# East London NHS Foundation Trust

## Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations.

For a summary of our inspection findings, see the inspection report for this trust.

## Is East London NHS Foundation Trust well-led?

### Leadership

The trust board consisted of the chair, chief executive, seven non-executive directors and six executive directors. In addition, there were three non-voting executive directors who were members of the board. There were no vacant posts.

The chair had been in post for over five years. The chief executive was appointed in August 2016; she had been a deputy chief executive and a psychiatrist in the trust prior to this. There was a good balance between new and longer established members of the board. This helped to promote stability, whilst at the same time encouraging innovation and development. The chair supported the board to carry out their role with confidence. Board members described how they made a difficult decision when there was a divergence of opinions. They described how the chair gave each board member the opportunity to explain their view-point and to consider the views of their colleagues. Ultimately the board had to vote to reach a decision, but all felt the process had been managed well.

The non-executive directors had the appropriate range of skills, knowledge and experience. They had experience as senior leaders in a range of organisations and brought an extensive range of skills to the trust leadership. They had expertise in areas such as finance and investment, strategic development, working in partnership, transforming services, delivering health care services and of being carers. More recent appointments promoted equality diversity and human rights and the chair was rightly proud of the diversity of the board. In addition an associate non-executive director was joining the board. This was part of a scheme to support the development of future non-executive directors.

The executive leadership of the trust had historically been clinically led and the same was true now. The chief executive, a number of the executive directors and the directors at a directorate level had clinical backgrounds.

There had been a number of changes of executive directors since the previous inspection. The changes had taken place smoothly and had provided opportunities for career progression within the trust and for external appointments to bring in their experience. The senior leadership team consisted of a chief finance officer, chief medical officer, director of corporate affairs, chief operations officer and interim chief nurse. The appointment of a permanent chief nurse role was underway. In addition, the other directors had responsibility for commercial development, quality improvement, integrated care and human relations and organisational development.

The trust reviewed leadership capability and capacity on an ongoing basis. A board succession plan was in place. The chair knew that three non-executive directors with finance expertise would be leaving in the next year, so she was working pro-actively to ensure replacements were found with the appropriate skills.

Careful consideration had also been given to ensure the executive directors were configured to provide the appropriate levels of support to the services in Luton and Bedfordshire. Two deputy chief executive roles had been developed. These roles were undertaken by the chief finance officer in Luton and Bedfordshire and the chief operations officer in London. The chief finance officer spent two days a week in Luton and Bedfordshire mostly meeting external stakeholders. In addition, one non-executive director was spending a day a week in Luton and Bedfordshire.

There was ongoing work to review the capacity of the executive directors. Portfolios had been reviewed and at the time of the inspection the committee structures were also being reviewed to try and ensure these were efficient and avoided too much duplication. The chief operations officer had seventeen direct reports and this number seemed extremely high. A decision had been made to appoint two directors to support this role. Other chief officer roles already had the support of directors to undertake specific areas of responsibility.

All the board members had lead areas of responsibility. Non-executive directors were linked with executive directors to provide support and challenge. In addition, where particular challenges were identified, working groups were established to oversee an area of work. For example, one of the non-executive directors, with a strong background in information systems was chairing a group looking at how the trust IT and information systems could be improved.

The non-executive directors were supported with their learning and development. Non-executive directors had completed an induction process. This had included individual meetings with the chair, attending board sub-committees and attending board development events provided by NHS Improvement. There were ongoing learning sessions at each board meeting. In addition, the chair was using external facilitators to support the board to consider how they could best perform their role. Opportunities were also provided for the board to meet informally. Non-executive directors had objectives and completed an appraisal.

Executive directors also had support with their leadership and development. This support was bespoke and tailored to their individual development needs. It included participation in leadership development programmes and having access to mentoring. The chair and chief executive showed insight into where people needed additional support and how this would be provided.

A random selection of trust board member fit and proper person checks were reviewed. This showed that all the necessary checks had been completed. This included disclosure and barring checks which was appropriate for people meeting patients and having access to confidential information. The trust board displayed integrity. For example, in relation to a recent decision about awarding a contract for a service that could have presented a conflict of interest, the trust was able

to explain how the board was kept informed and what arrangements were put into place to appropriately manage the potential conflict. However, the trust leadership team acknowledged that this could have been better communicated to ensure that staff understood the process that had been followed.

Interviews held with the trust leadership team demonstrated a high level of awareness of the priorities and challenges facing the trust and how these were being addressed. People were able to speak with insight about the work needed to achieve long term sustainability, the importance and complexities of the work with stakeholders, the development of new models of care and the workforce challenges.

The trust board recognised the importance of visiting services in order to understand the challenges they were facing and to inform their assurance work. For non-executive directors there was a co-ordinated programme of visits. Findings were fed back at the end of the visit and issues could be escalated if needed. Executive board members also had a programme of visits. Most staff commented on the approachability of senior leaders in the trust. They told us they had good access to leaders especially at a divisional level and felt that leaders had a good understanding of the challenges in their service.

The trust provided an ongoing well-embedded leadership development programme. This was one of the areas that made the trust outstanding at the previous inspection and remains an area of strength. The trust was evaluating some of the programmes to identify gaps and make improvements where needed. They were looking at progressing learning and development opportunities for allied health professionals and administrative staff. The trust was also looking at how they could develop a faculty so that people could be brought back together to continue their learning and sharing. The trust provided annual collective leadership development programmes, leadership for improvement programmes linked to quality improvement, nursing development programmes and medical leadership programmes. The leadership development opportunities were available for staff who were aspiring to be managers as well as existing managers. The trust had tailored development programmes for particular services. For example, staff working in community mental health services had programmes which focused on working effectively with partner organisations. During the inspections, we heard many positive examples from staff who had accessed these development programmes.

The trust was one of three national pilot sites working with NHS Improvement and the Kings Fund to develop a collective leadership strategy. One of the key drivers of this was to increase the diversity of staff in leadership positions. This work was a positive development as BME staff we met on the inspection still had mixed views about their opportunities to develop as leaders within the organisation.

## Vision and strategy

The trust had a set of values which were: we care; we respect and we are inclusive. These were known by staff throughout the trust.

At the time of this inspection, the trust were revisiting their vision, mission and strategic objectives. They had been holding a ‘big conversation’ consultation exercise with staff, service users and stake-holders. A series of events had taken place attended by over 800 people. The aim of these events was to discuss the trust’s strengths, areas for improvement and core purpose.

From this consultation, the trust was developing a new vision which linked the delivery of integrated care and their collaborative partnership work. They had identified four strategic outcomes which were: to improve outcomes based on the health of the populations they serve; to improve the experience of care; to improve the experience of staff and to improve value. The trust was in the process of developing measurable outcomes so they could monitor their progress. The new trust strategy was due to be in place by June 2018. Sitting beneath this overarching strategy

would be a number of updated supporting strategies covering workforce, clinical care, IT, finance, estates and other areas as needed.

The trust also had a two year operational plan for 2017-19 which had been updated having received the latest commissioning intentions.

The trust had made a conscious decision to be very actively involved in external partnership work to meet the needs of the populations it served. Since the previous inspection, the trust was delivering community services in Tower Hamlets and Bedfordshire. In both cases, the trust was working in innovative partnerships with other statutory and third sector organisations, providing opportunities for the delivery of new models of integrated care. For example, as part of the Tower Hamlets Together Partners development group, the trust had worked to support people to avoid hospital admissions and to provide care for people in their own homes. Other examples of partnership working had led to service developments such as the Luton and Bedfordshire street triage scheme; the Bedfordshire recovery college and the Luton and Bedfordshire employment services.

The trust had section 75 agreements in place with the City of London, Hackney, Bedfordshire and Luton. In Tower Hamlets, there was a trust hosted approved mental health professional (AMHP) service with a secondment agreement for staff employed by the local authority. However there were plans for a section 75 agreement to be implemented in this area in the near future. There was no section 75 agreement with Newham. The trust had a good relationship with all of the local authorities and there were no concerns reported in relation to Mental Health Act (MHA) governance. Regular police liaison meetings were held in each of the London boroughs to look at partnership working issues. A similar meeting was due to start in the Bedfordshire area in the near future.

AMHP teams covering each local authority were managed locally with an AMHP lead in each area. AMHPs were able to access MHA training provided by the trust. Out of hours there was a dedicated AMHP in all of the London boroughs. In Luton and Bedfordshire the out of hours AMHP service was provided by the local authority emergency duty team. We heard in East London about the challenges of there not being enough AMPHs and the impact this had on patients being assessed in a timely manner.

The trust was actively engaged in the work of two sustainability and transformation partnerships and led the mental health work streams. Within East London the trust participated in two delivery systems covering City and Hackney and another covering the rest of East London. Stakeholders had fed back positively about the trusts engagement and joint working.

The trust was also working to provide wider support to trusts in other parts of the country. They had been asked by NHS Improvement to support Norfolk and Suffolk Foundation Trust through a ‘buddying’ arrangement after they went into special measures for the second time.

## Culture

Staff were highly motivated, wanting to provide the best possible care for patients. Staff said they felt proud to work for the trust and were able to clearly articulate the contribution made by themselves and their teams.

Most staff we spoke to felt respected, supported and valued. There was lots of positive feedback from staff about the support they received from their line manager, team and the trust. Many staff described the high quality supervision, both managerial and clinical, that they received. They valued the open culture and felt that when concerns were raised they were taken seriously and where possible addressed. They also felt supported by the trust’s ‘no blame culture’ and willingness to learn when things went wrong.

Senior leaders were able to clearly articulate the culture they wanted to achieve within the trust. They talked about a 'bottom up' approach where staff were able to openly discuss challenges and empowered to find solutions. This culture was closely linked to the quality improvement methodology.

In the NHS Staff Survey 2017, the trust's overall staff engagement score was 3.90. This had reduced slightly from the previous year where the score had been 3.95. It was better than the 2017 national average of 3.79 for trusts of a similar type. The trust recognised there were areas where they needed to improve and was putting together action plans at a directorate and trust wide level. There were examples of where actions from the previous year had received a positive response. For example, we heard how teams had been supported to have regular team away days, giving them time to discuss their plans away from their day to day work. We also heard about the review of the 'respect agenda' in the forensic directorate.

Whilst there was more to do, the four workforce race equality standard (WRES) indicators monitored in the staff survey had all shown small improvements for BME staff over the previous year. The percentage of BME staff experiencing harassment, bullying or abuse from patents, relatives or the public had reduced from 36% to 33%; the percentage of BME staff experiencing harassment, bullying or abuse from other staff had reduced from 25% to 23%; the percentage of BME staff believing that the organisation provides equal opportunities for career progression had increased from 70% to 73% and the percentage of BME staff who had personally experienced discrimination at work had reduced from 14% to 13%.

During the previous year, the trust had done work to address inequalities in relation to BME staff entered into a formal disciplinary process through the use of quality improvement methodology. They were also increasing access to mentoring and reverse mentoring for BME staff. Other work included the extended delivery of unconscious bias training, training on mediation and expanding the pool of bullying and harassment support advisors.

The trust had four staff networks. Networks for BME staff, disabled staff and a LGBT network had been in place for some years. An additional women's network had been established in January 2018. We heard that the long-standing networks had lost their impetus over the last couple of years but the trust had recently decided to re-energise them. Each network was now sponsored by an executive director. The four networks now had a lead with a day of protected time each week to develop this work. The LGBT network members had contributed to the development of change ideas to apply to put the trust in the 100 best employers in the country for promoting positive working practices for LGBT staff. Staff from the three long established networks, had some reservations about their ability to share their views with the board. Network leads acknowledged that engaging staff from Luton and Bedfordshire was an area for development. Staff expressed the view that their team and line manager played a significant part in whether they felt comfortable being open about their protected characteristic and their confidence in members of their team being engaged in addressing equality and diversity challenges.

The trust were promoting the Freedom to Speak up Guardian (FSUG) as the way to raise concerns if staff did not wish to speak to their line manager. The trust had employed a member of staff in October 2017 to carry out this role part time. It was recognised that this was not sufficient for the role so the post was changing to full time in May 2018. The FSUG role had been launched, and there was ongoing work with the communications team to promote the role. The FSUG spoke at staff inductions and other staff events to raise awareness. The trust was also appointing 13 speak up ambassadors who will have one day a week of protected time to carry out this role. Since October 2017, 63 concerns had been raised with the FSUG. This included issues such as relationships with line managers, some bullying and harassment and the impact of staffing levels and workload on patient safety. The FSUG had access to a non-executive director for advice when needed. The FSUG reported back to the chief executive and chief nurse on a fortnightly basis and provided reports for the board.

The average staff sickness rate in December 2017 was 4% .The trust was focusing on the active management and support of staff on long term sickness. Staff had access to an occupational health service which provided counselling services and access to assistance with physical health needs. A recent trust quality improvement project had looked at what staff had found helpful, or would have been helpful, when they had experienced stress at work that resulted in sickness absence.

Managers across the trust said they were able to address poor staff performance where needed and received guidance from the human resources team when required.

Staff vacancies were around 12% for the previous six months. This was higher than at the previous inspection. The trust was aware of the specific services where the vacancies were higher, for example, in the Tower Hamlets community services and in Luton and Bedfordshire. Each directorate had specific recruitment plans in place. The trust had undertaken an innovative study to understand what their workforce prioritised at different ages. This had led to a better understanding of recruitment and retention challenges and the development of bespoke directorate workforce plans. The Newham mental health directorate had made progress using a rolling selection day. Staff turnover was around 16%. There were variations in the reasons for turnover across the trust. In London this was linked more to promotion whereas in Luton and Bedfordshire the reason for people leaving was for relocation and to achieve a work life balance. The trust was working to further understand these differences.

The trust's target rate for clinical supervision was 90%. As at 31 October 2017, the overall clinical supervision compliance was 83%. Five of the 11 teams (45%) achieved the trust's clinical supervision target. The clinical supervision compliance staff reported during this inspection was higher than the 80.9% reported at the last inspection.

| Core Service | Formal supervision sessions each identified member of staff had in the period | Formal supervision sessions required | Clinical supervision rate (%) |
|---|---|---|---|
| **CHS – Children, Young People and Families** | 1343 | 1476 | 91% |
| **MH – Community learning disability / autism** | 245 | 254 | 96% |
| **MH – Other Specialist Services** | 598 | 641 | 93% |
| **CHS – Community Inpatients** | 714 | 781 | 91% |
| **CHS – Adults Community** | 2,508 | 2,775 | 90% |
| **MH – Community-based mental health services for adults of working age** | 3241 | 3731 | 87% |
| **Other** | 1,692 | 1,963 | 86% |
| **MH – Mental health crisis services and health-based places of safety** | 417 | 497 | 84% |
| **MH – Wards for older people with mental health disorders** | 536 | 653 | 82% |
| **MH – Acute wards for adults of working age and psychiatric intensive care units** | 2752 | 3457 | 80% |
| **MH – Forensic Inpatient** | 3,374 | 4,601 | 73% |
| **MH – Community-based mental health services for older people** | 516 | 720 | 72% |
| **Total** | **17936** | **21549** | **83%** |

As at 31 October 2017, the training compliance for trust wide services was 85%. Of the training courses listed 32 failed to achieve the trust target of 90% and of those, 15 failed to score above 75%.The training compliance reported for the trust during this inspection was higher than the 83% reported at the last inspection.

Key:

| Below CQC 75% | Between 75% & trust target | Trust target and above |
|---|---|---|

| Training course | Trust target % | Trustwide training total % |
|---|---|---|
| **Infection Control Level 1** | 90% | **97%** |
| **Health & Safety** | 90% | **93%** |
| **Food Hygiene** | 90% | **92%** |
| **Safeguarding Adults Level 1** | 90% | **92%** |
| **Equality & Diversity** | 90% | **91%** |
| **Slip, Trips & Falls** | 90% | **91%** |
| **Safeguarding Children Level 1** | 90% | **90%** |
| **Conflict Resolution** | 90% | 89% |
| **Information Governance** | 90% | 87% |
| **Manual Handling** | 90% | 86% |
| **Safeguarding Children Level 2 (CHN)** | 90% | 85% |
| **CPA/CRAM** | 90% | 83% |
| **Therapeutic Handling (Children)** | 90% | 82% |
| **Medicines Safety** | 90% | 82% |
| **Fire Course** | 90% | 81% |
| **Mental Capacity Act (S12/AC)** | 90% | 81% |
| **Therapeutic Handling (Adults)** | 90% | 79% |
| **Prevent Awareness (Basic)** | 90% | 79% |
| **Client Handling** | 90% | 78% |
| **Care Handling** | 90% | 78% |
| **Safeguarding Adults Level 2** | 90% | 77% |
| **Breakaway PMVA** | 90% | 76% |
| **Fire Safety** | 90% | 75% |
| **Safeguarding Children Level 2 (MH)** | 90% | 75% |
| **Acute & Forensic PMVA** | 90% | 74% |
| **Resus – PLS** | 90% | 74% |
| **Safeguarding Children Level 3 (MH)** | 90% | 74% |
| **Prevent Awareness (Advanced)** | 90% | 73% |
| **Resus – ILS** | 90% | 71% |
| **National Early Warning Score (NEWS)** | 90% | 69% |

| Training course | Trust target % | Trustwide training total % |
|---|---|---|
| **Safeguarding Children Level 2 (CHN)** | 90% | 69% |
| **Resus – BLS** | 90% | 65% |
| **Fire Warden** | 90% | 65% |
| **Fire Competency** | 90% | 64% |
| **Mental Health Act (MHA)** | 90% | 58% |
| **Mental Capacity Act (MCA)** | 90% | 56% |
| **Infection Control Level 2** | 90% | 48% |
| **Deprivation of Liberty Safeguards (DoLS)** | 90% | 44% |
| **Venous Thromboembolism (VTE)** | 90% | 41% |
| **Trust Total %** | | **85%** |

The trust was working to improve compliance with mandatory training. For the previous six months, completion had been around 85% and the trust had a target of 95%. The trust was using social media to raise awareness of the importance of this training.

The trust recognised staff success. There were monthly directorate awards and a very popular annual awards ceremony. Most staff said that they felt the trust really valued staff and the annual awards ceremony was one of the ways this was demonstrated.

The trust had a health and well-being strategy. This was discussed as part of the staff induction. Staff had access to workshops, for example on achieving a work-life balance. Staff could attend subsidised yoga or pilates classes. A healthy life style was encouraged, for example, there was a cycle to work scheme.

We looked at five serious incidents to see how the trust applied the duty of candour. We found in all cases that families and carers had been contacted and were given an explanation of what had happened and where appropriate, an apology. Families and carers had contributed to deciding the terms of reference for the incident investigation. The trust shared the outcome of the investigations families and carers.

## Governance

The trust had effective structures, systems and processes in place to support the delivery of its strategic priorities. This included sub-board committees, directorate committees and team meetings. They had commissioned an external review and used the findings to make further improvements. The timings of the sub-committees of the board had been reviewed to ensure they could provide feedback to the board meetings. There had been further development of the performance report which had become an integrated quality and performance report. This report which was now more outcomes focused, clearly identified the main challenges and the actions being taken by the trust. The board assurance framework had also been refreshed. This now provided greater clarity about the risks and which sub-committee of the board was responsible for taking the lead in addressing them. Further work was planned to improve the clarity and reduce the length of the board assurance framework.

The trust board had six sub-committees which were: audit, quality assurance, appointments and remuneration, people participation, finance business and investment and the Mental Health Act. They each had clear terms of reference.

The papers for the board and the other sub-committees contained clear summaries and appropriate detailed information. Papers were always linked to the trust's strategic priorities. There was an annual work-plan to ensure that all the necessary areas were covered.

The non-executive directors were clear about their areas of responsibility. They chaired the board sub-committees. The executive directors had defined areas of responsibility. The clinical directors and service leads had operational responsibility for the nine directorates, which were a mixture of boroughs and specialist services. They, along with staff at a ward or team level, knew which issues needed to be escalated to the executive team and other stakeholders when they arose.

At a directorate level, scrutiny took place through a monthly performance meeting. More in-depth quarterly quality and performance review meetings took place led by members of the senior executive team. These meetings had a standard agenda which included quality assurance, quality improvement, quality control, planning and risk. The meetings se were supported with very thorough qualitative and quantitative information suitable for that directorate. The directorates also had their internal quality assurance groups which were the main links back to wards and teams. The agenda for the quality assurance group varied between directorates, but always included learning from serious incidents and complaints. Where an area of work needed a specific focus, then a committee could be established, for example, the chief executive was chairing an executive work-force committee and this reported to most board meetings. Meetings took place to address cross-divisional issues and also to enable more strategic thinking across the trust.

Key information was being shared with wards and teams within directorates. The wards and teams had access to a range of localised management information, which was available in the trust intranet, displayed in an accessible format that identified trends and areas for improvement. This localised data fed into the directorate and trust wide management information and supported the board assurance framework.

The trust had a wide range of agreements in place to ensure effective joint working. For example in forensic services, arrangements with partners, such as the local authority were in place that meant patients were able to access social work support in a co-ordinated manner.

The trust had ensured that all the breaches of regulation, identified at the previous inspection in June 2016 had been addressed. Good progress had also been made with best practice recommendations made at the previous inspection, with the majority met with a small number improved but still in progress.

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of identifying an incident. Between 1 November 2016 and 31 October 2017, the trust reported 155 STEIS incidents. The most common type of incident was 'Apparent/actual/suspected self-inflicted harm meeting SI criteria' with 95. Forty of these incidents occurred in community-based mental health services for adults of working age services.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. East London NHS Foundation Trust reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the same period on their incident reporting system. The number of the most severe incidents was broadly comparable with the number the trust reported to STEIS. From the trust's serious incident information, 86 were classed as unexpected deaths, of which 36 were instances of 'Apparent/actual/suspected self-inflicted harm meeting SI criteria' and 11 of these occurred in acute wards for adults of working age and psychiatric intensive care units.

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. They do not report staff incidents, health and safety incidents or security incidents to NRLS.

The highest reporting categories of incidents reported to the NRLS for the trust for the period 1 November 2016 to 31 October 2017 were 'Self-harming behaviour', 'Disruptive, aggressive behaviour (including patient-to-patient)' and 'Access, admission, transfer, discharges (including missing patient)'. These three categories accounted for 2,386 of the 4,175 incidents reported. Self-harming behaviour accounted for 55 of the 86 deaths reported.
Ninety-one percent of the total incidents reported were classed as no harm (71%) or low harm (91%).

| Incident type | No harm | Low harm | Moderate | Severe | Death | Total |
|---|---|---|---|---|---|---|
| **Self-harming behaviour** | 531 | 296 | 53 | 5 | 55 | **940** |
| **Disruptive, aggressive behaviour (includes patient-to-patient)** | 599 | 198 | 21 | 3 | 1 | **822** |
| **Access, admission, transfer, discharges (including missing patient)** | 557 | 32 | 34 | 0 | 1 | **624** |
| **Patient accident** | 339 | 197 | 29 | 1 | 0 | **566** |
| **Treatment, procedure** | 333 | 30 | 15 | 0 | 0 | **378** |
| **Implementation of care and ongoing monitoring/review** | 71 | 82 | 59 | 3 | 1 | **216** |
| **Medication** | 210 | 1 | 2 | 0 | 0 | **213** |
| **Other** | 104 | 2 | 2 | 0 | 29 | **137** |
| **Infrastructure (including staffing, facilities, environment)** | 109 | 3 | 0 | 0 | 0 | **112** |
| **Patient abuse (by staff / third party)** | 26 | 17 | 11 | 2 | 1 | **57** |
| **Clinical assessment (including diagnosis, scans, tests, assessments)** | 42 | 2 | 4 | 1 | 0 | **49** |
| **Consent, communication, confidentiality** | 25 | 4 | 1 | 0 | 0 | **30** |
| **Documentation (including electronic & paper records, identification & drug charts)** | 19 | 1 | 0 | 0 | 0 | **20** |
| **Infection Control Incident** | 4 | 2 | 1 | 0 | 0 | **7** |
| **Medical device / equipment** | 2 | 1 | 1 | 0 | 0 | **4** |
| **Total** | **2,971** | **868** | **233** | **15** | **88** | **4,175** |

According to the latest six-monthly National Patient Safety Agency Organisational Report (1 October 2016 to 31 March 2017), the trust was in the lowest 25% of reporters nationally for similar trusts. 'Self-harming behaviour' accounted for a higher proportion of the total number of incidents reported compared to similar trusts. The trust was aware of this but were also monitoring this in alternative ways through their quality improvement work on violence and aggression. In addition, staff in wards and teams were very confident in their knowledge about how to report.
Organisations that report more incidents usually have a better and more effective safety culture than trusts that report fewer incidents. A trust performing well would report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death).

East London NHS Foundation Trust reported fewer incidents from November 2016 to October 2017 compared with the previous 12 months. There were 86 deaths and 10 severe incidents between November 2016 and October 2017 as compared to 96 deaths and 16 severe incidents in the previous 12 months.

| Level of harm | November 2015 – October 2016 | November 2016 – October 2017 (most recent) |
|---|---|---|
| **No harm** | 4,650 | 2,346 |
| **Low** | 1,097 | 653 |
| **Moderate** | 279 | 201 |
| **Severe** | 16 | 10 |
| **Death** | 96 | 86 |
| **Total incidents** | **6,138** | **3,296** |

The trust had a process in place to manage the investigation of serious incidents. There were a team of five dedicated staff to review serious incidents and support the investigation process with staff from the directorates. Incident reports were reviewed on a daily basis and a report sent to the chief medical and nursing officers. For serious incidents a 48 hour report was prepared. A twice weekly serious incident review panel took place and the level of investigation was agreed. Where needed, an external review was commissioned, as had taken place after four deaths of patients on Ash Ward an acute inpatient service in Bedfordshire. At the time of the inspection, the trust reported that 80% of the investigations were being completed within the agreed timescales. The outcomes of investigations were fed back to the quality assurance committee and part 2 of the board depending on the severity of the incident. Thematic reviews of incidents took place when needed and had looked at areas such as family involvement. Five root cause analysis serious incident reports were reviewed as part of the inspection. They had been completed to a high standard; however, in three reports staff said they had not had access to a debrief following the incident. External stakeholders gave positive feedback about the quality of incident reports and action plans.

The trust had clear structures and procedures for keeping scrutiny of the Mental Health Act (MHA) and Mental Capacity Act (MCA) at the forefront of practice. The use of the MHA was overseen by the mental health law committee, chaired by a non-executive director, that meets quarterly and reports to the trust board. Operational use of the MHA and MCA was monitored through the quality assurance committee. The mental health law department was overseen by an associate director of mental health law. The department had a presence on the six inpatient sites. The mental health law department carried out audits and produced an annual report. This included an analysis of the use of the MHA, MCA and Deprivation of Liberty Safeguards over the past year. The department also looked at issues raised in CQC MHA monitoring visit reports and considered the actions required. For example, they were reviewing how mental capacity was recorded in the electronic patient record system. MHA and MCA training was mandatory and 70% of clinical staff had completed the training. This was delivered face to face and through e-learning and where needed bespoke training was delivered to teams. There were sufficient numbers of hospital managers, although further recruitment was taking place to improve the diversity of the people performing this role.

## Management of risk, issues and performance

The trust was well- informed on areas of risk and these were clearly articulated by members of the board. Team risk registers fed into directorate risk registers and then into a trust risk register where corporate risks were identified. The risks were all rated and actions to address them were in place. In November 2017, there were 20 items rated as a high risk on the trust register. Concerns raised during the inspection correlated with what was on the risk register.

The top risks to the trust in meeting its principal objectives went into the board assurance framework where the controls to mitigate the risks and the actions being taken to address the risk were recorded. An executive director lead was identified for each risk. The audit committee had the responsibility for risk management and the oversight of the board assurance framework. In December 2017, four risks were RAG rated as red, which meant the likelihood and potential impact were more significant. Two related to the ability to make financial savings and two related to the challenges of making service transformations, including completing consultations in a timely manner. The details are below.

**Key:**

| High (15-20) | Moderate (8-15) | Low 3-6 | Very Low (0-2) |
|---|---|---|---|

| ID | Description | Initial risk Score | Risk Score (Current) | Target level | Strategic Goal Link |
|---|---|---|---|---|---|
| **1.3** | It fails to transform district nursing services in order to meet the needs of health services and wider community | 16 | 16 | 9 | 1 |
| **3.5(a)** | The short-term impact and potential lack of achievability of CRES (cash releasing efficiency scheme) requirements, coupled with expenditure control and income generation, upon the overall financial sustainability of the trust. Further risk implications concerning the impact of the reputation of the trust and access to revenue streams such as STF funding. | 16 | 20 | 12 | 3 |
| **3.5 (b)** | The long-term impact and potential lack of achievability of CRES (cash releasing efficiency scheme) requirements over the next 5 years, threatens the overall financial sustainability of the trust. | 16 | 16 | 12 | 3 |
| **3.7** | Agreement via consultation with commissioners, the public and other external stakeholders may not be granted in time to execute major plans, which should result in reduced expenditure and a more efficient delivery of service. | 20 | 20 | 12 | 3 |

The trust was committed to achieving a balance between assurance, control and quality improvement. One of the means of achieving assurance was through the use of audits. The trust had an annual plan of audits focussing mainly on safety critical areas. These audits were completed on a quarterly cycle, to enable the data to be collected and then the findings discussed at directorate management teams and team meetings and changes fed back to the quality assurance team. Examples of audits included infection control, safe and secure handling of medication, record keeping, completion of patient records, accessible information and restrictive interventions (seclusion and restraint). Service users also completed audits including topics such as ward rounds, inpatient food, respect and understanding, knowledge and information. The trust also took part in a number of national audits, for example the prescribing observatory for mental health; national diabetes audit; national audit of intermediate care and falls and fragility.

As part of their assurance processes, the trust was also piloting a system of internal inspection. This self-assessment process had been tried across the community health services. This involved

clinicians and service users inspecting across services. Twelve teams had done inspections. The trust was looking to apply the same model in specialist services.

The trust had systems in place to ensure they were compliant or working towards compliance with NICE guidance. This work was led by an associate medical director and was monitored through the quality assurance committee. Clinical directors had to identify for their directorates any gaps in compliance and how these would be addressed. Audits were then carried out to ensure the guidance had been put into practice.

Appropriate systems were in place to ensure new staff had the correct recruitment checks prior to working in the trust. Records were checked for staff who had recently joined the trust and all the necessary checks were in place.

Systems were also in place to ensure medical and nursing revalidation had taken place for staff working in the trust. An annual report confirming progress in this area was provided for the board.

The trust recognised the need to have robust infection control systems in place. They recognised that there was more to do and had an infection control action plan in place. A number of actions were underway. This included the recruitment of an infection control nurse to support community health teams; input from estates to ensure water management and waste management; matron visits to monitor infection control; quarterly infection control audits; appropriate information for services users and visitors and input for staff such as ensuring they had the appropriate immunisations.

The trust had systems in place to ensure fire safety. They carried out an additional deep dive check post Grenfell Tower to ensure the buildings used for the delivery of trust services complied with best fire safety standards. Five buildings had external cladding which was checked. There was an annual fire safety assessment process in place across the whole property portfolio.

The emergency planning and business continuity plan was reviewed on an annual basis by the board. This covered all areas of the trust's resilience arrangements. During 2016-17, the trust received an overall rating of 'substantial compliance' from NHS England for their emergency planning and business continuity plans. Action plans were in place for the three areas with an amber rating. The trust also participated in local and London wide multi-agency exercises to prepare for an emergency. Links had been established in Luton and Bedfordshire with the local resilience forum.

At the time of the inspection, the trust was placed into segment 2 of the single oversight framework operated by NHS Improvement. This looked at five areas including quality of care, operational performance, strategic performance and leadership and improvement capability. The rating however, reflected NHS Improvement's concerns that they might not meet their control financial surplus for 2017-18.

Overall, the trust was in a strong position financially, having created cash reserves. The trust was confident that it would reach its £12.4m control total surplus in 2017/18. This had been achieved through a combination of income generation and cash releasing efficiency schemes (CRES).

There was strong engagement at a directorate level in the identification of areas for income generation and CRES for 2018/19. However, clinical directors and service leads had recognised that this would be a very challenging year. Many of the ideas being considered were service transformations that relied on partnership working with other stakeholders. At the time of the inspection, the trust was aiming to undertake £15m of CRES. Of this £7m were either fully or partially developed schemes and £8m still needed to be identified. It was recognised that this inspection was taking place early in the financial year when proposals for financial savings were still in development.

Financial governance in the trust was very strong. Finance was reviewed for each directorate as part of the performance monitoring process. Three of the non-executive directors had significant financial expertise. Financial scrutiny took place through the audit committee and the finance business and investment committee. The engagement of staff throughout the organisation from ward to board in managing the trust finances gave us confidence that the 2018/19 control total surplus of £10.8m could be delivered.

The larger transformational cost improvement project plans, including the impact assessments, were reviewed by the chief medical and nursing officers and approved by the board to ensure they did not compromise patient care. The chief medical and nursing officers had not yet attended meetings to undertake the impact assessments for the current financial year and did not appear as knowledgeable about the financial plans as other members of the senior leadership team. The board members were all clear about the need to maintain quality and would be prepared to challenge the proposed control surplus target if quality was compromised.

## Information Management

There was a high level of confidence in the reliability and accuracy of the data available throughout the trust. We heard that the weakest data related to staffing including training, as this was lifted from a system which required updating. The trust recognised that further work was needed to have data available in real time for services to use to make improvements.

The trust was very thoughtful about what data was collected and how information was presented. They had identified that information was needed to support work relating to assurance, control, improvement and planning. Where possible they were using data that was outcome focused. They presented information in an accessible format and made extensive of run charts to monitor progress over time.

The trust was making good use of technology in the delivery of patient care and had further plans underway. Examples of this included providing staff working in some community teams with technology so they could access patient records and record their work remotely. We did hear that some issues of connectivity were still being resolved. The trust was making use of tele-health services, such as apps to enable patients to monitor and submit data about their diabetes. The trust was making good use of video conferencing and this was particularly helpful in the more dispersed services in Luton and Bedfordshire. In Bedfordshire, the recent introduction of text messaging to remind patients to attend their appointments had led to significant improvements in attendance.

The trust was working through a dedicated lead to maintain cyber security through the use of updated software and security patches. Only six computers had been affected by the cyber security incidents in May 2017 and these had links to Barts Health where significant improvements in cyber- security needed to take place.

The trust had information governance processes in place. This included the provision of training, guidance and support directly to staff where needed. The latest completed information governance toolkit gave the trust a score of 74% and action plans were in date to make improvements. Information governance breaches were collated and areas for improvement identified. An annual report on this topic was prepared for the board.

## Engagement

The trust had further developed its patient participation work since the previous inspection.

The trust had a patient participation committee reporting directly to the board. This was attended by the chair, chief executive and other members of the board. There was also an assistant director leading on this work. This reflected how patient participation was central to the work of the trust.

The people participation strategy had been revised in 2017. Each directorate had a patient participation lead and a 'working together' group bringing together staff, patients and carers to oversee the development and implementation of plans for participation. The trust had an annual people participation awards ceremony. The trust had a reward and recognition policy and paid patients for their participation work.

There were lots of examples across the directorates of patients being actively involved in staff recruitment and developing and delivering training. For example, in Tower Hamlets there were co-produced recovery planning days to support staff to think about recovery.

Patients had received training in quality improvement (QI) and were participants in a number of projects. Examples of this included patients helping with the QI work to reduce waiting times for psychological therapies and to help improve complaints responses. In Bedfordshire, QI work had led to some recovery college courses taking place on the inpatient wards to help patients prepare for discharge.

Patients contributed to assurance activities for example designing and carrying out audits on a number of topics such as the quality of food and patient involvement in their own care planning meetings. In some areas, patients were now active participants in key work across a number of stakeholders, such as the work on suicide prevention in Tower Hamlets. In forensic services, patients had been involved with the work on reducing restrictive practices. They had also participated in team away days supporting staff to think about the work on 'respect'. Patients and carers had been involved in the 'big conversation' to develop the new trust strategy.

Patient participation work also helped to promote links with external communities and services. For example, in CAMHS there had been links made with the Olympic legacy programme to enable young people to participate in the well-being games. They had also helped to arrange a seminar for young people with sickle cell anaemia to discuss the transition to adult services. This was leading to a young person's user group being set up.

The trust also worked closely with carers and had recently updated the carer strategy. Each directorate had a carers lead and there were many examples of carers being actively engaged in the work of the trust.

At the time of the inspection, there were around 30 peer support workers in the trust working in some inpatient wards, community teams and enhanced primary care services. Whilst training was provided, the trust would like to see the numbers of peer support workers extended and to offer more opportunities for career progression.

The trust was actively promoting the use of volunteers. There were over 1000 volunteers. There was a volunteer co-ordinator and training was provided. The trust was able to offer a range of opportunities including befriending, helping at trust events and at crisis cafes.

The trust sought feedback from patients and carers. They promoted the use of the family and friends survey. The Patient Friends and Family Test asked patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 90% and 92%, for patients recommending it as a place to receive care for five of the six months in the period June 2017 to November 2017. Scores were similar to the England average throughout the six months.
The trust was similar to the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care in all six months.

| | Trust wide responses | England averages |
|---|---|---|

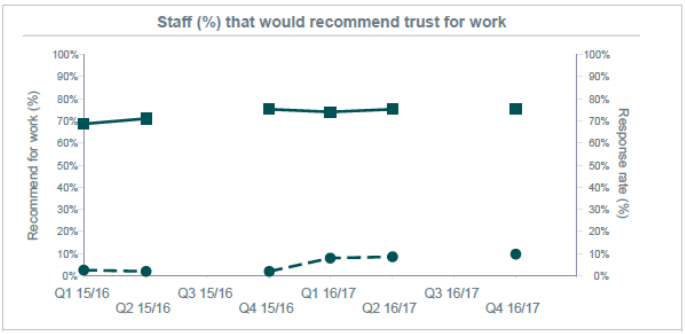
| | Total eligible | Total responses | % that would recommend | % that would not recommend | England average recommend | England average not recommend |
|---|---|---|---|---|---|---|
| **November 2017** | 16,996 | 941 | 89% | 5% | 88% | 5% |
| **October 2017** | 16,290 | 870 | 88% | 5% | 86% | 5% |
| **September 2017** | 15,642 | 935 | 89% | 4% | 89% | 4% |
| **August 2017** | 15,506 | 916 | 90% | 3% | 88% | 5% |
| **July 2017** | 16,050 | 899 | 89% | 5% | 89% | 4% |
| **June 2017** | 16,392 | 766 | 90% | 4% | 88% | 4% |

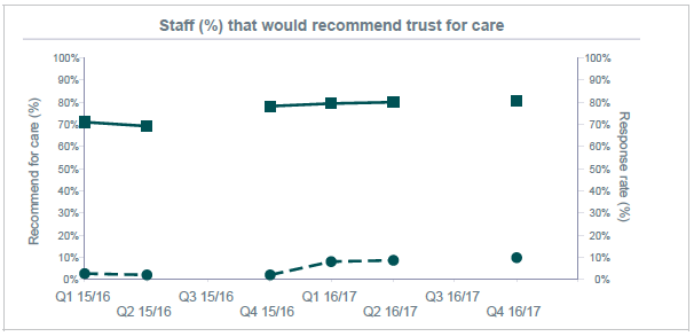
The Staff Friends and Family Test asks staff members whether they would recommend the trust as a place to receive care and also as a place to work.

The trust showed a steady trend over the last six quarters. Quarter 4 2016/17 had the highest scores for staff recommending the trust as a place to receive care and work. There is no reliable data to enable comparison with other individual trusts or all trusts in England.

**Key messages**

- The percentage of staff that would recommend this trust as a place to work in Q4 16/17 stayed about the same when compared to the same time last year
- The percentage of staff that would recommend this trust as a place to receive care in Q4 16/17 stayed about the same when compared to the same time last year




This trust — Response rate for this trust

Please note: Data is not collected during Q3 each year because the Staff Survey is conducted during this time

The trust performance against targets for responding to complaints in the last 12 months is below:

| | In Days | Current Performance |
|---|---|---|
| **What is your internal target for responding to complaints?** | 3 | 100% |
| **What is your target for completing a complaint?** | 25 | 90% |
| **If you have a slightly longer target for complex complaints please indicate what that is here** | N/A | N/A |

| | Total | Date range |
|---|---|---|
| **Number of complaints resolved without formal process in the last 12 months** | 470 | 1 November 2016 - 31 October 2107 |

Information on how to complain was on the trust website including how to contact the patient advice and liaison service and was available across the trust services. From 1 November 2016 to 31 October 2017there were 402 complaints. Of these, 83% of the initial responses were in 3 working days (target 85%). Of these, 60% of complaints were responded to in 25 working days or within an agreed extension (target 85%). The trust was working to improve the complaint response times and had recently increased staffing in the complaints team and was delivering complaints training throughout the trust. In last year, 8 complaints were referred to the ombudsman of which, 3 were upheld and 1 partially upheld. Themes from complaints were analysed and provided to directorates and teams to provide opportunities for learning and improvements. Commissioners fed back that the quality of complaint investigations and responses were generally good. In addition, specific work had taken place where needed such a review in Newham into variations in the numbers of complaints across the services. The trust had also carried out some quality improvement work to promote the informal resolution of complaints.

This trust received 370 compliments during the last 12 months from 1 November 2016 to 31 October 2017. This was higher than the 132 reported at the last inspection
Governors were actively involved in the operation of the trust. They told us that they found the trust open and transparent, that they were treated as equals and that the trust drew on their individual experience. This was an area of significant improvement since the previous inspection. Governors were now fully able to perform their role of appointing and holding the non-executive directors to account. The council of governors was made up of 26 public, staff and appointed governors and there were six formal meetings a year. Non-executive directors attended these meetings. In addition, between the formal meetings there was a governors open forum attended by a non-executive director where the governors could ask questions about how they carried out their role. Non-executive directors fed back that they felt their work was robustly scrutinised. Governors observed the board meetings and participated in sub-committees. Governors said their induction programme was very effective and new governors had been offered a mentor. Some suggested a buddying system for governors would be helpful. Governors felt well engaged with the work of the trust and had the opportunity to visit services. They actively participated in the work to develop the new strategy and were involved in important decisions, for example, about significant transactions being considered by the trust.

The trust had over 9000 public members and over 5000 staff members. They held an annual members meeting; members working lunch meetings; annual plan consultation events and an annual plan meeting. They also provided a quarterly newsletter. In 2017, the trust carried out a member’s survey to identify areas for improvement.

The trust continued to recognise the importance of engaging with staff. There were programmes of visits to services by senior trust leaders. Staff said that they found senior staff accessible and felt able to raise issues. Engagement took place within directorates with meetings and conferences. The importance of teams being able to have away days was recognised. Many staff fed back about the good standard of managerial and clinical supervision they received. Staff had opportunities to learn from other similar services. For example, the CAMHS quality events brought together trust CAMHS staff from different locations. The quality of the intranet was very good and provided staff with easily accessible information. The trust used social media such as blogs to engage with staff and the public.

The trust recognised the challenges of maintaining high standards of engagement with staff in Luton and Bedfordshire and also with trust services in Richmond and Barnet. They had taken steps to improve this through reviewing the leadership capacity available in these areas and making meetings such as the board meetings more accessible by holding them at Kings Cross which was easier for staff coming from Luton and Bedfordshire. They also provided training in different locations to enable staff to access these more easily.

The trust was using quality improvement methodology to focus on staff engagement. An initiative called ‘have you had a good day at work today’ was being piloted across five staff teams. Teams

would identify what got in the way of them having a good day and how this could be addressed. Staff satisfaction was measured before and then at various points through the process.

The trust had arrangements in place to work with staff including a joint staff committee with trade unions. Trade union representatives described how senior staff were generally responsive to issues raised by them. However, they also mentioned some occasions where they did not feel they had been consulted in a timely manner, such as when the Luton and Bedfordshire well-being services transferred to a new provider. Trade union representatives also felt that the human relations department was very slow to address some contractual issues.

External stakeholders, such as clinical commissioning groups fed back about the trust's style of engagement. They said they received open feedback about the performance and challenges faced by the trust.

## Learning, continuous improvement and innovation

The trust had continued to develop the use of quality improvement (QI) methodologies across the trust since the previous inspection. In December 2017, there were 179 active QI projects across the trust. These projects were continuing to offer opportunities for teams to improve outcomes, in areas such as reducing violence and aggression. There was now a focus on using the QI methodology to achieve strategic improvements to meet trust priorities. For example, QI project work was taking place to improve patient access and flow along pathways in a number of different types of services for example CAMHS services and access to speech and language therapy in community services. The QI work was overseen by the QI board with a QI forum in each directorate and progress was monitored through the quality assurance committee. The training on QI had also progressed, with staff being able to access 'pocket training' over two half days reaching out to more staff. Learning from QI was shared through a conference, website, newsletter and over 3000 followers on social media.

The trust participated in a range of accreditation schemes as follows:

| Accreditation scheme | Core service | Service accredited | Comments and Date of accreditation / review |
|---|---|---|---|
| **Accreditation for inpatient Mental Health Services (AIMS)** | Acute wards for adults of working age and psychiatric intensive care | Crystal Ward, Brett Ward, Conolly Ward, Emerald Ward | N/A |
| **AIMS – PICU (Psychiatric intensive Care Units)** | Acute wards for adults of working age and psychiatric intensive care | Crystal Ward | N/A |
| **Quality Network for Community CAMHS (QNCC)** | Specialist Mental health services for children and young people | Bedfordshire CAMHS, City & Hackney CAMHS, Luton CAMHS, Newham CAMHS, Tower Hamlets CAMHS, East London CEDS-CYP, Tower Hamlets Perinatal | N/A |
| **QNOAMHSL Quality Network for Older Adults Mental Health Services** | MH – older people wards | Columbia Ward | N/A |
| **ECT Accreditation Scheme (ECTAS)** | N/A | Luton (Bedfordshire), Tower Hamlets | N/A |
| **Psychiatric Liaison Accreditation Network (PLAN)** | MH – other specialist services | Newham University Hospital Psychiatric liaison (RAID) | N/A |

| | | | |
|---|---|---|---|
| **Memory Services National Accreditation Programme (MSNAP)** | MH – older people community | Bedford Memory Assessment Service, City and Hackney, Luton Memory Assessment Clinic, Mid Bedfordshire Memory Assessment Service, Newham Diagnostic Memory Clinic, South Bedfordshire Memory Assessment Clinic, Tower Hamlets Diagnostic Memory Clinic | N/A |
| **Perinatal: Perinatal Inpatient & Community settings** | MH – other specialist services | Margaret Oates Mother and Baby Unit (Hackney) | N/A |
| **CofC: Community of Communities (therapeutic community)** | MH - forensic services | Millfields Medium Secure Unit/East India ward | 2017 |
| **Quality Network Review for Forensic Services – Royal College of Psychiatry** | MH - forensic services | All forensic wards | N/A |
| **HTAS: Home Treatment Accreditation Service** | MH – Crisis and Health based places of safety | City & Hackney Home Treatment Team, Tower Hamlets Home Treatment Team | N/A |

One of the medical directors took the lead on research. Some very interesting research work was taking place. This reflected the importance the trust placed on patients being engaged in the work. It was also contributing directly to improving clinical practice. For example, through the Queen Mary's University unit for social and community psychiatry, patients were being trained as researchers and were looking at the impact of the trust's people participation work on well-being. The trust had also developed an evaluation tool for use by patients called DIALOG and DIALOG+. The tool was used when a patient met with a professional to rate patient satisfaction in a number of areas and from this identify the areas they wanted to address and agree actions. The use of this tool was mandatory in all early intervention services and was being further developed for other services.

The trust was keen for research to be multi-disciplinary and had just got funding to carry out a large scale study about patient preferences across a range of art therapy. This was offering the opportunity for art therapists to participate. Workshops were offered to medical trainees about participation in research. In psychology, two posts had been advertised offering two days a week to participate in research. For nursing staff, work with City University had led to two staff working on a telehealth project. The trust also had a horizon scanning group looking for good research ideas from elsewhere. This had led to a pilot in Newham taken from research in Scandinavia looking at patient-led admissions.

Learning from research was promoted through two research events each year, a research bulletin and updates on the trust website. The trust reviewed research through an annual report to the board.

The trust provided a number of innovative services that had achieved wider recognition. For example, in November 2017, memory services in East London won an award as the psychiatric team of the year at the Royal College of Psychiatry awards. In the City of London in August 2017 a street triage service was being piloted. In Newham, the trust was piloting enhanced nursing support to older people in three nursing homes to reduce hospital admissions.

The trust was making progress with its mortality review work, although having identified potentially avoidable deaths some of the detailed review work still needed to take place. The medical director

was the operational trust lead on learning from deaths. A lead non-executive director provided oversight. Deaths were addressed using the same approach as serious incidents with a twice weekly review panel that decided the level of investigation. The trust mortality review group took place monthly to oversee the whole process and to monitor trends and areas for learning. This committee also reviewed those deaths not reported as an incident (mostly in community services), to ensure these were also investigated if needed. The trust had adapted a mortality review tool from another trust to make it appropriate for the range of patients using the trust services and for collaborative work with other providers if needed. The trust was up to date in identifying the deaths that were potentially avoidable. However, the detailed review work still had to take place and a reviewer had been appointed with further staff coming into post to carry out this role. The need to include relatives in any review work was fully appreciated. The trust recognised its responsibilities to investigate and report on the deaths of patients with a learning disability.

The trust provided opportunities for learning from serious incidents including deaths. Immediate safety alerts were sent where needed. Learning from incidents was also shared on the trust intranet and discussed at team meetings, directorate quality assurance groups and then themes were reviewed at the trust quality assurance committee. Learning events took place which were attended by other stakeholders. These events were arranged trust wide or by directorates. Learning was also discussed at network meetings for services which operated across directorates, such as home treatment teams and early intervention teams.

# Mental health

## Forensic inpatient or secure wards

### SAFE

### Safe and clean environment

### Safety of the ward layout

Staff assessed risks to patients and staff arising from the layout of the ward and mitigated these through individual patient risk assessment, the observation of patients and regular security checks. On each ward there was an up to date ligature risk assessment and map which explained to staff the location of potential ligature anchor points and what actions were in place to mitigate risks. Staff told us ligature risks were highlighted to them when they first came to work on the ward and discussed at team meetings and away days. There were anti-ligature fittings throughout the wards. Staff knew which areas of the ward posed a risk and how patients should be observed when in these areas.

Some parts of the wards were not easy for staff to observe. At the last inspection in June 2016, the trust had not installed mirrors on Shoreditch and Clerkenwell wards where there were risks caused by poor lines of sight. These wards now have convex mirrors in the corridors which help staff monitor blind spots and improved patient safety.

Twice each day, at handover meetings, the staff team on the ward met to review individual risks to patients, such as suicidality and made plans to mitigate these. Staff could clearly explain to us the risks for each patient and how they should be observed. For example, some patients were on one to one observation to keep them safe.

The service complied with guidance on eliminating mixed sex accommodation. All the wards in the service were single sex. On all wards, patients had their own bedroom and bathroom.

Staff and visitors were issued with personal alarms. Staff tested alarm systems to ensure they worked well and staff responded appropriately to alarms. At the June 2016 inspection, the alarm system on Clerkenwell Ward did not meet the needs of patients with learning disabilities. Since then, the trust has installed a new improved alarm system. The alarm now operated quietly and was not distressing for patients.

The trust ensured the physical security of the service. At both the John Howard Centre and Wolfson House, entrance to and exit from the service was via an airlock controlled by staff. Visitors had escorts with them the whole time they were on site. All staff had security training before working on the wards and having any access to keys.

The trust had a procedural security policy which required staff to check the ward for any security risks three times each day. Staff informed us that they undertook these checks. However, we found gaps in the recording of these checks on Bow Ward and East India Ward.

Wards had fire risk assessments in place. Wards had fire blankets and fire extinguishers, which were serviced regularly, in case of a fire. At our last inspection in June 2016, we found there was a deficit in the training of bank staff in relation to fire safety. Bank staff now received training so they could support patients to leave the ward safely in the event of a fire.

The service planned for emergencies and staff understood their roles if one should happen. There was a programme of simulation training sessions to prepare staff to respond to emergency situations. Staff said they found these useful for practising life support skills and techniques for managing violent incidents.

## Maintenance, cleanliness and infection control

Patients were cared for in a clean and well maintained wards. Domestic staff completed records which showed that all parts of the ward were cleaned according to a schedule. Patients told us that wards were kept clean and well maintained. Staff and patients told us that any faults or repairs were swiftly identified and put right.

## Patient-led assessments of the care environment

There is no 2017 data for East London NHS Foundation Trust in the 2017 patient-led assessments of the care environment report and therefore we have used the 2016 data. This gave scores for the service of over 98% for cleanliness and over 94% for condition appearance and maintenance.

| Site name | Core service(s) provided | Cleanliness | Condition appearance and maintenance | Dementia friendly | Disability |
|---|---|---|---|---|---|
| **12 Kenworthy Road (The John Howard Centre)** | Forensic Wards | 98.1% | 93.8% | 80.3% | 68.1% |
| **Recovery Unit, Wolfson House** | Forensic Wards | 99.3% | 95.7% | N/A | 80.8% |
| **Trust overall** | | **87.8%** | **93.9%** | **82.5%** | **79.5%** |
| **England average (Mental health and learning disabilities)** | | **98%** | **95.2%** | **84.8%** | **86.3%** |

The service controlled infection risk well**.** Staff kept themselves, equipment and the premises clean. We observed that staff followed good practice in terms of hand washing.

### Seclusion rooms

Seclusion rooms were well designed and fully complied with the Mental Health Act Code of Practice guidance. For example, seclusion rooms had toilets and washing facilities and suitable furnishings. The secluded patient was able to view a clock.
Staff were able to clearly observe the patient during seclusion to ensure they were safe. Specialist equipment enabled the staff to monitor the patent's vital signs without entering the clinic room.

**Clinic rooms and equipment**
All of the wards had clean and well equipped clinic rooms. Equipment was clean. At the previous inspection in June 2016, we found that, on some wards, staff had not always appropriately checked the reliability of the equipment they used to monitor patients' physical health. At this inspection we found this had improved. Now there were records which showed that staff ensured equipment for physical health checks, such as blood pressure monitors, were in good working order.

However, on Bow ward, staff had not ensured that blood glucose monitoring equipment was calibrated every day. In the month prior to this inspection, 13 daily calibrations had been missed. Staff were not aware that the calibration fluid should be replaced every three months. The fluid had run out and been replaced in January 2018, so this was not a concern currently. Blood glucose readings are used to decide the dose of some medicines so it is important that they are always accurate.

On Clerkenwell ward clinic room temperature monitoring was not always completed; 13 daily checks had been missed in the two months prior to the inspection. Additionally the temperatures were above 25$^{o}$C on nine occasions during this time. Bow Staff were unaware how the thermometer for the room worked and had not escalated this issue. The medicines fridge temperatures were not always recorded; there were nine missing readings in the month prior to the inspection

Each ward had access to emergency resuscitation equipment including a defibrillator and oxygen supply as well as emergency medication supplies. Staff checked each day that medicines and equipment for use in an emergency were readily available and safe to use. However, we found some out of date items within the resuscitation bags on Butterfield Ward and Woodberry Ward, including urinalysis strips, syringes, vacutainers and airway openers. We reported this to the ward managers and these items were immediately removed.

On East India Ward, we observed that the clinic room door was not self-locking and someone could enter the clinic room whilst medicines were dispensed. We pointed this out to the ward manager and it was fixed whilst we were on the ward.

## Safe staffing

## Nursing staff
Across the service, wards were staffed with appropriate numbers of registered nurses and healthcare assistants. The trust specified the number of registered nurses and healthcare assistants required on each ward to ensure patient and staff safety. Vacancy rates were low. The vacancy rate for registered nurses was at 1% on 31 October 2017. This was lower than the 5.25% reported at the last inspection.

There was an overall vacancy rate of 14% for healthcare assistants on 31 October 2017. This was a higher vacancy rate than the -1.6% reported at the last inspection. Ward managers told us that there was ongoing recruitment of healthcare assistants.

The sickness rate for the service averaged 4% in the period 1 November 2016 – 31 October 2017. The service had 69.7 (15%) staff leavers between 1 November 2016 and 31 October 2017. This

was slightly higher than the 14% reported at the last inspection, from 1 January 2015 to 31 December 2015.

Safe staffing levels were maintained on the wards. The trust did not use agency staff. The trust used bank staff to cover all leave, absence and sickness. These were staff with current or previous experience of working at the service who wanted to work additional hours. Consequently, bank staff were familiar with the service, and often with the ward they were working on and knew the patients. Staff told us that on occasion, shifts were short staffed due to unforeseen circumstances. At such times, staff told us they were able to receive assistance from senior staff and staff from other wards to ensure the safety of patients.

At the June 2016 inspection, staff on a learning disabilities ward, Shoreditch Ward, told us they felt unsafe due to high levels of violence and aggression, which included sexual aggression directed at female staff. Since then, the trust has acted to improve the skills of the staff team in relation to working with patients with learning disabilities and autism spectrum disorders. The staff team now included more registered learning disabilities nurses. All staff on the ward now received a learning disability focused induction. Staff told us they had learnt communication skills to help them better understand the needs of patients. They said that knowing how patients were feeling helped them to prevent incidents of violence and aggression. Staff told us that they now felt safer on the ward.

Ward managers in the service were able to adjust staffing levels to take into account the needs of patients. They were able to book additional bank staff to assist with managing risks on the ward in relation to acutely unwell patients. During the inspection, Bow ward were using three additional staff to support a patient who was off the ward in an acute hospital. This meant that ward activities could go ahead as planned.

Across the service we observed that there were staff in communal parts of the wards to talk with patients and ensure they were safe. Care and treatment records showed that staff offered patients a one to one meeting at least weekly. Patients told us that staff spent time getting to know them.

Staff teams were able to safely carry out physical interventions. Duty rosters took into account any health issues that may prevent a staff member from carrying out physical interventions and ensured there were enough staff on duty to carry out restraint procedures safely. Training in physical interventions took place regularly and was part of induction for new staff. Staff told us that training was effective and included simulation exercises which prepared them to deal with difficult situations on the ward.

Some patients told us that they did not always have planned leave at the time specified due to staffing issues. For example, on Clerkenwell Ward, between 1 February and 25 March 2018 there were four incidents of leave being cancelled or re-arranged due to staffing issues. Staff also told us that the number of patients entitled to leave had recently increased to 14 out of 15 patients, and that it was difficult to schedule every patient's leave at a time they wished. Staff on the ward were aiming to reduce leave having to be rearranged. They avoided booking leave at busy times such as on the day ward rounds took place. Staff discussed leave with patients at community meetings and tried to make the organisation of leave as fair as possible.
The trust monitored whether patients went on leave as planned across the service. In the period October – December 2017, there were 85 instances of leave cancelled due to staff non-availability in the service. The service manager told that this issue was a priority for improvement and there was a quality improvement initiative in progress on this.

## Medical staff

Staff on the across the site reported there was sufficient medical cover at all times which meant a doctor could attend the ward in an emergency. There were two vacancies for consultant psychiatrists at the time of the inspection. The acting clinical director was providing cover for ward rounds and we did not find a negative impact on patient care.

## Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. All new and returning staff completed a mandatory forensic services induction which included training on security of the wards, personal safety and responding to verbal and physical aggression.

Ward managers held data on staff completion of mandatory training which showed a high level of compliance of over 80%. However, the trust target was 90%. They said they were advised when staff needed to renew training to ensure their continued competency. Staff advised us they could easily access mandatory training and were clear on which courses they were required to complete for their work role. Courses included basic and advanced life support, infection control and childrens and adult safeguarding.

## Assessing and managing risk to patients and staff

## Assessment of patient risk

Staff thoroughly assessed patient risks prior to admission to the service and continuously reviewed and updated risk assessments. We read 53 patient records across the service. The multidisciplinary team carried out a standardised pre-admission assessment of each patient. This included detailed information about the patient's past history, risks to self and others, safeguarding risks and security risks.

On admission to the ward, staff completed the risk assessment on the trust's electronic record system and updated this regularly and after each incident. In addition, psychologists completed additional risk assessment documentation within six months of a patient's admission.

## Management of patient risk

Blanket restrictions were used appropriately in the service and were consistent with good practice in a medium secure service. At our previous inspection in June 2016, there was an inappropriate blanket restriction in place on the John Howard site. All patients on escorted leave were required to wear an electronic tag, unless they had less than six months left until their discharge. During the June 2016 inspection, the trust recognised that this was too restrictive and was not based the individual risks for each patient. The trust immediately ensured that staff undertook individual risk assessments to determine whether a patient should wear a tag. However, procedures and record keeping required further improvement to ensure these risk assessments linked clearly to the patient's care plan and reflected their individual views.

At this inspection, we found that there were no unjustified blanket restrictions. Records showed staff assessed the individual risks in relation to a patient taking leave from the ward. Staff included a risk assessment on whether the patient should wear an electronic tag. At ward rounds and other multi-disciplinary meetings we saw that the staff team reviewed individual risks and stopped tagging patients when it was safe to do so. Staff routinely undertook risk assessments in relation to patient leave. The staff team cancelled the patient's leave when it was appropriate to do so. Patients were given clear information about the conditions of their leave from the ward.

## Use of restrictive interventions

The table below has data on restrictive interventions for the period: 1 December 2016 to 30 November 2017.

| Ward name | Seclusions | Restraints | Patients restrained | Of restraints, incidents of prone restraint | Rapid tranquilisations |
|---|---|---|---|---|---|
| **Bow Ward** | 59 | 71 | N/A | 6 (8%) | 30 (42%) |
| **Broadgate Ward** | 16 | 8 | N/A | 1 (13%) | 4 (50%) |

| | | | | | |
|---|---|---|---|---|---|
| **Butterfield Ward** | 3 | 3 | N/A | 2 (67%) | 0 (0%) |
| **Clerkenwell Ward** | 11 | 15 | N/A | 0 (0%) | 8 (53%) |
| **Clissold Ward** | 3 | 6 | N/A | 0 (0%) | 2 (33%) |
| **East India Ward** | 9 | 5 | N/A | 1 (20%) | 0 (0%) |
| **Hoxton Ward** | 1 | 2 | N/A | 1 (50%) | 1 (50%) |
| **Limehouse Ward** | 10 | 4 | N/A | 1 (25%) | 0 (0%) |
| **Loxford Ward** | 0 | 1 | N/A | 0 (0%) | 1 (100%) |
| **Ludgate Ward / Aldgate Ward** | 28 | 32 | N/A | 9 (28%) | 7 (22%) |
| **Moorgate Ward** | 7 | 13 | N/A | 2 (15%) | 3 (23%) |
| **Morrison Ward** | 8 | 6 | N/A | 3 (33%) | 1 (17%) |
| **Shoreditch Ward** | 29 | 19 | N/A | 1 (5%) | 8 (42%) |
| **West Ferry Ward** | 170 | 165 | N/A | 38 (23%) | 32 (19%) |
| **Core service total** | **354** | **350** | **N/A** | **65 (19%)** | **97 (28%)** |

Staff only restrained patients as a last resort after de-escalation had failed. The trust monitored the use of restraint in the service and had policies and procedures which aimed to reduce the need for restraint. Staff kept records which showed how they had attempted to avoid the use of restraint and how the restraint had been carried out. Incident reports included information on how long the patient was restrained.

The service had 350 incidents of restraint between 1 December 2016 and 30 November 2017. The wards with the highest number of incidents of restraint were West Ferry Ward with 165 and Bow Ward with 71. Staff told us this was due to the complex needs of the patients on these wards. The number of restraints fluctuated from month to month on all wards according to the patients on the ward. Ward managers had details and graphs of the episodes of restraint on their ward and were able to explain trends.

Staff were we spoke with were aware of trust policies on restraint and said they avoided the use of prone restraint whenever it was safe to do so. Across the service, 19% of restraints were carried out with the patient in the prone position. There were no incidents of mechanical restraint.

Rapid tranquilisation occurred in 28% of restraints across the service, in 32 instances of the 165 restraints. Staff told us about trust procedures on the physical monitoring of patients after rapid tranquilisation which followed National Institute for Health and Care Excellence guidance. We were unable to check records in relation to this as there had not been any recent examples of rapid tranquilisation on the wards we inspected.

Staff were able to tell us about how they worked with patients to prevent violence and aggression and avoid the need for the use of restraint. The trust had a number of initiatives in place which had been developed through the trust's quality improvement programme. For example, on all the wards there were safety huddles: stand-up meetings of no more than 15 minutes. These included as many ward staff as possible to discuss safety issues and individual patients. The team then immediately identifies and allocates any actions to manage and mitigate risks. All of the wards aimed to have a safety huddle at least two or three times a day at set times. In addition, a member of staff could also call a safety huddle when they felt the risk level was increasing outside of these times. We observed the safety huddle on West Ferry Ward which took place following the ward round. This was a sensitive time on the ward because some patients had been given distressing information relating to leave requests or medication reviews or discharge planning. Vulnerable or potentially volatile patients were identified and issues relating to their safety or to staff safety were discussed. The huddle did not take long but provided clear support and communication about risk

and risk management to staff in a direct and powerful way. Staff at all levels said they felt able to ask for a ‘safety huddle’ when they were they felt concerned.

Staff were mindful of what may lead to distress for patients such as hearing bad news or the cancellation of leave. They worked as a team to plan how to support patients when they became anxious or unhappy. Care and treatment records had full details of the actions taken by staff to de-escalate situations when patients were distressed. Management plans included input from patients on how they could be supported to avoid the need for restraint and staff followed these plans. For example, a patient on Bow ward was offered the use of art materials as a way of reducing stress.

There were 354 instances of seclusion in the service between 1 December 2016 and 30 November 2017. There were no patients in long term segregation at the time of the inspection. The wards with the highest number of incidents of seclusion reported were West Ferry Ward (an intensive care ward) with 170 and then Bow Ward with 59. This was due to the complex needs of the patients on these wards. Each ward had detailed information on seclusion and ward managers were able to explain the situation in relation to the rate of seclusion in their ward. It was common for the incidence of seclusion to reduce after the patient had spent a period of time on the ward. On West Ferry ward we read case records of five patients who were transferred to the ward from seclusion on another ward. In these cases, we observed a pattern whereby the use of seclusion reduced significantly on West Ferry ward.

Record keeping was comprehensive in relation to patients in seclusion. There were seclusion assessments, seclusion reviews by nurses and doctors and MDT seclusion reviews. There was clear evidence in the notes of successful attempts to de-escalate incidents without resorting to seclusion. Incidents of seclusion and restraint were cross referenced to the patient notes from the incident reporting system and there was evidence of de-briefings for patients and staff following incidents. Not all wards had a seclusion room. When it was necessary to use a seclusion room on a different ward, staff escorted the patient to the room appropriately.

At our previous inspection in June 2016, patients on Clerkenwell Ward, which is the only low secure ward on the John Howard site, were subject to the same restrictions as patients on the medium secure wards. At this inspection, we confirmed that the trust had made improvements. There were now fewer restrictions on Clerkenwell Ward in comparison to the medium secure wards. For example, patients on Clerkenwell ward used the laundry room unsupervised. Additionally, metal cutlery was being introduced because the risks associated with this were deemed to be very low with the current patient group. Patients were also able to go on group leave or trips with a smaller ratio of staff to patients.

## Safeguarding

Staff understood multi-agency procedures to protect patients from abuse and the service worked well with other agencies to do so. At our last inspection in June 2016, we said the trust should improve how staff reported adult safeguarding concerns. At this inspection, we found the trust had changed incident reporting processes. Now staff could more easily trigger a safeguarding referral when they reported an incident. When there were incidents between patients, staff appropriately reported into multi-agency safeguarding systems which included the local authority and the police.

The trust collected data on the number and type of adult safeguarding incidents reported into multi-agency safeguarding procedures. Across the service, staff reported 12 adult safeguarding incidents in the period 1 October 2017 - 31 December 2017.

Staff had received appropriate training on safeguarding children. Children could not come onto the wards but there were designated visiting areas.

Staff understood their responsibilities to ensure that patients were protected from bullying and harassment whilst on the ward. Patients told us they could report any concerns at community meetings or confidentially in a one to one meeting. Patients told us there were sometimes

incidents between patients. They said staff intervened to ensure patients were safe. Staff were able to give us examples of how they had made sure that patients with protected characteristics felt comfortable on the ward.

## Staff access to essential information

Staff kept appropriate records of patients' care and treatment. Records were clear and up-to-date. Staff used an electronic database for care and treatment records. The trust used the same system throughout all services and it was easy for staff to access the information needed when patients moved between wards.

At the previous inspection in June 2016, we found that it was not always easy for staff on the wards on the Wolfson House site to find the most up to date information. This was because, at that time, staff were in a period of transition from using paper to electronic records. This was now resolved. All records were now on the electronic system. Staff told us they could easily find information.

## Medicines management

The service mostly prescribed, gave, recorded and stored medicines well. Patients received the right medicines at the right dose at the right time. Staff followed trust procedures in relation to the safe management of medicines. These complied with National Institute for Health and Care Excellence guidance.

During the inspection, we checked arrangements for storing medicines. On each ward, a registered nurse kept the keys to the treatment rooms, medicines cupboards, trolleys and controlled drugs cabinets. Pharmacists visited the wards at least once a week to advise the multidisciplinary on the safe and effective use of medicines. The pharmacy team topped up the ward medicine stocks weekly. If staff needed medicines before the pharmacy visit, they could obtain them directly from the pharmacy. Pharmacists audited medicine stocks and out of date medicines were disposed of.

Overall, we found that the treatment rooms and fridge temperatures were checked on a daily basis and were within the correct ranges. However, on Clerkenwell Ward, room temperature monitoring was not always completed. Daily checks had been missed 13 times in the two months prior to the inspection. Additionally the temperatures were above 25$^{o}$C on nine occasions during this time. Staff were unaware how the thermometer for the room worked and had not escalated this issue. The medicines fridge temperatures were not always recorded; there were nine missing readings in the month prior to the inspection.

We checked a total of 47 medicines administration records across the service. Overall, staff had completed these well. It was clear from staff signatures that they had supported patients to receive their medicines as prescribed. All the medicines administration records had information about the patient for example, details of allergies, and had been seen by a pharmacist. However, on the Wolfson House site, the medicines administration record did not always have a photograph of the patient, to assist in avoiding misadministration.

In the case of patients prescribed high dose antipsychotics and high risk medicines, staff monitored their physical health in accordance with National Institute for Health and Care Excellence guidelines. We found one example on Bow ward where a patient had missed a prescribed dose of Lithium as they were asleep. It is important that doses of Lithium are not missed. There was no evidence on the medicines administration record chart or the patient progress notes that staff had tried administer the medicine later on or escalated the situation.

At the last inspection in June 2016, the trust had not always ensured that there were the appropriate records of authorised medicines for patients who were detained under the Mental

Health Act, This had improved. The appropriate forms were now attached each patient's medicines administration record. It was now clear that staff had lawfully administered medicines.

The trust ensured that staff made appropriate checks of patients' physical health in relation to the medicines they were prescribed. The trust had procedures in place which ensured staff arranged for patients to have the appropriate blood tests and health checks when they were prescribed antipsychotic medicines. For example, pharmacists completed a table for when a patient was prescribed on Clozapine to show their blood test results. Nurses used this information to determine if they could safely give the patient Clozapine.

At the last inspection in June 2016, we found that on some wards staff had not ensured that all controlled drugs were included in the controlled drug registers. At this inspection, we found that this had been rectified. Now if there were any controlled drugs on the ward, staff made sure that they were managed appropriately. For example, on Bow Ward, controlled drugs were stored in the ward's controlled drugs cabinet. The keys for the cabinet were kept by a registered nurse. We confirmed that stock levels matched the controlled drugs record book and all entries were signed by two nursing staff. Staff made daily checks of medicines records and pharmacy staff completed regular audits of stocks of medicines and record keeping.

## Track record on safety

Between 1 November 2016 and 31 October 2017, the trust reported seven serious incidents. Two of these were violent incidents. One was an incident of self- harm, one was an unauthorised absence. Two incidents related to treatment and one was not yet categorised.

## Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Staff could explain to us what incidents should be reported and knew how to make a report. Ward managers had clear information on what incidents had occurred on their ward and how they were being investigated. They met each month with other ward managers and the service manager and reviewed incidents in the service. Notes of team meetings and away days showed that ward managers shared learning from incident reports with their staff teams. This included information from reviews of incidents which had occurred on other wards in the service and elsewhere in the trust. The trust also communicated lessons learnt through newsletters and briefings for staff.

Staff understood the duty of candour. Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong.

Serious incident reports showed that staff were open and transparent, and gave the patient, and when appropriate their family, a full explanation of the incident. When there was an incident, managers ensured there were debriefs for staff, the patient concerned and other patients who may have been effected by the incident. Staff and patients told us they were able to talk freely at these meetings and say what they felt may have contributed to the adverse event. On all the wards there were also reflective practice sessions for staff where they were able to consider the impact of incidents on their practice and look at alternative ways of working with patients.

Staff were fully aware of the lessons learnt from previous serious incidents of violence and aggression which had occurred in the service. The service used this information to improve the service. For example, were aware of the importance of offering patients one to one time with staff so that they could raise any concerns without the fear of intimidation from other patients. Safety huddles were used to avoid incidents of violence and aggression. Staff teams displayed a 'safety cross' in the public area of the ward. This was a wall calendar that staff marked in colour to share incident data. The 'safety cross' provided a focal point on the ward for staff, people using the service and visitors. This meant that there was an open approach to sharing the experience of violence and aggression so that it became more of a ward community issue, which patients and staff worked

through together.

# EFFECTIVE

## Assessment of needs and planning of care

The service assessed patient needs and developed holistic, recovery focused care plans. We looked at 50 care and treatment records across the wards. Staff received assessment information prior to the patient's admission to the ward. On admission, a doctor made a physical health examination of the patient and carried out routine blood tests.

Patients in the service were registered with a GP practice. The GP practice took responsibility for ongoing monitoring of the patient's physical health and arranged for secondary health care as necessary. The GP was also responsible for annual health screening of patients in line with National Institute for Health and Care Excellence guidance.

The trust was rolling out a two-day physical health training course for staff, but at the time of the inspection few staff had completed this. The GP practice had monthly liaison meetings with the trust, and had provided training for staff in healthy living, foot health, and obesity.

Staff aware of the impact on physical health of long term mental health conditions and the medicines used to treat psychosis. Patient records showed that staff discussed issues such as healthy eating, physical activity levels and smoking cessation with patients.

Care plans were updated regularly and all the headings of the care plan template were completed in detail. The care plan headings were: mental health, physical health, medication, risks, rights, activities, religious/spiritual needs, social situation and family. In each case the patient's own view was noted, including instances where there was significant disagreement between the treating team and the patient. Patients told us that they were aware of their care plans and had been involved in their development and review.

Overall the care plans were holistic and recovery focussed. For example, on West Ferry Ward, even when the patient was still described as acutely unwell, the care plans included strategies for reducing levels of restriction, including transfer to conditions of lower security, if planning for community discharge was unrealistic at that point.

Assessments and care plans were stored on the electronic database. Staff could easily find information to provide effective care for patients.

## Best practice in treatment and care

The service provided care and treatment based on national guidance for adult mental health patients and forensic services.

Staff teams provided a wide range of personalised interventions which included medicines, psychological therapy and a wide range of therapeutic and rehabilitation activities. East India Ward operated as a specialist ward for patients with personality disorder and provided a mix of psychodynamic group interventions and accredited treatment programmes.

A range of psychological treatments recommended by the National Institute for Health and Care Excellence were available for patients. Care records showed that patients were able to access cognitive behaviour therapy and other evidence based psychological therapy.

Patients had good access to physical healthcare which included access to specialists when needed. Patients told us they were able to request to see the GP who visited the service weekly. They were also able to attend the dentist. Records showed staff escorted patients to the local acute hospital when they required specialist care.

Staff supported patients to have a healthy diet. The service made adjustments for patients' religious, cultural and other preferences. Care plans showed staff clarified with patients whether they had any dietary requirements related to their health or religion. Patients told us they could easily obtain food which satisfied them and met their needs.

Staff supported patients to live healthier lives. Patients told us staff supported them to be physically active and they had access to the gym and other opportunities for exercise. Staff on Woodberry Ward had been successful in encouraging patients to increase their physical activity with an innovative quality improvement project. On Shoreditch ward, staff held discussion groups with patients about healthy diets. Patients voted to reduce the number of desserts, and agreed to buy their own caffeine in a bid to reduce consumption of unhealthy foods. One patient had an exercise programme in place and had arranged with staff to for them to monitor their progress using an activity tracker.

Patients told us they were given advice in relation to healthy eating and smoking cessation. Patients were registered with a GP who arranged for appropriate screening tests.

The service monitored the effectiveness of care and treatment and used the findings to improve care and treatment. The service used health of the nation outcome measures (a standard outcome measure used across all hospitals originally developed in secure settings). Service managers ensured staff carried out a range of audits took place to check that staff followed best practice guidance. For example, there were audits of care plans, consent to treatment documents and medicines and missed doses, room search and mattress audits. Managers met monthly to compared local audit results and learn from each other.

## Skilled staff to deliver care

On each ward in the service, staff from the full range of mental health disciplines provided input to the planning and delivery of patient care and treatment. This included doctors, nurses, nursing assistants, occupational therapists, social workers and pharmacists. Art and music therapists worked across the service to support patients.

We spoke with a total of 65 staff during the inspection. Staff were experienced and qualified to work in a forensic service. Many of the staff we interviewed had worked within the service for several years. They told us they had developed their skills through formal training courses and learnt new skills from their colleagues and through learning events and meetings.

New staff and bank staff working on a ward for the first time, or after a gap of three months or more, had an induction to the ward. The trust had produced a checklist for this. The checklist included incident reporting and fire procedures. There was a specialised forensic induction for all staff, which had training on personal safety, managing violence and aggression, security procedures and safe restraint techniques.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and monitored their competence to carry out their work role. However, some staff did not receive regular clinical supervision. The trust's measure of clinical supervision data is the percentage of sessions delivered of those required. The trust target is 90%. Between 1 November 2016 and 31 October 2017 none of the wards inspected achieved this target. Supervision rates for these wards were: Clissold 80%, East India 73%, West Ferry 70%, Clerkenwell 69%, Shoreditch 65%, Butterfield 63%, Bow 59%, Woodberry 57% and Morrison 54%.

During the inspection, we clarified the current situation on the three wards which had the lowest supervision rates between1 November 2016 and 31 October 2017.Staff on Bow Ward said they had received recent supervision. The ward manager told us that the ward had been very unsettled prior to January 2018 which meant that supervision was sometimes cancelled due to pressures on ward staff. Staff on Woodberry Ward also said they had received recent supervision and we

confirmed this by checking supervision records. On Morrison Ward, we found that supervision sessions were often cancelled due to workload demands. The ward manager was seeking to improve the supervision compliance rate by booking supervision sessions further in advance.

Supervision records demonstrated that staff could discuss personal development, training opportunities and their wellbeing as well as clinical issues. Staff told us they felt supervision to be helpful and supportive. Occupational therapists, pharmacists and psychologists told us there were appropriate arrangements for their professional supervision and development. They were able to access both internal and external specialist training and attend conferences and other learning events.

The trust's target rate for appraisal compliance was 90%. As at 31 October 2017, the overall appraisal rates for non-medical staff within the service was 98%. Records of appraisals showed that manager's considered how staff had applied trust values to their work. There were clear development plans for staff. Staff told us they were enrolled in development and leadership programmes.

Ward managers told us they were able to address any poor staff performance. They said their managers and the trust human relations specialists offered them advice and support in relation to any staff performance issues.

## Multidisciplinary and interagency team work

On all of the wards in the service, staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals worked effectively together to plan and provide personalised care and treatment. All wards had regular monthly multi-disciplinary meetings. These were well attended by all staff disciplines and had a standard agenda. Topics covered included discussions on relational security on the ward and feedback on learning from incidents and the analysis of trends from incident reporting data. These meetings were recorded and the minutes were available on the ward so staff who were not present could have access to information discussed. Staff teams also held 'away days' to develop team practice.

There were effective handovers between outgoing and incoming staff twice each day when there was a change of the staff team on the ward. In the handover meetings we observed staff ensured that key information about each patient was shared. This included risk information and an update on the patient's mental and physical health. Staff told us these handover meetings enabled them to start their shift with a clear picture of the current risk issues and the priorities for their work with patients.

Staff told us there were effective working relationships with the GP who visited the service weekly and with external teams in the prison service. Each ward staff team included a social worker who led on inter-agency work with community services. Appropriate liaison took place with multi-agency public protection arrangements with regard to managing risk within the service. There was also appropriate liaison with children's services when relevant.

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

## Good practice in applying the Mental Health Act

Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. Ward managers showed us training information which confirmed that over 75% of staff had received training on the Mental Health Act. Staff told us they knew how to access up to date information on the implementation of the Act. The trust's Mental Health Act office staff visited wards to complete audits and to provide advice. Staff requested a second

opinion when appropriate. Patients told us that staff encouraged them to take their authorised leave

Care and treatment records included Mental Health Act documents, for example, in relation to tribunals and hospital managers' hearings. There was evidence that patients had been informed of their rights. An independent Mental Health Act visited the wards to support patients. We met with one advocate who reported having good access to patients and staff on the wards. Patients told us they were well informed about their rights and knew how to access advocates and solicitors. However, patients on East India Ward told us it was difficult to contact the advocate by telephone.

### Good practice in applying the Mental Capacity Act

Staff were trained in and had a good understanding of the Mental Capacity Act and the five statutory principles of the Act. Ward managers showed us training information which confirmed that over 75% of staff had received training on the Mental Capacity Act.

There was good practice in relation to the application of the Mental Capacity Act. For example, on West Ferry Ward, the intensive care ward, the responsible clinician completed assessments of mental capacity to consent to treatment when a patient was admitted or transferred to the ward. Records showed the clinician regularly reviewed these assessments. Patient records included certificates of second opinion and records of discussions with the patient by the responsible clinician, following the visit of second opinion appointed doctors.

On Clerkenwell and Shoreditch wards there were patients with learning disabilities. Staff understood their duty to ensure that these patients, who may have limited mental capacity, were supported to understand their care and treatment. Staff produced copies of care plans and other important information in easy read format.

Staff told us they were able to seek advice on the Act from ward social workers and leads within the service. When staff felt that a patient may have impaired capacity, staff acted appropriately and recorded an assessment of capacity to consent. We saw that staff completed capacity assessments in line with the Act. This meant that it was decision specific and time specific, and the best interests of the individual patients were considered.

## CARING

### Kindness, privacy, dignity, respect, compassion and support

The 2016 patient-led assessments of the care environment scores for privacy, dignity and wellbeing are below.

| Site name | Core service(s) provided | Privacy, dignity and wellbeing |
|---|---|---|
| **12 Kenworthy Road (The John Howard Centre)** | Forensic Wards | 87.7% |
| **Recovery Unit, Wolfson House** | Forensic Wards | 92.2% |
| **Trust overall** | | **87.6%** |
| **England average (mental health and learning disabilities)** | | **90.6%** |

Staff we spoke with highly motivated to work with forensic patients and to provide sensitive, person centred care. They were committed to ensuring that patients were empowered to take part in planning their own recovery with the lowest possible level of restriction. They said ward staffing levels allowed time for staff to get to know patients well. Patients said they felt that staff had a

genuine interest in their well-being and gave examples of where they felt staff had been exceptionally kind to them.

Staff spoke respectfully about patients and had in-depth knowledge of their personal needs and preferences. They were thoughtful and creative in their approach to getting to know patients and aware that it took time to establish productive relationships. Staff told us they used reflective practice to explore how they could build better relationships with patients.

Staff were very compassionate and mindful of the day to day restrictions placed on patients in a forensic service and the negative impact this could have on their mental health. We saw several examples of excellent practice where staff teams had been able to work closely with the patient to manage risks and achieve a positive outcome. For example, on West Ferry ward staff closely considered whether a patient who had recently been acutely unwell should have leave from the ward. They decided to grant leave and prepared the patient for it. The leave went well and a decision was then taken to discharge the patient.

We observed that staff were very respectful and friendly when talking with patients in communal areas. Staff were consistently patient and calm. Staff were always mindful of confidentiality and ensured they did not speak to each other about patients in communal areas.

Patients told us that staff asked them how they were feeling and supported them to understand their care. Patients were very positive about the way staff interacted with them. They said staff were honest and open with them and gave them hope for the future. Patients said this was very important to them as they were detained and subject to the restrictions of a medium secure unit. Staff supported patients to understand their mental health issues and to take responsibility for managing their health as far as possible. For example, on Morrison ward staff had supported a patient to develop their independence and administer their own medication.

## Involvement in care

## Involvement of patients

Patients received a welcome pack on admission which helped introduce them to the ward. This included information about the roles of different staff members and rules, routines and activities. For example, on East India ward patients were given a handbook which had been developed by patients and staff. This included information on meals, security, ward meetings, behaviour towards others and visitors.

Patients told us staff involved them in the assessment of risks and in care planning. They said they were invited to ward rounds to discuss and plan their care and treatment. Staff communicated well with patients in the ward rounds we observed. They were careful to use language that the patient could understand and to provide answers to any questions the patient had. Patients told us they were able to bring family members or an advocate to ward rounds and other meetings.

Care plans in the service demonstrated strong levels of collaboration between staff and the patient. The patient's views were clearly recorded and it was clear where the patient and staff did not have the same view about care and treatment. Staff offered each patient a copy of their care plan. Patients told us that staff took time to explain decision making to patients. Some patients had recorded advanced directives for how they wished to be supported in the event that they had to be restrained.

On wards where patients had learning disabilities, staff ensured that patients were always given information in a way they could understand. This meant that patients had 'easy read' copies of care plans. On West Ferry Ward, staff were sensitive to the needs of a patient who could not read. Staff had used pictures, including pictures of the patient, to help include them in the care planning process and to produce a document that was meaningful to them.

The trust involved patients in giving feedback and planning improvements to the service. There were weekly community meetings on each ward. Patients told us they were able to use these meetings express any concerns and suggest improvements. These meetings were recorded and actions were noted for follow-up. On all wards, patients told us that changes had been made to the food and activities on offer as a result of their feedback.

Patient representatives from each ward attended a weekly service - wide user involvement group. Ward representatives told us about recent improvements they had been involved in. These included enabling patients to have access to mobile phones without internet access. They said patients and staff were currently working towards the introduction of computers for patients on each ward.

Advocates attended each ward and contact details for advocates were on display on all wards. An advocate told us that staff teams had responded compassionately when they supported patients and had made positive changes to improve the patient's experience of care and treatment.

Patients could feedback on the quality of the service. The service carried out regular surveys and collected feedback from patients regarding their views about the service. This information was discussed in monthly clinical governance meetings.

Patients were involved in co-production of the recovery college courses, and were also involved in staff recruitment interviews. At the rehabilitation wards at Wolfson house, the service had developed a 'bridge project' for patients who had been discharged to return to the ward to attend weekly some activities. The aim was twofold: to ensure patients did not feel socially isolated on discharge and for discharged patients to provide a role model for inpatients regarding life after discharge. The service was in the process of recruiting three peer support workers to support patients on the wards at Wolfson House.

At the previous inspection ending in June 2016, we found that there was not sufficient patient information available on Clissold Ward. At the current inspection we found that all of the wards displayed a full range of useful information for patients and carers. There was information available on advocacy information, community meeting minutes, and quality improvement progress. All wards displayed information about the staff team with photographs.

### Involvement of families and carers

Staff involved families and carers appropriately and provided them with support when needed. Staff told us how they aimed to promote the involvement of families and carers as part of the patient's care plan for recovery. They told us they always contacted families when patients were admitted to the service to explain visiting arrangements and how they could be involved in care planning with the patient's consent.

We spoke with a relative of a patient who told us that they were kept up-to-date on their relative's care and treatment and any changes. Staff on the Wolfson House site planned a 'Family and Friends Day' for April 2018 to provide support, discussion and access to information. Family therapy was available to patients and their family members if appropriate. Social workers could provide carers with information about how to access a carer's assessment.

## RESPONSIVE

### Access and discharge

## Bed management

At the time of the inspection, all of the wards we visited apart from West Ferry ward were full. Bed occupancy in the period October 2016 – September 2017 was 90-100% for most wards in the service. There were no recorded readmission of patients within 90 days of discharge in the forensic services directorate during the same period. The trust measured the length of stay at the point of discharge. This meant the trust could not provide accurate figures for the average length of stay for the service as the rate of discharge was low. Staff told us that most patients stayed at the service for at least one year.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. Discharges were well planned. West Ferry ward operated as a high dependency unit and was available for patients who required more intensive care and treatment.

## Discharge and transfers of care

Between 1 October 2016 and 30 September 2017 there were 17 discharges from the service, of which seven were delayed. Staff told us that when there were delays this was generally due to partner organisations finding it difficult to find a suitable resource to meet a patient's complex needs.

Each ward had a social worker in the staff team who took the lead in coordinating arrangements for discharge with external teams and commissioners. All patients with a learning disability or autism received annual care and treatment reviews, where representatives from NHS England and patients' funding clinical commissioning group attended to discuss each patients' care pathway and discharge.
Staff from the service always escorted patients when they were treated in an acute hospital.

## Facilities that promote comfort, dignity and privacy

All patients using the service had their own bedroom and bathroom. A patient's privacy was protected by a vision panel on their bedroom door which could be controlled by the patient and by staff. Patients could personalise their bedrooms as they wished, subject to risk assessment. For example, on Shoreditch ward, some patients had decorated their bedrooms and used their own soft furnishings. On Morrison ward, patients' art work was on display in communal areas.

Patients were able to lock their rooms to keep their possessions secure. Every ward had at least one room for patients to receive visitors in private. There were spacious communal rooms on all wards with televisions. On West Ferry ward, we observed that patients were able to listen to music of their choice whilst in communal areas. This ward also had a recently refurbished sensory room in which patients could relax. It included light projection, and two multi-coloured lamps as well as soft furnishings. On all wards patients were able to access outside space at least once a day.

Wards had a range of rooms that could be used for therapeutic activities. All wards had some gym equipment, such as an exercise bike. On both the Wolfson House and John Howard sites, there were cafes staffed by patients which staff, visitors and patients used. Each ward had a kitchen for patients to prepare their own food with staff support. Patients told us they could make hot drinks or have a snack at any time. On Woodberry Ward, patients took turns in cooking the evening meal on six days weekly, in order to develop their cooking skills. This quality improvement project was being introduced on some of the other wards.

At the Wolfson House site one of the lifts was out of action. Patients told us this was a recurrent problem.

The trust had reduced restrictive practices in relation to telephones since the last inspection. Patients could now use their own basic mobile phone to make private calls. Patients on all wards had access to secure outside space.

The 2016 Patient-led assessments of the care environment score for ward food at the service locations scored better than similar trusts.

| Site name | Core service(s) provided | Ward food |
|---|---|---|
| **12 Kenworthy Road (John Howard Centre)** | Forensic Inpatients | 98.9% |
| **Recovery Unit, Wolfson House** | Forensic Inpatients | 93% |
| **Trust overall** | | **86.2%** |
| **England average (mental health and learning disabilities)** | | **89.7%** |

## Patients' engagement with the wider community

Patients had access to a wide range of education and work opportunities when appropriate. Occupational therapists were included in all the ward staff teams. They focused on ensuring patients had meaningful activities which improved their life skills. For example, on Morrison ward, patients were very positive about the work of the occupational therapist to support them with their recovery and integration with the wider community. Some patients from the ward were undertaking work placements at a local farm to build their interpersonal skills and employment prospects. On most wards, we heard about patients who were getting paid to work at the on-site cafes. Other patients had paid work undertaking jobs including leading patient exercise sessions, plant care, recycling, and chairing or note-taking at community meetings. Patients were also supported to improve skills such as their reading ability, whilst in the service.

Patients and staff co-produced and co-delivered a recovery college programme. This included workshops such as hearing voices, co-production, free movement, medication, and tribunals and legal rights. Other courses included acting skills, spoken minds performance poetry, and reading aloud.

Patients using rehabilitation wards on the Wolfson House site frequently went out into the community. Some patients attended external places of education such as the university of the third age. Patients chose and planned occasional group trips outside of the unit, including trips to the cinema, and the coast. There was also a regular 'explore more' group, encouraging patients to access local facilities.

Across the service, patients could access an indoor gym at specified times. Patients could participate in a range of sports including swimming, badminton, basketball and football. Patients on Bow ward had requested that staff arrange a dance exercise class for them. Patients left the ward to attend this during the inspection. Subject to risk assessment, some patients went out of the service to sports and leisure activities in the community.

When necessary patients attended the GP surgery for treatment of their physical health needs.

## Meeting the needs of all people who use the service

Staff had a full picture of the needs and preferences of patients and planned care and treatment to meet their diverse needs. Wards were level access and were suitable for people with mobility difficulties. On wards for people with learning disabilities, information was available in easy read format.

The service was able to meet the diverse cultural, religious and linguistic needs of patients in the service. There was an interpreting service available. Staff gave us examples of how interpreters were used to ensure patients and their families were fully included in care planning. At short notice, staff accessed a telephone interpreting service.

Cultural and religious needs were addressed in care plans. Patients had access to religious leaders who visited the wards. A multi-faith room was available on both sites for use by patients. Whenever possible, patients were granted leave to attend religious services and events.

Information was available about mental health conditions and medicines on the wards and this was available in community languages on request. Leaflets could be translated into any language for patients who did not have English as their first language. Patients had access to a variety of menu options which met their religious and dietary needs.
A lesbian, gay, bisexual and transgender social event was held in the week prior to the inspection. Staff supported patients in relation to lesbian, gay, bisexual and transgender issues. For example, staff supported patients to feel comfortable with their sexuality.

### Listening to and learning from concerns and complaints

The service received 19 complaints between 1 November 2016 and 31 October 2017. The trust did not provide information as to how many of these were upheld or not.

Patients across the service told us that they were aware of how to make complaints and understood the process. We saw that information about making complaints was clearly available and accessible on the wards, and provided to new patients as part of their orientation to their ward in an information pack.

Patients said they were able to raise concerns at community meetings on the wards or directly with the ward manager. Minutes and action logs from community meetings showed that staff responded to issues raised. For example, when patients had made suggestions about ward activities and outings staff had followed up this up. Patients said that staff listened to their suggestions and acted on them.

Ward managers told us they were supported by their managers and the central trust complaints department when responding to formal complaints. When there were learning points arising from a complaint this was either discussed with the individual staff member concerned or the whole team as appropriate.

## WELL-LED

### Leadership

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Ward managers, modern matrons and the service director had extensive experience of working in forensic services. They had appropriate professional qualifications and the trust had ensured they received management training. Modern matrons worked closely with the ward managers they supervised and knew the patients and staff well. Managers we spoke with were able to explain clearly explain to us how they led the ward and worked with their staff team to ensure the quality of the service.

The leaders of the service had made significant improvements to the service since our previous inspection. Leaders had worked in collaboration with patients and staff to reduce restrictive practices. Staff and patients were positive about the way they had been involved in planning and introducing these changes. Leaders had ensured that patients with learning disabilities on the low secure Clerkenwell Ward were now subject to fewer restrictions than patients on medium secure

wards. The trust had revised the staffing of the learning disability wards to ensure that patients received a service that was better tailored to their needs.

Patients told us ward managers and matrons were usually on the ward and they could easily talk with them at meetings and informally. Staff told us that their line managers were available to them for support and encouraged staff to raise any issues with them.

Staff told us that there were extensive development opportunities available for nurses and nursing assistants. Staff said this was one of the best things about the trust.

Staff and patients knew the managers of the service who visited the wards often. Staff said that more senior staff in the trust had visited the wards on occasion.

## Vision and strategy

Staff at all levels in the service had a very clear understanding of the trust vision which was 'to make a positive difference to people's lives'. They told us they felt they were improving the wellbeing and life skills of patients in the service. Staff said the trust values, 'we care, we respect and we are inclusive' were heavily promoted, appearing on trust literature and computer screens. Staff told us that they felt these values helped them to ensure they provided person-centred care. They said the trust's vision and values were reflected in the work done by the service to reduce restrictive practices and to involve patients in planning their own care and in improvement initiatives.

Staff said that managers now involved them in planning any changes that were happening in the service at team meetings and away days. This was an improvement from the situation at our last inspection in June 2016, when a change to the service's security arrangements was made without appropriate staff consultation. Staff had an understanding of the importance of working within the budgets available. For example, they understood the impact on the budget of using additional staff on the wards to manage unwell patients. Staff understood the importance of keeping staffing levels under review.

## Culture

Managers promoted a positive culture that valued staff, creating a sense of common purpose based on shared values. Staff told us they felt respected and appreciated by their immediate managers and by senior managers in the trust. They said they felt positive and proud to work in the service.

Staff were aware of the whistleblowing process if they needed to use it, and said they felt able to raise concerns without fear of retribution. Most staff were aware of the role of the Speak Up Guardian, who had been in post since October 2017 and was in the process of attending ward meetings to explain their role.

Managers ensured that teams worked well together. On one ward, where there had been issues of poor staff morale, managers had engaged an external facilitator, resulting in an improvement in team work. Managers reviewed staff performance through supervision appraisals and audits. Managers took the necessary action to deal with any competency issues. Managers told us that senior managers and the trust's human relations leads supported them to deal with any issues of poor performance. Sickness levels were similar to the trust average. Staff could access an occupational health service as necessary which included counselling services.

The staff appraisals we read showed that managers planned with the member of staff how to support them to progress. Many of the staff we interviewed told us they had received support and mentorship from the trust which had helped them to progress in their career.

Staff told us the trust promoted equality and diversity in its work with patients and in terms of the workforce. They said there were many positive role models in the trust and they did not think they would face any discrimination in terms of career progression. No staff reported bullying or harassment on the wards we inspected, nor any discrimination.

The trust celebrated success through a staff awards scheme. The trust was due to start a scheme in April 2018 for patients and carers who have helped to develop and improve services to be nominated for an award.

## Governance

The service systematically monitored standards of care and to continually improve outcomes for patients. All wards carried out a programme of audits to check care and treatment records, staffing levels, restraint records, take up of planned leave by patients, medicines management and staff supervision and appraisal. In addition there were checks on the maintenance of the ward and security checks. All of the patients in the service were detained under the Mental Health Act. There were teams on site who ensured that the service fully complied with the Act.

All wards had a framework of community meetings with patients, handover meetings, ward rounds and multi-disciplinary meetings, known as clinical improvement meetings. Agendas for clinical improvement meetings were standardised across the service and covered learning from incidents, complaints and safeguarding cases. These meetings were held monthly. Patient representatives were given a slot in the meeting to raise any concerns. Senior managers ensured that information was fed through meetings from the board to the ward and that information was shared across the service.

Ward managers, matrons met with senior managers in the service monthly to review performance data. Managers could view a dashboard to see how their ward was performing. It including information on complaints, care plans, patient survey feedback, staff supervision, and incidents.

Ward teams included a full range of mental health professionals. The service had clear admission criteria and well-developed discharge processes.

## Management of risk, issues and performance

Each ward had a risk register and ward managers were aware of the key risks on their ward. The risks were discussed at clinical improvement meetings and staff teams were aware of the key risks across the service. Common risks recorded included patient disengagement, physical health issues, and staffing, alongside actions taken to mitigate each risk.

The service had contingency plans for emergencies, which wards reviewed as part of their risk registers. Wards carried out regular health and safety monitoring, including emergency simulations, and regular fire drills.

An annual health, safety and security inspection was undertaken on each ward, with actions identified to improve compliance.

## Information management

The trust had effective systems to collect data from the service. Staff reported that the information technology infrastructure did not always work well on some wards. The trust was in the process of making improvements to the infrastructure with work scheduled in April 2018. Information governance training for staff covered the confidentiality of patient records.

The trust provided dashboards for ward managers which had accurate information on staffing, restraints, complaints, safeguarding, care planning and incidents. Information was presented in tables and graphs and it was easy to understand.

Staff made notifications to external bodies as needed. For example the CQC were sent notifications when appropriate.

### Engagement

The service engaged well with staff, patients and carers to obtain feedback about the service and make improvements. Each ward displayed a list of actions taken following requests by patients in the patient community meetings in the form of 'you said we did.' These included trips out to places of interest, provision of an exercise bike on Woodberry Ward, and work underway to install computers on the wards.

Each ward had a patient representative who attended the monthly service wide user involvement group. These meetings included senior managers of the service. Topics regularly raised included food provision, and restrictions on wards. In response to feedback from patients, restrictions on the use of mobile phones and computers had reduced.

Staff received feedback about the service through the family and friends test, which generally indicated a high level of satisfaction on each ward.

A weekly newsletter, Forensic Voice, was circulated to staff to share learning. On Woodberry Ward there was a ward newsletter for staff and patients.

The trust had a well-established programme of peer support workers who worked with patients on the wards. The service was recruiting more peer support workers at the time of the inspection.

### Learning, continuous improvement and innovation

There was a well-established quality improvement programme in the trust. Staff told us they were encouraged to learn about quality improvement initiatives in the trust and to develop their skills in this area. The trust's central quality improvement team supported staff through training and coaching to develop innovative projects. Staff in the service had participated in quality improvement work in the area of reducing incidents of violence and aggression. This work had led to positive changes across the service, through the introduction of safety huddles and safety crosses.

Staff told us they were involved in a range of quality improvement projects. For example, on Clerkenwell Ward, for patients with a learning disability, staff were working on a project to improve the ward round experience for patients. Staff had introduced an informal session was held with the patient and all the staff team prior to ward round, to help put the patient at ease. Staff now ensured that they did not give patients new sensitive information for the first time during a ward round. Patient satisfaction with ward rounds had improved. Staff were hoping that, with the support of the central quality improvement team, some of their positive work to make ward rounds less stressful for patients would be rolled out on other wards.

Wards were members of the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services. East India Ward had been accredited as a therapeutic community.

## Community mental health services for people with learning disabilities

### SAFE

## Safe and clean environment

The environments used by staff to see patients were clean and safe. Staff completed regular environmental risk assessments which included fire safety. The service also had protocols in place to maintain infection control.

All areas were clean, had good furnishings and were well-maintained. Cleaning records were up to date and demonstrated that the premises were cleaned regularly. Staff had access to gloves, hand gel and equipment to clean spillages of body fluids.

Staff maintained equipment well and kept it clean. 'Clean' stickers were visible and in date. At Tower Hamlets adult autism service, staff cleaned all objects used during the autism diagnostic observation schedule with anti-bacterial wipes after each assessment.

Interview rooms at the services in London were fitted with alarms that were regularly tested. Staff were always available on site to respond to these alarms. In Bedfordshire, the service had not fitted alarms in interview rooms. Staff there made arrangements to interview patients safely based on individual risk assessments.

None of these services had a designated clinic room. However, services did have equipment to carry out some basic checks such as measure patients' height, weight and blood pressure.

### Safe staffing

The following table shows the staffing figure across all the services covered in this report.

| **Substantive staff figures** | | | **Trust target** |
|---|---|---|---|
| Total number of substantive staff | At 31 October 2017 | 68 | N/A |
| Total number of substantive staff leavers | 1 November 2017 – 31 October 2017 | 12.3 | N/A |
| Average WTE leavers over 12 months (%) | 1 November 2017 – 31 October 2017 | 19% | N/A |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) | At 31 October 2017 | 10.6 | N/A |
| Total vacancies overall (%) | At 31 October 2017 | 13% | <10% |
| Total permanent staff sickness overall (%) | Most recent month (At October 2017) | 2% | 3.5% |
| | 1 November 2017 – 31 October 2017 | 3% | 3.5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | At 31 October 2017 | 26 | N/A |
| Establishment levels nursing assistants (WTE*) | At 31 October 2017 | 18.3 | N/A |
| Number of vacancies, qualified nurses (WTE*) | At 31 October 2017 | 2.7 | N/A |
| Number of vacancies nursing assistants (WTE*) | At 31 October 2017 | 2.5 | N/A |
| Qualified nurse vacancy rate | At 31 October 2017 | 10% | <10% |
| Nursing assistant vacancy rate | At 31 October 2017 | 14% | <10% |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (Qualified nurses) | 1 November 2016 – 31 October 2017 | 194 | N/A |
| Shifts filled by agency staff to cover sickness, absence or | 1 May 2017 – 29 October 2017 | 0 | N/A |

| | | | |
|---|---|---|---|
| vacancies (Qualified Nurses) | | | |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 November 2016 – 31 October 2017 | 7 | N/A |
| Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 November 2016 – 31 October 2017 | 306 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 May 2017 – 29 October 2017 | 0 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 November 2016 – 31 October 2017 | 27 | N/A |

The provider had determined safe staffing levels by calculating the number and grade of members of the multidisciplinary team required using a systematic approach. The trust and commissioners had jointly agreed the numbers of staff for each service. The number, profession and grade of staff in post matched the provider's staffing plans. Caseloads were manageable and vacant posts were covered by bank and agency staff. Services were recruiting staff to fill the vacant posts.

The trust employed large multidisciplinary teams to provide learning disability services. The specialist healthcare team in Bedfordshire included 10 nurses and 28 other staff, such as occupational therapists, clinical psychologists and speech and language therapists. The intensive support team in Bedfordshire provided services in both inpatient and community settings. This team employed 16 nurses, 13 support workers and seven staff from other professions. In Tower Hamlets, 64 staff worked within the community learning disability service. Of these, the trust employed six nurses and 30 other professionals. The local authority employed the other staff within this team. The adult autism services were much smaller. The adult autism services in Bedfordshire and Tower Hamlets employed six staff working hour's equivalent to four full-time staff. The service in Hackney employed five staff working hour's equivalent to two and a half full-time staff. Autism services were provided by multidisciplinary teams including doctors, nurses, occupational therapists and clinical psychologists.

The caseloads of staff varied between different roles and professional groups. For example, health facilitators in Bedfordshire worked with an average of 35 patients. Caseloads at Bedfordshire intensive support teams varied between 10 and 13. Managers monitored and discussed caseloads with staff during supervision sessions. None of the staff we spoke with were concerned about excessively high levels of casework.

Cover arrangements for sickness, leave, and vacant posts ensured patient safety. In each of the teams, staff covered for colleagues when they were absent due to leave or sickness. In most circumstances, staff worked additional hours through a bank system to cover for vacancies. However, services found it difficult to cover vacancies for specialist staff. For example, Tower Hamlets community learning disability service had found it difficult to recruit a speech and language therapist. The Tower Hamlets adult autism service had found it difficult to recruit a consultant psychiatrist. In both cases, the absence of these staff had led to increased waiting times for patients wishing to access the service.

The service used locum staff appropriately. The Tower Hamlets adult autism service had recently assigned an agency worker to the role of senior practitioner on a long term-contract. None of the other services used agency staff. The autism services in Bedfordshire and Tower Hamlets employed a consultant psychiatrist on a locum basis.

The service had rapid access to a psychiatrist when required. Psychiatrists were based in the learning disability teams throughout the week. These psychiatrists were able to work flexibly to ensure they could respond to the urgent needs of patients. Outside office hours, patients could be

seen by the psychiatric liaison service at the local accident and emergency departments or be seen by the mental health home treatment teams.

Not all staff had received and were up to date with appropriate mandatory training. This training programme included 26 training courses including fire safety, life support, safeguarding, equality and diversity and the Mental Capacity Act. Overall, staff in Bedfordshire had undertaken 89% of the various elements of training that the trust had set as mandatory. However, this figure fell to 78% for staff in the Tower Hamlets learning disability team, 72% at the City and Hackney Adult Autism Team and 40% for staff at the Tower Hamlets Adult Autism team. The team manager was aware of this. They explained there were only four staff in the team and that this figure was skewed by two part-time staff who were yet to engage with the mandatory training programme. The manager had raised the matter with these staff and confirmed that these staff would complete the training programme.

## Assessing and managing risk to patients and staff

### Assessment of patient risk

Patients all had a risk assessment in place. Staff developed crisis plans according to the specific needs of patients.

Staff did a risk assessment using a standard tool of every patient at initial triage and assessment and updated it regularly, including after any incident. The person who referred people to these services completed a referral form that included details of any risks the patient presented. Staff at each service completed a comprehensive assessment of risk at the first interview with the patient. Staff recorded the risks patients presented to others, specific vulnerabilities, and physical health risks.

When appropriate, staff created and made good use of crisis plans and advance decisions. Crisis plans were created according to patients' needs. For example, a patient presenting a risk of harm to themselves and other people had a personal support plan that included details of the crisis team, phone numbers of family members who could help in an emergency and a list of strategies for managing distress. Another patient had a safeguarding adults protection plan that included details of what to do in an emergency.

### Management of risk

The services were able to see patients quickly if their mental health or challenging behaviours deteriorated rapidly. For those waiting to receive a service they could contact the service again if the patient needed to be seen more urgently.

The service had developed good personal safety protocols, including lone working protocols that were followed by staff. These protocols stated that home visits only took place if there was information held about the patient in the trust's records or on the referral form. Staff completed a risk assessment prior to the visit and formulated a specific risk plan for each patient. If staff concluded there was a heightened level of risk, two staff would attend the assessment or staff made other arrangements, such as meeting that patient at an alternative location. Staff in Bedfordshire carried an electronic tracking device that enabled them to call for assistance in an emergency. In Tower Hamlets, staff carried a mobile phone and could call for assistance from a colleague allocated in advance of the visit using a code word. Staff at the adult autism services did not visit people at home except in very specific circumstances. If a home visit was required, two staff attended.

## Safeguarding

Most staff were trained in safeguarding, knew how to make a safeguarding alert, and did so when appropriate. Training on safeguarding was part of the trust's mandatory training programme. In the learning disability teams, over 90% of staff had attended training on adult safeguarding. At the Tower Hamlets adult autism service, only one out of four staff had attended the safeguarding adults level one training. However, staff demonstrated a sound understanding of their responsibilities and made appropriate safeguarding referrals.

All the teams were able to give examples of safeguarding alerts they had raised. In Bedfordshire, staff had reported 76 incidents to the local authority in the year before the inspection. The reports included incidents of domestic violence, physical abuse, institutional abuse and self-neglect. Staff monitored the progress of each referral they made to the local authority. Staff recorded the outcomes of enquiries on patients' records. In Tower Hamlets, the community learning disability service had raised 16 safeguarding referrals. The local authority provided the service with a report each month showing the progress of their enquiries. The adult autism services made fewer safeguarding referrals, although the team in Hackney had reported concerns about financial abuse that had arisen at an autism assessment.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. This included an example of where staff increased the frequency of visits to a patient when they suspected the patient of being neglected. Staff were also involved in providing an assessment of mental capacity in relation to an arranged marriage.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. For example, the learning disability service in Tower Hamlets held a quarterly safeguarding practice and performance review meeting with the local authority. In Bedfordshire, the service received regular feedback from the local authority safeguarding team on the progress of enquiries.

**Staff access to essential information**
All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and in an accessible form. That included when patients moved between teams. This information was stored on electronic patient records used across the trust. However, the trust and the local authority provided the Tower Hamlets learning disability service jointly. This meant that staff held some information on the trust's electronic record and other information on the system run by the local authority. Staff we spoke with were confident they knew where to find any information they needed.

**Medicines management**
None of these services administered medication.

**Track record on safety**
Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified. There were no STEIS incidents reported by this core service during the year before the inspection.

**Reporting incidents and learning from when things go wrong**
All staff knew what incidents to report and how to report them. All staff said they reported any incidents to their manager. Either the manager or the member of staff recorded the incident on the electronic patient record. Staff gave examples of incidents they would record. These examples included incidents relating to information management, care and treatment, falls, violence and aggression and any incidents that occurred at the trust's premises. This included reporting near misses as well as incidents that led to harm.
Staff reported all incidents that should be reported. Between 1 October and 31 December 2017, staff in Bedfordshire had recorded 28 incidents on an electronic incident recording system.

Staff understood the duty of candour. Services were open and transparent, and gave patients and families a full explanation if and when something went wrong. However, there had been no specific incidents that had required services' to use the trust's duty of candour procedure formally.

Staff received feedback from investigations of incidents both internal and external to the service. Managers completed a concise review in the 48 hours after an incident. Incident reports included details of lessons that staff could use to improve services. The trust held meetings to present and discuss the findings from incident reports at a trust-wide level, directorate level and a service level. Managers delegated staff to attend the trust-wide and directorate level meetings. Incidents were discussed at management forums and team meetings. The trust also produced a newsletter for all staff with information about incidents and lessons learned.

There was evidence of change having been made as a result of feedback. For example, following a serious incident involving a patient with severe constipation, the service included constipation in its list of long-term conditions that presented additional risks to patients.

Debriefing sessions were held after incidents. One member of staff had received specific training on how to facilitate debriefings. Staff said that managers and colleagues were supportive of each other and able to reflect together as a team.

## EFFECTIVE

**Assessment of needs and planning of care**
Care records demonstrated good practice in relation to holistic assessments and physical examinations.

Staff completed a comprehensive mental health assessment of each patient whenever this was necessary. Doctors completed mental health assessments at the initial assessment. Initial assessments also included assessments of physical health and mental capacity.

Staff carried out assessments of people with learning disabilities in accordance with national guidance. For example, professionals with experience in learning disabilities carried out assessments in a place familiar to the patient, such as their home. Staff involved family members and other carers that the patient wanted to be involved. Staff at the adult autism services completed assessments of people who showed indications of being on the autistic spectrum. All these assessments were carried out by staff who were trained and competent in assessing autism. Staff could assess patients in their homes if the patient had particular sensory sensitivities that would make it difficult for them to be assessed at an office.

Staff ensured that any necessary assessment of the patient's physical health had been undertaken and that they were aware of and recorded any physical health problems. The specialist health service in Bedfordshire and the long term care teams in Tower Hamlets were specifically dedicated to supporting the physical health needs of patients. These services ensured that patients with learning disabilities received comprehensive physical health assessments.

Staff developed care plans that met the needs identified during assessments. For example, the specialist healthcare team in Bedfordshire assessed a patient as needing an eyesight test. Staff developed a care plan with the patient to ensure that the patient was able to attend a sight test. This included a plan for a nurse to give the patient a practice sight test at home so the patient knew what to expect and would be less likely to become distressed. The care plan also included details of the days on which the test would be convenient for the patient.

Care plans were personalised and holistic. Care plans for people with learning disabilities included colour photographs and clear text in bullet points. Staff read through care plans with patients to check the patient understood the plan. Services used different approaches to care planning according to the different needs of patients. For example, the Bedfordshire intensive support team had developed a care plan using the dialog+ system. This system enabled staff to work

collaboratively with patients to develop holistic care plans. These care plans rated the patient's satisfaction with eight aspects of their life and three areas of treatment, and included a plan of how services could help to improve the scores in each area. Adult autism services met with patients after the assessment to discuss the diagnosis and provide information to the patient about support available to them. Services sent a letter and diagnostic report to each patient's GP. Staff copied this letter to the patient and included a plan for support.

Staff updated care plans when necessary. We reviewed the dates of four care plans in detail. Staff had updated all these care plans within the three months before the inspection. Other records showed that staff discussed care plans with patients at regular meetings.

**Best practice in treatment and care**

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by the National Institute for Health and Care Excellence guidance. Interventions for people with learning disabilities included psychological interventions, pharmacological interventions and occupational interventions. For example, psychiatrists prescribed medicines for patients with mood disorders or psychosis. Occupational therapists supported patients to develop their daily living skills. Clinical psychologists provided cognitive behavioural therapy, other behavioural interventions, mindfulness and systemic interventions for working with families. A clinical psychologist facilitated a women's trauma group in Bedfordshire that incorporated dialectical behavioural therapy and mindfulness skills. Services in Bedfordshire and Tower Hamlets provided art therapy. The services in Bedfordshire also provided drama therapy and music therapy. Social workers employed by the local authority provided support to patients in relation to housing and benefits.

The adult autism services in Hackney and Tower Hamlets provided short interventions to patients after the diagnostic assessment. These interventions included post-diagnostic support groups or courses, peer support groups, and social skills groups. The service in Tower Hamlets also provided formal interventions such as psychiatry, occupational therapy and speech and language therapy. These services also offered support to patients in requesting reasonable adjustments to their employer and referrals to local organisations that supported people to gain employment. In Bedfordshire, support after the diagnostic assessment was limited to one appointment. At this appointment, staff discussed the diagnosis with the patient and provided information about support that was available from other local organisations.

Staff ensured that patients' physical healthcare needs were being met, including their need for an annual health check. If the GP was responsible for that, the community health staff assured themselves that it was done and recorded details on the patient's care record. Staff also made a record of patients' refusal to have an annual health check.

Staff supported patients to live healthier lives. For patients with learning disabilities, the specialist healthcare team in Bedfordshire and the long-term care teams in Tower Hamlets specialised in working with patients with a range of long-term health conditions and complex needs resulting from physical and sensory impairments. For example, in Bedfordshire a sensory team supported patients with eyesight tests and hearing tests. We spoke with a patient who had been encouraged by staff to attend a cancer screening session. Following a positive result from the screening, staff ensured the patient was admitted to hospital quickly for an operation and continued to support the patient throughout their hospital admission. At the Tower Hamlets learning disability service, we observed an appointment at which a nurse provided support to a patient in relation to managing their asthma and pain relief. The trust's recovery college held groups to support patients with smoking cessation, healthy eating and well-being.

Staff used recognised rating scales and other approaches to rate severity and to monitor outcomes. Staff at adult autism services made extensive use of tools and assessment scales including the autism-spectrum quotient, the empathy quotient, and the autistic diagnostic observation scale. The services also asked relatives to complete a questionnaire. Within the learning disability services, staff used the health of the nation outcome scale to record the nature and severity of patients' mental health.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. Team managers across the trust carried out audits on infection control and hand hygiene. In 2017, managers in Bedfordshire completed an audit of patient records to ensure that staff were completing records consistently. The psychiatrists in the learning disability services were undertaking quality improvement projects to review the prescribing of anti-psychotic medicine to patients who presented challenging behaviour. The aim of the project was to reduce the prescribing of anti-psychotic medication by 20%.

**Skilled staff to deliver care**

The team included, or had access to, the full range of specialists required to meet the needs of patients. As well as doctors and nurses, services employed occupational therapists, clinical psychologists, speech and language therapists, art and drama therapists and physiotherapists.

Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. Many of the staff in the learning disability services had worked in the trust for many years.

Managers provided new staff with appropriate induction. New staff had the opportunity to shadow experienced staff during their first weeks. Managers worked with new staff to identify their learning needs. All staff completed a corporate induction to the trust where they learned about the trust's values and strategy.

Managers provided staff with regular supervision. During these meetings, managers carried out a comprehensive review of the staff member's casework. This included a review of all the patients the staff member was working with. Managers also discussed the staff member's well-being, sickness and training. The trust set a target for staff to receive supervision once a month. All the adult autism teams had achieved this target during the month before the inspection. At the Bedfordshire specialist healthcare team, 97% of staff had received supervision in the month before the inspection and at the Tower Hamlets learning disability service, 83% had done so. At the Bedfordshire intensive support team, compliance with this target was 35%. However, data from April 2017 to January 2018 showed that over half the staff received supervision each month, indicating that supervision was bi-monthly. Whilst this was not compliant with the trust's target, supervision was clearly taking place. All the staff we spoke with said they were well supported. They said the frequency and quality of supervision was sufficient to enable them to carry out their duties.

Staff received clinical supervision from a manager within the same professional discipline. For example, occupational therapists received clinical supervision from a senior occupational therapist. All staff received an annual appraisal. Managers completed appraisals on a standard form covering what had worked well for the employee, what had not worked well, and how they could improve their performance. Managers ensured there were regular team meetings each month across all the services.

The percentage of staff that had had an appraisal in the last 12 months was 95%. This was above the trust average of 88%.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Staff received the necessary specialist training for their roles. For example, two members of staff had completed specific training on conducting investigations into deaths of people with learning disabilities. Two staff in the Bedfordshire sensory impairment team had completed specific training on ear care.

Managers dealt with poor staff performance promptly and effectively. Managers provided examples of how they had managed poor performance. This included explaining to a staff member what they had done wrong, showing the staff member the standard of work required and monitoring performance. The trust's human resources department assisted managers in formal disciplinary and capability procedures.

Managers had recruited one volunteer to work within the speech and language service in Bedfordshire. The team manager provided support and supervision to this volunteer.

**Multidisciplinary and interagency team work**
Staff held regular and effective multidisciplinary team (MDT) meetings. Each team held a meeting once a month to discuss business matters, service developments, staff changes, rotas and policies. Teams held meetings to discuss referrals and casework more frequently. For example, the Hackney autism team held weekly meetings to review new referrals and the progress of current patients. At the Tower Hamlets adult autism MDT, staff similarly discussed new referrals, the progress of patients, safeguarding matters and the implementation of new outcome measures.

At this meeting, we observed staff working in a very integrated way, demonstrating extensive knowledge of their patients and listening respectfully to their colleagues' views. The Tower Hamlets learning disability service was a very large team. Therefore, the senior staff within this team held a monthly governance meeting. The consultant psychiatrist, team manager, lead occupational therapist and senior practitioners attended these meetings to discuss a standard agenda covering risk management, safeguarding and quality improvement.

The community mental health teams had effective working relationships, including good handovers, with other teams within the organisation. The main contact within the trust was with mental health teams. For example, the adult autism team in Tower Hamlets had worked closely with the mental health team to establish a diagnosis for a patient with symptoms of schizophrenia and autism.

The community teams had good working links, including effective handovers, with primary care, social services, and other teams external to the organisation. The learning disability services worked routinely with mainstream health services. For example, the specialist healthcare team in Bedfordshire continued to support patients when they were admitted to hospital. This team also supported patients to attend doctors' appointments, eye tests and hearing tests. The intensive support team in Bedfordshire worked with patients in hospital and in the community and were, therefore, able to continue working with patients when they moved between these services.

**Adherence to the Mental Health Act and the Mental Health Act Code of Practice**
Three patients were subject to community treatment orders (CTOs) under the Mental Health Act 1983 (MHA). All three patients were receiving services at the Tower Hamlets community learning disability service. We reviewed the records of two of these patients. Staff had completed Community Treatment Order paperwork correctly and it was up to date and stored appropriately. MHA administrators scanned and uploaded the statutory documents to the electronic patient record.

Staff in the learning disability service completed training on the MHA as part of the mandatory training programme. In Bedfordshire, 96% of staff had completed mandatory training on the MHA. In Tower Hamlets, 84% of staff had completed this course. The consultant psychiatrist was the responsible clinician for the patients who were subject to community treatment orders.

Staff had easy access to administrative support and legal advice on implementation of the MHA and its Code of Practice. Staff knew who their MHA administrators were.

The provider had relevant policies and procedures that reflected the most recent guidance. Staff could access these policies and procedures, and the MHA Code of Practice, through the staff intranet.

Staff explained to patients their rights in a way that they could understand, and recorded that they have done it. Staff provided information in an accessible format. Patient had easy access to information about independent mental health advocacy (IMHA) services. However, one record showed that staff had informed the patient of their rights when the community treatment began and on one other occasion. Staff did not inform the patient of their rights when there had been a

change to statutory authorisation of their medication and when the CTO was renewed. The MHA Code of Practice states that staff should inform patients of their rights on these occasions.

Care plans did not refer to patients' rights to aftercare services. Patients who had been admitted to hospital for treatment under the MHA had a right to aftercare services. Failure to mention this in the care plan could mean that staff and patients were not aware of the patient's rights to aftercare.

**Good practice in applying the Mental Capacity Act (E6)**

In Bedfordshire, 83% of staff had completed mandatory training in the Mental Capacity Act. At the City and Hackney adult autism team, 50% of staff had completed this training. In Tower Hamlets, 66% of the learning disability team had completed this training, but none of four staff at the autism team had done so. However, staff across all teams demonstrated a good understanding of the Mental Capacity Act 2005, particularly the five statutory principles. For example, staff told us about the importance of assuming capacity unless they established that the patient lacked capacity and that any act or decision made on the patient's behalf must be carried out in the least restrictive manner.

The provider had a policy on the Mental Capacity Act. Staff told us they were aware of the policy and could access it through the trust's intranet.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act. Staff usually spoke with social workers for immediate advice on the MCA. Staff could also contact the MCA lead within the trust. The trust had access to legal advice for more complex matters.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it. Staff provided encouragement to patients to make decisions, provided accessible information and used communication equipment such as talking mats. Speech and language therapists supported patient to communicate their views.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. Staff had recorded capacity assessments for all patients using learning disability services in relation to decisions about their treatment. Staff completed these assessments on a decision-specific basis with regard to significant decisions. For example, capacity assessments were carried out in relation to moving to new accommodation, medication and understanding of safeguarding allegations and consent to marry.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. Staff made best interest decisions in relation to the use of special equipment to prevent self-harm, moving to alternative accommodation and significant wheelchair adaptations. When making these decisions, staff held meetings to consider the relevant circumstances.

## CARING

**Kindness, privacy, dignity, respect, compassion and support**

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. For example, during an out-patient appointment at the Tower Hamlets learning disability team, the psychiatrist was empathetic towards the patient, listened carefully to the patient's explanation of their symptoms and praised the patient for their openness. When the patient became tearful, the psychiatrist spoke sensitively and provided reassurance. At a diagnostic assessment at the Tower Hamlets adult autism service, the doctor listened carefully to the patient, checked their understanding of what the patient had said and asked questions using simple language. During this interview, the patient became more relaxed and settled.

Staff supported patients to understand and manage their care, treatment or condition. Within the learning disability services, the specialist healthcare team in Bedfordshire and long-term care teams in Tower Hamlets were dedicated to supporting patients to manage care for long-term conditions. Within autism services, staff spoke with patients after the diagnostic assessment to help them understand their diagnosis and provide information on how they could manage their symptoms.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. For example, following a diagnostic assessment at Tower Hamlets adult autism service, staff referred a patient to the jobs and employment service for workplace support and advice on asking for reasonable adjustments at work. Staff also referred the patient to a speech and language therapist to improve the fluency of their speech. Staff at learning disability services supported patients to attend sight tests and hospital appointments.

Patients said staff treated them well and behaved appropriately towards them. Patients said that staff had helped them enormously, that staff were very good and that staff were kind and caring. Other patients said that services were friendly and welcoming and that staff listened to them.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. For example, at an occupational therapy referrals meeting, staff discussed each patient in depth. Staff were aware of each patient's specific difficulties and any worries the patient had about the referrals. Staff were aware of the views of other people the who supported the patient such as colleges and families. Within adult autism services, staff gained an understanding of patients through a diagnostic assessment that included personal circumstances and developmental history. Staff in Tower Hamlets said they enjoyed working with the Bengali community and valued the close support patients received from their families in this community.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. However, none of the staff we spoke with said they had needed to do so.

Staff maintained the confidentiality of information about patients. At initial meetings, staff agreed an information sharing arrangement with the patients. In these agreements, patients gave their consent to staff sharing information with people such as the GP and their family.

## Involvement in care

### Involvement of patients

Staff involved patients in preparing their risk assessments and care plans. Patients frequently attended care planning meetings. Care plans, risk assessments and adult protection plans included details of patients' views. Patients received copies of care plans, behavioural support plans and letters to GPs.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. At appointments with patients with learning disabilities, staff read through care plans with patients, phrasing the details in ways that patients could understand and checking patients' understanding throughout the discussion. If the patient did not understand what was being said, the member of staff described things differently, more simply or with very specific reference to things the patient understood. Learning disability teams employed speech and language therapists to help patients improve their verbal communication. Staff provided written information in accessible formats, including pictures and photographs.

Staff involved patients, when appropriate, in decisions about the service. For example, we met with a patient who had been involved in interviews for the recruitment of staff. The patient said they had enjoyed being part of these interviews and felt staff had considered their views when making the recruitment decision.

Staff enabled patients to give feedback on the service they received. Patients and carers could record their views on the service by answering simple questions on a tablet computer. Managers reviewed feedback from patients. The trust collated patient feedback from across all services and presented this information in a quality report to the trust board.

Staff ensured that patients could access advocacy. This included advocacy provided by a local organisation and an Independent Mental Capacity Advocacy service.

**Involvement of families and carers**

Staff informed and involved families and carers appropriately and provided them with support when needed. Carers were very positive about the services the people they cared for received. Within learning disability services, families and carers routinely attended appointments and reviews. The services offered specific support to families of patients with challenging behaviour. For example, the family of one patient had regular telephone contact with the service. Staff had offered this family crisis support outside office hours. At the adult autism services, staff sent a relatives questionnaire to families as part of the assessment process.

Staff enabled families and carers to give feedback on the service they received. Most services provided a carers group. Carers could also provide feedback through the computer tablet in the same way as patients could.

The services routinely provided carers with information about how to access a carer's assessment.

## RESPONSIVE

**Access and waiting times**

The service had clear criteria for which patients would be offered a service and, if waiting lists were used, who could be placed on them. The criteria did not exclude patients who needed treatment and would benefit from it. The criteria were set out in the operational policy for each service and varied according to local commissioning arrangements.

The provider had set a target for time from referral to triage/assessment and from assessment to treatment in adult autism services. The target time from referral to assessment for non-urgent referrals was 18 weeks. The adult autism services in Bedfordshire and Tower Hamlets had a waiting time from referral to diagnostic assessment of 36 weeks. The waiting time at City and Hackney was 24 weeks. The service in Bedfordshire and Tower Hamlets had appointed locum psychiatrists and set weekly targets for the number of assessments in order the clear the backlog of patients on the waiting list.

In Tower Hamlets, 12 patients were waiting to see a speech and language therapist. One patient had been waiting over two years and another had been waiting almost a year and a half. The service was recruiting a further speech and language therapist.

The team was able to see urgent referrals quickly. The learning disability service in Tower Hamlets allocated urgent health referrals within 48 hours. If the referral was not urgent, staff discussed the patient in a weekly referral meeting. Within learning disability services, the Bedfordshire intensive support team provided a 24-hour service that could respond quickly to any urgent referrals. In Tower Hamlets, the duty desk could respond to urgent situations. Adult autism services did not provide services that were appropriate for patients requiring an urgent intervention. However, the adult autism service in Tower Hamlets did occasionally prioritise assessments for some patients. For example, the service prioritised an assessment for a patient whose children had been assessed by the local authority as being in need.

The team responded promptly and adequately when patients telephoned the service. The intensive support service in Bedfordshire operated a 24-hour crisis line. In Tower Hamlets, the service allocated two members of staff to the duty desk to ensure that telephone cover was provided at all times.

Staff responded promptly to sudden deterioration in a patient's health. The intensive support team in Bedfordshire had specific responsibilities for people with a learning disability experiencing a crisis in relation to challenging behaviour or mental health need. When the service received an urgent call that required a nurse to attend, an on-call nurse responded within four hours. This service was committed to responding to patients in an emergency within four hours. The Tower Hamlets community learning disability team had a duty desk that could facilitate urgent access to support and assistance for patients. The adult autism teams did not provide interventions that would assist patients experiencing a sudden deterioration in their health.

The team tried to engage with people who found it difficult or were reluctant to engage with learning disability or autism services. Staff worked with patients to understand the reasons why a patient may be reluctant to engage and explore ways of addressing their concerns.

The team tried to make follow-up contact with people who did not attend appointments. When patients did not attend appointments, staff considered any risks to the patient and could arrange a home visit if staff considered it to be necessary.

Where possible, all the services offered patients flexibility in the times of appointments. One carer commented that staff always did their best to ensure that appointments did not conflict with anything else the patient was doing because this would cause a lot of anxiety.

Staff cancelled appointments only when necessary and when they did, they explained why and helped patients to access treatment as soon as possible. One carer explained that if staff needed to rearrange an appointment they would speak to the carer and the patient, and send a letter confirming the new time and date.

Appointments usually ran on time and people were kept informed when they did not. All the patients and carers we spoke said that appointments ran to time.

Some services used technology to support timely access to care and treatment. For example, the adult autism service in Hackney sent text messages to patients a week before their appointment. These messages could be sent automatically by the electronic patient record system.

Staff supported patients during referrals and transfers between services. For example, staff from the specialist healthcare team in Bedfordshire had recently supported a patient who was in hospital for the treatment of cancer.

The learning disability service in Tower Hamlets had a dedicated transitions team that supported patients from children's services to adult services. This service offered an assessment to all young people who were likely to become eligible for adult services to ensure a smooth transition between services when the young person became 18.

**Facilities that promote comfort, dignity and privacy**

The service had a range of rooms and equipment to support treatment and care. Each service had a clean and bright waiting area with plenty of chairs. Services had decorated interview rooms to provide a calm and pleasant environment. The art therapy room at Tower Hamlets community learning disability service was small but well equipped.

Interview rooms had adequate soundproofing, enabling services to maintain patients' confidentiality.

**Patients' engagement with the wider community**
When appropriate, staff ensured that patients had access to education and work opportunities. For example, the adult autism service in Tower Hamlets referred people to a local organisation that supported people into employment. The adult autism service in Hackney supported patients to request their employer made reasonable adjustments to accommodate any difficulties arising from the autistic spectrum disorder.

Staff supported patients to maintain contact with their families and carers. For example, the intensive support service in Bedfordshire provided significant support to families to enable patients to continue to live within the family home. Services also provided aids and adaptions to support patients to live at home.

Patients were encouraged to develop and maintain relationships with people that mattered to them, both within the services and the wider community. This included practical support, such as supporting a patient to apply for a taxi card to enable them to travel to places in the local community. The adult autism service in Tower Hamlets provided a social skills group to support patients who found it difficult to form relationships.

**Meeting the needs of all people who use the service**
The service made adjustments for disabled patients. All the premises were accessible for people with limited mobility. The services displayed information in an accessible format. However, there was no signage outside the premises to indicate what services were provided there, which could make it difficult for people to find the services.

Staff ensured that patients could obtain information on treatments, local services, and patients' rights. Services displayed information in waiting areas. Staff also provided information to patients that were specific to the patient's needs and circumstances.

Staff provided information they designed to meet the specific needs of each patient. For example, a care plan included a specific picture of the patients' medication in a cupboard at their home. This helped the patient understand where the medication was kept.

Staff made information leaflets available in languages spoken by patients. Leaflets could be translated on request.

Managers ensured that staff and patients had easy access to interpreters and signers. The services in London routinely used interpreters. Interpreters at these services assisted with a number of interviews during this inspection.

**Listening to and learning from concerns and complaints**
There had been one complaint in the previous 12 months. The complaint was made by a carer who was unhappy about the support provided after the person they cared for was discharged from hospital. The service partly upheld the complaint.

Patients and carers knew how to complain or raise concerns. For example, one patient told us that if he felt things were not being done properly he would speak to the manager.
When patients complained or raised concerns, they received feedback. The person who had complained had received a letter from the trust with details of the investigation and the outcome of the complaint.

Staff knew how to handle complaints appropriately. Managers were aware of the procedure for managing complaints, including the timescales for responses and investigations.

Staff received feedback on the outcome of investigations into complaints and acted on the findings. As there were so few complaints, there were no examples of this. However, discussions about complaints and patient feedback were a standing item on the agenda for team meetings.

## WELL-LED

### Leadership

Leaders had the skills, knowledge and experience to perform their roles. All the managers we spoke with had a professional background in the service they were managing. Most of the managers had managed services for many years.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Team managers maintained their understanding of services by facilitating team meetings and providing supervision to staff. Team managers were also able to monitor performance by receiving regular information about referrals, supervision rates and waiting times.

Leaders were visible in the service and approachable for patients and staff. Team managers were based at the services and worked alongside their colleagues each day. Staff spoke positively about their managers. Divisional directors regularly visited the offices.

Leadership development opportunities were available, including opportunities for staff below team manager level. All the team managers had worked at the trust for a number of years and been promoted up to manager level. The trust provided a leadership training course for new managers. The trust also provided leadership development programmes for qualified staff who were seeking to become managers.

### Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. At each staff appraisal, managers asked employees to give examples of how they have applied the trusts values of care, respect and inclusivity to their work.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. The trust displayed posters about its vision and values at all the services. The trusts also printed its values onto staff name badges. The chief executive sent a monthly email to all staff.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially when the service was changing. Staff could make these contributions individually at supervision sessions or collectively at team meetings. Managers had also asked staff to volunteer for specific work on service development. For example, the manager at Tower Hamlets learning disability team invited staff to be involved in the development of the lone working policy.

Staff could explain how they were working to deliver high quality care within the budgets available. All managers were aware of their service's financial situation. The learning disability service in Tower Hamlets had made five staff redundant in 2017. The manager had reviewed the impact of the redundancies and concluded they had not affected the quality of the service. The adult autism services were commissioned on a three yearly basis. All the services had had their contracts extended but managers were unsure about the long-term future. Managers commented that the trust still employed people on permanent contracts, rather than temporary contracts, to minimise the impact of this uncertainty on staffing and recruitment.

### Culture

Staff felt respected, supported and valued. Staff described working for the trust as being a very positive experience.

Staff felt positive and proud about working for the trust and their team. All the staff we spoke with were very positive about their team and their colleagues. Staff described their colleagues as being very supportive and commented that people worked together as a strong unit. In our interviews, almost all staff cited colleagues or team working as being one of the best parts of their work. Managers commented that staff often worked above and beyond the requirements of their role to support colleagues and patients.

Staff felt able to raise concerns without fear of retribution. All the staff we spoke with said they could raise concerns with their manager.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. The trust publicised the whistle blowing process by displaying notices at all staff sites. These notices included a photograph and contact details of the Speak Up Guardian.
Managers dealt with poor staff performance when needed. Managers gave examples of how they had dealt with performance positively by setting clear objectives and supporting staff to achieve them.

Teams worked well together and where there were difficulties managers dealt with them appropriately. For example, when the Tower Hamlets learning disability service transferred to the trust from another provider, there was a dispute about the use of IT equipment. The trust acted decisively to purchase new equipment straight away to minimise any disruption to the service. Staff appraisals included conversations about career development and how it could be supported. Managers encouraged staff in their career development through enabling staff to attend training courses, take on responsibility for specific pieces of work within the team and by participating in the trust's mentoring programme.

Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. Services made reasonable adjustments to assist colleagues with the effects of illness and disability. This included providing equipment or flexible working hours. The trust facilitated a lesbian, gay, bi-sexual and transgender forum. At some sites, the trust provided prayer rooms for staff.

The service's staff sickness and absence rates were similar to the average for the trust. The sickness for these services was 3%, ranging from 0% at Hackney adult autism service to 4.2% at Tower Hamlets learning disability service. These figures were below the trust's overall sickness rate of 4.3%.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The trust displayed information about the occupational health service at all of the services.

The trust recognised staff success within the service. Each year the trust held a staff award ceremony. Over 800 staff attended the awards ceremony in November 2017. The administration manager at the community learning disability service in Tower Hamlets won the employee of the year award.

**Governance**
Whilst overall, there were effective governance systems in place, improvements in some teams were needed. Premises were safe and clean; there were enough staff and patients were assessed and treated well. However, within adult autism teams some staff were not supervised on a monthly basis in line with trust policy; some teams had poor compliance rates with mandatory training and some patients had long waits after being referred before their assessment started.

There was a clear framework of what must be discussed at team and directorate level meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Each service had a clear structure for these meetings. For example, in Bedfordshire

there was a monthly service managers meeting to discuss quality, governance, business and performance. Information from this meeting was passed to other staff monthly team meetings. More urgent matters, or matters relating to specific patients were discussed at weekly multidisciplinary team meetings.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. For example, following the death of a patient that was linked to constipation the services classified chronic constipation as a long-term condition, staff reviewed relevant NICE guidance at a team meeting and the service arranged specific training for staff on the topic.

Staff undertook or participated in clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. The trust carried out audits on a number of topics including infection control, record keeping and hand hygiene.

**Management of risk, issues and performance**
Staff maintained and had access to the risk register at a team and directorate level and could escalate concerns when required. Managers escalated matters through their directorate management meetings.

Staff concerns matched those on the risk register. For example, the risk register for Tower Hamlets learning disability team covered risks that were very specific to that team. This included the risk of recording information on two systems and the risks presented by the waiting list for speech and language therapy.
The service had plans for emergencies, such as adverse weather or a flu outbreak. Business continuity plans were prepared at both a local and a trust wide level. The business continuity plan in Bedfordshire was reviewed every two months.

**Information management**
The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. None of the staff we spoke with raised concerns about data collection.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff at Tower Hamlets explained that they had to work on two different systems, one for the trust and the other for the local authority. However, they said that this did not have an impact on patients.

Information governance systems included confidentiality of patient records. Staff could only access patient records using a card and a password. Staff completed mandatory training on information governance.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. This information displayed in a ‘dashboard’ format.

Information was in an accessible format, and was timely, accurate and identified areas for improvement. Information on the dashboard was updated each month.
Staff made notifications to external bodies as needed. This included notifications to the Care Quality Commission and the local safeguarding authorities.

**Engagement**
Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. Staff had access to an intranet. The intranet included newsletters about

governance, quality improvement and clinical practice. The chief executive sent a monthly email to all staff with information about developments across the trust.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. At each site, patients and carers could provide basic feedback on the service. Feedback questionnaires were presented on a tablet computer using simple images and text.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. For example, the Tower Hamlets learning disability team patients had said the waiting room was crowded and dull. In response, the service moved the waiting area to a bigger room that was brighter and had more comfortable furniture. Services displayed information about changes they had made on a 'You said, we did' notice board.
Patients and staff could meet with members of the trust's senior leadership team and governors to give feedback.

Directorate leaders engaged with external stakeholders. All of the services maintained regular contact with commissioners through contract monitoring arrangements. The learning disability service in Tower Hamlets was part of the local learning disability partnership board alongside voluntary organisations in the borough. This board was responsible for leading an overall strategy for learning disability services.

**Learning, continuous improvement and innovation**
Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. The multidisciplinary team in Bedfordshire met each quarter to review updates of relevant guidance from the National Institute for Health and Care Excellence (NICE) and ensure that their professional practice was compliant.
Staff had opportunities to participate in research. The Tower Hamlets adult autism team was involved in the SHAPE project run by the University of York to evaluate service models within specialist autism teams.

Innovations were taking place in the service and were encouraged throughout the trust. For example, in Bedfordshire, staff had created a quality improvement project to improve the time it took for patients to receive an assessment after the initial referral. The service reduced average waiting times from 15 days to three days by changing the way referral meetings were run and attended.

Staff used quality improvement methods and knew how to apply them. For example, the consultant in Bedfordshire was aiming to reduce the prescribing of antipsychotics to people with challenging behaviour. They had reviewed all the patients with challenging behaviour currently receiving antipsychotics to establish a baseline figure. They had then set a target of reducing this level of prescribing by 20% in the following year.

Staff took part in mortality review work. For example, the services carried out investigations into patient deaths in accordance with the learning disabilities mortality review programme. NHS England had set up this programme to monitor the deaths of patients with learning disabilities.
This core service did not participate in any accreditation schemes.

## Wards for people with a learning disability or autism

### SAFE

## Safe and clean environment

### Safety of the ward layout

Environment audits, including ligature risk assessments were completed on the ward. We found that where ligature risks had been identified staff had mitigated these risks by increasing observation levels dependent upon the patient's mental state. Where risks had been identified the work had been completed. Mirrors were used in corridors to ensure there was a line of sight.

All the patients we spoke to said that they felt safe on the ward. Family and carers we spoke with also stated that they felt the ward environment was safe for their relatives.

The ward complied with the guidance on mixed sexed accommodation. Males and females had separate corridors where the bedrooms and bathrooms were situated. One bedroom had en-suite facilities and could be designated as a male or female room. This bedroom was situated near to the nursing office and was used when a patient presented with higher risks or needed close observation. There were observation panels in the bedroom doors to allow staff to observe patients. There was a female only lounge. Patients had access to therapy rooms including the pavilion and a dining room.

Managers told us that the trust had consulted with them about the potential re-development of the site and initial plans had been drawn up however they were not suitable for the patient's needs. Further consultation and discussions were ongoing and there were no dates as to when the redevelopment might take place.

Staff wore portable alarms on their person and rooms had fixed call bells to raise an alarm when necessary.

### Maintenance, cleanliness and infection control

The ward was clean and tidy and furnishings were in good condition and well-maintained. Staff were able to raise environmental issues with the trusts central maintenance department who would attend the ward in a timely manner to undertake repairs or replace furniture and equipment.

We observed the environment to be visibly clean and well maintained. All areas of the ward and bedrooms were decorated in neutral colours. Some patient bedrooms had items of furniture and personal items temporarily removed and stored securely as they had been assessed as presenting a safety risk.

Fire safety equipment such as extinguishers and fire blankets were inspected by staff monthly and routine fire alarm tests were undertaken by the trust. All electrical equipment on the ward had been tested in line with the trust policy of portable appliance testing and testing was in date.

Staff completed cleaning records and recorded fridge temperatures in the kitchen fridges and freezers to ensure that there were appropriate temperature controls to meet food handling and storage requirements. Staff prepared all meals for patients and we found that all the staff had undertaken relevant food hygiene courses.

Cleaning rotas were in place, staff and patients had access to hand washing facilities including alcohol based hand gel. Posters were displayed with hand washing guidance in the clinic, bathroom and kitchen areas. Domestic staff were present on the ward during the daytime to undertake cleaning tasks.

The most recent patient-led assessments of the care environment (PLACE) were in 2016 and showed the ward scored above the England average for cleanliness. It scored lower than the England average in the other three areas.

| Site name | Core service(s) provided | Cleanliness | Condition appearance and maintenance | Dementia friendly | Disability |
|---|---|---|---|---|---|
| **The Coppice** | MH – Wards for people with a learning disability or autism | 98.9% | 92.1% | 80.4% | 69.4% |
| **Trust overall** | | **93.9%** | **92.7%** | **82.5%** | **79.5%** |
| **England average (Mental health and learning disabilities)** | | **97.8%** | **94.5%** | **82.9%** | **84.4%** |

**Clinic room and equipment**
The clinic room was situated in the male bedroom corridor however staff mitigated the risk to female patients by escorting them to the clinic room for medication or by taking medication to them in a separate area of the ward. Staff maintained clinical equipment appropriately. There were “I am clean” stickers on equipment. Staff had access to an emergency bag with equipment and medication for use in an emergency situation. We found records of daily checks of this equipment.

At the last inspection in June 2016 we found that the trust was not always recording fridge temperatures. At this inspection we found that this had improved however we found that there were no minimum or maximum ranges of temperatures being monitored as the thermometer only recorded the current temperature. This meant that staff could not be assured that medications were being stored at the correct temperatures to ensure the efficacy of the medications stored in fridges.

## Safe staffing

**Nursing staff**
There were safe staffing levels on the ward. Staff on the ward worked as part of the Intensive Support Team (IST) and worked across the community and inpatient ward. Approximately 50% of the IST staff worked primarily at The Coppice to provide continuity to patients who were admitted. There was a mixture of both mental health and learning disability registered nurses. The trust reported vacancies between 1 November 2016 and 31 October 2017 as seen in the table below. However, at the time of this inspection there were no current vacancies for qualified staff or healthcare assistants.

Staffing levels were calculated using a matrix linked to a safer staffing protocol. Staff worked a morning, afternoon or night shift. Day shifts were staffed on a minimum of one qualified nurse and 2 healthcare assistants and one qualified and one healthcare assistant at night. Managers and members of the MDT worked on the ward between 9 am to 5 pm weekdays. Managers were able to adjust staffing levels in response to the occupancy and acuity of the patient group. For example where a patient may need increased level of observation managers were able to increase the amount of staff accordingly. The ward had not engaged agency staff in the last twelve months prior to inspection.

The trust submitted figures in relation to sickness levels and shifts filled by bank or agency staff.

| **Substantive staff figures** | | | **Trust target** |
|---|---|---|---|
| Total number of substantive staff | At 31 October | 28.9 | N/A |

| | | | |
|---|---|---|---|
| | 2017 | | |
| Total number of substantive staff leavers | 1 November 2016 – 31 October 2107 | 3 | N/A |
| Average WTE* leavers over 12 months (%) | 1 November 2016 – 31 October 2107 | 10% | N/A |
| Vacancies and sickness | | | |
| Total vacancies overall (excluding seconded staff) | At 31 October 2107 | 5.1 | N/A |
| Total vacancies overall (%) | At 31 October 2107 | 15% | <10% |
| Total permanent staff sickness overall (%) | Most recent month (31 October 2017) | 2% | 3.5% |
| | 1 November 2016 – 31 October 2107 | 3% | 3.5% |
| Establishment and vacancy (nurses and care assistants) | | | |
| Establishment levels qualified nurses (WTE*) | At 31 October 2017 | 16.8 | N/A |
| Establishment levels nursing assistants (WTE*) | At 31 October 2017 | 16 | N/A |
| Number of vacancies, qualified nurses (WTE*) | At 31 October 2017 | 2.1 | N/A |
| Number of vacancies nursing assistants (WTE*) | At 31 October 2017 | 3 | N/A |
| Qualified nurse vacancy rate | At 31 October 2017 | 13% | <10% |
| Nursing assistant vacancy rate | At 31 October 2017 | 19% | <10% |
| **Bank and agency Use** | | | |
| Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) | 1 November 2016 – 31 October 2107 | 194 | N/A |
| Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | 1 November 2016 – 31 October 2107 | 0 | N/A |
| Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 November 2016 – 31 October 2107 | 7 | N/A |

Overall there was a low level of sickness as of 31 October 2017 at 2%; this was below the trust target of 3.5 %. Managers told us that staff had incentives offered by the trust if they did not take any sick leave in 12 months.

Between 1 November 2016 and 31 October 2017 turnover of staff for the IST service including the ward was 10% which was lower than the trust average.

Bank nursing staff were given an induction to the ward on their first shift. Managers told us that because the staffing for the ward was managed within the wider IST staff were familiar with the patients and the ward environment.

Whilst on inspection we saw that the qualified nurse was located in the nursing office with the door open or in the communal areas of the ward, this meant that they were able to observe what was happening.

Staffing levels were maintained to enable patients to have one to one time with their named nurse. Managers and staff told us that there were rarely staff shortages. In the recent adverse weather conditions managers explained how they were able to meet the staffing levels by asking staff that lived locally to fill shifts.

Staff told us that activities were rarely cancelled due to staff shortages and appointments for GP's and other physical healthcare were prioritised and never cancelled. There were enough staff for physical healthcare observations to be taken when necessary.

**Medical staff**

The ward had two psychiatrists' one consultant and one higher trainee psychiatrist. The consultant had approximately 60 patients on their caseload which was within the Royal College of Psychiatrists guidance. The ward also had a junior doctor three sessions per week. The doctors split their time between the community office and were based on the ward two days per week. If medical cover was required on other days or out of hours staff would use the on-call rota. Medical staff could attend the ward within 30 minutes where necessary.

**Mandatory training**

Eighty nine percent of staff had completed mandatory training, including fire safety, infection control, equality and diversity and safeguarding adults and children. At the last inspection in June 2016 we found that staff had not received training in the Mental Health Act (MHA) and the Mental Capacity Act (MCA). At this inspection we found this had improved and that the trust had delivered training to staff in the use of the MHA and the MCA. Take up of some mandatory training courses was below the trust target of 90%. These included Care Programme Approach (50%), conflict resolution (67%) and medicines safety (73%).

## Assessing and managing risk to patients and staff

**Assessment of patient risk**

Staff undertook an initial risk assessment of every patient and these risk assessments were updated regularly following changes in the patients risk presentation. Concerns regarding patient's physical health were escalated to medical staff and appropriate action taken. For example, one patient had recently transferred to an acute hospital for treatment of a physical health condition. Their risk assessment reflected the increased risk of falls.

At the last inspection in June 2016 we told the trust they should ensure that risk assessments included greater detail about how to support patients. On this inspection we found this had

improved. For example patients risks to themselves or others were documented and interventions that would minimise risk clearly identified.

The risk assessment tool was comprehensive and included risks to self, others and the environment. It was stored electronically on the care records and printed out for patients to have a copy.

**Management of patient risk**
Staff were aware of each individual patients needs in relation to slips, trips or falls and risks to self or others. Risk assessments were discussed in detail at weekly ward rounds by the multidisciplinary team. The team recorded the discussions directly onto the electronic care records so they were accessible immediately. We found that two patients had their wardrobes removed from their bedrooms. We raised this at the time of inspection with the manager and found that these decisions had been made to reduce the risk of harm to the patients. The nursing staff and consultant reviewed this decision on a daily basis.

Managers had a weekly “leads huddle” which was a meeting that looked at the management of risk including patients, environment and wider trust risk issues, this had recently been introduced in January 2018.

An observation policy was in place for patients. Nursing staff could increase levels of observation in line with their assessed needs or changes in risk. Appropriate policies were in place addressing the searching of patients and their bedrooms. Staff told us they did not have a list of prohibited items but advised patients and relatives what items could not be stored on the premises. For example there were no plastic bags allowed on the ward.

The ward and its grounds were designated “smoke-free” in line with trust policy. Staff reported that this had not been an issue as none of the patients in the last twelve months had been smokers.

**Use of restrictive interventions**
There were no seclusion facilities on the ward. The trust reported one use of rapid tranquilisation and seven prone restraints between 1 November 2016 and 31 October 2017. However managers told us that there had been no restraints or rapid tranquilisation from 1 November 2017 to the time of this inspection. Most staff were trained in prevention and management of violence and aggression which included de-escalation skills. Staff were clear about using restraint as a last resort.

There was no use of seclusion or long term segregation in the last twelve months prior to inspection. We found no evidence of the use of blanket restrictions on the ward.

Staff proactively managed behaviour that could be seen as challenging aggression using risk assessments and interventions such as positive behaviour support plans and communication passports. If a patient’s presentation required seclusion then arrangements were made for a transfer to the local psychiatric intensive care unit.

**Safeguarding**
Staff were trained in safeguarding and knew how to recognise and raise a safeguarding concern when appropriate. There was a local safeguarding team and a named safeguarding lead for the trust that staff could speak to. For example a patient had made allegations toward staff and this had been raised with the local authority and the multidisciplinary team. Staff gave examples of where a safeguarding referral had been made to local authority for example when a patient became physically aggressive towards another patient.

We found there were information leaflets, trust policy guidance and a flow chart for staff to guide them in relation to raising a safeguarding concern, but we did not see easy read or pictorial safeguarding information leaflets for patients.

Staff had also received children's safeguarding training. Children rarely visited the ward, but when this did occur, visits would be facilitated in supervised areas such as the visitor's room or the garden.

**Staff access to essential information**
Staff used both electronic and paper notes. Notes were stored securely in locked cabinets or offices and access to electronic care records was via a secure key card issued to each member of staff. Bank staff were able to access electronic care records. Staff in the community teams also had access to these records.
Staff were able to record information on both paper and electronically without this causing excessive difficulty. Recently the multidisciplinary team had entered ward round discussions directly onto the care records during the meeting so that they were accessible immediately. The risk assessments were accessible to the community staff via the electronic records which meant they could easily access them.

**Medicines management**
Medicines were managed safely on the ward. The trust pharmacist visited the ward weekly to reconcile medications and to complete audits. Staff had access to a wide range of stock medications and could order medicines in a timely manner. There was a storage cupboard for controlled drugs (CD) although there were no patients currently being prescribed CD's. Staff told us that should a patient be prescribed CD's then a healthcare worker would be a second signatory to the qualified nurse dispensing. Specific training would be given to the healthcare assistant to undertake this role in line with trust policy.

Staff reviewed the effects of medication including 'as required medication' on patients physical health by following NICE guidance. No patients were on high dose antipsychotic regimes.

**Track record on safety**
There were no reported serious or untoward incidents on the ward in the twelve months prior to this inspection.

Patients at The Coppice had a history of presenting with behaviour that could be seen as challenging. We observed some patients becoming agitated whilst on the ward and staff intervened immediately to re-direct them and de-escalate the situation.

**Reporting incidents and learning from when things go wrong**
Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified. Between 1 November 2016 and 31 October 2017 there were no STEIS incidents reported by this core service.

Staff were clear about how to report incidents and would complete a trust incident reporting form as necessary. Managers were able to reflect on serious incidents that happened elsewhere within the trust and recommendations that had been cascaded to staff, for example that there were no plastic bags on the ward to reduce the risk of patients harming themselves.

Staff said that they received a de-brief following an incident from a clinician who was separate from the nursing team. They reported feeling supported by colleagues and managers following incidents.

Staff were able to give examples of incidents that had occurred on the ward where a patient presented with behaviours that may be seen as challenging. Staff had developed and implemented appropriate plans to reduce the recurrence of this behaviour.

Staff understood the 'duty of candour' and their responsibilities. Duty of candour is a legal requirement, which means providers must be open and transparent with patients about their care and treatment. This includes being honest about with patients when something goes wrong.

## EFFECTIVE

**Assessment of needs and planning of care**
We looked at all four patient care records. All patients had a comprehensive assessment in place. One patient, who had recently been admitted, was still in the process of being assessed. Assessments of new referrals were carried out by a clinical professional such as a psychiatrist, nurse or community support worker.

All patients received a physical examination on the day of admission. There was evidence of physical healthcare observations of the patients in their care records. Managers told us the ward staff would, wherever possible, continue to escort patients to see their own registered GP in order to reduce anxiety for the patient and for continuity of care. If patients were staying for a long period of time on the ward they could be registered with a nearby GP.

Patient assessments covered their mental health history, personal and emotional needs and communication needs. Every patient had a psychological assessment of their mental health needs.

At the last inspection in June 2016 we found that patients did not have positive behaviour plans (PBS). At this inspection we found that this had improved. Safety plans including positive behaviour support plans or wellness recovery action plans (WRAP) were in place for all patients. Staff used a red, amber, green (RAG) rating system to look in detail at the triggers for patients whose behaviour could be challenging. This meant that the ward was following the Department of Health's guidance on Positive and Proactive Care: reducing the need for restrictive interventions. There was a designated nurse responsible for the monitoring of PBS plans and communication passports to ensure they were reviewed regularly.

Some patients were administered medications which could have an adverse effect on their physical health. When this was the case staff undertook appropriate checks of their vital signs such as blood pressure, pulse and temperature. Staff recorded these in the patient's notes.

We found that staff developed care plans that met the needs of patients identified during assessment For example a patient was assessed and a wellness and recovery plan was developed in line with their needs.

Care plans were personalised, holistic and recovery-oriented. All care plans we looked at were individualised and had aims that were clear.

All four care planning documents we looked at reflected the patient's voice and involvement. Where this was not possible staff recorded the nearest relative or carer with a power of attorney views of the patients' care within the care plan. For example one patient who had significant communication difficulties had their relatives input in their care plan.

We observed a ward round on the Coppice and found that patients and their relatives were invited in to discuss progress, activities and issues that had arisen in the previous week. Care plans were updated when necessary.

**Best practice in treatment and care**
Staff provided a range of care and treatment interventions suitable for the patient group. Clinicians were following the five good communication standards guidance and NICE guidance for challenging behaviour and autism. Since the previous inspection in June 2016, the trust had continued to improve access to psychology and therapy staff. A speech and language therapist undertook swallowing assessments and communication assessments. The occupational therapist assessed and offered sensory integration as an intervention where appropriate. Staff provided care in line with the national transforming care programme model of support. A range of therapeutic activities was available including sensory work, art therapy, music therapy and activities of daily living to promote skills towards independent living.

Patients were prescribed medication in accordance with the National Institute of Clinical Excellence (NICE) guidance. No patients were on high dose antipsychotic regimes. A trust pharmacist visited the ward weekly to monitor the quality of medicines management.

The ward staff supported patients to access comprehensive annual health assessments. We found that staff supported patients with health care needs specific to medical conditions associated with a learning disability and or autism such as epilepsy or diabetes. Patients had routine weekly physical health observations taken for example, blood pressure, pulse, temperature. These results were recorded in the electronic records and discussed at ward round.

Patient's physical healthcare needs were well met. There were strong links with the patient's own GP or the local GP. Where patients required screening for cancer or cardiovascular concerns staff could undertake electrocardiograms (ECG's) and blood tests on site or refer to the GP. Staff were able to access blood test results by telephone and copies of blood tests were received directly to the ward for doctors to review.

Patient's nutritional needs were assessed and met by staff. All meals and snacks were cooked on the ward in the kitchen by staff. There were pictures available for patients to make choices of what they would like to eat each day.

Staff actively encouraged patients to have healthier lifestyles and could offer smoking cessation and nicotine replacement therapy to patients if required.

Staff participated in various clinical and environmental audits including infection control, hand hygiene, Mental Capacity Act, Mental Health Act and controlled drugs. Managers completed these audits and the results were monitored by the trust. Managers also told us that there were local audits for record keeping compliance and patient related experience.

Managers and staff were involved in a quality improvement programme which was in place to increase activities and ensure good quality support to patients that would reduce incidents and the need for physical interventions.

**Skilled staff to deliver care**
Staff were experienced and qualified to meet the needs of the patient group. Nursing staff were skilled in working with patients who had learning disabilities and/or autism. In addition to the nursing staff and managers, there was a consultant psychiatrist, junior doctor and higher level specialist doctor. The multidisciplinary team was also complemented by a psychologist, art therapist, occupational therapist, speech and language therapist and a band 4 activities coordinator.

Staff were receiving regular supervision within the Bedfordshire intensive support team which included staff working at The Coppice. Compliance with the trust target was low at 35% however, data from April 2017 to January 2018 showed that over half the staff received supervision each month, indicating that supervision was bi-monthly. Whilst this was not compliant with the trust's

target, supervision was clearly taking place. All the staff we spoke with said they were well supported. On the ward staff received on average six-weekly supervision either individually or in a peer supervision group. We looked at six supervision records for staff and found that they had all received supervision in the previous six week period.

Staff received an annual appraisal in line with trust targets. The trust's target rate for appraisal compliance was 90%. As at 31 October 2017, the overall appraisal rates for non-medical staff within this core service was 93%. See table below;

| Team name | Total number of permanent non-medical staff requiring an appraisal | Total number of permanent non-medical staff who have had an appraisal | % appraisals |
|---|---|---|---|
| **IST** | 29 | 27 | 93% |
| **Trust wide** | **3,214** | **2842** | **88%** |

Staff and managers told us that they received support from the trust to complete additional qualifications such as specialist degrees, nurse prescribing courses and promoting healthy lifestyles.

At the last inspection in June 2016 we found that the trust had plans in place to deliver training to all staff in the use of positive behaviour support. On this inspection we found that all staff had received this training which had been delivered by trainers from the British Institute for Learning Disabilities (BILD).

**Multidisciplinary and interagency team work**
Staff held regular and effective multidisciplinary meetings where all members of the multidisciplinary team (MDT) would attend. Information was shared about patients at handover meetings within the team.

There were effective daily handovers across the day, afternoon and night shifts for nursing staff and members of the MDT. The handovers included information about the patient's presentation, including risk and physical health as well as activities for the day.

Ward staff had developed effective working relationships with the Adult Autism Team in Bedford, local commissioning groups, GPs and local authority safeguarding teams.

**Adherence to the Mental Health Act and the Mental Health Act Code of Practice**
On this inspection no patients were subject to detention under the Mental Health Act 1983 (MHA).

Over 95% of staff had completed Mental Health Act (MHA) training and staff understood the guiding principles of the act and their responsibilities when working with patients who were detained. We spoke with clinicians who said they had all received training in the MHA.

Staff could access support from the trust MHA administrators to advise them on paperwork and legal matters related to the MHA.

Patients who were detained under the MHA 1983 were given information in an easy read format, including information about their rights. Staff told us they ensured that patients and their relatives understood their rights.

There was access to an Independent Mental Health Advocate (IMHA), they attended the ward regularly and supported patients at ward rounds and care programme approach meetings when needed.

Regular audits took place to ensure that the Mental Health Act was being applied correctly.

**Good practice in applying the Mental Capacity Act**

Overall 83% of staff had completed training in the Mental Capacity Act (MCA).
At the last inspection in June 2016 we told the trust that they should ensure that all staff working at the ward were confident in using the Mental Capacity Act including an improvement in the documentation of best interests' decisions for people who were unable to consent to care and treatment. On this inspection we found this had improved. Capacity assessments and best interest decisions were routinely carried out and recorded clearly in the patient's notes.

Staff used various communication methods, according to patient need, to ensure they assisted the patient to make a specific decision for themselves before they assumed that the patient lacked capacity. Where patients were assessed as lacking capacity, staff made decisions in their best interests, respecting the importance of the patient's wishes, feelings and culture.

We spoke to medical, allied healthcare professionals and nursing staff all of whom had good understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). Staff understood the importance of gaining consent and supporting patients to make their own decisions wherever possible.

The service had access to an independent mental capacity advocate via an independent advocacy service. The advocate visited the ward weekly and was able to support patients in relation to the MCA.

The trust told us there were seven DoLS applications made to the local authority between 1 November 2016 and 31 October 2017. We found that all of the patients currently on the ward at the time of our visit were subject to DoLS.

The trust undertook audits of the Mental Capacity Act recently to ensure the service was compliant.

## CARING

**Kindness, privacy, dignity, respect, compassion and support**

Patients received high quality care and support from an experienced staff team that operated within a strong person-centred culture. Staff were aware of each patient's unique and diverse needs and understood what helped them. Staff were familiar to most patients as they had worked with them in the community setting as part of the wider IST.

During our visit to the ward we observed kind and caring interactions between the staff and patients. Staff clearly demonstrated a respectful and dignified approach towards the patients who at times presented with behaviour that could be seen as challenging. When a patient was distressed staff worked hard to distract them and used interventions that were meaningful to help calm and reassure the patient.
We observed that staff stopped what they were doing if a patient wanted to talk to them. During an activity session the staff encouraged and praised patients in a supportive manner.

Patients we spoke with said staff were nice to them and that they felt safe and cared for. They felt staff had improved their situation and understood them.

Relatives we spoke to also spoke highly of the staff and how the Coppice had provided a safe and caring environment for their relative to receive care and treatment.

**Involvement in care**
The service had a comprehensive welcome pack for patients coming into the service. The pack was in an easy read format including photographs of the environment.

Patients and their relatives were included in the care and treatment provided and their views were respected by the staff. We found evidence in all four care records of patient involvement including the recording of patient and relatives views.
We saw that relatives were invited to ward round and that their views about their relatives care were carefully considered and noted by staff. Patients were also routinely invited into the ward round and care and treatment reviews (CTRs) or consulted beforehand if they felt unable to attend. We observed that a relative was attending a CTR to advocate for their relative during our visit.

The service ensured that patients could access the advocacy service and posters were displayed on the ward in an easy read format with contact information.

**Involvement of patients**
Patients were asked regularly to feedback into the service provision, this included weekly meetings and the “you said, we did” board which displayed information regarding recent issues that had been raised.

Inpatients were not involved in the recruitment of staff to the unit, but patients who were in the community supported by the IST had involvement in recruitment panels.

Staff routinely gave patients and where appropriate, carers a copy of their care plan. If the patient did not want to be involved in the development of their care plan this was recorded in the patients notes.

Care records were detailed and staff worked with patients and relatives to develop their communication passports and PBS plans. This meant that the plans were highly individualised and used interventions that were identified in a consultative manner with the patient and/or relative.

**Involvement of families and carers**
Staff spent time gathering information from relatives to better understand the patient’s needs, likes and dislikes. This was demonstrated by a patient whom had not received treatment before either in the community or an in-patient setting. Their nearest relative was asked to attend meetings and consulted with regarding their relatives care and treatment.

Staff provided information for carers about how to access a carer’s assessment.

## RESPONSIVE

## Access and discharge

**Bed management**
New referrals to the Coppice were primarily made by local commissioners. At the time of inspection it was 57% occupied with 4 out of 7 beds filled.

The trust reported bed occupancy between 1 October 2016 and 30 September 2017 was 30% to 96%. Managers told us that there was no minimum bed occupancy level and that they would run the service with just one patient if necessary.

The average length of stay between 1 October 2016 and 30 September 2017 ranged from 1 to 358 days. The service worked with patients that had very complex needs and this meant that move on placements were sometimes difficult to identify.

The trust reported no out of area placements in this service between 1 October 2016 and 30 September 2017. Staff confirmed there had been no out of are placements in the previous six months prior to our visit.

Managers stated that beds were available for patients in the local catchment area. We found that patients could go on leave overnight or for some patients over a weekend and their bed was available at all times should they need to return.

Where patients were moved or discharged this was done at appropriate times of the day. The trust did not report any incidents of patients being moved to the local psychiatric intensive support unit (PICU) at night.

Staff had access to PICU beds within the trust where patients required more intensive care. Staff reported that this rarely happened and there was only one patient who required a PICU bed in the twelve months prior to this inspection. The PICU beds were based in the local catchment area to enable relatives to maintain contact with the patient.

**Discharge and transfers of care**

Between 1 October 2016 and 30 September 2017 the trust told us there were 24 discharges on the ward, two of which were delayed discharges. There were three patients identified as having delayed discharges at the time of our inspection. This was due to the challenges in identifying appropriate placements that could meet their complex needs.

Staff told they worked closely with commissioners and the local authority to identify placements or to return the patient to their community setting, as quickly as possible. The ward was staffed by the IST and this meant that patients' named nurses worked with them across inpatient and community settings. The care records of one patient, who had recently been admitted, showed that discussions regarding discharge planning were already underway.

Managers told us that staff from the IST and the ward would visit patients whilst they were in another service, for example a PICU or general hospital and we found evidence of liaison with other health care professionals in the local general hospital.

**Facilities that promote comfort, dignity and privacy**

All patients had their own bedroom which they could personalise. Although patients could not access secure storage in their rooms we found that staff kept valuable items in the ward safe with a log book of these valuables. Furnishings in the ward were suitable for the patient's needs.

Patients had access to several rooms where therapy could take place however staff told us there were not enough rooms on some days and whilst on inspection we found that the ward felt very busy when ward round and a CTR meeting were held on the same day. There was a visitors rooms and a quiet lounge but staff would pass through the quiet lounge to get to other areas and this could be disruptive.

At the last inspection in June 2016, we told the trust that they should ensure that there was more choice of activities provided and that these should be monitored and reviewed. On this inspection

we saw improvement. There were more activities including art therapy and occupational therapy activities which were supported by a new band four activities coordinator and the OT. Activities were person centre and patients had a pictorial activity menu. During our visit we saw patients participate in an Easter activity which was well organised and fun.

Patients could have mobile phones if they wanted them. Patients could take phone calls in private in the visitor's room or the quiet lounge.

Patients could access outside space and there was a pathway around the garden, but the garden was on an uphill gradient and may not be suitable for patients with mobility issues.

The ward scored well above the trust and the England average for meals provided.

| Site name | Core service(s) provided | Ward food |
|---|---|---|
| **The Coppice** | MH - Wards for people with learning disabilities and autism | 95.8% |
| **Trust overall** | | 86.2% |
| **England average (mental health and learning disabilities)** | | **91.9%** |

Food was prepared on the ward from fresh ingredients. All patients and relatives we spoke with commented on how healthy and good the food was. Staff were proud that they had been able to maintain the ability to cook food and to offer a different meal on each day. Staff asked patients what their likes and dislikes were and offered alternatives wherever possible.

Patients could access drinks and snacks day or night. For safety reasons the kitchen was locked outside of meal times, but patients could ask staff for refreshments at any time.

**Patients' engagement with the wider community**
Staff recognised the importance of the need for patients to maintain contact with their relatives, carers and friends.

Staff had access to transport, for example a minibus and local taxis, to facilitate external appointments and trips.

**Meeting the needs of all people who use the service**
The ward was accessible to patients who had disabilities including wheelchair users. All rooms were on the ground floor as the building was a bungalow design.

Information leaflets about medications, advocacy and how to complain were available in an easy-read format to meet the communication needs of the patients.

Patients had access to their activities timetable and communication passports in an accessible or pictorial form however, patients care plans were not produced in accessible formats. Managers told us they had plans to introduce the "dialog +" care programme approach for inpatients, which was already in use in community settings.

We spoke to two staff that were qualified in British Sign Language. Managers told us they had access to interpreters for BSL and for other languages accessible via the intranet.

Patients had a choice of food and could contribute to menu planning. For patients who had dietary needs related to religious needs, food could be ordered in from specialist companies.

Staff supported the patient's spiritual needs for example if patients requested a priest or other religious leader staff were able to request this through the trust chaplaincy.

### Listening to and learning from concerns and complaints

The trust had a clear complaints policy and a patient liaison advice service that patients and carers could access. Staff displayed information on the ward in an accessible form to help patients understand how to complain. The policy had clear timeframes in place for response times to complaints.

The ward received no complaints between 1 November 2016 and 31 October 2017. Managers told us there had been one complaint received in the twelve months prior to this inspection. This complaint was partially upheld. Staff met with the relative to discuss the concerns. No complaints were passed to the Parliamentary and Health Service Ombudsman.

All the patients and relatives we spoke to knew how to raise a complaint and felt able to do so easily. Patients could raise complaints at ward level through the community meeting or directly with staff.

## WELL-LED

### Leadership

Both the service manager and ward manager were experienced and had the knowledge and skills to undertake their roles. The ward manager had undertaken a leadership programme to progress to a senior manager's position and understood the service very well. One team worked across inpatient and community teams to reduce hospital admissions in line with the transforming care programme.

Staff we spoke to felt well supported by their leaders and managers. They said that managers were visible and approachable, this included the service manager and members of the senior leadership team.

The trust had strongly embedded leadership development opportunities. Band 5, 6, 7 & 8 professionals could enrol on leadership development courses. There were training courses for bands 3 & 4 to develop their skills in healthcare.

### Vision and strategy

Staff we spoke to understood the trusts visions and values. We saw that staff reflected these values in their daily practice. The service had a positive, caring, respectful and open culture towards patients and their families/carers. The service focussed on providing inpatient support for as shorter time as possible and to find appropriate placements for those patients with complex needs. This meant that there were lengthy discussions at care and treatment review meetings with commissioners and on occasion, appropriate placements took longer to find.

Managers and staff had opportunities to contribute to developments in the service delivery. For example managers told us there were plans to re-develop the site to improve the environment. The initial plans had been reviewed by staff and leaders however they felt they could be further improved and had fed back to the trust on this matter.

Managers were able to explain how they worked effectively within the budget constraints. For example they had used staffing budgets in an innovative way to recruit staff.

**Culture**

Staff felt respected, supported and valued by their colleagues and managers. They felt positive about the trust whilst reflecting on the changes to the service provided over the last two years since our last inspection.

Staff reported that despite the geographical distance between the trusts headquarters, based in London, they felt included in the trusts strategy.
All staff we spoke to felt confident to raise concerns without fear of reprisal. Staff were aware of the trust Freedom to Speak up Guardian and how to access this.

Managers were clear about the process of performance managing staff. They reported that no staff had been under performance management in the twelve months prior to our visit.

We observed how staff worked well together, if there were difficulties between team members, managers encouraged openness and mediation.

Annual appraisals included discussions about career development and identified training needs. For example the ward manger had been successful in progressing from Band 6 to Band 7 and this career progression was identified in their appraisal last year.

Staff sickness and absence levels were lower than the trust average. Managers told us there were two permanent members of staff on long term sick leave however this was not work-related sickness.

Medical staff participated in peer groups every two months where they could discuss cases and professional matters. We saw that this group occurred on the day of inspection and was well attended.

**Governance**

The leadership, governance structures and culture were used to improve the delivery of high quality person-centred care. There was National Institute for Clinical Excellence (NICE) guidelines group which met bi-monthly to discuss how the service was meeting NICE guidance.

Staffing numbers including the skill mix of the nursing teams and MDT meant that patients were well supported to receive safe and effective care from staff that knew and understood their needs.

There were systems and processes in place to ensure the ward environment was safe and clean.

There were sufficient numbers of staff to ensure that staff delivered patient care in a safe and effective way. Staff were clear about their roles and responsibilities and understood the management structure.

Staff received regular supervision, mandatory and specialist training and their work performance was appraised annually. The provider facilitated LGBT, Disability, Black and Minority Ethnic and women’s network meetings and had recently appointed network leads for these groups.

Across the ward staff participated in clinical audits and quality improvement projects. Some staff had received training in quality improvement. The service was actively trying to reduce the use of restrictive interventions and had implemented positive behaviour plans for patients who needed them.

Staff and managers had clear agendas for what must be discussed at team meetings and had recently introduced the weekly “leads huddles” meeting for managing risks in the service.

Safeguarding’s, complaints and reviews of deaths trust wide and within the service were discussed at senior management meetings and cascaded to staff through local team meetings and the trust intranet to ensure learning outcomes were understood by all staff. The trust participated in the Learning Disabilities Mortality Review programme (LeDeR); this meant that any death of a patient who had learning disabilities would be reported nationally to the programme via an online reporting form. The death would be reviewed as part of the programmes of work nationally and fed back to the trust. Staff were aware of the LeDeR programme and the reporting system.

Staff worked well with their community colleagues and staff worked across both inpatient and community settings which meant they were skilled in both areas of specialism.

**Management of risk, issues and performance**

Managers had access to the trust risk register and would record risks at local level through team meetings. The team risk register corresponded to the concerns raised by staff. At the time of inspection there were no concerns posing a high risk regarding the ward on the trust register.

Staff were able to escalate concerns regarding placements that were not meeting patients’ needs to commissioners. Managers gave a recent example of a patient’s placement breaking down within one day and the actions that happened following this.

The ward had clear contingency plans in place for electrical outage, adverse weather conditions and other emergencies which meant there would be minimal interruption to service delivery.

**Information management**

Staff had access to equipment and information technology that helped them to undertake their work. Information stored on paper records was scanned into electronic notes and held securely. All staff received training in how to use the electronic notes system. The trust provided IT support services for staff to access in a timely way. Staff understood that patient notes must be kept confidential and there were systems in place to report data information breaches if they occurred.

Managers had access to trust audit and performance information, rotas, supervision, appraisal and human resources records electronically to assist them in monitoring the performance of staff and the service.

Managers and staff had access to the service dashboards which provided up to date information about the ward including areas for improvement. Staff received reminders for renewal of mandatory training in advance of when it would expire so they could book onto training in a timely way.

Staff made notifications to external bodies such as the CQC, local authority and commissioning groups as necessary.

**Engagement**

All staff had access to the trusts’ intranet which gave them up to date information about the provider’s performance, planned changes to service provision and developments within the trust. For example there was a quality improvement (QI) newsletter and a governance newsletter which informed staff of shared learning from serious incidents that had been investigated.
Staff were invited to complete a staff survey and the uptake from this core service was above the trust average. The trust routinely collected service user satisfaction surveys and fed results back to the service.

The ward sought feedback from patients and relatives through community meetings and ward rounds. They reflected the wards responses by displaying information on a “You said, we did” board” which we observed on the ward at the time of inspection.
Patients and their relatives were routinely invited into ward rounds, CPA meetings and care and treatment review meetings. Relatives were visible in the ward round at the time of inspection.

**Learning, continuous improvement and innovation**
Staff actively engaged in quality improvement projects and clinical audits. The ward was monitoring the use of restrictive practices and had seen an improvement. There was increased psychology and allied health professionals involvement.

The Coppice had been accredited for the second time under the Accreditation for Inpatient Mental Health Services (AIMS LD) scheme for a further two years until 2018. This scheme is run by the Royal College of Psychiatrists, Centre for Quality Improvement and sets standards for learning disability wards.