CareQuality Commission

North East London NHS Foundation Trust

Quality Report

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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

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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?

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

Requires improvement ●

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?

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.

Requires improvement ●

Summary of findings

- 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?

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

Requires improvement ●

Summary of findings

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?

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.

Requires improvement ●

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.

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- 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

Summary of findings

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:

Summary of findings

- 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

Detailed findings

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

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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

Detailed findings

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

Detailed findings

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.

Track record of safety

- 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.

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- 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

Detailed findings

- 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.

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.

Are services effective?

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

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

Are services effective?

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.

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.

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.

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

Are services responsive to people's needs?

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

Are services responsive to people's needs?

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

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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.

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

Are services well-led?

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

Are services well-led?

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.

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

Are services well-led?

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.

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	

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:

· 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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
Diagnostic and screening procedures	**Regulation 13 HSCA (RA) Regulations 2014**
Treatment of disease, disorder or injury	
	Safeguarding service users from abuse and improper treatment
	Child and adolescent mental health wards:

·   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

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)

Regulated activity	Regulation
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**

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.

· 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	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Treatment of disease, disorder or injury	**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:

- 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.

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)

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.

· 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