware of their care plans.

Summary of findings

Specialist community mental health services for children and young people:

- The trust should ensure that all risks to the health and safety of young people receiving care and treatment is assessed to manage any such risks. There should be a more pro-active system in place to assess the risks to children and young people while they were waiting for assessment or treatment.

Community health services for children, young people and families:

- The trust should review trust incident reporting processes to ensure all staff can record incidents or concerns independently of senior staff and ensure all staff receive direct feedback from reported incidents.
- The trust should take steps to further reduce the backlog of transferring signed consent forms on the trust electronic record systems.
- The trust should improve compliance of paper record keeping in the Havering audiology service and all other services that use paper records.
- The trust should take steps to improve completion of mandatory training, particularly in occupational therapy services.
- The trust should take steps to reduce caseload allocation for therapy staff to ensure compliance with relevant national guidelines.
- The trust should take steps to reduce waiting times for therapy and diagnostic services such as speech and language therapy, occupational therapy and social communication pathways.
- The trust should ensure standard operating procedures for referrals are applied consistently across services and localities
- The trust should review the trust's lone working policy which expired in December 2015.
- The trust should improve measurement and analysis of patient outcomes across services and localities.
- The trust should ensure adequate, protected time for community paediatricians in all localities to conduct research, clinical audit and service development activities.
- The trust should take steps to develop consistent transition arrangements from paediatric to adult services across services and localities.
- The trust should ensure all relevant community health services for children, young people and families staff are aware of trust processes for the identification and dissemination of new clinical guidelines.
- The trust should take steps to improve reliability of remote connections to the electronic records system so practitioners can access and record patient information contemporaneously.
- The trust should develop a formal documented vision and strategy for the community health services for children, young people and families as a whole.
- The trust should provide further opportunities for staff interaction to improve shared learning and communication of different practices and priorities across localities.
- The trust should communicate to staff how community health services for children, young people and families are represented at trust board level, and the named individual ultimately accountable for community health services for children, young people and families within the trust.

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

- The trust should remove the broken pay phone on the ward in line with the environmental suicide and ligature point assessment action plan.
- The trust should ensure that patients have timely access to psychology.
- The trust should review the blanket restriction concerning staff searching all patients.

Forensic inpatient/secure wards:

- The trust should review their policy of searching patients after both unescorted and escorted leave to ensure dignity and respect is afforded for patients.
- The trust should consider inviting advocacy services to hold dedicated, regular drop in clinics for patients.
- The trust should consider a plan of action to ensure staff receive training on the Mental Health Act.

Child and adolescent mental health wards:

Summary of findings

- The trust should ensure that all staff understand Gillick competence. This is when a patient under the legal age of consent is considered to be competent enough to consent to their own treatment rather than have their parents' consent.
- The trust should ensure that young people understand their rights. We found evidence young people were given their rights on admission. However, there was no evidence regarding a patient's level of understanding or that rights were represented at regular intervals.
- The trust should ensure each patient is able to access patient protected time on a regular basis.

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

- The trust should ensure staff receive regular supervision and appraisals.

North East London NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

- Administrative support and legal advice on the implementation of the Mental Health Act and the associated code of practice was available from the central Mental Health Act office.
- Mental Health Act documentation was kept on the wards and the original documents were kept in the central office. This meant that legal papers in the wards' own files and on their database system were not as up to date as the original documents. The system of not having copies of the detention documents on file in the ward areas meant that should a patient need to be transferred out of hours to another unit no papers would be available for staff to enable this. We were told that the documentation was uploaded to a computer system, however, staff were unable to access these during the period of the inspection and informed us that this was always difficult.
- The Mental Health Act documentation we viewed on the mental health wards was generally completed appropriately. The exceptions were the acute adult inpatient service and the child and adolescent mental health wards, where improvements were needed to the recording of consent to treatment and capacity. This included improvements to ensuring the appropriate consent forms were attached to medicine charts to inform staff of what medicines the patient consented to.
- Patients had their rights explained on admission to hospital, but we found that these were often not re-explained if the patient had not understood them. There was limited evidence across the mental health wards that patients' rights were explained regularly as required by the Mental Health Act code of practice.
- There were audits carried out to ensure compliance with the Mental Health Act, but some had not been completed, such as in relation to monitoring the use of restraint and rapid tranquillisation. This meant there was a lack of oversight of these areas to ensure they were not used inappropriately or excessively.
- The Mental Health Act was not part of the mandatory training for staff and compliance rates were not collated. Teams requested training when needed. This meant that staff in the mental health service had not always received training in this and did not have a working knowledge of the Mental Health Act and associated code of practice (amended in 2015). This may lead to staff not having essential knowledge to work effectively with people at risk to themselves or others.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act and Deprivation of Liberties Safeguards became part of the trust mandatory training for an extended staff cohort in October 2015. The compliance rate for staff having received training in this was 62%. The inpatient mental health wards scored highest for having completed this training, ranging from 81–100%. The lowest uptake for this training was in the

children and younger people inpatient and community services at 41% and 47% respectively. The community adults mental health, community learning disability and crisis/ health based place of safety teams all had under 61% compliance rate for having done this training.

- Implementation of the Mental Capacity Act varied across the services. Staff in the adult and older people mental health services had a clear understand of the Mental Capacity Act and Deprivation of Liberty Safeguards. Capacity to consent was assessed and recorded and patients were supported to make decisions where appropriate. The records indicated that decisions were made in the best interests of the patients. However, the feedback we received from stakeholders was that staff do not always have a clear understanding of capacity issues. This was the case for the community adult services where staff did not feel comfortable carrying out capacity assessments, and would ask someone else to do this, even where they had received the training. Most staff we spoke with in these services said they had not completed a mental capacity assessment and were unaware of the role of clinical staff in completing such an assessment. This meant that staff may not be identifying patients that did not have capacity to consent to treatment or to make decisions.
- The Mental Capacity Act does not apply to young people aged 16 or under. For children under the age of 16, their decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke with in the children and young person mental health community teams were conversant with the principles of Gillick and used this to include the children and young people where possible in the decision making regarding their care. However, in the child and adolescent mental health wards at Brookside there was no consideration of the use of Gillick competence for young before under 16 years of age, or of application of the Mental Capacity Act for young people over 16 years.

There were 172 Deprivation of Liberties Safeguards applications made between June and November 2015. These were highest on the older people mental health wards with 84 applications, followed by the community inpatient service with 66 applications.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Our findings

Safe and clean environments

- The services provided by the trust were across different sites, with the majority of mental health inpatients services at Sunflowers Court. Community health inpatient services were provided at across 18 sites including Mayflower Community Hospital and Thurrock Community Hospital. There were 154 community sites providing community health services and/or community mental health services.
- The community sites visited by the inspection team were generally well maintained apart from those which were due to close and move to different sites in the near

future. An example of this was at the site of the Havering older people mental health team where there were concerns over staff safety in the event of a fire, as the only fire escape route was through the window. There was also a lack of working panic alarms. The trust had added the environment as a risk to the borough wide and trust wide risk register and the team were due to move to a different site in August 2016. We also found in the community health services for adults, the district nursing staff across Redbridge Health & Adult Social Services had moved to a new shared base in the week prior to our inspection, the environments had not been properly prepared for staff to work in, with a lack of desks, chairs, IT access or working telephones. Staff stated that they had returned to their old base to use IT facilities as they could not access the systems they needed to for patient notes at the new facilities. The inpatient sites were generally in a good state of repair and comfortable for patients, though Willow child and adolescent mental health ward at Brookside was stark and unwelcoming for the young people. Items of furniture in the dining area were broken and had not been repaired or replaced, despite having been damaged for some months.

- At the last inspection of Sunflowers Court in October 2015 a requirement notice was issued as the trust had failed to ensure that risks to patients from ligature anchor points had been identified, assessed and works taken to address these. At this inspection we found multiple ligature points remained throughout the wards. Ligature assessments did not sufficiently detail the ligature anchor points or how the risks to patients would be mitigated. Staff were unable to state how risks were managed. The trust had not taken adequate action to ensure that risks to patients were minimised and we issued a Warning Notice to ensure that these areas were addressed.
- Across the mental health inpatient areas there was variation in the management of ligature risks. There was good management observed on the long stay rehabilitation ward, but with a lack of a plan to remove risks due to the planned closure of the ward. The older people mental health wards mitigated risks through ligature risk assessment, however the associated action plans lacked the dates when the ligature risks would be removed. The health based place of safety (Section 136 suite) had a potential ligature risk that could not be observed at all times. This meant that there was a risk of people using these areas to harm themselves.
- Across the inpatient wards there were call alarms so that patients could summon assistance when needed or in an emergency. However, Cook older people mental health ward did not have bedroom alarms in 18 of the 20 bedrooms. In Brookside child and adolescent mental health unit the alarm system did not activate in the education area. These findings could put patients at risk in the event of an emergency and we issued a Warning Notice for the trust to address this.
- Where there were mixed gender wards, these were managed in accordance with Department of Health guidance on same sex accommodation. However, on Moore learning disability ward the internal access to the ward garden was via a door situated at the end of the female corridor, which meant that males could only access this when escorted by a member of staff.
- Patient-Led Assessment of the Caring Environment (PLACE) assessments are self-assessments undertaken by teams of NHS and private/independent health care providers and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness. In the 2015 patient-led assessment the trust scored 100% for cleanliness, which was 2% higher than the national average for trust sites.
- Teams had infection control leads and there were visible posters reminding staff of the safest way to wash their hands and minimise risk of infection. The ward and community environments were visibly clean and well maintained. However, there were not always records to demonstrate that the environment had been regularly cleaned, such as at Barking and Dagenham older people mental health team and on the older people mental health wards. The child and adolescent mental health wards at Brookside were not clean, with dirty and stained floors and a lack of completed cleaning schedules to demonstrate what had been cleaned. The findings at Brookside were subject to a Warning Notice, as there was no assurance that the wards were being kept clean.

Detailed findings

Safe staffing

- The trust employed approximately 5350 staff. During the 12 month period to end of October 2015, 875 staff had left the trust leaving 19% staff vacancies. The majority of these vacancies were for nursing posts, with 437 whole time equivalent qualified nurse vacancies and 129 healthcare assistant vacancies. The highest number of vacancies was on the child and adolescent mental health wards at Brookside unit, which had 38% qualified nurse vacancies and 41% healthcare assistant vacancies. Within the community health services, those for children, young people and families had the highest number of vacancies with 26% qualified nurse and 15% healthcare assistant vacancies. At the time of inspection the service managers confirmed 20-70% vacancies in some community health services for children, young people and families. At the time of the inspection the qualified nurse vacancy rate at Brookside had increased to 58%. During two days of the inspection we identified that there were less than the safe staffing numbers of qualified staff on duty and this was impacting on the safe operation of the ward. We also observed situations where patients asked staff members to access drinks or toilet areas and staff informed patients they were too busy to assist. As a result of these findings we issued a Warning Notice to ensure that safe staffing limits were maintained at all times.
- We found there were vacancies across all the teams we inspected. Temporary staff were used to cover shortfalls in an attempt to maintain a consistent level of service. There was a high use of temporary nursing staff, with 21313 shifts covered by agency or bank staff in the 12 month period leading up to the end of October 2015. During this period 2727 shifts were not covered by agency staff. The trust monitored the use of bank and agency staff, which included monitoring the reason for the request to ensure this was appropriate. Staffing levels were increased dependent upon the acuity of need on the wards, for example with higher levels of close observation or to support escorted leave on the mental health wards. At Sunflowers Court the trust had recently employed four 'floater' staff that could be called to work on a ward if a shift could not be filled. All staff reported that even in its infancy, this had been a great success and eased workload pressures.
- The overall staff turnover rate for the trust was 16%. The highest turnover rate by core service was the child and adolescent mental health wards at Brookside with 27% and the lowest was the learning disability and long stay rehabilitation mental health wards.
- Since the staffing data had been provided to the Care Quality Commission, the trust had taken on the emotional well-being and mental health services for children and young people in Essex. This took place in November 2015. In this area nursing recruitment was identified as a safety risk and was listed on the local and trust risk registers. At the time of our visit no posts were being recruited into on a permanent basis until the completion of a community staff consultation taking place at the time. This was the case for all six teams we visited. The impact of this was the increased use of temporary staff and fixed term contracts to maintain a consistent service.
- The services used 'health roster' to roster staff on a daily basis. Within the mental health inpatient services a daily operational meeting was held to review staffing and bed capacity, to ensure the wards were safely staffed. Operations teams were responsible for managing staffing levels on a daily basis. The chief nurse reviewed safe staffing retrospectively each month.
- The trust leadership were aware of recruitment and retention issues and this was an area of concern for them and commissioners of the services. The trust was challenged with recruitment and retention of staff and this was identified as one of their top risks on the Board Assurance Framework. Staff across all services were clear that this presented a challenge to the delivery of clinical services. In some instances this meant that caseloads were exceptionally high, such as health visiting well above nationally recommended levels and physiotherapists caseloads in the community health services for children, young people and families above recommended guidelines. Some community mental health teams were experiencing increased demand for services. Despite these pressures the majority of staff we spoke with were highly motivated and focused on ensuring that patients received the best possible care. The trust had developed the Well Together programme which was aimed to engage staff and to try encourage recruitment and retention. The

trust leadership had introduced different initiatives aimed at recruitment and retention, such as final placements to students and rotational nurse programme.

- There was generally sufficient medical cover across the wards, with staff and patients confirming that there was no difficultly accessing a doctor out of hours. However, at Brookside the out of hours cover was variable, with long wait times and doctors without the relevant skills and knowledge in child and adolescent mental health.
- As at 31 October 2015, the staff sickness rate for the previous 12 months was 4%, this was average for similar trusts. The highest sickness rate was in the mental health rehabilitation wards with 14% and the lowest was in the learning disability ward.
- The internal mandatory training compliance set by the trust was 85% and at the time of the inspection this was at 88%. The long stay rehabilitation and older people inpatient mental health wards scored with the highest percentage of trained staff, with an overall training rate of 95%. However, the community based services for people with a learning disability had the lowest rate of training at 77%. The mandatory training provided by the trust included safeguarding adults, health and safety awareness, infection prevention and control and information governance. Mental Health Act training was not mandatory. In some services we were informed that this had just been made mandatory but that staff had not received the required training. This meant that all staff working in the mental health settings did not have the relevant knowledge around the application of the Mental Health Act or associated code of practice.

Assessing and managing risk to patients and staff

- The trust had good overall systems and processes for managing safeguarding children and adults at risk. The chief nurse of the trust was the board member with oversight of safeguarding and there were a number of individuals with responsibility for safeguarding, such as the assistant director, named clinical leads and nurses. The trust safeguarding duty desk was staffed and managed by the corporate safeguarding team. All queries that came in to the duty desk were recorded. This gave the trust a set of data and intelligence on trends, themes and hotspots. There had been a recent increase in referrals pertaining to historical abuse and as such the safeguarding team had responded by developing a bespoke advice on this. An internal review of safeguarding was carried out last year by Mazars. This review identified a number of actions the trust had to take to improve the safeguarding approach across the trust. Specific actions included the need to improve safeguarding supervision and the development of a standard operating procedure for children's safeguarding. There was an annual audit programme of safeguarding which included the quality of record keeping and review of consent and the use of deprivation of liberty safeguards. There was an annual safeguarding report to the board, bi annual and quarterly reports for both adults and children which went to the quality committee. The reports were also reviewed by each of the seven directorates to their individual safeguarding groups.
- The trust was represented at all local authority safeguarding boards and contributed to the sub groups that worked to the safeguarding board. There were good relationships across the trust and local authority and this was confirmed in our meetings with commissioners and local authorities, who told us that the trust contributed well to the safeguarding agenda. The trust had signed up to the national Sign up to Safety Campaign and had successfully seen a reduction in pressure ulcers, falls and aggression on mental health inpatient wards. The clinical commissioning groups confirmed that the trust was a good reporter of pressure ulcers and that these had reduced. The trust had also undertaken themed analysis around documentation and engaged with care homes to reduce pressure sore risks.
- All safeguarding training was delivered in house, but staff could also access local authority training. Specialist training could also be an be brought in where needed. At the time of inspection 85% of staff had received Prevent training which aimed to help staff understand how vulnerable individuals may be drawn into extremist activities. Across the majority of services staff had a good understanding of safeguarding issues and what to report. In the community health services there was good understanding of child sexual exploitation risks and this was particularly evident amongst the trust's looked after children staff. However, we identified a safeguarding

concern in the child and adolescent mental health wards which had not been identified by the staff. This was reported following our feedback, but the delay put children at risk.

- During the inspection we reviewed 258 care records. The inspection teams found that the completion of risk assessment varied across the services. In some services the risk assessments were comprehensive, reviewed regularly and supported staff to minimise risks to patients. However, in other areas such as the adult mental health acute and child and adolescent mental health wards, there were gaps in risk assessments and the clinical risk assessments did not reflect patient need or make necessary links to environmental risks in trying to keep people safe. For example, patients who expressed thoughts of harming themselves/ taking their own life did not always have a care plan in place to promote their safety. On Cook ward for older people with mental health problems, staff had not assessed patients at risk of falls adequately for this risk and a patient had sustained an injury as a result of a fall. In the community health services inspectors were not always able to determine if risk assessments had been completed or if they were just not being recorded in the patient records. For example, in the district nursing service at Waltham Forest, inspectors looked at ten sets of patient records. Staff had completed and recorded Waterlow assessments (which estimates risk for the development of a pressure sore) in four sets of patient records and, the Malnutrition Universal Screening Tool in one out of ten patient records. This inconsistency in recording risk assessments was present across other areas of the community health services and could have an impact on monitoring the development of care and patient safety.
- The children and young person community mental health services did not have an effective system in place to assess the risks to young people while they were waiting for assessment or treatment. Senior managers told us that the waiting lists were reviewed by the local teams in the weekly multidisciplinary triage meetings. However, the records of these meetings showed that unless referrers raised any concerns about children or young people awaiting assessment and/or treatment there was no active risk management of these people. This meant that staff did not assess, monitor or manage risks for children or young people waiting to use the service. Similarly patients in the community adult services who had been flagged as a risk at referral, had not continued to be flagged as this on the trust electronic recording system, which the trust referred to as electronic patient records. This meant that some high-risk patients were not recorded as such in their patient record and their needs not always met in a timely way.
- Between April and October 2015 there were 597 uses of restraint of 229 different patients. Of these, 46% were in the prone (face down) position and 27% resulted in rapid tranquilisation. The highest use of restraint occurred on the child and adolescent mental health wards (55% of incidents), followed by acute wards for adults of working age and psychiatric intensive care unit (35% of incidents). These wards also had the highest use of restraint in the prone position where 51% occurred on wards for adults of working age and psychiatric intensive care units and 41% occurred on child and adolescent mental health wards. For rapid tranquilisation, 56% occurred on acute wards for adults of working age and psychiatric intensive care units and 36% occurred on children and young person mental health wards. The trust did not have a reduction strategy in accordance with the Department of Health guidance: 'Positive and Proactive Care: reducing the need for restrictive interventions' 2014. This meant there was a lack of planning and Board oversight of the use of restraint or plans to reduce the use of restraint or prone restraint.
- Data provided by the trust showed that in the six months between April and October 2015 there were 11 uses of seclusion, which all took place on Titian ward, the psychiatric intensive care unit. At the time of inspection, this was the only seclusion area available in the trust. However, during our examination of care records at Brookside child and adolescent mental health unit the care plans showed evidence that patients' may have been secluded without proper safeguards in place. For example, one patient care plan indicated that they agreed to being restricted to their bedroom for brief periods if they were finding it difficult to manage their behaviour in ward areas and that staff will stand directly outside the door and prevent the patient from leaving the room. We issued a Warning Notice to the trust in respect of this as we were

concerned this amounted to seclusion but was not being treated as such and the patient not afforded the correct safeguards as detailed in the Mental Health Act code of practice.

- Blanket restrictions and restrictive practices were in place throughout the child and adolescent mental health wards where the internal doors were locked and patients had to ask permission to move from one area of the unit to another at all times and needed to be escorted by staff who could open doors with key fobs. We observed patients being left locked behind doors with no way of summoning staff members. The locked doors meant patient movement was excessively restricted and affected their dignity. Staff searched young people on returning to the ward after leave despite a lack of policy or procedure for this. One of these occasions triggered a safeguarding alert (as highlighted above), as this had not been managed appropriately.
- In the areas we visited the medicines were stored securely. The pharmacy team provided a clinical service to ensure people were safe from harm from medicines. On the inpatient wards pharmacy staff had made comprehensive records on the prescription charts to guide ward staff in the safe prescribing and administration of medicines. Examples of this included reminding the prescriber when prescriptions should be reviewed, noting when blood tests were due and checking that the maximum dose was not exceeded when a medicine was prescribed both regularly and when needed. Pharmacists regularly attended handover meetings to advise ward staff on medication issues.
- Pharmacy technicians carried out regular audits on wards and in community teams to check the safe storage and handling of medicines and we saw that the results were communicated to ward and team managers along with action plans for making improvements. An example of this was where the school nurse team was reminded to calibrate the data loggers, which monitored fridge temperatures. However, we did find on the acute wards for adults and psychiatric intensive care units that there was some out of date medications in some of the clinic rooms and there was no destruction of medication procedures on two wards we visited.

- We analysed data about safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning system (NRLS) and to the Strategic Executive Information System (STEIS) and serious incidents reported by staff to the trust's own incident reporting system (SIRI). These three sources are not directly comparable because they use different definitions of severity and type and not all incidents are reported to all sources. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents.
- Providers are encouraged to report all patient safety incidents of any severity to the NRLS at least once a month. The most recent Patient Safety Incident Report (covering 1 October 2014 – 31 March 2015) states that for all mental health organisations, "50% of all incidents were submitted to the NRLS more than 26 days after the incident occurred." For North East London, "50% of incidents were submitted more than 52 days after the incident occurred which means that it is considered to be a consistent reporter."
- The trust reported a total of 7,458 incidents to the NRLS between 1 January 2015 and 31 January 2016 . 60.4% of incidents (4,506) reported to NRLS resulted in no harm, 29% (2171) of incidents were reported as resulting in low harm, 10% (741) in moderate harm, 0.3% (21) in severe harm and 0.2% (19) in death. The NRLS considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture. The trust took an average of 11 days to report incidents to the NRLS (from the Jan 2015 – Jan 2016 data set).
- Of the incidents reported to NRLS, 24.8% were related to 'Implementation of Care and Ongoing review', 13.1% to 'Patient Accident' and 13% to 'Self-harming Behaviour'. Details of NRLS incident by service and by type can be found in the Appendix 8.
- Trusts are required to report serious incidents which include 'never events' (serious patient safety incidents that are wholly preventable). Between 1 November 2014 and 20 October 2015 the trust reported 358 serious incidents. None of these were never events. The largest number of incidents occurred in the adult community services with 267, of which 262 were pressure ulcers.

Track record of safety

- A total of two prevention of future death reports had been sent to the trust at the time of data submitted on the 16 February 2016. These reports highlight concerns found by Coroners (at inquests) in the systems or processes of organisations which, if they are not improved, could lead to future deaths. The trust had responded with an action plan to both reports.

Reporting incidents and learning from when things go wrong

- There have been five reported serious incidents relating to the acute mental health wards between 1 November 2014 and 31 October 2015. These were categorised as deaths, suicide and attempted suicide, some which were the result of ligatures on the wards and lack of risk management.
- The CQC intelligence monitoring reflected that the trust was flagged as an elevated risk for, the number of deaths of patients detained under the Mental Health Act. This specifically related to the number of suicides of patients detained under the Mental Health Act (all ages). This was based on 12 month's data from August 2014 – July 2015 from the Mental Health Act database. This, coupled with existing compliance breaches meant that these risks to people were not being effectively managed.
- The trust had a central team of five investigating officers who carried out investigations at any one time. The serious incident reports reviewed by the inspection team were of good quality and this was supported by feedback from the commissioners. The reports demonstrated the involvement of families and carers in the process. There was a clearly documented sign off process following the completion of the investigation, culminating with an executive director. Most reports were completed within the 60 day contractual requirement, unless an extension had been agreed as a result of the complexity of this.
- The recommendations of serious incidents were owned and implemented by the locality integrated care director. They developed and monitored the implementation of the recommendations and the governance team tracked completion. Where the result of any incidents were subject to Coroner report recommendations, the relevant locality director took responsibility for developing and implementing the action plans. However, despite a well-documented process, during the inspection we found some inconsistency in terms of staff being clear about their roles and accountability in managing the quality and safety of their services. This meant that in some services there was an under-reporting of incidents and therefore missed opportunities to learn from when things went wrong, such as clinical risk assessments, managing environmental risks on the acute mental health inpatient service and supporting children and young people within the inpatient services who self-harmed.
- The feedback we received from commissioners was that the trust had a desire to strive to get better and learn from incidents. In 2013 there had been a backlog of approximately 100 serious incidents which included pressure ulcer investigations. In 2014 the backlog was cleared and these continue to be managed. Feedback from commissioners highlighted the backlog and acknowledged the improved processes used to effectively review and thoroughly investigated serious incidents. The trust had monitored implementation of its action plan, however, there was a lack of assurance that practice had changed in response to this. An example of this was evidenced in our findings on the acute mental health inpatient wards. For example, despite a serious incident involving a plastic bag there was an inconsistent approach across the mental health wards to mitigating or removing risks posed by the use of plastic bags. The trust had implemented a daily ward check protocol to monitor what contraband (banned) items were brought onto each ward. However, this was applied differently across the wards, with some older people inpatient wards allowing the use of plastic bags in bins in patient bedrooms. This did not demonstrate a consistent approach to learning from incidents and put patients at risk.
- There were six open serious case reviews happening across the trust at the time of the inspection. Action plans arising from these reviews were monitored through the directorate performance quality and safety meetings. The trust had a data base which monitored the progress of investigations and captured actions and learning. This data base was monitored monthly at the senior safeguarding meeting where all named nurses and doctors were present.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- In 2015 the trust had not effectively identified a serious incident that required investigation in line with the NHS England serious incident framework. On this occasion the trust was alerted to the need to conduct an investigation by the Coroner issuing a Regulation 28: Prevention of Future Death Report. In this circumstance the trust failed to ensure that the outcomes of investigations into incidents was shared with the person concerned and, where relevant, their families, carers and advocates, in keeping with duty of candour. The trust did not have sufficient oversight and assurance that the duty of candour process was followed. Since this time that trust had learnt from this. We sampled a number of incidents and found that the new processes embedded were effectively implemented and the duty of candour requirements were met. The trust appointed a lead clinical professional to undertake the first duty of candour visit to the family of the deceased. Investigating officers then contacted the family to get their views on the terms of reference for the investigation. When the investigation was finalised the report was shared with the family by an appropriate member of staff. This process was monitored on the incident reporting system. A mortality group chaired by the medical director had recently commenced, with the plan to meet quarterly to review all deaths including unexpected deaths.

Anticipation and planning of risk

- All risks clinical and non-clinical were managed through the trust's incident reporting system. Any member of staff could identify a risk and each risk was considered at differing levels throughout the trust. The most serious risks were pulled through to the strategic risk register and ultimately the Board Assurance Framework. The main areas of risk were identified as service capacity, staffing in nursing and therapies, and telephony and connectivity. Each locality had a risk register that was discussed at their individual locality patient safety and quality group.

Requires improvement

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

Our findings

Assessment of needs and planning of care

- Comprehensive care assessments were documented in the care records we reviewed. The assessments were service-specific to each core service so that they were relevant to the individual needs of the patient. The quality of the care plans varied across the services but were generally of good quality, holistic and kept under regular review. The child and adolescent mental health wards were an exception. Here the care plans were not recovery orientated and in most cases did not reflect the patient's personal preferences, goals or views. In the children and young person community mental health teams we found that nine out of the 47 care records we reviewed did not have current care plans.
- There was good access to physical healthcare across the services. The care plans showed evidence that staff regularly reviewed patients physical healthcare. In the mental health services we observed doctors discussed physical health problems alongside mental health problems. Community mental health teams had a key performance indicator that required all patients to have received a physical health check in the last 12 months, and they liaised with the patients' GP to ensure this took place. We noted that risks to physical health were identified and managed effectively.

Best practice in treatment and care

- Across a number of services staff referred to the best practice National Institute for Health and Care Excellence guidance and showed us how their practice met this. For example, staff in the inpatient mental health services followed guidelines around physical health monitoring following rapid tranquilisation to ensure people were safe. However, access to psychological therapies for people with mental health problems varied across the trust. The National Institute for Health and Care Excellence recommended that the psychological therapies of cognitive behavioural therapy and interpersonal psychotherapy are available for patients. The inspection found that people using the older people and children and young person community mental health teams had access to psychological therapies. However, on the inpatient mental health wards this input was lacking. On Picasso mental health rehabilitation ward there was no dedicated psychology therapy available due to the planned closure of the ward. The older people mental health wards had one full time psychologist across the services and no structured activities took place. This meant that therapy was offered to patients on an out-patient basis with no structured therapy available on the wards.
- The trust had a number of processes to measure and improve the outcomes of patients and people using their services. This included the use of nationally recognised rating scales such as the health of the nation outcome scale, which uses scales covering a variety of health and social care domains, to enable the clinicians to build up a picture over time of their patients' responses to interventions. The family nurse partnership service used nationally recognised approaches and techniques as prescribed in the family nurse partnership model. Health visitors used the 'ages and stages questionnaires' assessment tool during home visits and clinics, to highlight any areas of concern about a child's development across five different areas. On the learning disability inpatient ward staff used the 'life star' holistic tool to help patients to measure their personal progress on the ward. Paediatric therapies measured outcomes using standardised assessments and goal attainment scales such as disabilities of the arm, shoulder and hand questionnaires and risk measures including pain, strength, balance and endurance. Within the children and young person community services the trust had implemented the 'Thrive' model of service delivery which focused on outcomes and the engagement of children and young people in designing services.

However, improvements were needed in some community adult services and the learning disability community teams, as they did not use outcome measures. This meant that there was a lack of evidence of people's health or wellbeing changing while using the service.

- Staff participated in clinical audit to measure and improve on practice. The trust had completed a number of national and local audits in areas such as use of family intervention therapy, national asthma audits and prescribing of combined oral contraceptives. The findings of these were used to make improvements to the services. For example, in the older people community mental health, teams participated in clinical audits, such as the national clinical audit for antipsychotic medication. The last audit identified the need to improve recording and teams had developed new templates for this. However, in some areas we found no evidence teams of clinical audit work, such as in the learning disability community teams and the community health adults teams.
- The national audit of schizophrenia (an audit of community treatment for people with schizophrenia) found that improvements had been made to the people being offered cognitive behavioural therapy and people's views were increasingly being considered in the medicines prescribed. However, improvements were still needed in some areas, such as recording of the rationale for giving patients antipsychotic medicines above recommended limits and offering of psychological therapies.

Skilled staff to deliver care

- The teams across the trust had of a range of experienced staff in different disciplines including nurses, social workers, occupational therapists, doctors, psychology assistants and recovery support workers. Some of the memory services in the older people community mental health services had specialist dementia nurses, called Admiral nurses, who have expert practical and emotional care and support to carers and patients with dementia. Most of the services could access additional support for patients when needed. However, the learning disability and older people mental health inpatient wards did not have access to a dedicated speech and language therapist. Patients who had an identified need for this service had to be referred to the speech and language therapist by the community team in their home area.
- All new staff received a trust induction and local induction to their service. This included meeting members of the executive team, which staff appreciated. However, there was a lack of robust induction or training for the trust governors and some felt that this meant they were not as effective as they could be in their role.
- Staff generally had access to additional specialist training. For example, a member of staff at Barking and Dagenham older people mental health team had completed a master's degree in advanced dementia care which the trust supported by enabling time off to study. Care co-ordinators had also applied for training in cognitive stimulation therapy which the trust had recently made available. Staff in the learning disability inpatient ward were trained in positive behavioural support, accredited by the British Institute of Learning Disabilities. However, in the older people mental health inpatient services not all of the staff were trained in dementia as recommended by the National Institute for Health and Care Excellence.
- The overall appraisal rate for staff working at the trust was 75%, as at 31 October 2015. Rates of medical appraisal and revalidation were good and a quality audit of medical appraisals had been conducted. However, the percentage of non-medical appraisals completed needed to improve, with corporate services the lowest at 59% and mental health inpatient services the second lowest at 68%.
- There was inconsistency in supervision provided to staff across the trust. For example, in the community health services for children, young people and families this was good. However, on the child and adolescent mental health wards between 1 September 2015 and 29 February 2016 an average of only 55% of supervisions were completed.
- Team managers monitored staff performance regularly and at the time of our inspection were managing a small number of cases where performance was being monitored for improvement.

Multi-disciplinary and inter-agency work

Requires improvement

Are services effective?

- Across the core services there was effective multi-disciplinary work taking place to support people's needs. Throughout the inspection we observed a number of multi-disciplinary meetings and staff handovers that took place regularly in the services. These reflected some good practice and staff worked well across the disciplines to make the most of each other's skills and experience. There was appropriate sharing of information to ensure continuity and safety of care across teams, including involvement of external agencies, for example the local authority, local schools, primary care services and the police. The bed manager ran a weekly meeting which was attended by ward managers, the community mental health and home treatment teams to facilitate the supported discharge of people into the community. Members of the community mental health services attended ward meetings to promote joined up care in the work with people in the community and inpatient settings, though this did vary in attendance. Pharmacists did not regularly attend ward rounds due to resource capacity but they did try to attend handover on ward when possible.
- The medical director had introduced 'Grand Round' discussions between members of a multi-disciplinary team, focusing on complex case (past or current), to support multi-disciplinary work with patients.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- The central Mental Health Act office provided staff with administrative support and legal advice on the implementation of the Mental Health Act and the associated code of practice.
- Mental Health Act documentation was kept on the wards and the original documents were kept in the central office. This meant that legal papers in the wards' own files and on their database system were not as up to date as the original documents. The system of not having copies of the detention documents on file in the ward areas meant that should a patient need to be transferred out of hours to another unit no papers would be available for staff to enable this. We were told that the documentation was uploaded to a computer system, however, staff were unable to access these during the period of the inspection and informed us that this was always difficult.
- The Mental Health Act documentation we viewed on the mental health wards was generally completed appropriately. However, in the acute adult inpatient service and the child and adolescent mental health wards, improvements were needed to the recording of consent to treatment and capacity. This included improvements to ensuring the appropriate consent forms were attached to medicine charts to inform staff of what medicines the patient consented to. Patients had their rights explained on admission to hospital, but we found that these were often not re-explained if the patient had not understood them. There was limited evidence across the mental health wards that patients' rights were explained regularly as required by the Mental Health Act code of practice.
- Staff carried out audits to ensure compliance with the Mental Health Act. However, there were gaps. For example, staff had not monitored the use of restraint and rapid tranquillisation. This meant there was a lack of oversight of these areas to ensure they were not used inappropriately or excessively.
- The Mental Health Act was not part of the mandatory training for staff and the trust did not collate compliance rates. Teams requested training when needed. This meant that staff in the mental health service had not always received training in this and did not have a working knowledge of the Mental Health Act and associated code of practice (amended in 2015). This may lead to staff not having essential knowledge to work effectively with people at risk to themselves or others.

Good practice in applying the Mental Capacity Act

- The trust had mandated training in the Mental Capacity Act and Deprivation of Liberties Safeguards. The compliance rate for staff having received training in this was 62%. The inpatient mental health wards scored highest for having completed this training, ranging from 81–100%. The lowest uptake for this training was in the children and younger people inpatient and community services at 41% and 47% respectively. The community adults mental health, community learning disability and crisis/ health based place of safety teams all had under 61% compliance rate for having done this training.
- Implementation of the Mental Capacity Act varied across the services. Staff in the adult and older people mental

health services had a clear understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Capacity to consent was assessed and recorded and patients were supported to make decisions where appropriate. The records indicated that decisions were made in the best interests of the patients. However, the feedback we received from stakeholders was that staff do not always have a clear understanding of capacity issues. This was the case for the community adult services where staff did not feel comfortable carrying out mental capacity assessments, and would ask someone else to do this, even where they had received the training. Most staff we spoke with in these services said they had not completed a mental capacity assessment and were unaware of the role of clinical staff in completing such an assessment. This meant that staff may not be identifying patients that did not have capacity to consent to treatment or to make decisions.

- The Mental Capacity Act does not apply to young people aged 16 or under. For children under the age of 16, their decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke with in the children and young person mental health community teams were conversant with the principles of Gillick and used this to include the children and young people where possible in the decision making regarding their care. However, in the child and adolescent mental health wards at Brookside there was no consideration of the use of Gillick competence for young people under 16 years of ager, or application of the Mental Capacity Act for young people over 16 years.
- There were 172 Deprivation of Liberties Safeguards applications made between June and November 2015. These were highest on the older people mental health wards with 84 applications, followed by the community inpatient service with 66 applications.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

Our findings

Kindness, dignity, respect and support

- Caring was good across the majority of services inspected. Staff were compassionate, kind and respectful, demonstrating a good level of commitment to their work and supporting people in their care. During the inspection we observed many examples of positive interactions where staff communicated with people in a calm and professional manner using an empathetic approach at all times.
- We identified some occasions where improvements were needed. This was particularly in the child and adolescent mental health wards where patients were not always treated with dignity and respect. We observed a mixture of interactions between staff members and patients. Some were friendly and respectful to young people. We observed situations where patients asked staff members to access drinks or toilet areas and staff informed patients they were too busy to assist. We observed six young people in a bedroom corridor that was locked at either end.
- The feedback from surveys carried out was mixed. The 'friends and family test' was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment. The latest friends and family test data found that 85% of patients would recommend the trust for mental health services. This was below the England average of 88%, for people using their mental health services. For community health services, the result data shows that 97% of patients would recommend the trust. This is compared to the England average of 95% showing that the trust scored above average for the experience of people using the community health services.
- The 'staff friends and family test' was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff whether they would recommend their service as a place to receive care and whether they would recommend their service as a place of work. The trust had a higher staff response rate than the England average (14% compared to 11%) during 1 July – 31 September 2015. However, the percentage of staff who would recommend the trust as a place to receive care is 66%, which was 13% lower than the England average of 79%. In addition, staff who would not recommend the trust as a place to receive care is also 4% higher than the England average.
- The trust's overall score for privacy, dignity and wellbeing in the 2015 patient-led assessment of the cleanliness and environment (PLACE) score was 85%. This figure is similar to the national average of 86%. However, there were three sites that scored below the national average: Mayflower Community, Brookside and Woodbury Unit. The lowest of these was Woodbury, scoring 75%,with Brookside the second lowest with 78%. The trust was working on improvements to this and reviewing the services carried out on the sites. There were 30 trained PLACE assessors within the trust, who had also received training in the Butterfly Scheme and dementia awareness to enhance their awareness of the patient experience when on the older people wards.
- The Care Quality Commission survey of patients using community services for 2015 showed that the trust scored 'about the same' as other mental health trusts, with the top performing scores relate to 'organising your care' and 'your health and social care workers', scoring 8.6 and 7.7 out of 10. The trust scored 8.3 out of 10 where people felt that the professional they had seen most recently listened carefully to them. Of the respondents, the trust scored 8.2 out of 10 for people being treated with respect and dignity.

Good

Are services caring?

- Throughout the inspection patients and people who use the services people spoke of being treated with dignity and respect. In the community mental health and crisis services, the people we spoke with felt that staff were caring and supportive when they were in crisis. However, some people felt that they could be overlooked and receive minimal help when they were in need of general support. This view reflected feedback we had gathered prior to the inspection from patient groups.

The involvement of people in the care they receive

- Across the services we found examples where patients and carers were involved in their care. Children and young people who used the community mental health services were familiar with their care plan and had been involved in the development of it. They spoke of being involved in goal setting and reviewing their care regularly. During our visits in the community mental health services we saw that carers were invited to and attended discussions with their relatives. All carers we spoke with had been involved in developing their relatives' care plans. On the child and adolescent mental health wards staff had developed a video to give new patients an overview and orientation when they arrived at the ward. Where possible, new people being admitted could visit the ward in advance of their stay.
- The trust widely advertised methods for children, young people and their carers to get involved and provide feedback about the services. This included well-advertised messages, which asked and encouraged comments for people to feedback their views on the service they received. For example, we saw an easy to read leaflet was designed with the help of young people using services to encourage feedback. In the older people mental health wards carers were involved in discharge planning. Staff invited carers to patient discharge planning meetings and signposted them to other sources of help when this was appropriate, including for an assessment of their needs as a carer.
- The trust website was available in different languages and easy read version, and provided information of how people could get involved as a patient representative. The website also encouraged people to feedback about the services with links to an online survey and information about the friends and family test. The 'initiatives at NELFT' section of the website provided feedback to patients through the process of 'you said, we did'.
- The trust had a patient experience strategy that was in the process of being reviewed at the time of inspection. We met with representatives from the patient experience group. They told us that availability of advocacy was an issue, particularly in Waltham Forest and for people leaving inpatient care. They also identified the need to focus on young people and informed that this was a key priority for their 2016-17 strategy. Patients and people who used services were supported into volunteering and paid work experience opportunities across the trust. We were given examples of where people had taken on full-time employment with the trust as a result of these opportunities. All volunteers were able to access the trust training to enhance their skills and understanding. There was a recovery college that supported people with techniques to manage their impairment, as well as support for carers within the college.
- The trust board meeting minutes indicated that patients were invited to each board meeting to give a presentation of their experience of the patient journey in a particular core service. Board meeting minutes from December 2015 show that there had been an increase in patient involvement over the past year and their being involved on interview panels. This was confirmed by the representatives of the patient experience group, who confirmed that is was standardised practice to have a user of the service on interview panels.

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

Our findings

Service planning

- The staff we spoke with recognised the different cultures and healthcare needs within the localities in which they worked. This included the diversity and specific needs of different groups within these populations. Staff in the community teams highlighted challenges of socio-economic and cultural diversity, transient populations and inward migration. The local population also had many families in temporary accommodation, increasing birth rates, and high levels of reported safeguarding concerns, including child sexual exploitation.
- In accordance with the Equality Act 2010, the trust collated data about its workforce and the local population. The trust monitored the local population using the census and had clear information about the cultural diversity of populations across the different boroughs they served. From this the trust has an understanding of the diversity of needs and used the information to compare the staff profile of the trust to the local population demographics to see how it reflected the diversity of the population it served. However, we found that further improvements were needed in the capturing of information about people who use the services. In the trust 'Equality and Diversity report 2015' it was identified that diversity information was not always being established for people using services. Examples of this included patients' disability not being recorded on the computerised system for almost 100% of mental health and community services in London; 88% of community health and 37.2% of mental health services did not record religious beliefs of patients; and 99% of data had not been collected on the sexual orientation of patients.
- The trust worked collaboratively with commissioners and other NHS trusts in East London and Essex to plan and meet the needs of local populations. Senior practitioners and service managers told us they had regular communications and, for the most part, constructive working relationships with commissioning bodies. Feedback from stakeholders such as clinical commissioning groups, local authorities and HealthWatch was that the trust worked proactively with them and other stakeholders to meet the needs of people across the seven boroughs covered by the trust.
- Although the trust was moving towards a more integrated care model and standardised practice across the different localities, we found teams were often unaware of what similar teams were doing in other parts of the trust. Staff we spoke with stated that they were aware of work going on within their local area and did not have much opportunity to meet with similar staff in other areas to share learning or practice. The trust had a plan to move community health services towards a model of integrated care, however there was a lot of variation across the trust in how this had been implemented. Some services had moved to fully integrated models (such as Waltham Forest and Redbridge), however other boroughs were waiting to see the outcome of other integrated care models before moving forward (such as Havering). Inspectors saw no evidence of a single strategic document for the development of these services. At the time of the inspection the trust was looking at further integrated of community services and skilling up staff to work seamlessly across these.

Access and discharge

- The trust worked to make the access to services as straightforward as possible. For example, within the mental health services, the home treatment teams were able to respond to referrals to the service within four hours. The trust also operated a street triage service, where staff from the trust worked with the police and helped to identify people who needed mental health services and arranged for them to access the health based place of safety if necessary. Across the community mental health services for children and young people, the trust had developed a single point of

access and assessment. Urgent referrals were prioritised and where possible were seen and assessed within 24 hours. The trust had a target of 48 hours to assess urgent referrals.

- The trust provided details on 'referral to initial assessment' and 'referral to treatment' for some of their community health services, however this was not available for all services including community adult services and community mental health services. The national target for referral to assessment is for 95% of patients seen within four weeks and for assessment to onset of treatment, 92% of patients treated within 18 weeks. The trust met the national referral to assessment target in five out of seven services. The trust met the national target for five out of the six relevant services for initial assessment to onset of treatment.
- Feedback we received from local stakeholders and parents was critical of the wait for treatment that children and young people had to experience after referral to community emotional wellbeing and mental health services and child and young person mental health community services. In Essex from November 2015 (at the start of the contract for the child and young people emotional well-being and mental health services) through to February 2016, 91% of referrals met the 12-week target between referral and assessment and all children and young people had commenced treatment within 18 weeks. In the London services from September 2015 through to February 2016 (six months) all referrals met the 12-week target from referral to assessment and 95% of children and young people had commenced treatment within 18 weeks from referral. The Barking child and young person mental health community services did not have a waiting list at all.
- Between 1 May 2015 and 31 October 2015, the average bed occupancy rate was 84% across all 22 wards. This meant that demand for beds was high, but a bed could generally be available when needed. Of the wards, 12 wards had a bed occupancy over 85%. These were in the forensic and acute mental health wards, as well as the community inpatient wards. The mental health wards at Sunflowers court had the highest in terms of bed occupancy. The lowest occupancy was Reeds ward, the child and adolescent mental health high dependency ward at Brookside.
- Delayed discharges were a key concern on a number of wards. Between May and October 2015 there were a total of 96 delayed discharges. The older people mental health wards of Cook and Woodbury were the highest with 18 and 17 respectively. Ainslie Ward at Waltham Forest Rehabilitation Centre had 15 delayed discharges. The main reasons for these were patient or family choice and awaiting residential care. At Alistair Farquharson community health inpatients service we were told that referrals came from GPs and the local acute trust and there was a waiting list of nine people. Patients were sometimes admitted after 8pm. There were a number of factors that influenced this, which included the lack of access of transport to support discharges until 4pm and cleaners not able to clean the bed until they came on duty at 4pm.
- There were nine out of area placements between July 2015 and December 2015. The majority of the placements were made to locations out of the London area, and the remaining placements were made to locations in South East London.
- Patients were rarely moved between the wards after admission unless this was for clinical reasons. Staff we spoke with on the child and adolescent mental health wards informed us that patients were able to return to their bedrooms after coming back to the ward from leave. This meant that the ward did not admit new patients to beds that belonged to patients who were on leave.
- We rated the forensic inpatient/secure wards service as outstanding for its responsiveness to patient needs. This was because the ward offered a three month follow up with the psychologist after discharge to prevent readmissions to the service. This work was not funded or commissioned, but the team felt it was a very important service to offer for patients. The social worker had set up a community links group to further ease the transition once out of hospital. This group occurred out of normal working hours and invited major stakeholders in patient care (vocation/education providers/ accommodation providers/voluntary groups) from the community to speak with patients about services that could assist them in recovery on the ward and in the

community. The ward also had good links with the local college and some patients were learning trades and gaining formal qualifications to help with recovery and better prepare patients for when they left the hospital.

The facilities promote recovery, comfort, dignity and confidentiality

- The services were delivered from a range of sites across the seven boroughs served by the trust. The adult and older people inpatient mental health services were purpose-built and predominantly on the site of Sunflowers Court, where patients could access different facilities, such as communal areas, quiet lounges, female-only lounges and outside space. However, access to the garden for patients of Moore ward, which accommodated people with learning disabilities, was problematic for people with restricted mobility. For anyone who was unable to negotiate the stairs to access this, the route to the ward garden was protracted and not very accessible.
- In the community team reception areas there was relevant information on display regarding local services, medication and how to make complaints. For children and young people age appropriate information was available. On admission to the wards patients were given a welcome pack which included relevant information to help orientate them to the service and ward routines, such as times of meals, relative and carers information, how to complain, the advocacy service as well as how to access information in other languages. Staff were able to access interpreters as necessary.
- The older people mental health and child and adolescent mental health wards did not always promote the dignity of patients, where they were kept locked during the day and patients had to ask staff to unlock these. Due to the location of the rooms, staff had to stay with the patient, which impacted negatively on patients privacy and dignity, and it appeared that patients were discouraged from going to their rooms during the day. In the child and adolescent mental health wards there were no curtains or blinds on the windows in the bedrooms of the Willows ward to promote the dignity of the young people. Similarly, the privacy and dignity of patients was compromised on Picasso long stay mental health rehabilitation ward where they could not open or close the viewing panels from inside their bedrooms.
- Confidentiality was promoted across the services and during the assessments and home visits we observed. Staff in all team handovers and meetings discussed people in a positive, respectful manner. Staff were aware of the need to ensure a person's confidential information was stored securely and staff access to electronic case notes was protected. However, improvements were needed in the older people mental health wards where patient names were displayed in the communal areas. In the community health services for children, young people and families there were some data protection risks where some health visitors used paper diaries to record sensitive personal information. Paper diaries could be easily misplaced, lost or stolen, which presented a data protection risk and contravened the trust's data protection policy.

Meeting the needs of all the people who use the service

- Staff in the older people mental health teams knew the composition of the local population and that patients using the service were not possibly representative of the local population. The patients who used the service tended to be predominantly white and so staff had tried to engage with local black and minority ethnic groups. Staff conducted memory matters roadshows and visited different localities and shopping centres to engage the community. Staff worked with day centres for black and minority ethnic people and had tried outreach working at local spiritual centres.
- The patients were generally positive about the choice and quality of food provided. There was a good variety and choice of food options, including a healthy choice, vegetarian, halal, Caribbean, pureed and gluten-free food. Patients told us that it was easy to request and access these options. This was apart from in the child and adolescent mental health wards, where the food did not cater for cultural and religious needs.
- Access to faiths were supported by the wards and chaplaincy services visited on a regular basis.
- Teams had made adjustments in community environments for people requiring disabled access. Community sites were both accessible and had bathroom facilities appropriate for patients who used a

wheelchair. The purpose built mental health wards had accessible toilet and bathing facilities for patients with mobility needs, or who used a wheelchair. The wards also had an accessible bedroom for use.

Listening to and learning from concerns and complaints

- Patients and carers were told about the complaints process upon admission and supported to make complaints if they wished. Carers told us they were sent information in the post about how to complain and information of how to complain was displayed across the wards and in community reception areas. Staff were able to describe the complaints process and how they would process any complaints. Staff knew how to respond to anyone wishing to complain and team managers demonstrated how both positive and negative feedback was used to improve the quality of services provided. For example, one team had received a complaint about incorrectly addressed mail and the process for checking address accuracy was changed.
- The trust did not have a Patient Advice and Liaison Service and so this advice was not available to people. Therefore, if a patient wanted advice around making a complaint then the person who received this handled their initial query before passing this on to the complaints team. This meant that patients and people who used the service had to contact the service directly and go through the complaints procedure, without the additional support of an advice and liaison service. This might deter people from raising concerns or complaints.
- Formal complaints were investigated by a member of staff who was external to the service involved. The trust followed the national process with the investigating officer contacting the complainant to enable them to participate in the development of terms of reference. The response time to complainants within the timescale negotiated with them was 53% during 2014/15, which was low. The board received six monthly reports on complaints. The main themes from complaints were communication, staff attitude, diagnosis and care and treatment.
- The trust received 158 complaints during the period May 2014 – December 2015. Of these complaints, 30 were upheld and 60 were partially upheld. Community health services received 55 complaints with 12 upheld (27 partially upheld). Mental Health services received 102 complaints with 18 upheld (33 partially upheld). Community health services for adults had the highest number of complaints with 34. Of those complaints, seven were upheld (16 partially upheld). Within the mental health services, the crisis and health-based places of safety received the highest number of complaints with 38. Of those, eight were upheld (10 partially upheld). According to the parliamentary and health service ombudsman there has been injustice or hardship, whereby the trust have not acted properly or fairly or has provided a poor service in one case, with three cases partly upheld. There were 10 open cases under investigation.
- At the time of inspection, the trust had recently undertaken work to link the complaints and serious incident work to improve response rates. This was to ensure there was opportunity to learn lessons about the patient journey in an informed way to assist with service improvement.

Requires improvement

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

Our findings

Vision, values and strategy

- The trust had five values which were:

- people first;

- prioritising quality;

- progressive, innovative and continually improving;

- professional and honest;

- promoting what is possible - independence, opportunity and choice.

There were posters of these displayed in the services and work areas. Staff knew and agreed with the trust values and felt that objectives reflected the trust's vision. Staff spoke about how the values of putting the patient first worked well in the trust.

- The board assurance framework detailed the trust's strategic priorities along with risks linked to achieving these objectives. Each executive director was responsible for a priority. The document listed various controls in place to mitigate risks along with progress to date. The high priorities were identified as relating to poor accommodation and lack of commissioner investment which would lead to increased clinical risk.

Good governance

- There were governance systems and processes in place that were supported by a clear cycle of governance meetings to ensure that the quality and safety of the trust services were monitored, reviewed and maintained. The governance process worked from division through to locality, through to quality and safety board subcommittee and by exception to the trust board. This was known in the trust as the three tiers of governance. At the time of inspection these systems were at various levels of development and implementation. This meant that there was inconsistency in terms of how the trust could effectively monitor the risk to the quality and safety of its services. An example of this was that, at the time of the inspection the trust had outstanding compliance issues in its mental health inpatient services which had not been addressed. It was not clear how the board had gained assurance that these issues had been addressed. We were informed that that areas of non-compliance were managed at a locality level and only if rated a high risk would this be escalated to the quality and safety board subcommittee. However the localities did not rate outstanding compliance issues as a high risk and therefore the board was not provided with assurance that these had been addressed.
- Board assurance was lacking around the oversight of the clinical risks that were present within services and in particular the mental health services. There was insufficient governance to monitor the completion of risk assessments across services which meant that there was the potential for patients to be placed at risk of avoidable harm. The trust governance structures did not ensure that learning from incidents had been implemented across wards in relation to a serious incident involving a risk item, where the inspection found that these continued to be used on the acute adult and older people mental health wards.
- The trust governance systems did not ensure there was consistency across the trust's services in rates of staff supervision. The average rate of supervision was 81% compared with the trust target of 85%. Within the child and adolescent mental health wards the rate of supervision was 55%, with 19 teams across the trust recording a supervision rate of 50% or lower.
- The governance systems did not ensure staff appraisals took place consistently across all services. Whilst the average completion was 75%, corporate services had the lowest at 59% and mental health inpatients at 68%.
- The overall mandatory training compliance rate for staff was good. However, these varied across the core

services. The trust had not ensured that the uptake of mandatory training was consistent across services and meeting the trust target of 85%, with the community based learning disability services at 77%.

- There was a strategic risk register which highlighted 45 risks, split by directorate and detailed actions undertaken against each of these and their progress. Of these, 33 related to community health services or corporate trust-wide issues.
- Whilst there were a number of key performance indicators linked to the trust objectives of quality and safety, these were not consistently available in an accessible format and for use across the organisation. This meant that in some instances there was the potential for the trust to miss the early warning signs that a service may be deteriorating. Examples of this included the inspection findings of continued non-compliance within the acute adult mental health wards and the concerns identified in the child and adolescent mental health wards.
- The feedback we received from stakeholders was that they had positive working relationships with the trust, who they found to be open and transparent. They believed that the growth of the trust had been done in a considered way, with patients at the centre of everything they did. Commissioners spoke of good communication with service leads and directors and working together to deliver cost efficiency savings to services with a limited impact on output and delivery. There was good financial management with a clear sustainability plan set out and accepted by NHS Improvement (previously known as Monitor).
- The trust had a programme of clinical and internal audit which was used to monitor quality and systems to identify where action should be taken. These included compliance for the supply and administration of combined oral contraceptive pills, prescribing of benzodiazepines and hypnotics on mental health inpatient wards and monitoring of attention deficit disorder in children.

Leadership and culture

- Directors and managers demonstrated commitment and enthusiasm to the trust and spoke passionately of the work being undertaken to develop services. Executive directors and non-executive directors had a clear understanding of their roles and responsibilities.
- In the NHS staff survey 2015, the trust had 21 questions where they scored below average compared to other combined mental health, learning disability and community trusts. These included: staff recommendation of the organisation as a place to work or receive treatment, recognition and value of staff by managers and the organisation, reporting good communication between senior management and staff, ability to contribute towards improvements at work and satisfaction with the level of responsibility. The survey showed that 25% of staff said they experienced harassment, bullying or abuse from staff in the last 12 months. This is the same score as 2014 and higher than the national average for combined trusts, which was 21%. As a result of the NHS staff survey an action plan had been presented to and agreed by the board. The trust had implemented a number of measures to improve staff engagement, including: regular breakfast meetings within each locality to enable staff to meet with the chief executive to ask questions or discuss specific issues. Monthly locality meetings between the senior management team and staff at those localities. An 'innovative care' panel where staff could pitch their ideas and receive funds to take these forward and a member of the senior management team meeting all new staff during their induction. The 'Meet and Greet' executives when staff joined the trust had been very successful and was well evaluated by staff. In addition, the trust ran a 'Make a Difference' scheme to recognise the achievements of staff. During the inspection we found that morale across the teams was mixed but had improved recently. Reasons given for low morale included staff turnover, loss of posts and an uncertainty about future changes in services.
- There were opportunities for leadership development in the trust. The trust had a line manager development programme and some staff had completed leadership and management training courses. Managers in the services spoke of education and training opportunities available and there was an organisational development

programme in place. Deputy and associate directors described how they had been brought together to understand how the trust could support their development which they found supportive.

Staff engagement

- The trust had identified that effective staff engagement must include listening to staff views, effective systems of support, supervision and appraisal, access to education, training and personal development opportunities. The trust also promoted improving working lives initiatives, such as flexible working and involving staff in change processes.
- The trust recognised the different professional group unions that included UNISON, the Royal College of Nursing and the British Dental Association. We were informed that meetings were held on alternate months for the joint consultative committee and these were attended by a board director. The union representatives spoke of positive relationships with senior trust leadership, who they said were supportive and listened to their concerns. The feedback was that the trust board were forward thinking and innovative, but that this and changes to work did not always filter through to frontline staff. It was reported that some changes were not always communicated appropriately and as a result were viewed negatively. Some staff did not feel supported by middle managers in changes that affected them. Some of the representatives said they were consulted about issues that affected staff, though others said that they felt consultations occurred after a decision had been made; or they received little or no feedback from comments on consultations. The trust directors who met with the unions were the directors of nursing, director of human resources and also the chief executive. The union representatives comprised of different grades of staff working across the trust. We asked if they felt there was enough support around staff whistle-blowing. The feedback we received was that the trust has taken on board learning from the Francis report and promoted awareness of whistle-blowing and the need to raise safeguarding concerns to staff. The representatives felt that at a senior level, whistleblowing was taken seriously and concerns investigated appropriately. Union representatives were provided with half a day union duties, which they felt was not always sufficient to carry out the role effectively. Some said that their line managers did not always support them with fulfilling these duties, which led to delays in arranging meetings, investigations and writing reports.

Workforce race equality standard

- We undertook a pilot inspection of the implementation of the workforce race equality standard on this inspection. The workforce race equality standard is a mandatory requirement for NHS organisations to identify and publish progress against nine indicators of workforce equality to review whether employees from black and minority ethnic backgrounds have equal access to career opportunities, receive fair treatment in the workplace and to improve black and minority ethnic board representation.
- The trust held detailed information on the equality characteristics of its workforce. This was acknowledged in its most recent workforce race equality standard report, which was shared with the board in July 2015. Key findings from the workforce race equality standard report showed that 23% of black and minority ethnic staff held senior management positions (band 8a and above for non- medical staff) compared with the overall workforce which was 32% black and minority ethnic. All interview panels for band 8a and above included a member of the ethnic minority staff network.
- In the 12 months to July 2015, black and minority ethnic staff were over 1.5 times more likely to be subject to formal disciplinary procedures than white staff groups. The data also indicated that when compared to the previous year's data, the percentage of black and minority ethnic staff subject to disciplinary procedures had increased by 8%, whilst for white staff groups there had been an decrease in 10% in the number of formal disciplinary procedures. The trust had identified that staff from band 5 were most likely to be subject to disciplinary proceedings and had identified the need for improved induction processes to address this issue.
- The human resources department held overall responsibility for the delivery of the trusts equality and diversity action and ethnic minority staff network strategy action plan. The trust was in the process of developing its ethnic minority staff network action plan for 2016 – 2020. An equality and diversity manager was in post.

Requires improvement

Are services well-led?

- The trust's executive management team comprised of 15 members, three of whom were from a black and minority ethnic background. Since 2013, the trust has increased representation at band C and above from 13 to 26 black and minority ethnic staff.
- The trust had been nominated for the diverse company of the year award at the national diversity awards 2016. The trust had been cited as one of the top ten global black and minority ethnic networks by The Economist in February 2016. The trust was developing a "reverse mentoring" programme, where members of the senior management team would be paired with black and minority ethnic staff at grade 5, with the aim of increasing their understanding of the challenges facing black and minority ethnic staff providing front line services.
- The trusts ethnic minority network was launched in 2012. It met each month and hosted two conferences each year. The purpose of the ethnic minority network was to provide a platform for sharing ideas and experiences, exploring ways of bringing issues to the attention of the board, to develop links with other groups within the trust and other national black and minority networks and to celebrate and promote successes.
- The most recent staff survey showed the trust had several areas where they scored below average compared to other combined mental health, learning disability and community trusts. These included the percentage of staff experiencing discrimination at work in the last 12 months and the percentage of staff who believed the organisation provided equal opportunities for career progression and development. In response, to develop black and minority leaders, the trust had introduced an "Unlocking potential programme". At the time of our inspection 52 staff were undertaking this programme. A business case to roll this programme out to more staff was under review.
- The inspection team met with black and minority ethnic staff from across the trust in a focus group. Staff told us that there was strong leadership for the equality and diversity agenda from the senior management team. They commented that they felt safe raising equality and diversity issues and that where they did, these were listened to. Overall, staff said that the trust had taken an innovative approach to addressing equality and diversity issues and that these were a clear trust priority. The group felt that the ethnic minority network strategy for 2016 – 2020 appropriately highlighted the over representation of black and minority ethnic staff in disciplinary proceedings and aimed to address this. Some staff commented that human resources policies required revision to include learning made to date. Some staff also commented that at band 5 level, some black and minority ethnic staff "felt stuck" with no clear route for career progression.
- The black and minority ethnic staff focus group also commented positively on the implementation of a black and minority ethnic ambassador for each borough and the appointment of a black and minority ethnic representative on interview panels. Staff told us that this role was being developed to include a black and minority ethnic representative during the shortlisting process.

Engaging with the public and with people who use services

- The patient engagement structure for the trust was through the 'patient experience partnership', where each locality had an integrated care partnership which was patient led, with an overall Chair. These groups fed into the overall patient experience strategic group, headed up by the director of nursing for patient experience. There were patient representatives on different strategic groups, including the equality and diversity group, recovery and social inclusion and 'sign up to safety' group.
- Each interview panel had a user representative and they received interview skills training for this work. As part of the recruitment of new doctors, 'psychiatric simulation centres' had been set up, where users, actors and doctors acted out different scenarios and candidate doctors had to respond to these.

Fit and proper persons test

- The trust did not meet the fit and proper persons' requirement for directors and was not compliant with the law. This regulation of the Health and Social Care 2014 ensures that directors of health service bodies are fit and proper persons to carry out their roles.
- The trust had not developed a fit and proper persons policy or procedure. The trust recruitment policy had a flowchart of some checks to be carried out in relation to

the fit and proper person requirement and a copy of the regulation. However, there was a lack of policy or procedure in relation to the fit and proper person requirement to ensure this was carried out appropriately.

- We reviewed nine personnel files of five directors and four of non-executive directors, most of these had been in post prior to the implementation of the fit and proper person requirement in November 2014. The trust had not ensured that all checks had been carried out for the new directors to fulfil the requirements of the fit and proper person requirement. Checks with the Disclosure and Barring Service were not carried out for all directors. There was a lack of evidence of photographic identification, professional registration and right to work checks. We were informed that these checks were not carried out on non-executive directors as they did not have contact with patients. However, the non-executive directors we spoke with confirmed that some of them did have contact with patients when they visited the wards and some did speak with patients individually. Similarly, the trust governors did not have disclosure and barring checks, yet some did interview patients as part of their governor work. We found that no retrospective work had taken place of the directors for the trust to assure itself of the ongoing fitness of the existing directors.

Quality improvement, innovation and sustainability

- In order to monitor and improve the quality of services the trust undertook a series of internal visits which were led by the directors of nursing and executive team. These visits mostly focused on the environment of the team or service visited. For example considering first impressions, reviewing notice boards and information available to visitor. The team undertaking the visit would also consider the governance of a the service, such as checking performance data, reviewing the minutes of meetings and looking for evidence that teams were learning from complaints and serious untoward incidents. In between October and December 2015 there had been eight such visits, three of which had identified minor concerns and had resulting action plans. The trust board received a quarterly report which focused on regulatory requirements. For example, updating the board on submissions to the financial regulator NHS Improvement, considering any focused inspection and statutory notifications to the Care Quality Commission, such as detained patients who might have gone absent without leave or admission of a child to an adult ward.
- On Cook ward the nurse consultant was involved in a quality improvement project called 'making patients on an older people's mental health ward feel safer'. The project found that by enhancing the therapeutic environment to make it more dementia friendly, the incidence of physical aggression reduced by 40%, and there was an increase of 64% in the number of patients who stated they felt extremely safe. The nurse consultant had been shortlisted by the Royal College of Nursing for the Nursing Older People Award.
- In Havering, nursery nurses piloted nursery nurse led child health clinics to increase capacity and reduce health visitor workload. The nursery nurse clinics were rolled out across the borough following positive evaluation by parents and 100% satisfaction rate.
- The learning disability mental health ward was one of four units across England who piloted the first cycle of the Quality Network for Inpatient Learning Disability Services accreditation scheme.
- The Waltham Forest community mental health team for adults was a pilot site for 'open dialogue', a psycho-social approach to working with people experiencing mental health crisis.
- The street triage team worked with the police between the hours of 5pm and midnight. Street triage consisted of mental health professionals who provided on the spot advice to police officers who were dealing with people with possible mental health issues. They assessed risk and whether less restrictive options were appropriate.
- The trust was setting up a 'Care City' as joint venture with the London Borough of Barking and Dagenham. The aim is for Care City to become a centre of excellence to help deliver better outcomes for local people and act as a catalyst for regenerating one of London's most deprived regions. The project also aims to improve the delivery of health and social care through innovation, integration and investment.

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 were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors **Regulation 5 HSCA (Regulated Activities) Regulations 2014** **Fit and proper persons: directors** **How the regulation was not being met:** · The provider did not have appropriate policies and procedures to carry out checks of directors in regard to the fit and proper person requirement. **This was a breach of Regulation 5**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014** **Person-centred care** **How the regulation was not being met:** The trust did not ensure a consistent access to psychological therapies for people with mental health problems across the trust.

This section is primarily information for the provider

Requirement notices

Specialist community mental health services for children and young people:

· The trust did not ensure all children and young people had a care and/ or treatment plan. In the Walthamstow CAMHS community service nine care records had no care plan developed or available.

Child and adolescent mental health wards:

· Care plans were not recovery orientated and in most cases did not reflect the patient's personal preferences, goals or views. Care plans we reviewed contained brief statements that were not holistic or recovery focused. We reviewed 13 care records.

· Risk assessments were sparse and not personalised. They did not contain historical information about young people.

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

· Care plans were not recovery orientated and in most cases did not reflect the patient's personal preferences, goals or views. Care plans we reviewed contained brief statements that were not holistic or recovery focused. We reviewed 13 care records.

This was a breach of Regulation 9(1)(a)(c), (3)(a)(b)(d)(f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
Diagnostic and screening procedures	

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 10 HSCA (RA) Regulations 2014

Dignity and Respect

How the regulation was not being met:

Wards for older people with mental health problems:

· Patient bedrooms on Cook ward were locked during the day and patients were not able to easily access their rooms to obtain peace and quiet.

· Patients' bedrooms were very bare and unpersonalised. Ward Managers told us that patient's were allowed to personalise their bedrooms however we saw only one bedroom (on Woodbury unit) that had anything that could be considered personal in it.

· Each patient had a safe in their bedroom that was accessed by a numbered keypad which were not being used by patients. It is likely that people with a cognitive impairment may not be able to memorise the numbers to access the safe. This compromises patient's dignity and independence.

· Patients were not able to open or close the viewing panel on their bedroom door, which could impact on their privacy and dignity.

· Staff had written patients' forenames and the first letter of their surname on boards in communal patient areas on both Cook and Stage wards. This could compromise the patients' right to privacy and confidentiality.

Child and adolescent mental health wards:

This section is primarily information for the provider

Requirement notices

· Patient bedrooms on Willows ward did not have curtains or blinds on the windows

· Patient's bedrooms were bare and unpersonalised.

· The family visiting room provided little privacy for young people and their visitors.

This is a breach of 10(1)(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 HSCA (RA) Regulations 2014** **Need for Consent** Child and adolescent mental health wards: Capacity and Consent to treatment. There were high levels of restraint and IM medication being used. We were told parental consent was sought for patients. We found limited evidence of this within the patients notes or no evidence of the use of Gillick competence. In patient care plans we found statements such as "I may be restrained". **This is breach of Regulation 11**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

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

Regulation 12 HSCA (RA) Regulations 2014

Safe care and treatment

How the regulation was not being met:

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

· People who were assessed to have a mental disorder were not always seen by an Approved Mental Health Practitioner before being discharged from Section 136 of The Mental Health Act 1983. This does not meet requirements under Mental Health Act Code of Practice; paragraph 16:51. This meant that a vulnerable person could be returning to an inappropriate social situation.

Community-based mental health services for older people:

· Care and treatment must be provided in a safe way for patients

· Premises used by the Havering older adults mental health and memory service team were not safe to use for their intended purpose.

· The provider did not ensure the safety of equipment and that interview rooms had working safety alarms within its premises at Waltham Forest and Havering.

Community-based mental health services for adults of working age:

- In the community recovery teams the trust did not have adequate risk assessments recorded in all peoples' electronic records to ensure that care and treatment was provided in a safe way. Risk assessments were limited in content, and not updated in a timely way, or after significant events.

This section is primarily information for the provider

Requirement notices

Community health services for adults:

· Staff did not follow policies and procedures in relation to the safe administration and recording of medicines. Staff in Redbridge did not consistently use medication charts to record administration and prescription in patient notes.

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

· On Kahlo ward we found some out of date medications were being used.

· The destruction of medication recording systems were not being completed on all wards.

· Medical equipment on some wards was not routinely calibrated or within review dates.

This was a breach of Regulation 12(1)(a)(b), (2)(b)(d)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA (RA) Regulations 2014** **Safeguarding service users from abuse and improper treatment**

Child and adolescent mental health wards:

This section is primarily information for the provider

Requirement notices

· Bank and agency staff did not always have formal training on safeguarding.

· Blanket restrictions and restrictive practices were in place throughout the unit. All internal doors were magnetically locked. Patients were required to ask permission to move from one area of the unit to another at all times and needed to be escorted by staff who could open doors with key fobs. The locked doors meant patient movement was excessively restricted and affected their dignity.

This is a breach of Regulation 13(2),(4)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Regulation 14 HSCA (RA) Regulations 2014** **Meeting nutritional and hydration needs** Child and adolescent mental health wards: Patients told us food was of poor quality and the menu choice available was not varied enough. Cultural and religious foods, including halal, were not available at the unit. **This is a breach of Regulation 14(4)(a)(c)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014** **Premises and equipment** **How the regulation was not being met:** Community health inpatient services: · Equipment at the Alistair Farquarson Centre was inappropriately stored and therapy equipment was not properly maintained. · Equipment such as blood pressure machines, beds and bed pan macerators were not properly maintained. Acute wards for adults of working age and psychiatric intensive care units: · We found a number of maintenance issues across the wards that had not been rectified. For example there were 40 outstanding issues on one ward. **This is a breach of 15 (1)(c)(e)(f)**
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Good governance**

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

- There were insufficient governance structures to monitor the clinical risk in services and learning from incidents had been implemented. This meant that there was the potential for patients to be placed at risk of avoidable harm.
- The trust did not have a reduction strategy in accordance with the Department of Health guidance: 'Positive and Proactive Care: reducing the need for restrictive interventions' 2014. This meant there was a lack of planning and Board oversight of the use of restraint or plans to reduce the use of restraint or prone restraint.

Community health services for children, young people and families:

- Care records were not kept secure at all times and only accessed, amended or destroyed by people who are authorised to do so. The system of using paper diaries to record sensitive information did not support the confidentiality of people using the service and contravened the Data Protection Act 1998.

Child and adolescent mental health wards:

- Under reporting of incidents. Incidents found in progress notes on RiO which had not been reported on DATIX. Inspectors found information in progress notes that would meet the threshold for being reported as an incident. When compared against data in the DATIX system such incidents had not been reported

- No search policy was in place. Staff use wand device to search patients. Incident reported during inspection visit of a patient being asked to remove clothes and then shake out underwear.

Community health services for adults:

· There was not an effective system to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. There were insufficient governance structures in place to monitor the quality of patient records and a lack of measuring and comparing quality and performance across services.

This section is primarily information for the provider

Requirement notices

· The services did not consistently maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The staff did not consistently complete risk assessment documentation in patient notes.

Community mental health services for people with learning disabilities:

· Teams did not keep data on waiting times from assessment to referral. This meant there was no evidence if waiting time limits were being breached.

This was a breach of Regulation 17(1),(2)(a)(b)(c)(d)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing** **How the regulation was not being met:** · Mental Health Act training was not mandatory for mental health staff. There was poor staff uptake for Mental Health Act Introduction training and no staff had completed the refresher course. Community health inpatient services:

This section is primarily information for the provider

Requirement notices

- At Mayflower Hospital and the Alistair Farquharson Centre, the numbers of suitably qualified therapy staff were not sufficient to meet the needs of the rehabilitation service.

Wards for older people with mental health problems:

· Mental Health Act training was not mandatory for staff. There was poor staff uptake for Mental Health Act Introduction training and no staff had completed the refresher course.

Child and adolescent mental health wards:

· Brookside unit had 58% staff vacancies.

· During our unannounced visit to the unit on the evening of 14 April 2016 there was only one regular member of staff on duty, the nurse in charge, with one agency nurse and four healthcare assistants who were a mixture of bank and agency. The qualified nurse in charge was clearly under pressure and had to make all decisions regarding the safe running of the unit. On the high dependency unit it was a similar picture of one qualified nurse who was the only regular member of staff and five health care assistants who were also a mix of bank and agency. This was one member of staff less than their numbers.

· During the afternoon of April 7th 2016 the unit was down by three staff members.

· Review of staff rotas showed numerous occasions when shifts were not filled sufficiently.

· Staff supervision was not being regularly undertaken.

· Only 43% of staff on Reeds ward and 40% of staff on Willows ward had received an annual appraisal.

This section is primarily information for the provider

Requirement notices

Community health services for adults:

· Community health services for adults were not meeting targets for supervision and appraisals set by the trust, and there was a lot of variation in compliance across different localities.

This was a breach of 18(1)(2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care **Section 29 A of the Health and Social Care Act 2014** Child and adolescent mental health wards: · Furnishings were damaged and the décor was dated and in poor quality. The ward was dirty and no evidence of regular cleaning. In particular the dining area and visiting area in the high dependency unit. The visiting area had a stained carpet that had not been hoovered in some time. Cupboards in the room were broken and not fixed with a staff fridge in the corner and electrical plant equipment on the wall that was not boxed in. · Ward layouts do not allow good observation of young people. Blind spots throughout the ward and no convex mirrors. Ligature points in disabled toilet on Willows (HDU) · Poor cleanliness throughout Reeds ward and the Willows (HDU). Ripped chairs in dining area of Willows ward, with exposed foam, posing infection control risks. Wards for older people with mental health problems: · Taking into account the number of incidents involving falls on the Cook ward and our observations and interviews during the inspection, there were not adequate measures in place to anticipate or mitigate the risks to patients who might have been at risk of falls.

This section is primarily information for the provider

Enforcement actions

· There were no call bells or pull cords in 18 of the 20 bedrooms and ensuite shower rooms on Cook ward. This meant that patients were unable to call staff in an emergency, or when necessary in order to meet their needs such as food and nutrition, toilet, personal care and emotional care if they became distressed.

· Staff on Cook ward had placed a hand held bell in each patient bedroom for patients to use to summon staff. However, it is possible that these would not be sufficiently audible to staff if the level of noise was high elsewhere. The bells were placed on shelves on the wall opposite to the patient's bed which could mean they were out of the patient's reach.

· Between 1 November 2014 and 31 October 2015 Cook ward recorded that there were two falls (one suspected). Two days prior to our visit there was another fall; staff told us that a patient sustained a fracture during an unwitnessed fall when the patient slipped on their incontinence while getting out of bed. We looked at previous records concerning the patient which showed that they was known to be at risk of falls, however there was no evidence of a specific falls risk assessment or falls care plan in place prior to the fall. These were completed post-fall.

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

· The quality of risk assessments varied across the wards. There was evidence that risk planning was not always being carried out. For example there was a patient with a high risk of suicide by hanging and drug overdose. There was only a risk assessment in place for a drug other dose.

· We raised similar concerns in relation to a lack of risk planning during an inspection in 2014.

This section is primarily information for the provider

Enforcement actions

Havering
LONDON BOROUGH

OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 18 JULY 2017

Subject Heading:	Reports from Healthwatch Havering
Report Author and contact details:	**Anthony Clements, Principal Democratic Services Officer, London Borough of Havering**
Policy context:	**The attached reports detail two recent reviews undertaken by Healthwatch Havering.**
Financial summary:	**No impact of presenting of information itself.**

SUMMARY

The attached reports on Queen's Hospital in-patient meals and the NELFT Mental Health Street Triage Scheme are presented to the Joint Committee by Healthwatch Havering. The Joint Committee is asked to consider the reports and take any action it considers appropriate.

RECOMMENDATIONS

1. That the Joint Committee considers the attached Healthwatch Havering reports and takes any action it considers appropriate.

REPORT DETAIL

Officers will present and summarise the main features of the attached Healthwatch Havering reports on Queen's Hospital in-patient meals and the NELFT Mental Health Street Triage Scheme.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

healthwatch Havering

Presentations to Outer North East London Health Joint Overview and Scrutiny Committee 18 July 2017


healthwatch Havering
Enter & View
Queen's Hospital, Romford: In-patient meals
6 October 2016
Healthwatch Havering is the operating name of Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383
healthwatch Havering
Enter & View
NELFT Mental Health Street Triage Scheme
Goodmayes Hospital
Barley Lane, Goodmayes IG3 8XJ
23 November 2016
Healthwatch Havering is the operating name of Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

Queen's Hospital, Romford: In-patient meals

Patients have a right to expect food that is:

- nutritious
- able to meet special dietary requirements (halal or kosher, vegetarian or vegan, or medically-necessary or non-allergenic nature such as gluten-free or nut-free)
- provided in sufficient quantity
- complementary to their clinical needs where necessary
- served in a reasonable manner, with assistance to eat if they need it

Patients also have a right to be – and remain – hydrated, particularly as hospitals are often dry, warm places where it is possible to become dehydrated quite quickly

We received various complaints:

- Inadequate portions
- Lack of variety
- Failure to observe dietary requirements
- Lack of assistance with feeding

Enter and View visit, October 2016 to the following wards:

- Blue Bell A and B – medical and respiratory patients
- Harvest A – elderly patients
- Sunrise B – elderly patients

Headline findings:

- Blue Bell A and B – food served in adequate portions, in accordance with patients' wishes
- Harvest A – food served in adequate portions, in accordance with patients' wishes
- Sunrise B – very different picture to the other wards

In Sunrise B ward:

- Limited offer of food – “meatballs and potatoes”
- Insufficient staff available (bearing in mind most patients cannot self-feed)
- Indifferently served (staff were too pressed to attend to each patient)

Accept Queen's in a difficult position:

- There to treat, not to feed
- Staff are under great pressure
- Seeking to improve service
- No simple answer

Queen's tell us they :

- Have relaunched "feeding buddy" scheme: volunteers (including staff on lunch break) assist with feeding
- Refer to dietitians when necessary
- Have adjusted the food ordering system in the light of experience
- Ensure patients are aware of the wide range of menus available for them

Queen's also tell us they :

- Closely monitor the delivery of meals to the wards
- Ensure at least two staff dish out meals, which are served main first, followed by dessert served separately
- Have staff assisting with ordering arrangements
- Change food if it does not meet expectations
- Ensure food needs are noted and catered for

healthwatch Havering

We will be carrying further visits later this year to follow up the report and the actions promised by BHRUT

Queen's Hospital, Romford: In-patient meals

NELFT
Mental Health
Street Triage Scheme

This innovative scheme:

- First came to attention at the July meeting of this HJOSC last year
- Is operated by NELFT in conjunction with Metropolitan Police and British Transport Police
- Works in co-operation with LAS as well
- Aims to intervene with people having a mental health crisis in the street without risk of criminalising them
- Aims to get such people to the best place for their recovery

Mental health staff respond to requests from police for assistance:

- Across Outer North East London (the areas covered by this HJOSC)
- 5pm to 1am, Monday to Friday
- 8am-midnight, Weekends and Bank Holidays

This avoids police taking people in crisis to a police station as a place of safety or to the Emergency Department at an acute hospital, neither of which is necessarily the right environment for a person in crisis

British Transport Police interest stems from the high number of suicides on railways, both National Rail and London Underground.

Outer NEL has a large number of railway routes:

- Rainham to Barking (c2c)
- Upminster to Barking (c2c and Underground)
- Upminster to Romford (London Overground)
- Harold Wood to Ilford (TfL Rail)
- Chingford to Walthamstow (Greater Anglia)
- Barking to Blackhorse Road (London Overground)

Healthwatch Havering

Healthwatch Havering strongly supports the scheme.

We have made recommendations to NELFT, the BHR and Waltham Forest CCGs, the Police and the LAS

healthwatch Havering

Recommendations to NELFT:

(1)Consider operating the scheme for longer than at present, ideally 24-hours at all times

(2) Arrange with the Metropolitan Police and the BTP for all police officers in the ONEL area to be given training on dealing with mental health crises without unnecessarily resorting to their Section 136 powers

(3) Explore scope for use of a dedicated LAS vehicle to convey triage team members to an incident

healthwatch Havering

Recommendations to LAS:

(1)Ensure attendance of senior LAS officer at Street Triage Team meetings

(2) Explore scope for use of a dedicated LAS vehicle to convey triage team members to an incident

Recommendation to Police:

Arrange for all police officers in the ONEL area to be given training on dealing with mental health crises without unnecessarily resorting to their Section 136 powers

Recommendation to CCGs:

Support development of the Street Triage Scheme and consider funding for:

(a) training police officers

(b) further development of the scheme to provide up to 24 hour, all times cover; and

(c) use of an LAS vehicle to convey team members to incidents

Responses:

- NELFT have welcomed our support for the scheme

- The CCGs have confirmed:
  - They are working together on the approach to crisis care
  - The scheme is a priority area in the STP
  - They are looking at options for improving the service and its place in the investment programme

- LAS are considering their involvement

There has been no police response (but Havering Council will be raising it through their Crime & Disorder Committee)

NELFT
Mental Health
Street Triage Scheme

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Enter & View

Queen's Hospital, Romford: In-patient meals

6 October 2016

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff and a number of volunteers, both from professional health and social care backgrounds and people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is an Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Background and purpose of the visit:

Healthwatch Havering (HH) is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the safety of the resident is not compromised in any way.

Introduction

The principal purpose of a hospital is to treat the sick and injured. Most patients are seen and dealt with quickly, and most leave the same day.

Inevitably though, many patients stay as in-patients, some for a considerable period, especially elderly patients who need a support package of care

before they can return home. These patients must, of course, be fed and kept hydrated.

No one expects "hospital food" to match home-cooked food, or indeed that which would be served in a multi-star hotel or restaurant; on the other hand, patients have a right to expect food that is:

- nutritious
- able to meet special dietary requirements (whether of a religious nature such as halal or kosher, of a personal/lifestyle-choice nature such as vegetarian or vegan, or of a medically-necessary or non-allergenic nature such as gluten-free or nut-free)
- provided in a quantity sufficing to satisfy their hunger
- complementary to their clinical needs where necessary and
- served to them in a reasonable manner, with assistance to eat if they need it.

Patients also have a right to be – and remain – hydrated, particularly as hospitals are often dry, warm places where it is possible to become dehydrated quite quickly.

Over the years, there have been many humorous references to inadequacies in the quality and quantity of hospital food – many of the "Carry On" films of the 1950s and 1960s drew much comedic effect out of hospital food, and numerous films and TV programmes since have maintained that caricature.

Against that, clearly it is impossible to satisfy completely the expectations of every patient. What to one person is a perfectly-acceptable meal will be to others either too much or too little: food likes and dislikes are highly personal and no two people will agree on what is their "favourite meal". It is particularly difficult to produce a consistent and acceptable offering when catering for many hundreds of patients for two main mealtimes every day, all with different needs and expectations, not only in quality, quantity and nature of food but in terms of the amount of time and assistance they need to eat it.

Healthwatch Havering set this report in hand because of reports from patients and others alleging inadequate dietary arrangements [1] (not necessarily at Queen's Hospital).

As an initial step, several wards in Queen's Hospital were visited on 6 October 2016 at lunchtime to enable Healthwatch members to observe the delivery and presentation of the midday meal, the help available to those patients who needed assistance with feeding and how patients with varying needs coped with their meals. The team comprised of seven Healthwatch members, who visited individual wards in pairs or threes.

Following that visit, members of Healthwatch Havering met senior staff from the hospital and its catering contractor to discuss various issues, emerging from both the Enter & View visit and earlier patient reports.

Nutritional standards

NHS England (NHSE) has identified 10 key characteristics of good nutrition and hydration care [2]. These are:

1. Screen all patients and service-users to identify malnourishment or risk of malnourishment and ensure actions are progressed and monitored.
2. Together with each patient or service user, create a personal care/support plan enabling them to have choice and control over their own nutritional care and fluid needs.
3. Care providers should include specific guidance on food and beverage services and other nutritional & hydration care in their service delivery and accountability arrangements.
4. People using care services are involved in the planning and monitoring arrangements for food service and drinks provision.
5. Food and drinks should be provided alone or with assistance in an environment conducive to patients being able to consume their food (Protected Mealtimes).
6. All health care professionals and volunteers receive regular raining to ensure they have the skills, qualifications and competencies needed to meet the nutritional and fluid requirements of people using their services.

[1] See for example "Fix Dementia Care: Hospitals" – The Alzheimer's Society 2016
[2] NHS England (NHSE) website: https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics

7. Facilities and services providing nutrition and hydration are designed to be flexible and centred on the needs of the people using them, 24 hours a day, every day.
8. All care providers to have a nutrition and hydration policy centred on the needs of users, and is performance-managed in line with local governance, national standards and regulatory frameworks.
9. Food, drinks and other nutritional care are delivered safely.
10. Care providers should take a multi-disciplinary approach to nutrition and hydrational care, valuing the contribution of all staff, people using the service, carers and volunteers working in partnership.

The catering service at Queen's Hospital must be judged against those criteria. In addition, sources of advice and guidance on nutritional standards and guidance used by the hospital include the British Dietetic Association [3], BAPEN (a charitable organisation that seeks to advance the nutritional care of patients as well as the wider community, which has produced a Malnutrition Universal Self-Screening Tool [MUST]) [4] (see later in the report), Public Health England (Healthier and More Sustainable Catering: Nutrition principles) [5] and Government Buying Standards for Food and Catering Services from the Department of the Environment, Food and Rural Affairs (DEFRA) [6].

Catering arrangements

Catering services at Queen's Hospital (and at its sister hospital, King George in Goodmayes) are provided by Sodexo Limited under contract to the Barking, Havering and Redbridge University Hospitals Trust (BHRUT). Sodexo provides a range of non-clinical services at the two hospitals, including canteen/restaurant facilities for staff and public (such as a Costa Coffee outlet). Different arrangements for catering apply at King George Hospital, so the observations in this report are not necessarily relevant to the in-

[3] BDA website: https://www.bda.uk.com/publications/professional/NutritionHydrationDigest.pdf
[4] BAPEN website: http://www.bapen.org.uk/
[5] PHE website: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/347883/Nutrition_principles.pdf
[6] DEFRA website: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/347883/Nutrition_principles.pdf

patient service at that hospital (which was, in any event, not included in the study now reported on). Catering is part of a Total Facilities Management contract following a competitive tendering exercise for which the evaluation criteria valued quality 60% and cost 40%. The food is sourced from a major hospital catering supplier, Tillery Foods, based in South Wales [7] but which has a London depot in Croydon.

On average, some 2,200 meals are prepared and served each day, and the average cost of feeding a patient is about £10.50 per day.

Hospital management told Healthwatch that:

> The Trust has monthly patient dining meetings with Dietitians, Speech and Language Therapists, Sodexo Catering Manager and the Trust's soft Facilities Manager Contract Manager, to keep up to date with any new catering developments and ensure food quality and nutritional standards are continued to be met.
>
> Dietitians are involved in meal taste tests which are held on the wards, and the Nutrition and Dietetic Department undertake 'Nutrition - how are we doing' audits to monitor patients' experience of the food and mealtimes. The results of the audits are reported to the Trust's Nutritional Advisory Group for review.

In addition:

> Meal taste tests are carried out monthly by the Trust Facilities Team, Dieticians, Catalyst Quality and Performance Manager Sodexo Management team, Tillery Valley food supplier, Senior Sisters/Charge Nurses, nurses and Healthcare Assistants.

Food is delivered from Tillery Foods frozen and ready to be reheated. It is stored in the hospital's food storage area until required, when it is taken by trolley (called a "food cassette") from the food storage area in the hospital to appropriate ward. On arrival at the ward, the trolley is connected to the electricity supply and the food is prepared for serving hot.

A range of foods is available through a variety of menus. Food for patients who do not have special dietary requirements is varied by rotation of menus over a two-week period; food for patients who have special dietary

[7] Tillery Valley Foods website: http://www.tilleryvalley.com/home.html

requirements is also available – should a patient require a specialised menu not generally catered for, a diet chef is available to discuss their specific needs with that patient.

There is inevitably wastage of food. In 2015/16, 176 tonnes of food waste were recorded, approximately 6% of the total waste tonnage at Queen's Hospital [8]. Food waste is collected separately and recycled.

Serving arrangements

In common with many hospitals, food orders used to be based on choices made by patients the previous day. This inevitably meant that many patients were served food not of their choice but that of the patient who had previously occupied the bed.

To overcome that, and to ensure compliance with a recommendation following the PLACE inspection that food be ordered within five hours of the time it is due to be served, the hospital is introducing the use of Saffron, an electronic, tablet-PC based, ordering system (similar in concept and operation to the ordering system used in an increasing number of restaurants). A "host" (an employee of Sodexo) takes the patient's order which is sent electronically to the food store so that meals can be prepared.

Once the food has arrived at the ward for final preparation and is ready to be served, ward staff report to the ward kitchen area and take the food to the patient.

Mealtimes are "protected", which means that all routine and non-urgent medical and nursing tasks are suspended and all available staff are used to take meals to patients. Where a patient is unable to feed themselves, assistance should be available either from staff or from volunteers to ensure that they are fed. Staff receive regular training in nutrition and food preparation and handling.

[8] Source: Barking, Havering & Redbridge University Hospitals Trust, in response to enquiry from Healthwatch, October 2016

The visit

The visit on 6 October involved three teams of Healthwatch members. As different teams were involved, the following accounts of their observations accordingly reflect their different experiences: two teams had a generally good impression of the arrangements they observed but the third found the experience disappointing.

Bluebell Wards A and B – specialities: medical and respiratory

There are six bays, each with four beds, in each ward (together with four barrier rooms, which the team did not enter), which have mainly elderly people as patients. There are four Consultants responsible for these wards, and nursing staff including a Matron and a Senior Sister.

The team was met by the Duty Manager, who escorted them around, introducing staff whenever possible.

The team visited Bluebell B ward first, where there were three duty stations, all staffed. In addition to the wards (48 beds plus 4 barrier beds), a Friday day clinic is held each week for day patients. The team was told that visiting is from 10.30am to 7.30pm daily.

The team arrived at midday and the heated food trolley arrived on the ward at 12.10pm. Meal times are "protected", which means that no routine work or doctors' rounds take place during them, to ensure both that staff are available to concentrate on feeding and that patients are not avoidably disturbed from their meals; lunch time is noon to 1pm. Coffee or tea is offered at about 2pm hours

The team observed that patients' hands were cleaned with wet wipes prior to their eating. A "red tray" and "red jug" system was in operation (to indicate to staff those patients who needed help with eating and drinking) and all patients had access to plenty of drinks, including water. The team noticed one jug that was nearly empty; it was quickly filled when staff were made aware. Tables

were well positioned.

The food arrived hot, had an acceptable appearance and a pleasant odour. It was vegetarian goulash, beef stew and dumplings with mashed or sautéed potatoes and macedoine of vegetables (obviously from a freezer). Plates were served with covers that were removed at the bedside. The menus had been ordered earlier that morning which the staff told the team was better, with patients usually getting food of their choice, rather than the choice of the patient who had previously occupied the bed. One man was eating tuna salad and one lady had chosen ham sandwiches which had been unwrapped for her.

The team noted, however that, despite the pre-ordering system, the last patients to be served (usually those in the bays) sometimes were given what was left, rather than what they had ordered. For example, one patient told the team that she had been served quiche for both lunch and dinner the day before the visit, which was corroborated by a visitor. Condiments and serviettes were available and help was being given to those who needed it by staff (nurses and health care assistants (HCAs)), and visitors were also helping. Most meals were being eaten and the patients whom the team spoke to were mostly quite happy with their meal. The team noted a lack of fresh vegetables, that hot desserts were served at the same time as the main course, and had thus cooled by the time they came to be eaten, rather than being served separately. They also considered that better quality fruit juice could be offered.

The team was told that dietary requirements were assessed on admission and that notes about such requirements were displayed above the beds; and that requirements seemed to be adhered to. Patients were weighed and the dietitian was involved in that. Some patients were having puréed food, and one liquidised. The patient in question told the team that he did not like having liquidised food as it did not taste nice from a plastic feeder.

Although the staff seemed hard pressed all the time they were very

cheerful and treated their patients kindly and with respect. Almost all patients to whom the team spoke were full of praise for the staff, as were their visitors.

One of the younger patients to whom the team spoke, however, happened to be a dietician by profession and she described the food as "appalling, with little nutritional value at all". She was very critical of the lack of fresh vegetables and fruit.

Dessert on the day of the visit was rice pudding or yoghurt. The whole meal is presented to the patient at the same time so a hot dessert soon gets cold before being eaten. The dietician patient was also very critical of the cartons of fruit juice, which she said had no flavour and was just coloured sugar water. She was, however, the only person to voice criticism. Having professional background knowledge of dietary matters, her comments are noteworthy but it is equally notable that she was the sole critical voice.

Portions were not large but appeared adequate. The team was told that patients could ask for more food and that snacks were available (however, when the team enquired later whether food was available on the wards, they were told there was none). The plates were cleared after a reasonable time and the waste was disposed of in a black plastic sack.

The team noted one elderly lady, bedbound, in Bluebell A who had, unnoticed, fallen asleep with her lunch on her lap, which had gone cold. The team drew her to the attention of a nurse, who woke her up, removed the cold lunch and then helped her eat some cold rice pudding.

No leaflets or information appeared to be available for patients, visitors or staff about time procedures on the wards and no-one appeared to use the anti-bacterial hand wash, despite there being four barrier rooms.

The staff told the team that they were happy with the meal

service. They spoke freely and were generous with their time despite being very busy; they seemed to be a good team working flat out, which the team found impressive.

HCAs and Nurses complete the fluid charts and the nurses monitor them. Comfort rounds are made about every two hours, consisting mainly of toilet needs and drinks. A Sister said she thought it was necessary to have several menus to accommodate the diverse dietary needs and ethnicities on the wards. Patients had a variety of illnesses, although those with respiratory problems were the majority on these wards. All patients are assessed using the Malnutrition Universal Screening Tool (MUST), which takes place on admission.

The team noticed that one bed that was very low, with a mattress on the floor next to the bed. Staff explained that the patient in question tended to fall out of bed so precautions were taken for his protection. For that reason, his table had been placed out of reach at the foot of his bed, as he could have hurt himself if the table was in the usual position. His drinking and toileting needs was checked every two hours, an arrangement that appeared to work well. The team was unable to speak directly to the patient as he was sleeping.

The team was unable to talk every patient, as some were not well enough to be bothered.

Harvest A Ward - speciality: care of the elderly

The team considered that meals were well presented, in reasonable portions and were appetising; they appeared to be nourishing and in accordance with patients' requests. Hot meals were checked for temperature constantly, and cold meals were pre-plated before arriving on the ward. These also appeared appetising and well presented.

Specific conditions and dietary needs were well signed above the beds.

Beds were adjusted at meal times to enable patients to sit in comfortable eating positions, although some tables needed renovation. Tables were

placed in position for meals. Sanitizer hand gel was available for all patients to use before meals, and water jugs were available and within easy reach of all patients, although some appeared over-full.

However, on the day of the visit, the meals were very late arriving at the ward; staff explained that there had been a problem in the kitchen and this had caused the delay. When questioned about effect of the delay in meals on patients, the team was told that snacks and fruit were available for patients if needed.

Although sufficient staff to were available to serve the meals to patients and help was given to those who required assistance with eating their meal, there was only one person dishing the meals onto the plates from the trolley. Both main meal and dessert were served at the same time and this took some time to reach the patients. Patients in single rooms were last to receive their meals and they seemed to have a long wait before being served.

The team was told that a new system of ordering meals was being trialled on this ward. The staff told the team that they were not happy with the system as it required a lot of staff time. The logic of experimenting with a new ordering system on a ward where patients needed assistance to make their choices was not immediately obvious.

The team spoke to many patients, all of whom said they were happy with the meals they were receiving, and with the quality and quantity of the meals. Visitors praised the meals that their relatives and friends had been receiving.

Sunrise B Ward – speciality: care of the elderly

The team arrived on the Ward at approximately 12 noon. They were met by the Matron, who was pleased to see them and very happy for them to be there. She felt mealtimes had improved a lot since she had originally joined the Trust.

The heated food trolley arrived just after 12.15pm and staff, all

of whom were wearing plastic aprons, were ready to serve and feed patients. There were six nurses to feed patients, with two staff serving the meals.

The team walked around the bays observing what was happening. The only food available was meatballs and mashed potato, which the team was told was classed as a "soft food". Dessert was also available on the trays but no patient appeared to eat theirs.

The team concluded that there were not enough staff available to feed every patient their food, which was becoming cooler and less appetising by the minute. One nurse to whom the team spoke appeared exasperated by the situation (her facial expressions said it all).

Meals are ordered during the morning of the day in which they will be served, by a kitchen assistant using a tablet computer app, who must go to up to 100 patients asking them what they want to eat for the day. As many of the patients are frail and elderly, they never seem to get what they order as the assistant guesses what they might eat.

Every patient had their meal served up on a red tray, and all had a water jug with a red lid, denoting they need help. Some jugs were out of patients' reach because they knock them over. The families that were there to help their relatives were not very happy with what was being served and a patient told the team that the food was unappetising and she would have loved something with a bit of flavour. The team spoke to the son of a patient waiting to be discharged after two weeks on the ward and he said that his mother had continually been served chicken, which she did not like, and that she had only had one meal that she had ordered during her entire stay on the ward!

All patients who were being fed had been propped up, although some were clearly very drowsy, which caused considerable problems for the nurses trying to feed them, and was very time consuming. The result was that no desserts were eaten. One patient was given two dinners and desserts as part of a plan to get him to put on

weight. It was also noted that some patients were given gluten-free cake for dessert even though they were not on a special diet.

To illustrate the problems staff had to contend with, some patients were observed with their arms tucked inside the bed sheets and were thus unable to wash their hands or feed themselves. The team was told that one patient in a side ward, who had dementia, tended to throw things and so her hands were permanently tucked down the bed. Her daughter told the team she was exasperated by the situation. Despite that, staff were unable to help all patients with their food as they did not have the time to do so.

Condiments were available on the trolley but not used (and were probably not appropriate for the type of patient on the ward). There was no evidence that indications of dietary requirements were within easy view of staff, such as discrete notices above the beds.

The portions of food served up appeared very small. Basic food is kept in the ward kitchen, such as bread and milk, which is not always brought up to the ward when ordered and staff must go down to get it. They also have Complan-type drinks to try and build patients up.

During the visit, the team saw no evidence of a comfort round being offered, and the levels in the water jugs suggested that not all patients were drinking sufficient water to remain properly hydrated. There appeared to be a very limited choice of food, restricted mainly to meatballs and mashed potato for the main course and rice pudding or Bakewell tart for dessert; small quantities of other foods were in evidence but too little to make any difference, and seemingly indifferently prepared.

The team gained the impression that choice was limited because this is an elderly care ward – but the consequence was that, because patients were not being fed the food of their choice, they were not eating what they were offered and wastage levels were accordingly high. The team was told that one family had complained about the lack of choice of food and were clearly not happy with the new system.

Although staff were enthusiastic about the meal time, there were too few of them to make a difference.

Conclusions

The Healthwatch teams that carried out the visits had a mixed experience. The conduct of the mealtime at both the Bluebell and Harvest wards was satisfactory: food was served in adequate portions, seemingly in accordance with patients' orders and assistance with eating was available to those needing it. In Sunrise B ward, however, the story was very different: the food on offer was limited to "meatballs and potato", there were insufficient staff available to assist all patients with feeding, some patients' ability to move had been restricted for their own safety (but, by doing so, their ability to take food had been likewise restricted), and the food was indifferently served because the nursing and HCA staff were too stretched to attend properly to every patient.

Clearly, the hospital is conscious of the need to improve management of the patients' mealtime experience. The introduction of a new system to manage the ordering of meals is potentially a significant step but the evidence of the visit suggests that there is some way to go yet. More importantly, more needs to be done to address the problem of ensuring that those patients who are unable to feed themselves are helped to do so.

Moreover, whilst it is recognised that some patients lack the ability to order their own food – so some element of choice is unavoidably left to staff – it seems inappropriate simply to order a bland meal of "meatballs and potato" virtually automatically and that perhaps more effort could be made to encourage some at least of the patients to take a more active part in ordering their own food.

That said, it is also recognised that nursing and HCA staff are very busy and may not have time to spare to help every patient who needs it to order food. But good nutrition is a key part of recovery from illness or injury and there is always the possibility not only that some time spent with a patient

to organise the food they want would assist in reducing the amount of time they spend as an in-patient before being discharged, but also in promoting a better quality of life for them once they are discharged.

It is accepted that the food on offer meets all requisite standards for nutrition and hygiene; it is served hot when necessary and cold alternatives are available. But no matter how good the food may be, if the patient cannot or does not eat it for any reason, it will simply go to waste. The teams on the visit reported instances of patients not eating, or being able to eat, because they did not like what they were served or were unable to feed themselves and no one was available to help them.

There is clearly no simple answer. The hospital has used a "feeding buddy" scheme, with volunteers coming in to help patients who cannot feed themselves but such a scheme can only succeed if there is a ready supply of volunteers in sufficient numbers – but at the time of the visit, this did not seem to be the case. Nursing and HCA staff have numerous other tasks and duties to attend to and feeding is too easily overlooked (even though, as noted already, good feeding is one of the keys to prompt recovery).

It would not be feasible for Healthwatch to make specific recommendations about mealtimes. It is hoped, however, that the hospital will encourage staff to engage more with patients during mealtimes and, in particular, encourage patients who are have the ability to do so but for some reason are finding it hard, to feed themselves, and to respond to suggestions that a food is not liked or is not acceptable in a more positive way by taking action to ensure that something more to the patient's liking is made available to them. The greater use of volunteer "feeding buddies" would also help in that respect and the hospital is urged to develop that scheme further, as a matter of urgency.

Finally, since the visits were undertaken, comments have been received to the effect that the new food ordering scheme is not working as envisaged. The difficulties of managing the ordering of food in the quantities required

are obvious and the use of innovative solutions is to be encouraged. But new systems need to be bedded in over a period and closely-monitored to ensure that they are effective and working as expected.

The teams would like to thank all staff and patients who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to the visit on 6 October 2016 and is representative only of those patients and staff who participated. It does not seek to be representative of all service users and/or staff.

Participation in Healthwatch Havering

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Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**; or email
enquiries@healthwatchhavering.co.uk

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ENTER AND VIEW VISIT MEALTIMES – 6TH OCTOBER 2016

1 INTRODUCTION

Healthwatch Havering is the local consumer champion for both health and social care. Their aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally. Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

2 HEALTHWATCH HAVERING REPORT 6TH OCTOBER 2016

Healthwatch authorised representatives undertook a visit to several wards at Queen's Hospital to enable Healthwatch members to observe the delivery and presentation of the midday meal, the help available to those patients who need assistance with feeding and how patients with varying needs copied with their meals.

Following on from that visit, Healthwatch Havering met with senior staff from the hospital and it's catering contractor to discuss various issues, emerging from both the enter and view visit and earlier patient reports.

3 BACKGROUND

The following wards were visited:

Harvest A & Sunrise B are both 31 bedded acute medicine wards specialising in care of the elderly. There are 4 Consultants responsible for these wards, with nursing staff including a Matron and a Senior Charge Nurse/Senior Sister.

Bluebell A & Bluebell B – are both 28 bedded specialist medicines wards specialising in respiratory. There are four Consultants responsible for these wards, with nursing staff including a Matron and a Senior Sister.

The catering services at Queen's Hospital are provided by Sodexo Limited, on average 2,200 meals are prepared and served each day.

4 BHRUT RESPONSE TO HEALTHWATCH HAVERING REPORT

Although there were no specific recommendations contain within the report we would like to take the opportunity to address any areas of concern where improvements can be made to enhance patient experience during meal service.

4.1 GENERAL FEEDBACK

The 'Feeding buddy' scheme was relaunched and re-branded to 'Mealtime Assistants' in February 2017 to date we have 27 Mealtime Assistants, which consist of 15 volunteers and 13 staff members who volunteer their time during the lunch period. They have attended the awareness program and are now supporting wards during meal times. Further training is scheduled for June 2017 and future dates planned throughout the year.

There are five required standards for NHS hospital food in England as set out in the NHS standard contracts for hospitals. These 5 standards are:

1. The 10 Key Characteristics of good nutrition and hydration care, NHS England
2. Nutrition and Hydration Digest, the British Dietetic Association
3. Malnutrition and Universal Screening Tool, BAPEN
4. Healthier and More Sustainable Catering – Nutrition Principles, Public Health England
5. Government Buying Standards for Food and Catering Services (GBS), the Department for Environment, Food and Rural Affairs.

Dietitians are not involved in weighing patients: Ward staff weigh the patient and calculate the patients MUST score and if necessary, refer the patient to the dietitians.

New meal ordering system is not working - The new meal ordering system has been reviewed on a regular basis and any recommendations/ issues raised by the Trust have been picked up. We believe that the initial issues are resolved, however we are currently working with the patient dining group to explore different ways to order for the care of the elderly wards.

4.2 BLUEBELL A & BLUEBELL B FEEDBACK

Dietary needs and ethnic menus on the wards: There are a large number of menu's available to meets the cultural and medical needs of our patients. Further promotion of the menus was conducted during Nutrition and Hydration week in March 2017. We are also including a list of the various menu options on the main menu that is currently accessible on the wards so that patients and relatives are made aware of what is available.

No fresh vegetables available - The food service at Queen's is cook chill and the majority of the vegetables are cooked from fresh at our suppliers factory and chilled before delivery, however some vegetables such as peas and mixed vegetables are a frozen product. Fresh fruit is available to choose at every meal service.

A patient comment that food was appalling with little nutritional value and juice cartons were coloured sugar water - All menu items are agreed with the Trust dietician for nutritional content during the menu planning and reviews.

4.3 HARVEST A FEEDBACK

The meals were arriving late on the ward - the staff explained that on the day of the visit there was a problem in the kitchen and this caused the delay. When this happens patients are offered fruit and snacks. The time of delivering meals are now very closely monitored by the Matron and any delays are reported to Sodexo Management.

There was only one person dishing the meals onto the plates from the trolley - this has now changed. The ward ensures that at least two members of nursing staff are involved in dishing out the meals alongside Sodexo Hostess. The other members of staff are required to help patients with eating and drinking during Protected Meal Times, the ward has protected meal times between 12:00-13:00 and 17:00-18:00. Staff members are not allowed to have breaks during these times and they are required to assist patients with feeding. The Ward Manager ensures that band 6 nurse takes a lead on serving food to the patients every day.

Both main and desert were served at the same time and this took some time to reach the patients - the ward

has now introduced "meal by meal" serving for the patients. The main meal is always served first and the desert follows as soon as patients finish with the main one.

Patients in the side rooms were last to receive their meals and they seemed to have a long wait before being served - patients in the side rooms are now being served at the same time as patients in the main ward areas

4.4 SUNRISE B FEEDBACK

The only food available was meatballs and mashed potato (classed as a soft food) - the ward is now offering more choice for the patents and this includes soft food. There are currently 3 soft main course choices on the normal menus daily and 2 hot options for dessert and one cold. In addition to this we offer a dysphasic menu which consists of soft choices

It was concluded during the visit that there were not enough staff available to feed every patient their food - the ward follows Protected Meal times and all members of staff are required to be present and assist patients with feeding during these times. Staff members are not allowed to have their breaks during these times and patients do not go for CT scans and others investigations. This is a designated time for the elderly patients to have their meals. Food serving is always lead by the senior nurse (band 6 and above).

There is only one kitchen assistant trying to order food for the patients electronically using tablet - the food ordering is now being done not just one member of Sodexo staff, but nursing staff also assist with this activity. This allowed facilitating food ordering for all patients on the ward. Patient who are able to perform this task themselves are encouraged to do so. When the system was introduced the host was responsible for ordering of 60 patient meals on review this was changed in January 2017 to each host taking 30 orders

One patient was served chicken which she did not like for the entire stay on the ward - food is now ordered in the mornings and if the food does not meet patients' expectations, it is being changed. The Ward Manager was not made aware that patient was served wrong food for the duration of her stay as this had not been escalated to her. The Ward Matron also ensures and randomly checks if the right patient is served the right food he/she ordered.

Gluten-free cake was given to the patient who did not require special diet - issues regarding wrong food being served to the wrong patients were addressed by the Ward Manager Karuna with immediate effect. If this happens as a result of the human error, the wrong food is disposed of and the right food is given to the right patient.

Condiments were available on the trolley but not used - all patients are now being asked if they would like any condiments and they are available to all patients upon request.

There was no evidence that dietary requirements were within easy view of the staff, such as discreet notices above the beds - the Ward Manager and unit Matron now ensure that patients' white boards are being updated at least twice daily with regards to patients' dietary requirements. Night staff also ensures that extra checks are performed in the early hours of the morning to ensure that the patients receive the right diet throughout the course of the day.

Water jugs suggested that not all patients were drinking sufficient water to remain properly hydrated - not all patients require their fluid intake to be closely monitored, however, patients admitted with dehydration and kidney injuries require their fluid intake to be closely monitored. These patients are put on fluid charts and their input and output is closely monitored. The Ward Manager ensures that fluid charts and comfort rounding charts

are filled out properly and accurately.

It was felt that patients were not offered choice of food they had - the ward now ensures that all patients are getting the right food of their choice (whether of religious nature such as halal or kosher or of the personal nature such as vegetarian or vegan). The Ward also offers food of a medically - necessary or non-allergenic nature such as gluten free or nut free diet.

5 CONCLUSION

We would like to take the opportunity to thank Healthwatch Havering for undertaking this Enter and View visit and for the feedback provided in the report. We are aware of some of the issues identified and are managing these as part of the on-going aim to improve patient experience in relation to meal times.

ENTER AND VIEW – MEALTIMES 6TH OCTOBER 2016

ACTION LOG FOR MATTERS ARISING FROM HEALTHWATCH ENTER AND VIEW INSPECTIONS

Item No.	Ward	Issue	Lead	Target closure date	Action	Status
1	Bluebell A & B	We are also including a list of the various menu options on the main menu that is currently accessible on the wards so that patients and relatives are made aware of what is available	Lindsay Newell	T.B.C	Next printing date for menu's to be confirmed	
2	Bluebell A & B	Dessert being served at the same time as the main course	Environment & Catering Manager – Sodexo	Ongoing	This practice is now being closely monitored by the Sodexo supervisors and Housekeepers are being retrained in the correct procedure which is for all courses to be served separately	
3	Bluebell A & B	Patients not being given choice and last patients being served left over food	Environment & Catering Manager – Sodexo	31.05.17	The Sodexo Hosts have been trained to ensure all patients are given a choice. We are in the process of making the menu's more visible so that patients and their relatives will be able to have their choice ready when the host arrives to take their order. The menu's will be placed in a menu holder on the table in the centre of the bays or in side rooms on the bedside table	
4	Harvest A	Meals service late and experimental meal ordering system observed	Environment & Catering Manager – Sodexo	Ongoing	The meal ordering system was introduced in order to ensure patients could order their meals closer to meal service therefore ensuring they get their meal of choice. The system implementation was fazed over a period of 4 months and was closely monitored during implementation with changes made as and when issues were raised .The new service is still being closely monitored	
5	Sunrise B	Dessert being served at the same time as the main course	Environment & Catering Manager – Sodexo	Ongoing	This practice is now being closely monitored by the Sodexo supervisors and Housekeepers are being retrained in the correct procedure which is for all courses to be served separately	
6	Sunrise B	Patient comment that the food was unappetising	Environment & Catering Manager – Sodexo	Ongoing	Regular food tasting is carried out at ward level with a varied range of people attending .We would welcome patients representatives to attend in order that the patient view is represented	

Item No.	Ward	Issue	Lead	Target closure date	Action	Status
7	Sunrise B	Patients relative comment that his mother was not given an opportunity to choose her meal therefore resulting in her being given food she did not like	Environment & Catering Manager – Sodexo	31.05.17	Hopefully now that the new ordering system is in bedded this type of feedback will reduce. The menus as in point 2 will be more readily available for patients to make their choice	
8	Harvest A & Sunrise B	Meeting to be scheduled with Harvest A & Sunrise B Ward Managers and Sodexo to discuss the most recent Healthwatch report and their findings.	W Szarek	31.05.17		

Enter & View

NELFT
Mental Health
Street Triage Scheme

Goodmayes Hospital
Barley Lane, Goodmayes IG3 8XJ

23 November 2016

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff and a number of volunteers, both from professional health and social care backgrounds and people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is an Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

The visit that is the subject of this report was arranged through NELFT.

Although the visit was not undertaken as part of Healthwatch Havering's 'Enter and View' programme of visits using statutory powers, its content was similar and this report sets out the findings of Healthwatch participants.

Background and purpose of the visit:

Healthwatch Havering (HH) is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the safety of the resident is not compromised in any way.

The Scheme

The NELFT Mental Health Street Triage Scheme is operated by NELFT in association with the Metropolitan Police, British Transport Police (BTP) and London Ambulance Service (LAS). Through the scheme, a dedicated team of mental health practitioners (the triage team) is available for call out by police or the LAS to assist with people who appear to have a mental disorder who are causing a disturbance in a public area. The intention is to avoid the unnecessary arrest and potential criminalisation of a person whose problem is essentially one of mental distress and whose care is better left to mental health professionals. Having responded to a call out, the triage team can assess the individual and decide whether the best course of action is to take them to a mental health facility, to the Emergency Department at an acute hospital or leave them for the police to deal with under their statutory powers. The scheme operates across the four Outer North East London boroughs, Havering, Barking & Dagenham, Redbridge and Waltham Forest.

At the invitation of NELFT, a team of Healthwatch Havering members attended one of the regular management meetings for the Scheme. The meeting was also attended by a Police Sergeant from Romford (who is the liaison officer for the scheme), a liaison officer from the BTP and members of the street triage team (the LAS had been invited to attend but did not do so). The discussion focused on the police use of Section 136 of the Mental Health Act, 1983 (which contains the statutory authority for police officers to initiate the “sectioning” of people who have mental disorders and can lead to their compulsory detention in a mental health facility). It was agreed that a police station custody area was not ideal as a place of safety for people showing mental health problems and one of the main objectives of the scheme was to ensure that properly trained police officers and others attended a location and dealt with the matter.

The mental health facility at Goodmayes Hospital has two rooms dedicated for the use of patients detained under Section 136.

Another objective of the team is to stop people being taken to an Emergency Department (A&E) suffering from apparent mental issues unless they need

immediate medical assistance for an injury or illness. The consensus is that an ED/A&E is really not an appropriate place of safety for those suffering from mental health issues, not least because of the pressure that such departments are under currently.

At the time of the visit, the triage team was operating Monday to Friday from 11am until 1am but not at weekends or on public holidays; from December 2016, the team was merged into the Integrated Acute Service Response Team with revised hours of 5pm-1am Monday to Friday, and 8am-12midnight at weekends and bank holidays. Typically, 2 or 3 incidents will be attended each day, with some additional referrals signposted. Outside the scheme's operating hours, police respond to people suffering mental disorder and deal with them as a policing issue. Police officers approach such people as sympathetically as possible but their training, priorities and powers are focussed on "maintaining the peace" rather than handling complex individual mental health problems and so they will take a person either to a police station as a place of safety or to an ED/A&E if that person is injured.

The BTP interest in the scheme stems from the fact that many people with mental health problems seek to end their lives by suicide on the railways, both National Rail and London Underground. The BTP is in the forefront of measures to reduce suicide on the railways and has developed training programmes for their own and railway operating staff to deal sensitively with people who have mental health problems.

Development of the scheme

Public service resources are, of course, heavily constrained. There are funding pressures, not only on the NHS but also on the police service (both Metropolitan and BTP). National policy is, however, moving to favour improvements in services for people in mental health crisis, not least to reduce their dependence on ED/A&E services and it may now be time to promote innovative, multi-agency schemes such as this. In the context of the railways, an incident caused by a person in mental distress can lead to

disruption in the travel arrangements of thousands of people, at enormous overall cost, both public and private.

The scheme clearly has the potential to be cost effective in supporting people in a mental health crisis. At present, outside the times when the triage team operates, police officers (who are largely untrained in mental health issues) are left to cope with people in mental health crisis as best they can; whilst the officers undoubtedly deal with the situation to the best of their ability, their efforts are no substitute for assessment by trained and accredited mental health staff.

Healthwatch Havering would therefore support any move to extend the operating times of the triage team, ideally to provide 24 hour cover all the time. While accepting that this is dependent on the availability of funding, it is surely more cost effective to provide specialist intervention at the earliest opportunity and avoid unnecessarily taking people in mental health crisis to a police station.

In the same vein, Healthwatch Havering believes that consideration should be given to providing the triage team with a dedicated LAS emergency vehicle able to use "Blues and Twos" (two tone siren and blue lights), in a similar way to the service provided by the K466 Rapid Response Car (run jointly by the LAS and NELFT) to attend calls to elderly people who have had a fall. This would enable the rapid deployment of triage team members to an incident – currently, they use ordinary vehicles that, complying with traffic law, can take a considerable time to get to an incident. This will require development with the LAS – but ought not to require much additional expense, given that an ambulance will often attend an incident in any event (and may even lead to some reduced cost, given that attendance by a paramedic in a car is less costly than deploying a crewed ambulance). It would also be possible for the paramedic to deal with minor physical injuries, thus avoiding need for unnecessary hospitalisation.

Ideally, the triage team could be supported by a team of dedicated police officers working from the same hub as the NELFT staff. That may not be practicable but arrangements should be made to provide all police officers in

the three boroughs (including their BTP colleagues) with an understanding of mental health issues and the work of the triage team.

Conclusions and recommendations

The street triage scheme appears to be an excellent idea that will lead to an improved service for people suffering from mental health crises in a public place. It will also ensure that police officers will no longer have to deal unnecessarily with events using their Section 136 powers. It is an innovation that deserves support and development, not least as a cost-effective alternative to dealing with people in mental health crisis by putting them at risk of being dealt with inappropriately through the criminal justice system.

To secure development of the scheme, the following recommendations are made:

To NELFT:

(1) That consideration be given to operating the scheme for longer hours than at present, ideally on a 24-hour basis at all times;

(2) That arrangements be made with the Metropolitan Police and the BTP for all police officers in the BHR area to be given training to enable them to cope confidently with people undergoing a mental health crisis up to the point where a mental health street triage team can intervene, without unnecessarily resorting to their Section 136 powers;

(3) That the scope for use of a dedicated LAS vehicle to convey triage team members to an accident be explored with the LAS and police.

To the LAS:

(4) That effort be made to ensure that a LAS officer of suitable seniority attends future meetings of the Street Triage Team;

(5) That scope for use of a dedicated LAS vehicle to convey triage team members to an accident be explored with NELFT and the police;

To the Metropolitan Police and BTP:

(6) That arrangements be made for officers in the BHR area be given training to enable them to cope confidently with people undergoing a mental health crisis up to the point when a mental health street triage team can intervene, without unnecessarily resorting to their Section 136 powers;

To the BHR and Waltham Forest Clinical Commissioning Groups:

(7) That development of the Street Triage Scheme be supported, and that consideration be given to providing funding for:

(a) training police officers as recommended in (2) and (6) above

(b) further development of the scheme to provide up to 24 hour, all times cover; and

(c) use of an LAS vehicle to convey team members to incidents.

Healthwatch Havering would like to thank all staff who were seen during the visit for their help and co-operation, which is much appreciated.

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Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**; or email
enquiries@healthwatchhavering.co.uk

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Joint Health Overview and Scrutiny Committee, 18 July 2017

Response to Healthwatch Havering report on North East London NHS Foundation Trust (NELFT) Street Triage Service

Statement on behalf of Waltham Forest and BHR CCGs

Thank you for your email of 12 April about the North East London NHS Foundation Trust (NELFT) Street Triage services.

Waltham Forest Clinical Commissioning Group (CCG), together with Barking and Dagenham, Having and Redbridge (BHR) CCGs, initiated this project in 2014/15 and was successful in receiving the grant from NHS England to pump prime this service. All four CCGs are working closely together given their common approach to crisis care. We are pleased to see the benefit the service has already provided to mental health patients and their carers in crisis. The service has been identified as a priority area in our Sustainability and Transformation Plan (STP) programme. The four CCGs involved will work together to look into the options available and recommend decisions to improve services further. The CCGs are considering their investment priorities including the importance of securing this aspect of crisis care, along with improving the whole of the crisis pathway, with the aim of reducing people requiring this kind of intervention wherever possible.

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OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 18 JULY 2017

Subject Heading:	Joint Committee's Work Plan 2017-18
Report Author and contact details:	**Anthony Clements, Principal Democratic Services Officer, London Borough of Havering**
Policy context:	**The information presented gives suggestions for the Committee's work plan for the coming year.**
Financial summary:	**No impact of presenting of information itself.**

SUMMARY

An outline work plan is attached for discussion and agreement by the Joint Committee.

RECOMMENDATIONS

1. The Joint Committee to review the proposed work plan, make any amendments that it wishes and agree the final work plan for 2017-18.

REPORT DETAIL

Attached at appendix A is a proposed work plan for the Joint Committee for the 2017-18 municipal year. This has been drawn up following initial discussions

between borough health scrutiny officers. It should be noted that some gaps have been left in the work plan as the municipal year progresses as previous experience has shown that is often prudent to leave some spare capacity to deal with consultations or other urgent matters that may arise during the year.

The Joint Committee is asked to review the proposed work programme, discuss any amendments that it wishes to make and agree the final work plan for the 2017-18 municipal year.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, PROPOSED WORK PLAN 2017-18

18/07/17, Barking & Dagenham	**10/10/17, Redbridge**	**16/01/18, Havering**	**27/03/08, Waltham Forest**
BHRUT INTEGRATED QUALITY DASHBOARD	BHRUT – UPDATE ON SAFETY OF SERVICES	GP RECRUITMENT (CCGs)	NELFT
NELFT – IMPROVEMENT PLAN	CCGs – SPENDING NHS MONEY WISELY (PROVISIONAL)		
HEALTHWATCH HAVERING – MEALS AT QUEEN'S HOSPITAL	REFERRAL TO TREATMENT UPDATE (BHRUT/CCG)		
HEALTHWATCH HAVERING – MENTAL HEALTH STREET TRIAGE	WHIPPS CROSS – CARE FOR PATIENTS WITH DEMENTIA		
COMMITTEE'S WORK PLAN			

Site visit – To Whipps Cross and to meet new chief executive (late 2017)

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