North East London NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Sunflowers Court	RATY1
Wards for older people with mental health problems	Woodbury unit Sunflowers Court	RATY1 RATY1
Child and adolescent mental health wards	Brookside Unit	RATRK
Community health services for children, young people and families	Trust Head Office Phoenix House Brentwood Community Hospital Mayflower Community Hospital Grays Court Community Hospital	RAT RATX8 RATX5 RATDK RATGC
Specialist community mental health services for children and young people	Phoenix House	RATX8
Community health services for adults	Trust Head Office Phoenix House Brentwood Community Hospital Thurrock Community Hospital Mayflower Community Hospital Grays Court Community Hospital	RAT RATX8 RATX5 RATX4 RATDK RATGC

Summary of findings

End of Life Care	Trust Head Office	RAT
	Thurrock Hospital	RATX4
	Mayflower Community Hospital	RATDK
	Grays Court Community Hospital	RATGC
	Phoenix House	RATX8

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

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

After this most recent inspection we have changed the overall rating for the trust to **good** because:

- Following the last inspection in April 2016, the trust had implemented a comprehensive improvement plan and had taken action to meet the requirement notices and enforcement action taken after the inspection in April 2016. In addition the majority of recommendations had also been put into practice.

- Following this most recent inspection, only one of the fifteen core services remains rated as requires improvement (wards for adults of working age and psychiatric intensive care unit). The rest are rated as good and one core service (child and adolescent mental health wards) is now rated outstanding.

- The most significant improvement was for child and adolescent mental health inpatient wards where, in an 18 month period, the ratings for the service had improved from inadequate to outstanding. The trust had shown vision and strong leadership in reviewing the model of the service being provided.

- In addition the trust had stable leadership through the board and the executive leadership team who had an appropriate range of skills, knowledge and experience.

- The trust was making good use of IT and promoting mobile working. The systems also promoted access at different levels of the organisation to timely information on performance.

- The trust had a strong track record in terms of its equality and diversity achievements and had made good progress with their workforce race equality standard results from 2016 whilst recognising there was more to do particularly in relation to some of the other protected characteristics.

- The trust was working to ensure a good balance between providing assurance and promoting quality improvement. The first year of adopting a formal quality improvement methodology had gone well and was producing positive results.

However:

- The safe key question remains rated as requires improvement and there are further improvements that the trust must make in six of the core services. This includes addressing areas such as ensuring staff had completed mandatory training, hand-washing, fire safety, medicines management, use of prone restraint, updating risk assessments and maintaining clinical equipment. The trust must address these as a matter of urgency.

- There is also scope for the trust to improve leadership and management further. This included reviewing the capacity of the executive leadership team, having a clear strategy for the trust, strengthening board visits and the feedback from these, supporting governors to perform their duties, strengthening the freedom to speak up guardian role and completing the review of some of the key documents used by the board as part of their assurance process.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

At our last inspection in April 2016, we rated two of the 14 core services provided by the trust as inadequate and seven as requires improvement for safe. This led us to rate the trust as requires improvement overall for this key question.

Our rating for safe remained the same. We rated it as requires improvement because:

- Following this most recent inspection, we rated six of the 15 core services provided by the trust as requires inprovement for this key question.
- Staff working on the acute wards for adults of working age and psychiatric intensive care units did not undertake physical health checks when they administered rapid tranquilisation. Some medicines used for rapid tranquilisation were not in line with trust policy.
- Call alarm systems were not in place at specialist community mental health services for children and young people. At acute wards for adults of working age and psychiatric intensive care units, alarms were not available in sufficient numbers. At child and adolescent mental health wards, staff radio checks did not take place regularly.
- Across most services, we found that some equipment required to maintain patients' physical health was not calibrated regularly.
- Whilst overall, medicines management was robust, some improvements were needed. The trust-wide medicines management report did not contain analysis and actions taken as a result of medicines incidents. On acute wards for adults of working age and psychiatric intensive care units, when patients were admitted with unlabelled medicines, these were not managed in accordance with trust policy.
- In some services, (acute wards for adults of working age and psychiatric intensive care units, child and adolescent mental health wards and specialist community mental health services for children and young people) actions were needed to ensure fire safety. These included training staff in the use of a fire evacuation chair, addressing the risk of patients smoking on wards and carrying out an overdue fire evacuation drill.

Requires improvement ⬤

Summary of findings

- Whilst take up of mandatory training had improved, this was variable across teams and further work was required to ensure that all teams met the 85% trust target. At community health services for adults, agency nurses were not providing documentary evidence of their clinical competencies.
- The trust had a strategy to reduce the use of prone restraint across mental health inpatient wards, but at Titian PICU, the number of prone restraints had increased.
- At acute wards for adults of working age and psychiatric intensive care units, some risk assessments were not updated following incidents, or did not identify all patient risks.
- Across services, some improvements were needed to ensure the efficacy of infection control measures. At acute wards for adults of working age and psychiatric intensive care units, clinic cleaning records were not available. At community health services, some teams needed to improve hand hygiene. At specialist community mental health services for children and young people, records that demonstrated all toys were regularly cleaned were not available. Some community team environments across core services needed improving.

However:

- The trust had made improvements since the last inspection. At wards for older people with mental health problems, there was now a robust system in place to reduce the risk of falls. Patients were now able to access their bedrooms at any time as they wished. The trust had improved ward premises. Patients on all wards now had easily accessible call bells to alert staff if they needed support.
- The trust had increased staffing levels on acute wards for adults of working age and psychiatric intensive care units. A programme of works to address ligature risks on wards was underway and new measures had been introduced to identify and manage the risks associated with ligature anchor points.
- Across core services, staff reported incidents and learned lessons from investigation of these. Some improvements were needed at acute wards for adults of working age and psychiatric intensive care units, as incident reports were not always accurately graded to reflect whether harm had occurred as a result of the incident.
- Robust safeguarding procedures were in place across all core services and staff understood their safeguarding responsibilities. Staff in community and inpatient teams working with children, young people and families received safeguarding supervision.

Summary of findings

Are services effective?

At our last inspection in April 2016, we rated one of the 14 core services provided by the trust as inadequate and six as requires improvement. This led us to rate the trust as requires improvement overall for this key question.

Our rating for effective improved. We rated it as good because:

- At this inspection, we rated 13 of the 15 core services provided by the trust as good for this key question. This led us to rate the trust as good overall for this key question.
- Individual care plans were in place for patients. Most were holistic and person centred and clearly indicated the clinical support patients would receive.
- Staff assessed patients' physical health needs in a timely manner. Mental health inpatient wards used the National Early Warning System to monitor patients' physical health.
- Staff in each service could demonstrate how they delivered care that met national best practice guidance. These included access to psychological therapies for mental health wards and specialist community mental health services for children and adolescents. Staff used recognised rating scales to assess and record severity and measure outcomes.
- Most teams included or had access to the full range of specialists required to meet the needs of patients. Staff were experienced and qualified, and they had the right skills and knowledge to meet the needs of the patient group. Most staff were able to access specialist training to develop skills.
- There was consistent use of multidisciplinary working and coordinated care and treatment pathways for patients in all services. Staff held regular and effective multidisciplinary meetings in most services.
- Most staff demonstrated appropriate knowledge and understanding in relation to the Mental Capacity Act and Mental Health Act.

However:

- Not all staff at community health services for adults were receiving regular supervision and appraisal. We saw some improvement in staff supervision rates at acute wards for adults of working age and psychiatric intensive care units, but further work was needed to embed this. Ward managers were not able to access accurate data for appraisal rates. At specialist community mental health services for children and young people, systems to monitor the content and frequency of supervision were not in place at all sites.

Good ●

Summary of findings

- At community health services for adults, actions identified during audit were not always followed up and improvements or changes to services documented and monitored.
- At acute wards for adults of working age and psychiatric intensive care units. The full range of disciplines were not represented in multidisciplinary meetings on Turner ward.

Are services caring?   **Good** ●

At our last inspection in April 2016, we rated 12 of the 14 core services provided by the trust as good. This led us to rate the trust as good overall for this key question.

Our rating for caring stayed the same. We rated it as good because:

- At this inspection, we rated 14 of the 15 core services provided by the trust as good and one as outstanding for this key question. This led us to rate the trust as good overall for this key question.
- Most staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients and carers with help, emotional support and advice at the time they needed it. Staff supported patients to understand and manage their care, treatment or condition.Most patients said staff treated them well and behaved appropriately towards them.
- Staff involved patients in care planning and risk assessment. Care and treatment records included information on how staff had involved patients in discussions about risks and care planning.
- Staff communicated with patients so that they understood their care and treatment, finding effective ways to communicate with patients with communication difficulties.
- Staff enabled patients to make advance decisions about their care and supported them to access advocacy services.
- Carers were provided with information about how to access a carer's assessment.
- Staff enabled patients and carers to give feedback on the service and involved them in decision making about the service.

  However:
- On acute wards for adults of working age and psychiatric intensive care units, feedback from patients and carers was variable around staff attitudes.

Summary of findings

Are services responsive to people's needs?

Good ●

At our last inspection in April 2016, we rated four of the 14 core services provided by the trust as requires improvement. This led us to rate the trust as requires improvement overall for this key question.

Our rating for responsive improved. We rated it as good because:

- At this inspection, we rated 13 of the 15 core services provided by the trust as good and one as outstanding for this key question. This led us to rate the trust as good overall for this key question.
- There had been improvements in how referral procedures were implemented at community health services for children, young people and families. These were now fully embedded and applied consistently.
- The teams could see urgent referrals quickly and most non-urgent referrals within an acceptable time. Skilled staff were able to assess patients rapidly. Teams responded promptly and adequately when patients telephoned the service.
- Appointments usually ran on time and staff informed patients when they did not. Staff cancelled appointments only when necessary and when they did, they explained why. At some community health services for adults' teams, staff used text messages to remind patients of their appointments.
- There had been improvements in how staff supported patients during referrals and transfers. At community services for children, young people and families, a transitional lead had been appointed and a transitional policy introduced.
- Across mental health inpatient core services, discharge planning started at the point of admission. There were robust systems to identify and manage delayed discharges.
- There had been improvements to ensure that across mental health inpatient services, patients were able to store their personal possessions securely.
- Services considered how to meet the varied needs of all patients. We saw positive work had been undertaken on child and adolescent mental health wards with regard to gender identity and sexuality. Community health services for adults had developed services to meet the needs of an aging patient group living with HIV. At end of life services pathways had been developed for patients from travelling communities, homeless people and patients in secure units.
- There had been improvements in accessing interpreting services. Teams and wards were able to access interpreters when needed. The trust was rolling out mobile devices to support online translation within community health settings.

Summary of findings

- The trust had robust systems in place for managing complaints. Staff understood the complaints system and most patients knew how to make a complaint. However, some improvements were needed to ensure that the investigation and outcome of informal complaints was recorded. At community health services for children, young people and families, some complaints records did not include risk or lessons learned.

  However:

- Bed occupancy across all acute wards for adults of working age and psychiatric intensive care units was high. Not all patients had a bed when they returned from leave. Some patients were moved between wards without a clinical justification during their admission.

- At end of life services, at Waltham Forest integrated community teams, most patients were not achieving their preferred place of care at the end of their life.

- At specialist community mental health services for children and young people, some patients experienced delays in commencing their assessment and treatment. At community health services for children, young people and families, there were significant performance variations across teams against trust targets for health visiting teams, for example the two and a half year review.

- Some improvements were needed to promote patients privacy and dignity. At wards for older people with mental health problems, some patients were accommodated in dormitories. At acute wards for adults of working age and psychiatric intensive care units, some patients could not make a phone call in private. On Hepworth ward, it was difficult for patients to meet with visitors in private on the ward. At specialist community mental health services for children and young people, some patients' physical health checks were carried out in a corridor.

- At child and adolescent mental health wards, the quality of food needed improving.

Are services well-led?   Good ●

At our last inspection in April 2016, we rated one of the 14 core services provided by the trust as inadequate and four as requires improvement. This led us to rate the trust as requires improvement overall for this key question.

Our rating for well led improved. We rated it as good because:

Summary of findings

- At this inspection, we rated 12 of the 15 core services provided by the trust as good and one as outstanding for this key question. This led us to rate the trust as good overall for this key question.
- The board and the executive leadership team had an appropriate range of skills, knowledge and experience and provided stable leadership.
- The chair and non-executive directors were engaged in the work of the trust.
- The trust had a clear vision and values. A recently developed clinical strategy was being implemented across the trust.
- The trust was making good use of IT and promoting mobile working. The systems also promoted access at different levels of the organisation to timely information on performance.
- The trust had a strong track record in terms of its equality and diversity achievements and had made good progress with their workforce race equality standard results from 2016 whilst recognising there was more to do particularly in relation to some of the other protected characteristics.
- There were positive examples throughout the trust of engaging patients and carers. However, this could be promoted further for example by extending the number of peer workers and the use of volunteers.
- The trust was working to ensure a good balance between providing assurance and promoting quality improvement. The first year of adopting a formal quality improvement methodology had gone well and was producing positive results.
- The trust engaged with staff and made good use of a range of communication approaches. The trust was aware of areas where staff morale and attitudes needed to improve.

However:

- The trust had not formally developed a strategy to provide good quality and sustainable care, in consultation with patients, carers and stakeholders, to guide its organisational development in the short and longer term.
- As the trust had grown this had resulted in capacity challenges for the executive team especially the executive director of nursing role.

- Visits to services by non-executive directors were not always taking place in a structured manner and issues identified from these visits fed back to the board.

Summary of findings

- Althouth the chair was promoting their role, governors did not fully fulfil their function of holding the non-executive directors to account for the trust's performance.This need to be reviewed.
- The insection took place at a time when the trust was reviewing a number of key reports that provided assurance to the board. This included the performance report and quality dashboard. In addition the board assurance framework was being refreshed and the trust leadership team could not consistently state the most significant risks for the trust. Further work was needed to complete and embed these systems and ensure processes were in place to provide the board with the information they needed to undertake their role.

- Whilst staff were encouraged to raise any concerns more work was needed to implement the Freedom to Speak Up Guardian in the trust.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Paul Devlin, Chair Lincolnshire Partnership NHS Foundation Trust

Team Leader: Jane Ray, Head of Inspection for mental health, learning disabilities and substance misuse, Care Quality Commission; Lea Alexander and Max Geraghty inspection managers.

Acute wards for adults of working age and psychiatric intensive care units (PICU)

The team that inspected this core service comprised three CQC inspectors, one inspection manager, two psychiatrist specialist advisors and two nurse specialist advisors with experience of working in acute inpatient services and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using mental health services.

Child and adolescent mental health wards

The team that inspected this core service comprised two CQC inspectors, one inspection manager, one specialist advisor who was a psychiatrist with a background in the mental health of young people, a nurse specialist advisor who had a background in the mental health of young

people and an expert by experience.

Wards for older people with mental health problems

The inspection team comprised one CQC inspector, one specialist advisor who was a psychiatrist with a background in the mental health of older people, a nurse specialist advisor who had a background in the mental health of older people and an expert by experience.

Specialist community mental health services for children and young people

The team that inspected this core service consisted of one inspector, one specialist advisor who was a nurse with a background working in child and adolescent mental health services, an occupational therapist specialist advisor with a background working in child and adolescent mental health services and an expert by experience.

Community health services for adults

The inspection team included an inspection manager, two inspectors and a number of

specialists, including community nurses, community physiotherapist, a pharmacist, a safeguarding nurse for adults, and an expert by experience.

Community health services for children, young people and families

The inspection team included an inspection manager, two inspectors and a number of specialists, including two health visitors, a school nurse, paediatrics service senior manager, a safeguarding nurse for children, a speech and language therapist, community paediatric physiotherapist and an expert by experience.

End of life care

The team included an inspection manager, three CQC inspectors and a community nurse specialist advisor.

Well-led review

The team that completed the well-led review comprised the head of hospital inspection, two CQC inspection managers, three CQC inspectors, a Mental Health Act reviewer, a specialist pharmacy manager, an inspection assistant, a specialist advisor with experience of working at board level within an NHS trust and a CQC national professional advisor for nursing. Two managers from NHS Improvement also participated in the well-led review.

Why we carried out this inspection

For this inspection, we looked at and rated six core services which had been previously rated as either requires improvement, good or had not previously been inspected. In addition we carried out a focused inspection of specialist community mental health services for children and young people in response to information of concern regarding the unrelated deaths of three young people who were all known to the service.

Summary of findings

We undertook this inspection to find out whether North East London NHS Foundation Trust had made improvements to their: acute wards for adults of working age and the psychiatric intensive care units; wards for older people with mental health problems; child and adolescent mental health wards; specialist community mental health services for children and young people; community health services for adults; community health services for children, young people and families and end of life care since our last comprehensive inspection of the trust, that we undertook in April 2016, where we rated the trust as requires improvement overall.

When we last inspected the trust in April 2016, we rated the acute wards for adults of working age and the psychiatric intensive care units as requires improvement overall. We rated the core service as inadequate for safe. We rated the other four domains as requires improvement.

Following that inspection, we told the trust it must make the following improvements to the acute wards for adults of working age and the psychiatric intensive care units:

- The trust must ensure that risk assessments are completed and consider potential patient risks.

- The trust must ensure that all ligature assessments and action plans identify all ligature points and how to mitigate the risk to patients.

- The trust must ensure that care plans are recovery orientated and reflect the personal views and preferences of patients.

- The trust must ensure that out of date medications are not being used and are destroyed and recorded appropriately.

- The trust must ensure that medical equipment is calibrated and within review dates.

- The trust must ensure that maintenance issues are rectified on all wards.

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

- We issued the trust with a Section 29A warning notice in relation to safe care and treatment.

At our last comprehensive inspection of the trust, in April 2016, we rated wards for older people as requires improvement overall. We rated wards for older people as requires improvement for safe, effective, responsive and well led. We rated the caring domain as good.

Following the April 2016 inspection we told the trust that it must take the following actions to improve wards for older people:

- The trust must improve upon the prevention and management of falls on wards for older people.

- The trust must ensure that patient dignity and privacy are maintained by reviewing the viewing hatches on patient bedroom doors and enable patients access to their bedrooms in the day.

- The trust must ensure that any changes that are made to ward procedures as a result of learning from a serious incident is applied consistently across the wards.

- The trust must ensure that there is an adequate alarm system in place in all patient bedrooms and ensuite shower rooms so that patients can alert staff in the event of an emergency or urgent need.

- The trust must ensure that the ligature risk assessment clearly specifies when the work to remove ligatures will be completed by.

- The trust must ensure that all staff have Mental Health Act 1983 training.

- We issued the trust with a Section 29A warning notice in relation to safe care and treatment.

At our last comprehensive inspection of the trust, in April 2016, we rated specialist community mental health services for children and young people as good overall. We rated specialist community mental health services for children and young people good for safe, caring, responsive and well-led and requires improvement for effective.

Following the April 2016 inspection we told the trust that it must take the following actions to improve specialist community mental health services for children and young people;

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

Summary of findings

At our last comprehensive inspection of the trust, in April 2016 we rated child and adolescent mental health wards as inadequate overall. We reinspected the service in October 2016 when the service was rated as good.

At our last comprehensive inspection of the trust, in April 2016 we rated community health services for adults as requires improvement overall. We rated community health services for adults as requires improvement for safe, effective, responsive and well led and good for caring.

Following the April 2016 inspection we told the trust it must take the following actions to improve community health services for adults:

- The trust must ensure that staff consistently record medicines administration in case notes so that it is clear what medication has been given to a patient.

- The trust must implement a system for monitoring and frequently auditing the completion of risk assessments in patient records across community health services for adults.

- The trust must ensure community services for adults are meeting minimum targets for supervision and appraisals for all staff.

- The trust must develop an effective system of governance for adult community health services, which includes means for measuring and comparing quality or performance across services through audit. This to include the quality and completion of patient records across the services and referral to treatment (RTT) times for universal and specialist services across all localities.

At our last comprehensive inspection of the trust, in April 2016 we rated community health services for children, young people and families as requires improvement overall. We rated community health services for children, young people and families as requires improvement for safe, effective, responsive and well led and good for caring.

Following the April 2016 inspection we told the trust it must take the following actions to improve community health services for community health services for children, young people and families:

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

We had not previously inspected end of life care.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?

- Is it effective?

- Is it caring?

- Is it responsive to people's needs?

- Is it well-led?

Before visiting, we reviewed a range of information we hold about North East London NHS Foundation Trust and asked other organisations for information. We also attended a board meeting on 25 July 2017. We gave the trust two weeks notice prior to visiting core services.

We carried out a series of short notice announced visits to core services on the following dates:

- Acute wards for people of working age and psychiatric intensive units - 15 to 17 August 2017

- Wards for older people with mental health problems - 15 to 17 August 2017

- Child and adolescent mental health wards - 15 to 17 August 2017

- Specialist community mental health services for children and young people - 15 to 17 August 2017

- Community health services for adults - 10 to 12 October 2017

- Community health services for children, young people and families - 10 to 12 October 2017

- End of life care - 10 to 12 October 2017

- Well-led review – 30 to 31 October and 3 November 2017.

Summary of findings

We looked at information provided to us on site and requested additional information from the trust both immediately before and following the inspection visit relating to the services.

We contacted Healthwatch groups and clinical commissioning groups to gather feedback on progress made since the last CQC inspection. We also carried out a well-led review on the 30, 31 October and 3 November 2017 to look at any changes that had taken place in the leadership and governance of the trust since the previous inspection. This also involved receiving feedback from external stakeholders.

During the seven inspection visits and well led review, the inspection team:

- visited the trust's health and children's centres at the Acorn Centre, Axe Street Child and Family Centre, Thames View Health Centre, Harold Wood Clinic, Harold Hill Health Centre, South Woodford Health Centre, Brentwood Community Hospital, Redbridge Child Development Centre and Wood Street Child and Family Centre
- visited the trust's community services for adults at Brentwood Community Hospital, Grays Court Community Hospital, Harold Wood Polyclinic, Orsett Hospital Minor injuries unit, Anthony Wisdom Centre for sexual health, Thurrock Community Hospital, Billericay Health Centre, Harold Hill Health Centre, Hainault Health Centre, Vicarage Field Health Centre, Oliver Road Polyclinic, Porters Avenue Health Centre and Phoenix House
- visited the trust's end of life services at Chadwell Heath Health Centre, Thurrock Hospital, Mayfield Community Hospital, Grays Court Community Hospital, Phoenix House; Redbridge District Nursing, Wood Street Health Centre, Mellmead House, Langthorne Health Centre, Harold Hill Health centre, Havering District Nursing and Hainault Health Centre
- visited three community child and adolescent mental health teams in Essex
- visited all three wards for older people; the Woodbury unit located in Leytonstone, Stage ward and Cook ward located in Sunflowers Court on the Goodmayes hospital site
- visited all six acute and PICU wards located at Sunflowers Court on the Goodmayes hospital site

- visited the trust's child and adolescent mental health wards and young persons' home treatment team based at the Brookside unit
- checked the quality of these environments and observed how staff were caring for patients.
- spoke with 121 patients
- spoke with 60 relatives or carers
- we also spoke with carers and patients of community health services for adults at nine focus groups before we visited services
- observed 14 home visits

- spoke with 289 staff members in a variety of leadership, clinical and administrative roles during our core service inspections
- reviewed 96 comments cards completed by patients and carers
- spoke with advocacy services
- looked at 119 care and treatment records
- carried out a specific check of the management of medicines, which included reading 32 medicines administration record charts and arrangements for the storage of medicines
- looked at 11 looked after children (LAC) records
- attended and observed eight shift hand-over meetings, six multidisciplinary meetings, two risk meetings and two governance meetings. We also observed initial assessments, consultation sessions, a complex pathway discussion, clinical discussion groups, occupational therapy sessions and ward based community meetings.
- held a focus group with the non-executive directors of the trust
- held a focus group with the governors of the trust
- interviewed members of the trusts executive team, including the chair, chief executive, executive medical director, executive director for HR, executive director of finance, chief nurse and executive directors of integrated care for London and Essex
- interviewed the trusts directors of nursing and met with the chief pharmacist and Mental Health Act law lead
- interviewed the trust 'freedom to speak up' guardians
- held focus groups with integrated care directors and associate medical directors, assistant and deputy directors, trade unions and BME staff
- looked at a range of policies, procedures and other documents relating to the operation of the service

Summary of findings

The inspection looked at the four mental health core services and three community health core services provided by the trust. A well-led review was also completed.

Information about the provider

North East London NHS Foundation Trust provides community health and mental health services in Essex and across the North East London Boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest. With an annual budget of £355 million in 2015/16, the trust provides care and treatment for a population of about 2.15 million whilst employing around 6,000 staff. Since we last inspected the trust, they have started providing specialist community mental health services for children and young people in Kent and Medway.

The trust provides the following 11 mental health core services:

- Acute wards for adults of working age and psychiatric intensive care units (PICUs)

- Child and adolescent mental health ward

- Forensic inpatient/secure wards (low secure)

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

- Wards for older people with mental health problems

- Wards for people with a learning disability or autism

- Mental health crisis and health-based places of safety

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

- Community-based mental health services for older adults

- Community-based mental health services for people with a learning disability or autism

- Specialist community mental health services for children and young people

It also provides four community health core services:

- Community end of life care

- Community health services for adults

- Community health services for children, young people and families

- Community inpatient services

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

The Care Quality Commission has inspected North East London NHS Foundation Trust 19 times since registration. There have also been five joint inspections with Ofsted looking at children's services at Thurrock, Barking and Dagenham, Havering, Waltham Forest and Redbridge.

There were three Mental Health Act reviewer visits between September 2016 and October 2017, all of which were unannounced. There were five issues in total that were followed up as part of this inspection. The issues included access to the MHA records systems, staff explanation of patient rights and care planning.

At our comprehensive inspection in April 2016 we identified a number of areas for improvement at the Alistair Farquharson Centre that have not been re-inspected. As of April 2017, the community health rehabilitation service operating out of the Alistair Farquharson Centre has moved to the Mayfield Unit.

What people who use the provider's services say

Trust Wide

Summary of findings

- Overall, patients we spoke with felt positive about the trust. Most felt staff treated them with kindness, compassion and respect.

- Patients and carers in the acute wards for adults of working age and psychiatric intensive care units (PICU) provided more mixed feedback.

- Prior to the inspection, we placed comment card boxes throughout the trust. We received 96 responses, the majority of which related to acute wards for adults of working age and psychiatric intensive care units (PICU). Of these, 77 gave feedback on the quality of the service: 48 recorded positive feedback, 27 negative feedback mostly relating to acute mental health wards and 3 mixed feedback.

Specialist community mental health services for children and young people

- We spoke to seven young people and 33 family members or carers. Most spoke highly of and were positive about the service and its staff. They said staff were compassionate, caring and offered interventions that had made a difference to them.

- Some carers said the wait for assessment and treatment was too long and that they were not fully involved with the care plans for their child. Most carers and young people told us the environment in which they had their clinical appointments was clean and comfortable.

- The majority of comments cards received from young people and their carers were positive about the service. All of them said they felt listened to and supported by staff.

Wards for older people with mental health problems

- We spoke with 11 patients and seven carers. We collected 19 comments from patient feedback cards. We read feedback collected by the trust about the service.

- Patients and carers were very positive about the attitude and behaviour of staff. They said staff were caring, patient and kind. They told us that staff had the skills and knowledge to respond to the needs of frail older people.

- Patients and carers told us that they found the ward environment to be comfortable and suitable for their

needs. Carers told us staff made them feel welcome on the wards and involved them in decision making. They said staff gave them the support and information they needed.

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

- We collected 56 comment cards in total. Twenty seven of these were classified as positive, 26 were classified as negative and three were mixed. Positive themes included patients feeling safe and good access to psychology and activities. The majority of patients complemented the food. Areas for improvement were identified as some staff members' attitude to patients and some personal items going missing on wards.

- We spoke with 24 patients who were using the service. Feedback on Turner and Ogura ward was generally positive as was feedback on Monet ward. However, we received less positive feedback for Kahlo and Hepworth wards. Concerns identified by patients included staff attitude and theft of personal belongings.

- Patients noted that staff would rarely cancel escorted leave and that wards were clean and well maintained. However, some patients felt the wards could be violent due to patient on patient confrontations and on Hepworth ward, a noisy environment.

Child and adolescent mental health wards

- We spoke with 14 young people and their families. They said that the care they received from clinicians was excellent, supportive and well organised. They also said that staff were caring, polite and interested in the wellbeing of young people. Parents and carers told us that staff were interested in their well-being. They also told us staff supported them in their parenting role and this helped to allay their fears.

- Young people said that the staff were amazing, young people felt well informed about the care they received and could make their own choices. Teams gathered the views of young people and families using surveys, community meetings and in focus groups. Young people knew how to make a complaint and understood their rights.

- All of the young people on the ward we spoke with said they were happy with the environment and the

facilities on offer. The young people said that when other young people displayed aggressive behaviour that the ward staff were good at managing this and keeping everyone safe.

• All the young people we spoke to said that the food served on the ward was not of a good quality and needed to be improved. They had shared their views with the managers. The managers were working with the young people and the catering team to make improvements.

Community health services for children, young people and families

• We spoke with 45 patients and their families during the course of the inspection. Although some patients reported long waiting times, the patients we spoke with talked positively about the care and treatment they received once in the system.

• Patients and their families told us they found staff to be kind, caring, compassionate, informative,

• professional and respectful. The following was representative of the feedback received: "very happy with the care", "staff do a wonderful job", "staff have time to talk to you and encourage children" and "good emotional support".

Good practice

Trust Wide

• The trust had a strong track record in terms of its equality and diversity achievements and had made good progress with their workforce race equality standard results from 2016.

• The trust was making good use of IT and promoting mobile working.

Wards for older people with mental health problems

• The staff team on Stage ward had been commended for their outstanding contribution to nurse training by nurse tutors.

• The staff team on Cook ward had won a national award in recognition of their work to improve the ward environment for older frail patients.

Child and adolescent mental health wards

• The teams based at Brookside services were in the process of identifying internal quality improvement projects.

• Managers were gathering data regarding the work undertaken by the YPHTT to begin the process of evaluating the effectiveness of the model.

• Managers were reviewing the work undertaken by their services and identifying whether there was a gap in provision for young people who had emerging personality disorder.

End of life services

• The trust had developed a tiered package of end of life staff training which was being rolled out across community services.

• Integrated community teams in Barking and Dagenham had rolled out training in palliative and end of life care to staff in residential care homes.

• District nurses had received training on the use of a magnet to deactivate implantable cardioverter defibrillators (devices fitted under the skin which regulate abnormal heart rhythms) in the home environment for patients.

Community health services for children, young people and families

• The service demonstrated highly effective internal and external multidisciplinary working, facilitated by colocation of services and partnership working with other service providers.

• The trust had comprehensive safeguarding supervision processes in place for staff. There was very good compliance with the trust's child safeguarding training and comprehensive safeguarding supervision processes in place.

• Most of the service used a single point of access referral system with a single point of contact, such as a specialist health visitor (except Redbridge and Thurrock) to simplify the process for patients.

Community health services for adults

Summary of findings

- The harm free care team provided a multidisciplinary, sustained improvement to safety performance that demonstrated improved patient outcomes and experience. This included through a highly active pressure ulcer investigation group and engagement.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve Trust wide

- The trust must develop a strategy to guide its organisational development in the short and longer term to achieve its priorities and develop good quality sustainable care. This must be produced in consultation with patients, carers and other stakeholders.

Action the provider MUST take to improve acute wards for adults of working age and psychiatric intensive care units

- The trust must ensure that patients receive required physical health checks when rapid tranquilisation has been administered. The trust must also ensure that when 'Acuphase' is administered for rapid tranquilisation this is in line with trust policy and procedure.

- The trust must ensure that patients have a bed when they return from leave unexpectedly. The trust must also ensure that patients are not moved between wards without a clinical justification during their admission.

- The provider must ensure there are further improvements to ensure the consistency, quality and application of governance processes to monitor the safety and performance of wards.

Action the provider MUST take to improve community health services for adults

- The trust must ensure staff are given regular supervision, including clinical supervision, and appraisal.

Action the provider MUST take to improve specialist community mental health services for children and young people

- The trust must ensure that appropriate alarm systems are in place at all sites.

Action the provider MUST take to improve community health inpatient services which have not yet been reinspected

- The trust must ensure that equipment at the Alistair Farquarson Centre is appropriately stored and therapy equipment properly maintained.

- The trust must ensure that equipment such as blood pressure machines, beds and bed pan macerators were are properly maintained.

- The trust must ensure that there are suitably qualified staff to meet the needs of the rehabilitation service at Mayflower Hospital and the Alistair Farquarson Centre.

Action the provider MUST take to improve community mental health services for people with learning disabilities or autism which have not yet been reinspected

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

Action the provider MUST take to improve community-based mental health services for adults of working age which have not yet been reinspected

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

Action the provider MUST take to improve community-based mental health services for older people which have not yet been reinspected

Summary of findings

- The trust must ensure that the premises used by staff and patients are safe.

- The trust must ensure safety alarms work and are present in interview rooms.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve trust wide

- The trust should review the capacity of the senior leadership team, in particular the executive director of nursing post.

- The trust should support non-executive directors to have regular visits to services across the trust and provide feedback to the board on issues identified from these visits.

- The trust should ensure there is sufficient time to discuss complex issues during the board meeting and review whether information in part two of the meeting could be put into the public domain.

- The trust should ensure governors have regular opportunities to meet with non-executive directors so they can hold them to account, including reviewing non-executive attendance at the formal council of governors meetings. The governors should also be kept updated on the non-executive director lead roles.

- The trust should complete the work it has started on key aspects of its governance systems and processes so the board have access to the information they need to undertake their role. This includes having clarity of the most significant risks and how these are being mitigated.

- The trust should complete the recruitment and embedding the role of the Freedom to Speak up Guardian.

- The trust should further develop patient and carer engagement for example through extending the numbers of peer workers.

- The trust should continue to support the pockets of staff who feel they are bullied and to address concerns raised as part of the staff survey and the workforce race equality standards.

- The trust should ensure that the biannual medicines management report contains analysis and actions of medicines incidents.

- The trust should ensure that where complaints are investigated informally, records of the investigation undertaken and its outcome are maintained.

Action the provider SHOULD take to improve acute wards for adults of working age and psychiatric intensive care units

- The trust should ensure that personal alarms are available in sufficient numbers on Titian ward.

- The trust should ensure that the outstanding action from fire risk assessment on Hepworth ward is addressed. The trust should also ensure that staff and visitors on Monet and Kahlo wards are protected from the risks of patients smoking covertly on the ward.

- The trust should ensure that all equipment required to maintain patients' physical health is calibrated and safe to use.

- The trust should ensure that their plan to reduce the use of prone restraint by 50% is implemented on Titian ward.

- The provider should ensure that action is taken to improve feedback from patients and carers regarding staff attitude.

- The trust should ensure that on Kahlo ward all patient risk assessments are updated following an incident.

- The trust should also ensure that when caring for pregnant women all potential risks are identified and managed.

- The trust should ensure that accurate data for appraisal rates is available to ward managers.

- The trust should ensure that staff take up of mandatory training continues to improve and that all staff complete required training.

- The trust should ensure that staff supervision rates continue to improve and that all staff receive supervision in line with trust policy and procedure.

- The trust should ensure that staff are aware of the Freedom to Speak Up Guardian and their role.

Summary of findings

- The trust should ensure that the full range of disciplines are represented in multidisciplinary

  meetings on Turner ward.

- The trust should ensure that on Kahlo ward when patients are admitted with unlabelled medicines these are managed in accordance with trust policy and procedure.

- The trust should ensure that patients privacy and dignity is protected when making phone calls and receiving visitors on the wards.

- The trust should ensure that staff understand the incident report rating system and accurately record whether harm has occurred as a result of an incident.

- The trust should ensure that staff are able to access specialist training appropriate to their role, for example training in caring for patients with personality disorder.

- The trust should ensure that activity rooms on Monet and Kahlo wards are comfortably and appropriately equipped. The trust should also ensure that the outside space on Turner and Hepworth wards is comfortable and therapeutic.

- The trust should ensure that cleaning records for the clinic rooms on Hepworth and Titian wards are appropriately maintained.

Action the provider SHOULD take to improve end of life care

- Waltham Forest integrated community teams (ICT) should improve the number of patients achieving their preferred place of care at the end of their life.

- Ensure staff at Mayfield Community Hospital are fully prepared for the palliative care remit.

- Improve staff awareness of the specific risk register for end of life care (EOLC).

Action the provider SHOULD take to improve community health services for children, young people and families

- The trust should consider aligning compliance targets across the trust so that there is better uniformity of approach to the delivery of health visiting services.

- The trust should ensure all of the trust locations within all the localities comply with hand hygiene and infection prevention and control standards.

- The trust should ensure that all equipment is calibrated regularly including safety testing of equipment in schools.

- The trust should improve the completion of the online recording system for complaints ensuring risk assessments and the lessons learnt sections were completed.

Action the provider SHOULD take to improve community health services for adults

- The trust should ensure agency staff, including agency nurses, have documented evidence of their clinical competencies.

- The trust should ensure audit action plans are followed up and improvements or changes to services documented and monitored.

- The trust should ensure all staff, regardless of work location, have the opportunity to provide feedback and engage with senior teams.

Action the provider SHOULD take to improve specialist community mental health services for children and young people

- The trust should ensure that children and young people are assessed and commence their treatment within target times.

- The trust should ensure that all care plans include the patient voice and are recovery orientated.

- The trust should ensure that team environments are appropriately maintained.

- The trust should ensure that staff are trained in the use of fire evacuation chairs, where these are available.

- The trust should all ensure that all equipment used to monitor physical health is regularly calibrated.

- The trust should ensure that where decision specific capacity assessments are undertaken, these are appropriately recorded in patient care and treatment records.

Summary of findings

- The trust should ensure that suitable arrangements are in place to promote the privacy and dignity of patients when physical health observations are taken.

- The trust should ensure that toys at all sites are regularly cleaned, and that records to support this are maintained.

- The trust should ensure that systems to monitor the content and frequency of supervision are in place at all sites.

Action the provider SHOULD take to improve wards for older people with mental health problems

- The trust should develop plans so that all patients are accommodated in single bedrooms to ensure their privacy and dignity.

- The trust should consider ways of improving how staff can observe patients in the corridors of the wards.

- The trust should ensure that all staff complete mandatory training.

- The trust should review the template for team meetings to ensure that learning from incidents is always documented.

Action the provider SHOULD take to improve child and adolescent mental health wards

- The provider should ensure that fire evacuation drills take place when scheduled. The provider should also ensure that fire alarm checks take place in accordance with trust policy.

- The provider should ensure that radio checks take place in accordance with trust policy and that records of these checks are appropriately maintained.

- The provider should ensure that all equipment that may be required to monitor patients' physical health is regularly calibrated.

- The provider should ensure that the quality of food provided on the inpatient unit is improved.

- The provider should ensure that staff are aware of the trust Freedom to Speak Up Guardian and their role.

Action the provider SHOULD take to improve community health inpatient services which have not yet been reinspected

- The trust should consider whether the layout of the premises and the environment of the Alistair Farquarson Centre is suitable for modern needs.

- The should ensure that the staff rota on Alistair Farquarson reflects the actual time staff started work. For instance, staff were starting their shifts at 7.15am when the rota said 8.15am.

- The trust should ensure that at Mayflower Hospital there are sufficient groups such as exercise groups and activities of daily living groups.

Action the provider SHOULD take to improve community mental health services for people with learning disabilities or autism which have not yet been reinspected

- The trust should ensure that teams undertake mandatory training to ensure they meet the trust's training completion target.

- The trust should ensure that the teams use outcome measures when supporting people. Teams did not use outcome measures to monitor and evidence people's progress while receiving support.

- The trust should ensure safety alarms work and are present in interview rooms.

- The trust should ensure that all risks to the health and safety of people who use the service receiving care and treatment is assessed to manage any such risks. There must be an effective system in place to assess the risks to people who use services while they were waiting for assessment or treatment.

- The trust should address the standards of assessing and recording of the risks of people who used the learning disabilities community recovery teams. Risks should be re-assessed following incidents relating to people who use the services.

- The trust should ensure that the Waltham Forest team provide a range of easy read resources in the waiting area for people who use their service.

- The trust should ensure that the teams receive Mental Health Act training. Lack of this training may lead to staff not having essential knowledge to work effectively with people with learning disabilities regarding their rights under the Act.

Summary of findings

- The trust should ensure that all members of the Cranbrook and Loxford team are provided with mobile phones and personal alarms in line with the trust's lone working policy to promote their safety when working in the community.

- The trust should ensure the environment at Waltham Forest is dementia friendly for people who used the services who have a learning disability and dementia.

Action the provider SHOULD take to improve community-based mental health services for adults of working age which have not yet been reinspected

- The trust should address the standards of care plans in the community recovery teams. Some care plans we saw did not include the involvement of the person using the service in the creation of the plans, nor did they evidence a broad range of recovery focussed goals for each person.

- The trust should ensure that an accessible system for recording and resolving of complaints is in place for each team. The complaint log for complaints resolved informally at each of the three community recovery teams could not be accessed by managers at the time of our visit.

- The trust should ensure that all people being supported by the access assessment and brief intervention teams are aware of their care plans.

Action the provider SHOULD take to improve community-based mental health services for older people which have not yet been reinspected

- The trust should ensure risk assessments are monitored and updated when needed.

- The trust should ensure that team managers have access to information systems to support their management of the team.

- The trust should ensure care plans in the Barking and Dagenham team have a focus on recovery.

- The trust should ensure the environment at Barking and Dagenham is dementia friendly.

- The trust should ensure managers had sufficient authority and resources to make decisions about their service.

Action the provider SHOULD take to improve forensic inpatient/secure wards which have not yet been reinspected

- The trust should consider inviting advocacy services to hold dedicated, regular drop in clinics for patients.

- The trust should consider a plan of action to ensure staff receive training on the Mental Health Act.

Action the provider SHOULD take to improve long stay/rehabilitation mental health wards for working age adults which have not yet been reinspected

- The trust should remove the broken pay phone on the ward in line with the environmental suicide and ligature point assessment action plan.

- The trust should ensure that patients have timely access to psychology.

- The trust should review the blanket restriction concerning staff searching all patients.

Action the provider SHOULD take to improve wards for people with learning disabilities or autism which have not yet been reinspected

- The trust should ensure that all staff receive mandatory training in each of the specified topics.

- The trust should seek to reduce (or eliminate) the use of restraint in the prone position and the use of rapid tranquilisation.

- The trust should consider increasing the amount of specialist speech and language therapy input available to the ward.

- The trust should ensure that meal arrangements are flexible to accommodate the needs and wishes of all patients.

- The trust should ensure that patients have access to hot drinks at any time of day.

- The trust should look to actively encourage patients to personalise their bedrooms.

- The trust should seek to improve ease of access to the ward garden for patients with restricted mobility.

North East London NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

- The trust had clear structures and procedures for monitoring the administration of the Mental Health Act 1983 (MHA). Policies were reviewed and revised in line with changes in legislation and other developments around the MHA. The trust mental health law manager was responsible for the strategic role out of any new or revised policy and the dissemination of information about new legislation.A strategy was in place with regard to the most recent legislative change relating to sections 135 and 136 of the Act.A policy had been drafted and training sessions were ready for delivery. The trust was reviewing the provision of the section 136 pathway together with the East London NHS Foundation Trust and the Healthy London Partnership.

- Mental Health Act training was mandatory for all clinical staff and the trust offered both e-learning and classroom sessions as well as bespoke training for certain groups of staff. This included patient rights, approved clinician refresher training, community treatment order (CTO) recall training and a course on the interaction of the MHA and the MCA.The mental health law manager took the lead in delivering this training.

- The mental health law office was managed by the trust mental health law manager, supported by MHA managers and administrators. Two MHA managers were

an active presence on the inpatient wards, offering advice and scrutiny. All but one of the trust's inpatient wards were located at the Goodmayes site, enabling centralisation of Mental Health Act administration.

- The assistant medical director took the lead on MHA issues with the trust's doctors.A director of nursing was the executive lead for mental health law and oversaw the work of the mental health law team. The mental health law manager provided quarterly and annual reports to the acute and rehabilitation leadership team and to the directorate performance, quality and safety group. A Mental Health Act Annual performance report was presented to the board. This included analysis of trends over the past year, and incidents of unlawful detentions, unlawful treatment, and other issues with MHA assessments.

- The mental health law office conducted a number of audits each year including matters brought to its attention by CQC Mental Health Act review reports. Data was collected from electronic records systems. There was also a monthly consent to treatment audit. CQC MHA review reports were fully considered and meetings took place with ward managers and the MHA office to discuss action points. A MHA law newsletter had just been launched.

- Audit findings and the outcomes of MHA review visits were discussed with the relevant ward managers, approved mental health professionals (AMHPs) and consultants. Lessons learned were disseminated across the trust.

- There had been little change in the overall number of detentions over the past two years which did not follow

Detailed findings

the national trend. However, in keeping with the national picture, there was a marked increase in the number of applications for section 2 as opposed to section 3.

- The number of CTOs had increased and as of 31 October 2017, stood at 167, more than the total number of detained patients on the wards at any one time. We were told that this reflects the relatively low bed base, a short average length of stay and the utilisation of CTOs as the 'least restrictive' option. Approximately half of the trust's CTOs were for patients from the London Borough of Waltham Forest.

- There were 20 associate hospital managers. The lead for the associate hospital managers was the trust chair. Hospital managers held a quarterly meeting which included training. All Mental Health Tribunals for inpatients were held at Goodmayes Hospital. Overall the number of applications and references to the tribunal was increasing.

- From September 2016 to October 2017, CQC conducted three visits to review the implementation of the MHA. CQC made actions with regards to access to the MHA electronic records system on one occasion, staff explanation of rights on one occasion, capacity on one occasion, Deprivation of Liberty Safeguards on one occasion and care plans on one occassion.

- The mental health Law manager had started a quality improvement initiative based on integrated working with South Essex Partnership Trust in the development of a single overarching MHA policy with a suite of procedures that cross reference directly into the Code of Practice.

- The trust maintained regular contact with external stakeholders, including approved mental health professionals (AMHPs).

- On all of the wards we found that people had access to independent mental health advocacy (IMHA) services and information on IMHA services was provided to patients. Patients and staff knew how to access IMHA services appropriately.

- At this inspection, we found staff followed the MHA and its code of practice for most patients and that this had improved since the previous inspection.

- There was good staff take up of MHA training. Staff understood the requirements of the Act, the code of practice and its guiding principles. Staff knew how to access trust policy relating to the Act and how to seek advice from the MHA office. Both informal and detained patients were made aware of their rights in a way they could understand. Copies of Section 17 leave forms were kept on wards. All the wards displayed a notice to tell informal patients that they could leave the ward freely.

- At the April 2016 inspection we found there was poor take up of Mental Health Act training on wards for older people with mental health problems. During this inspection, we saw improvement. All staff on the wards had received training in the Mental Health Act.

- At the inspection in April 2016, on acute wards for adults of working age and psychiatric intensive care units, some records had no further explanation recorded when patients had not understood their rights. During this inspection we saw this had improved. Staff explained to patients their rights under the MHA in a way they could understand and recorded this in their care and treatment records.

- At the inspection in April 2016, on acute wards for adults of working age and psychiatric intensive care units, documents relating to detention were not available on the ward. During this inspection we found this had improved.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had an up to date policy on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

- The adult safeguarding team provided support to staff regarding the MCA.

- The trust monitored adherence to the MCA through a programme of audits. On the PICU ward a quality improvement project had been introduced to improve capacity assessments.

Detailed findings

- The trust provided mandatory training in the MCA and DoLS. Staff take up rates for this training were generally high.

- Overall, staff demonstrated a sound knowledge and application of the MCA . Most staff were confident in applying the MCA, but on the PICU ward some staff were not.

- Where decision specific MCA assessments had been carried out and the patient lacked capacity, best interests meetings were held to make decisions. At end of life services, we saw prompts for staff to follow in relation to best interest decisions for patients who did not have capacity to make decisions about care and treatment, including in relation to nutrition and hydration.

- Staff in services working with children considered Gillick competence and Fraser guidelines. Gillick competence is a test in medical law to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge. Whilst staff at specialist community mental health services for children and adolescents, demonstrated a sound understanding of capacity isues, where decision specific capacity assessments were made, these were not recorded in patients' records and there was no system to monitor the appropriate use of the Mental Capacity Act.

- During this inspection we saw improvements had been made at child and adolescent mental health wards, issues of capacity were promptly assessed. Where a patient's capacity to make a specific decision had been assessed, this was documented appropriately in their care records.

- Staff made DoLS applications when required and monitored the progress of applications to supervisory bodies. Records showed that ward staff monitored the progress of deprivation of liberty safeguards applications with the local authority.

Are services safe?

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

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

Summary of findings

Please see overall summary

Our findings

Safe and clean environments

Safety of the ward layout

- Staff completed regular risk assessments of care environments to ensure they were safe and well maintained.

- At the previous inspection of child and adolescent mental health wards in October 2016, we found that records relating to environmental checks were not being completed. During this inspection we saw that this had improved and that records were available.

- In April 2016, we identified that there were a number of blind spots on acute wards for adults of working age and psychiatric intensive care units, that prevented adequate observation of patients and staff had not taken steps to mitigate these risks. At this inspection, we found improvements in how staff mitigated these risks and they were safely managed. For example, general observations of the ward were completed every 15 minutes. Patients assessed as being at high risk were placed on one to one observations. On Hepworth and Turner wards, bedrooms located on a corridor without clear lines of sight, were not used for patients assessed as being at high risk.

- The layout of child and adolescent mental health wards did not allow staff to view all areas of the ward, but appropriate measures were in place to manage and mitigate this. The nursing office overlooked the communal lounge and part of the corridor. There were restricted areas for patients and these could only be accessed via pre-programmed key fobs. For example,

young people could only access the laundry accompanied by a member of staff. Staff carried out regular observations and ensured that staff were present in communal areas at all times.

- The layout of wards for older people with mental health problems did not allow staff to easily observe all parts of the ward from the nurses' station. There were no mirrors in corridors which may have assisted staff to observe patients more easily when they were moving around the ward.

- At the previous inspection of wards for older people with mental health problems, we found that the trust did not have a completion date for works to address potential ligature anchor points. In April 2016 we saw multiple ligature points throughout the acute wards for adults of working age and psychiatric intensive care units, both in communal areas and bedrooms. Ligature risk assessments of the environment varied in quality and detail. At this inspection we saw that improvements had been made across both core services.

- On Stage ward for older people with mental health problems, works had been completed to remove ligatures.

- An ongoing programme of works to reduce potential ligature points across the acute wards for adults of working age and psychiatric intensive care units was due for completion by December 2017. At the time of our inspection these had been completed on Ogura ward. Kahlo ward had been temporarily relocated whilst anti ligature works were carried out.

- Staff on all wards completed an individual risk assessed of each patient regarding the fixing of ligatures with appropriate measures in place, including the use of increased or one to one observations, to manage and mitigate these. In addition a ligature heat map was in place on all wards, staff were familiar with this and the measures in place to mitigate each potential ligature anchor point.

- Some wards for older people with mental health problems and the child and adolescent mental health

Are services safe?

ward provided mixed sex accommodation. Where this was the case, the ward layout ensured that guidance was complied with. There were separate bedroom and bathroom areas for male and female patients and female only lounges.

- Staff and patients working on wards had appropriate access to call alarm systems. This had improved since the last inspection. In April 2016, we found that patients on Cook ward for older people with mental health problems, were at risk because ensuite bathrooms did not have a call bell. At this inspection, we found that the trust had addressed this. A new call bell system was in place on Cook ward. Patients were able to call for help from their bedroom and ensuite bathroom.

- At child and adolescent mental health wards we saw that radios which were provided to staff in addition to alarms were not being checked regularly.

- At acute wards for adults of working age and psychiatric intensive care units, on Titian ward, there were not always sufficient numbers of personal alarms available.

- At specialist community mental health services for children and young people, interview rooms were not fitted with alarms. At Chelmsford and Harlow staff had not been issued with personal alarms which meant staff may not receive prompt assistance as they had no effective means to raise an alarm when using interview rooms.

- Inpatient settings were regularly assessed for fire safety with any identified works taking place promptly. However, some actions from the fire risk assessment at acute wards for adults of working age and psychiatric intensive care units, on Hepworth ward, had not been addressed. Some patients at acute wards for adults of working age and psychiatric intensive care units, on Monet and Kahlo wards, were smoking on the ward covertly.

- On most inpatient wards fire evacuation drills were taking place regularly. On child and adolescent mental health wards a fire drill was overdue. This was escalated at the time of the inspection and addressed by staff.

- At Harlow specialist community mental health services for children and young people, an evacuation chair was, but staff had not received training in how to use it.

Maintenance, cleanliness and infection control

- Ward areas were clean, had good furnishings and were well-maintained.

- During the inspection in April 2016, we identified that Ogura Ward and Monet ward had a number of outstanding maintenance issues. These included plumbing issues and bathrooms still in the process of renovation. At this inspection, we saw improvement. Staff had addressed the majority of maintenance issues quickly and patient feedback was positive.

- Some of the community buildings used by the trust were in a poor state of repair and presented challenges to staff in maintaining appropriate standards of infection control.

- The majority of staff adhered to infection control principles, including handwashing. Personal protective equipment was available to staff in all services. The trust undertook annual infection control audits.

- In community health services for children, young people and families some improvements were needed to ensure that all staff complied with hand hygiene and infection control standards.

- The specialist community mental health services for children and young people did not have cleaning rotas in place for toys and equipment to minimize the risks of infection control.

- Most cleaning records were up to date and demonstrated that community sites and inpatient ward areas were cleaned regularly.

Seclusion room

- The seclusion room on Titian ward had been taken out of use shortly before this inspection as a result of damage whilst in use. Required maintenance works and some refurbishment works were planned, with an estimated completion date of late September 2017. Whilst the seclusion room on Titian ward was out of use the trust had implemented a contingency plan that patients who needed to access seclusion would use the seclusion room on Morris ward, which was located in a low secure ward within the same building.

- At the inspection in April 2016, we found that there was no clear observation or operating policy regarding observation for the en-suite bathroom area in the seclusion room on Titian ward. During this inspection

Are services safe?

we found that whilst the en-suite bathroom in the seclusion room on Morris ward did not have a viewing panel in the bathroom door, improvements had been made as each patient using the seclusion room was risk assessed with a management plan put in place to ensure they could use the en-suite bathroom safely. Trust policy covered how to let patients use the toilet safely while in seclusion.

- At the time of the inspection staff transferred patients requiring seclusion from Titian ward to Morris ward. Public and service areas were cleared prior to the patient being transferred.

Clinic room and equipment

- On inpatient wards staff and patients were able to access clinic rooms that were visibly clean and contained the necessary equipment to monitor and maintain patient health. This included emergency medicines and equipment that were regularly checked, but at some services equipment was not regularly calibrated.

- At child and adolescent mental health wards, we saw that some equipment required to monitor patients' physical health was not regularly calibrated.

- At specialist community mental health services for children and young people, whilst the sites did not have designated clinic rooms, staff did have access to equipment to take physical healthcare observations such as blood pressure, pulse, weight and height. We found that equipment for taking physical observations such as height, weight and blood pressure was not always calibrated. At Colchester we did not find any paediatric blood pressure cuffs on site.

- In end of life services staff were able to access necessary equipment without delay and had been issued with mobile devices so that equipment could be ordered whilst visiting the patient at their home.

- At community health services for adults, healthcare assistants took the lead role in preparing clinic rooms each room in accordance with a check list. We checked a sample of clinic rooms across each of the sites we visited and found variable practice in the checks on equipment and the emergency equipment available.

- At community health services for children, young people and families, clinic rooms were visibly clean and suitably equipped. Centres managed equipment appropriately, with up to date safety testing stickers displayed. Staff cleaned equipment before and after each patient. However, at some sites equipment was not always calibrated regularly.

- At the previous inspection we found that at acute wards for adults of working age and psychiatric intensive care units, some medical equipment had not been calibrated. During this inspection we found that whilst this has improved, further embedding was needed as across all three inpatient core services a small number of uncalibrated machines were identified during this inspection. We also saw that some equipment at community health services for children, young people and families had not been calibrated within its due date.

- In April 2016, we identified that the light in the entrance to the clinic room on Ogura ward was not working. At this inspection, we saw improvement. The lights in all clinic rooms were working and staff reported no problems. Whilst the wards and clinic rooms were visibly clean, records to show the cleaning of clinic rooms on Hepworth and Titian wards, which the trust required, were not completed.

Safe Staffing

Nursing staff

- The trust had determined safe staffing levels by calculating the number and grade of members of the multidisciplinary team required using a systematic approach across the majority of services. Staffing levels were sufficient to meet the needs of patients. Most posts were filled with permanent staff.

- The trust had strategies to recruit more staff and to speed up recruitment processes.

- The trust used bank staff to cover vacancies on wards and community services, pending the recruitment of permanent staff and when staff were sick or on leave. Bank staff were often staff who had previously worked permanently on the wards. Bank staff they were familiar with trust procedures and knew the wards and patients well.

- At specialist community mental health services vacant posts were filled by locum agency staff. Specialist community mental health services for children and adolescents had staff turnover rates of 23%.

Are services safe?

- The trust had improved vacancy rates across community services for children, young people and families. At our last inspection vacancy rates averaged 20% across all services, with between 50-67% vacancies in some services and localities. At this inspection, staff vacancy rates showed an improvement. The current vacancy rate as of August 2017 was 13%, against a trust target of 10%. Data supplied by the trust showed that despite the use of bank and agency staff, there were some gaps in specialist therapy roles, such as physiotherapy, occupational therapy and speech and language therapy.

- At our last inspection community services for children, young people and families, we found heavy caseloads for staff across universal and specialist services. During this inspection, caseloads remained high in some services for a number of reasons. These included decreased staffing levels, growing populations and recruitment challenges for specialist therapy staff. The trust had mitigated this with regular allocation meetingsand a caseload weighting tool.

- Within community health services for adults, the average staff vacancy rate across all services was 13% in September 2017, although vacancy rates across teams varied significantly. Staff in each service told us one of their main challenges was managing capacity alongside staff vacancies. Individual service leads had implemented innovative service changes to reduce vacancies and improve waiting times. For example the senior team in the community health and social care services integrated care team had created a new rehabilitation support worker role, which helped to increase capacity.

- At our last inspection we identified significant gaps in the monitoring and management of agency nurses within community health services for adults. This was because the trust could not be assured agency nurses always had appropriate training and in some cases they did not have access to patient records or recording systems. At this inspection we found nurses completed self-declared competency checklists before they were able to complete shifts. However, documentary evidence to support declaration was not available.

- At end of life care services, bank staff were used to cover vacant posts. Some teams had increased staffing challenges, for example, Waltham Forest team had a vacancy rate of 17%, however, this was an improvement on a previous vacancy rate of 30%.

- At the previous inspection in acute wards for adults of working age and psychiatric intensive care units, we found that activities on Monet and Hepworth ward were cancelled due to staffing issues. At this inspection, we found improvements. Staff and patients told us they rarely experienced activities being cancelled because of staffing issues.

- The trust had made positive changes to the staffing arrangements on wards for older people with mental health problems since the last inspection. The trust had appointed a general nurse to work on each ward to improve physical health care for patients. These changes had enabled them to provide a better standard of care to patients.

- The trust had also made staffing changes at child and adolescent mental health wards where staffing establishment had recently increased staffing establishment

- At acute wards for adults of working age and psychiatric intensive care units, the number of nurses and healthcare assistants was met on most shifts. We saw that Ogura ward had six shifts during the previous six months where there was not the required number of qualified nurses on the ward. On these occasions, healthcare assistants replaced the qualified nurse's vacancies, which meant that overall safe staffing levels were maintained.

- Staffing turnover rates within acute wards for adults of working age and psychiatric intensive care units, had reduced over the previous 12 months. Sickness rates were variable, decreasing on Kahlo, Monet and Ogura wards but increasing on Hepworth and Turner wards.

Medical staff

- The trust had ensured that wards and teams had adequate medical cover day and night. The trust had on-call arrangements in place, which it reviewed on an ongoing basis.

- The trust supported medical staff to complete revalidation.

Are services safe?

Mandatory training

- The trust had a target of 85% staff take up for mandatory training and was overall performing well against this.

- At end of life services we found that specialist palliative care staff had completed 100% of trust mandatory training. This included mandatory training for nurses in the use of syringe drivers and end of life care medicines. The trust were rolling out a programme of tiered end of life care training, with all staff completing the level of training that was essential to their role.

- At our last inspection, we found the completion of mandatory training at community health services for children, young people and families, required improvement. During this inspection staff compliance rates for mandatory and statutory training across the service had improved and met the target of 85%.

- Within community health services for adults we found whilst there were variances between teams, the majority of staff had completed mandatory training.

- At specialist community child and adolescent mental health services, 80% for staff had completed mandatory training courses.

- On wards for older people with mental health problems, whilst the take up of mandatory training averaged over 80% in most areas, there were some exceptions. On Cook ward, management of violence and aggression training rates were 71%. At the Woodbury unit, training on safeguarding adults take up was 69%. Ward managers were taking action to ensure staff attended any courses they had not yet completed.

- Take up of mandatory training by staff on acute wards for adults of working age and psychiatric intensive care units, had improved since the last inspection. Overall 85% of staff had completed mandatory training, but staff take up of some individual elements of mandatory training, including safeguarding adults, Mental Capacity Act (MCA) and information governance, was below this target and further work was needed to improve this.

- When child and adolescent mental health wards were inspected in October 2016, we found that the overall mandatory training compliance rate was 82%. During this inspection, we saw that the training compliance rate had improved and overall mandatory training compliance rate had exceeded the trust target in all areas except information governance. The completion rate for this course was 79%, the manager stated that they expected the completion rate to improve in the near future as more courses were being run.

Assessing and managing risks to patients and staff

Assessment of patient risk

- Staff completed risk assessments using recognised tools. Since the last inspection, the services had made improvements. At this inspection, we found examples in a small number of care and treatment records of risk assessments not being completed or updated. This was atwards for adults of working age and psychiatric intensive care units and specialist community mental health services for children and adolescents.

- At our last inspection of community services for adults, we identified the quality of records in Waltham Forest district nursing as an area for improvement in relation to risk assessments. In response the trust introduced a quality of care audit to measure improvements. During this inspection we saw there had been improvements. We found patient risks were individually assessed. The harm free care team audited a sample of risk assessments across the service against relevant NICE guidance leading to the implementation of revised risk assessments that complied with all relevant guidance. Across the service risk assessment was used to triage referrals.

- At community services for children, young people and families, staff appropriately recorded assessment information, for example in baby record books and in patients' notes. Staff assessed infants for actual and potential risks related to their health and well-being. The service had mechanisms to identify patients at risk, such as vulnerable women and children and record details in electronic records. Where a child was identified as being in need an appropriate risk assessment was completed.

- At end of life services, there patients at risk of deterioration were clearly flagged and appropriate plans put in place.

Are services safe?

- At child and adolescent mental health wards staff completed a risk assessment for each young person when they were admitted and reviewed and updated this regularly.

- In April 2016, we identified that risk assessments and care plans for patients on acute wards for adults of working age and psychiatric intensive care units, were not always completed or reviewed. Care and treatment for patients was not always provided in a safe way and risks to the health and safety of patients were not mitigated. During this inspection we saw improvements. A risk assessment had been completed on admission for all patients. The majority of risk assessments were detailed, comprehensive and updated regularly. However, two of the 23 patient records showed that risk assessments had not been updated following recent incidents. An additional two patient risk assessments on Hepworth ward did not address all risks relating to the care of two women who were pregnant.

- Staff on wards for older people with mental health problems understood how to manage risks associated with frailty and old age. The trust had improved the procedures to assess and manage the risk of falls. At the previous inspection of wards for older people in April 2016, we found that the trust did not have appropriate arrangements to assess a patient's risk of falls. At this inspection, we found that the trust had rectified this. Staff also assessed patients comprehensively in relation to risks associated with falls, their mental health, physical health, nutrition and pressure care.

- At specialist community mental health services for children and adolescents, patients were comprehensively assessed. The service used a flagging tool to ensure that risk

assessments were updated at least every six weeks. For the majority of patients risk assessments had been updated more frequently when there had been a change. For two patients risk assessments had not been updated to reflect recent events. The trust was rolling out training to support the introduction of a specialist child and young person risk assessment.

Management of patient risk

- Staff in most wards and teams were aware of and dealt with specific risk issues. They identified and responded to changing risks to, or posed by, patients. Acute wards

for adults of working age and psychiatric intensive care units and specialist community mental health services for children and adolescents, needed to improve some of their management of risks.

- At community health services for adults, we found patient risks were individually assessed and a plan to mitigate and manage identified risks was in place. We saw from our observations of home visits that staff supported patients to manage risks relating to their treatment, for example the safe storage of a sharps bin in a patients home.

- At end of life services, we saw the use of emergency health care plans to ensure that all patients had a plan in place should their condition deteriorate.

- At child and adolescent mental health wards, where potential risks were identified, management plans were in place to mitigate these. Staff from both teams regularly reviewed and formulated plans to manage risk behaviours of patients and risks to staff through the handover and risk meetings

- At the inspection in April 2016 we found patients on acute wards for adults of working age and psychiatric intensive care units, patients with pressure care needs were not having their pressure areas monitored and attended to as required. During this inspection there were no patients with pressure area concerns. Staff demonstrated that they knew how to prevent and respond to pressure area concerns.

- Staff on acute wards for adults of working age and psychiatric intensive care units, identified and responded to changing risks to, or posed by, patients. Staff did this through regular one to one sessions with patients, reporting of incidents and daily handover meetings which updated staff on the changing risk profile of patients.

- At the previous inspection of wards for older people with mental health problems in April 2016, we found that the trust did not have appropriate arrangements to manage the risk of falls. At this inspection, we found that staff developed effective management plans in response to the risk of falls and other risks. The staff team were alert to emerging risks and kept risk management plans under review to ensure they were effective.

Are services safe?

- At this inspection, we found that when appropriate staff on wards for older people with mental health problems, used assistive technology to support them to manage the risk of falls. For example, the provision of sensor equipment which would alert staff when the patient got out of bed.

- At specialist community mental health services for children and adolescents, where patients were waiting to be seen, there were systems in place to identify and respond to changes in risk.

- Staff understood and implemented trust policies and procedures on the observation of patients on mental health wards.

- Staff applied blanket restrictions on patients' freedom only when justified. In April 2016, we found some blanket restrictions in place on acute wards for adults of working age and psychiatric intensive care units. During this inspection, we found improvements. Staff did not search every patient, only those whose risk assessment indicated that they were at risk of bringing contraband onto the ward.

- At the April 2016 inspection, we found that on acute wards for adults of working age and psychiatric intensive care units, plastic bin bags were still in use. The trust had banned plastic bags across all inpatient wards following learning from a serious incident. At this inspection, we found improvements. We did not see plastic bags in ward areas. We observed staff asking visitors to remove plastic bags from their belongings at ward entrances and wards displayed signs informing staff, patients and visitors that plastic bags were banned.

- There was mixed adherence to the trust's policy of providing a smoke free environment on mental health inpatient wards. Staff said the smoke free policy was difficult to enforce. On all wards, staff created care plans to address healthy lifestyles, including smoking cessation. Nicotine replacement therapies were available for patients that needed them.

- Staff ensured that informal patients on mental health wards understood their right to leave the ward when they wished.

- There was a safe lone worker policy in place that staff followed.

Use of restrictive interventions

- The trust was committed to reducing the number of face down (prone) restraints. They had a reducing restrictive interventions strategic action plan which aimed to reduce the use of prone restraint by 50%. The trust had trained staff in supine restraint techniques. Training in the prevention and management of violence and aggression was mandatory, with good staff take up. Staff used restraint only after de-escalation had failed.

- At child and adolescent mental health wards there had been reduction in the use of prone restraint.

- On wards for older people with mental health problems there were low numbers of prone restraints and staff were aware of the possible adverse consequences of using restraint on a frail older patient.

- Data supplied by the trust showed variable success in reducing the number of restraints on acute wards for adults of working age and psychiatric intensive care units. Whilst progress had been made on acute wards and the use of prone restraint had reduced by 40%, on the PICU ward the use of prone restraint over the six months prior to the inspection had doubled.

- At acute wards for adults of working age and psychiatric intensive care units staff did not follow trust policy and NICE guidance when intramuscular rapid tranquilisation was administered. Not all patients were monitored and appropriate physical health checks carried out after rapid tranquilisation was administered.

- A small number of patients on acute wards for adults of working age and psychiatric intensive care units were administered a type of medicine during rapid tranquilisation that was not recommended by trust policy as a first line rapid tranquilisation.

- Child and adolescent mental health wards did not nurse patients in seclusion. There had been no recent seclusions on wards for older people with mental health problems. On acute wards for adults of working age and psychiatric intensive care units there had been an increase in the number of seclusions since we last inspected, however, the needs of patients were frequently reviewed to ensure they were nursed in the least restrictive way.

- During the April 2016 inspection, we found that staff did not record sufficient detail in the seclusion records and

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that there was a need for better monitoring of seclusion. At this inspection, staff maintained appropriate records for seclusion and checks had taken place to ensure this took place in line with the Mental Health Act code of practice.

Safeguarding

- The trust had safeguarding leads and participated in local safeguarding boards.

- Staff used the trust's electronic record system to highlight possible safeguarding concerns and record the actions taken.

- Staff received mandatory training in safeguarding and staff take up of this was generally good.

- Staff reported and managed safeguarding appropriately, although in community services for adults some staff were less familiar with trust safeguarding procedures.

- Staff were aware of the government's prevent strategy, and staff had received training in identifying radicalisation and extremism.

Staff access to essential information

- Information needed to deliver patient care was available to all relevant staff when they needed it and in an accessible form. That included when patients moved between teams.

- The trust had implemented 'agile working' in community teams. This equipped trust staff with mobile devices. Staff could access patients' electronic records on their agile working devices. For community teams operating in Essex, staff could also access information from the patients GP, as GPs used the same electronic record system as the trust.

- At our last inspection, we found sensitive personal information recorded in paper diaries at community services for children, young people and their families. This had improved since the last inspection. The trust had implemented electronic diaries for staff.

- At the April 2016 inspection we found that bank and agency staff at acute wards for adults of working age and psychiatric intensive care units, did not have access to electronic recording systems and relied on

permanent staff members to complete entries on their behalf. During this inspection we saw that this had improved. Bank staff could access the electronic care records and update notes and care plans.

- Since the last inspection, the trust had put in place an electronic records system champions, to support staff with agile working.

Medicines management

- The trust had clear structures and procedures for monitoring medicines management. Policies and procedures were in place that were regularly reviewed.

- The chief pharmacist was the controlled drug accountable officer and produced annual reports for the quality committee and quarterly incident reports to the local controlled drug intelligence network. Priorities for medicines optimisation were fed into the drug and therapeutic and medicines safety groups. The biannual medicines management report, containing risks and new initiatives was presented to the quality and patient safety Committee. The report noted the number of reported medicines incidents but did not include any analysis or actions.

- One of the priorities for medicines optimisation was the introduction of electronic prescribing. A system had been agreed and staff were being recruited in order to implement this from April 2018.

- The pharmacy team disseminated learning from incidents and made changes where appropriate. Medicines errors and near misses were reported to the medication safety group. Learning was disseminated through training, team meetings and through pharmacy flyers.

- Medicine recalls and alerts were managed appropriately, including liaison with the supplying pharmacy. Audits were conducted on local medicines themes and on the national POMH-UK program, where the trust could benchmark against other trust results for mental health themes.

- Since the last inspection, the trust had made improvements in the management of medicines.

- Medicines audits were completed regularly within teams and on wards. Staff we spoke with knew how to report incidents involving medicines.

Are services safe?

- Community services included non-medical prescribers. Prescription pads were stored securely.

- Wards and community teams had access to pharmacist support.

- Medicines including controlled drugs were stored securely. Where these required refrigeration, temperatures were monitored and appropriate action taken should these fall outside of acceptable temperature ranges.

- All prescription charts were clearly written and included patient demographics and information about allergies. Where appropriate, documentation regarding legal authority to administer medicines to individual patients was readily available.

- The physical health of patients was generally monitored appropriately. For high risk medicines such as high dose anti-psychotics, all patients had received an electrocardiogram reading. In addition, all patients on lithium and clozapine had received the appropriate blood tests.

- Medicines reviews and changes were clearly recorded on the trust's electronic records system. We saw patient involvement in decisions and information about medicines related risks. Pharmacists gave advice to both staff and patients to improve medicines optimisation.

- Staff could access all the medicines policies via the trust intranet.

- At end of life services, there was use of anticipatory prescribing of medicines.

- On wards for older people with mental health problems, some patients were receiving medicines covertly. In line with trust policy, staff had assessed the patient's capacity to consent, held a best interests meeting and sought advice from the pharmacist.

- At our last inspection at community services for children, young people and families, we found there was a backlog of consent forms that required uploading onto the electronic system. During this inspection we saw this had improved. The initial backlog was cleared and systems were being developed to introduce portable scanning of consent forms.

- In April 2016, at acute wards for adults of working age and psychiatric intensive care units we found that improvements were needed in how medicines were managed. Out of date medicines had not been disposed of, fridges used to store medicines were not regularly having their temperatures checked and one medicines fridge was broken. Some clinic rooms were hot. Some patient prescription charts had not been signed and there were some missing signatures in the controlled drugs log. At the April 2016 inspection we also found that some patients' medicines charts had not been completed with allergy information. During this inspection all of these issues had been addressed. However, on Kahlo ward, patients who were admitted with unlabelled medicines had these returned to them when they were discharged. This contravened trust policy.

Track record on safety

- There had been no never events and no serious incidents reported from September 2016 to September 2017 in relation to end of life care services.

- Community services for children and young people reported no never events and eight serious incidents between September 2016 and August 2017. These included an unexpected death of an infant, a safeguarding incident, pressure ulcers causing moderate harm, potential loss of personal identifiable data and actual or alleged abuse.

- Community services for adults reported 115 serious incidents between September 2016 and August 2017. Of these, 65% related to grade 3 or grade 4 pressure ulcers.

- Child and adolescent mental health wards reported no serious incidents between 1 January 2017 and 30 June 2017.

- Two serious incidents, both related to unexpected deaths of inpatients had occurred at acute wards for adults of working age and psychiatric intensive care units since our previous inspection. On the PICU ward, a serious incident in August 2016 had occurred when a member of staff was assaulted by a patient with a weapon bought onto the ward.

- On wards for older people with mental health problems, in the period July 2016 to June 2017, there had been two serious incident investigations.

Are services safe?

- At specialist community mental health services for children and adolescents, there were 187 incidents from July 2016 to July 2017 of which three were serious incidents involving the unexpected death of a young person.

Reporting incidents and learning from when things go wrong

- The trust had an electronic incident reporting system. Staff knew what incidents to report and how to report them. All staff were aware of, and had access to the trust's online incident reporting system. The trust reported serious incidents to the Strategic Executive Information System (STEIS).

- Learning from incidents was shared. Across the services, staff made changes as a result of investigations and feedback. Trust wide events which focused on learning from incidents had been held. Staff were debriefed after serious incidents.

- At specialist community mental health services for children and young people, the trust had carried out a thematic review into the three deaths and learning points had been implemented. As a result of preliminary findings changes were being made to how the service assessed and managed risk and to the process for supporting young people when they transitioned to adult services.

- At acute wards for adults of working age and psychiatric intensive care units, learning from a recent unexpected death had resulted in changes in how physical health concerns were managed. On the PICU, changes had been made to how patients were searched when they returned from leave following learning from an incident. However, the majority of incidents involving patients physically attacking staff were recorded as 'no harm' despite many staff receiving injuries.

- At wards for older people with mental health problems, we saw that whilst learning from incident was discussed at team meetings, this was not always recorded.

- At end of life services, incident reporting rates for palliative and end of life care were low in integrated community teams when compared to specialist palliative care teams.

- At community health services for adults, in response to learning from incidents a deteriorating patient protocol had been developed for use by staff in care homes. Where incident investigation teams found themes in SI reporting, they carried out a multi incident root cause analysis (RCA) investigation which involved multidisciplinary teams and an investigation of each patient's journey through the trust. Identification of incident themes from this core service had led to a quality improvement project which aimed to achieve 100% accurate grading of pressure sores at the point of referral.

- During our previous inspection, at community services for children, young people and families, we found the trust incident reporting processes meant that not all staff could report incidents directly. During this inspection we saw that improvements had been made. Trust policy had been changed, and all staff could directly report incidents. Staff had received training to enable them to do this.

Duty of Candour

- We looked at seven serious incidents to see how the trust applied 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. They had also been asked to give their views on the incident. From the root cause analysis reports we saw that whilst the incident report stated that the findings of the investigation had been shared with the family, it was not clear how this had been done.

Are services effective?

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

Summary of findings

Please see overall summary

Our findings

Assessment of needs and planning of care

- Individual care plans were in place for patients. Most were holistic and person centred and clearly indicated the clinical support patients would receive.

- Staff in mental health services completed a comprehensive mental health assessment for patients in a timely manner at, or soon after, admission or referral.

- Staff assessed patients' physical health needs in a timely manner. Mental health inpatient wards used the National Early Warning System (NEWS) to monitor patients physical health.

- Within end of life services advance planning including 'do not resuscitate' information was in place. Care plans in this service had been recently revised to ensure conversations about end of life took place and informed the service provided.

- At community services for children, young people and families, there was variability in care plans. Whilst most were comprehensive and had been developed with the patient and their carer, some did not include clear outcomes.

- Within community services for adults, community treatment teams used the Manchester Triage Tool for all first telephone assessments, which enabled them to identify the level of clinical risk for each patient.

- At the previous inspection in April 2016, we found that not all patients at specialist community mental health services for children and adolescents, had a plan that outlined their care and treatment. During this

inspection, we saw that this had improved. However, further improvements were required to ensure that care plans were recovery oriented and included the patients voice.

- At the previous inspection, at acute wards for adults of working age and psychiatric intensive care units, we found that care plans were not holistic and did not include individual patient needs. During this inspection this had improved. All the care plans we viewed were personalised, holistic and recovery-oriented. At the previous inspection we also found that patients' personal preferences were not always reflected in care plans and some patients said that their care plans did not reflect their views. This has also improved during this inspection.

- When the child and adolescent mental health ward was inspected in October 2016, we found that the initial assessments did not cover all the areas relevant to young people. During this inspection, we found that the assessments were comprehensive, person centred, recovery orientated and relevant to the needs of young people.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group. Staff in each service could demonstrate how they delivered care that met national best practice guidance from relevant organisations, including the National Institute for Health and Care Excellence (NICE). These included access to psychological therapies for mental health wards and specialist community mental health services for children and adolescents.

- In mental health community and inpatient settings, staff followed NICE guidance when prescribing medicines.

- Staff participated in clinical audit, benchmarking and quality improvement initiatives. However, at community health services for adults, we found audit action plans were not always followed up and improvements or changes to services were not documented or monitored.

Are services effective?

- Staff used recognised rating scales to assess and record severity and outcomes across all core services. For example, Health of the Nation Outcome Scales in mental health inpatient settings and Reason, Observation, Comment, Assessment/Analysis, Intervention, Plan (ROCAIP) at community services for children, young people and families.

- Staff ensured that patients' physical healthcare needs were being met, including their need for an annual health check. Where the GP was responsible for carrying out tests, staff assured themselves this was done.

- Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration.

- Services were engaged in health promotion, both in interactions with patients and the use of promotional materials, such as poster campaigns for flu vaccinations.

- At our last inspection, we found some consultants at community services for children, young people and families said workload pressures limited opportunities to audit outcome measures or benchmark against peers and similar services. On this inspection, community paediatricians told us they had adequate time to complete audits to monitor patient outcomes and clinical performance.

Skilled staff to deliver care

- Most teams included or had access to the full range of specialists required to meet the needs of patients.

- Staff were experienced and qualified, and they had the right skills and knowledge to meet the needs of the patient group.

- The trust offered staff the opportunity to attend specialist training to develop skills. For example at end of life services, the trust was rolling out 'difficult conversations' training. However, at acute wards for adults of working age and psychiatric intensive care units, staff said they would benefit from specialist training, for example training in caring for patients with personality disorder.

- Managers provided new staff and agency staff with appropriate inductions. Newly qualified nurses were supported with preceptorship. Newly recruited health care assistants were enrolled in a training programme to achieve the care certificate.

- Most staff received regular clinical and managerial supervision. However, in community health services for adults, not all staff were receiving regular management and clinical supervision. In specialist community mental health services for children and young people, systems to monitor the content and frequency of supervision were not in place.

- At the previous inspection in April 2016, staff at acute wards for adults of working age and psychiatric intensive care units, were not able to access regular supervision. During this inspection we saw that whilst supervision rates were improving, further work was needed to embed this.

- Staff working with children and young people in community or mental health settings received specialist safeguarding supervision in addition to the clinical and managerial supervision.

- Most staff received an annual appraisal, however, at community health services for adults, not all staff who were due an appraisal had received one.

- At the previous inspection in April 2016, staff appraisal rates at acute wards for adults of working age and psychiatric intensive care units, were low at 67%. During this inspection we found that further work was needed to improve, as not all ward managers were able to access data with compliance rates.

- Teams held regular, effective meetings in which they shared information. Some teams were able to access reflective practice sessions.

- The trust supported managers to deal with poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

- There was consistent use of multidisciplinary working and coordinated care and treatment pathways for patients in all services.

- Staff held regular and effective multidisciplinary meetings in most services.

- At acute wards for adults of working age and psychiatric intensive care units, multidisciplinary meetings on Ogura and Turner wards restricted attendance to the consultant psychiatrist and nurse.

Are services effective?

- At community health services for adults, some teams said their geographical distance from Trust HQ left them at risk of being isolated and they would welcome opportunities to engage with the senior trust team.

- Staff shared information about patients at effective handover meetings within the team.

- Services had effective working relationships with other teams in the trust and outside of the trust, including clinical networks and excellence groups and effective links with care partners including GPs.

Adherence to the MHA and the MHA Code of Practice

- The trust had clear structures and procedures for monitoring the administration of the Mental Health Act 1983 (MHA). Policies were reviewed and revised in line with changes in legislation and other developments around the MHA. The trust mental health law manager was responsible for the strategic role out of any new or revised policy and the dissemination of information about new legislation. A strategy was in place with regard to the most recent legislative change relating to sections 135 and 136 of the Act. A policy had been drafted and training sessions were ready for delivery. The trust was reviewing the provision of the section 136 pathway together with the East London NHS Foundation Trust and the Healthy London Partnership.

- Mental Health Act training was mandatory for all clinical staff and the trust offered both e-learning and classroom sessions as well as bespoke training for certain groups of staff. This included patient rights, approved clinician refresher training, community treatment order (CTO) recall training and a course on the interaction of the MHA and the MCA. The mental health law manager took the lead in delivering this training.

- The mental health law office was managed by the trust mental health law manager, supported by MHA managers and administrators. Two MHA managers were an active presence on the inpatient wards, offering advice and scrutiny. All but one of the trust's inpatient wards were located at the Goodmayes site, enabling centralisation of Mental Health Act administration.

- The assistant medical director took the lead on MHA issues with the trust's doctors. A director of nursing was the executive lead for mental health law and oversaw the work of the mental health law team. The mental health law manager provided quarterly and annual reports to the acute and rehabilitation leadership team and to the directorate performance, quality and safety group. A Mental Health Act Annual performance report was presented to the board. This included analysis of trends over the past year, and incidents of unlawful detentions, unlawful treatment, and other issues with MHA assessments.

- The mental health law office conducted a number of audits each year including matters brought to its attention by CQC Mental Health Act review reports. Data was collected from electronic records systems. There was also a monthly consent to treatment audit. CQC MHA review reports were fully considered and meetings took place with ward managers and the MHA office to discuss action points. A MHA law newsletter had just been launched.

- Audit findings and the outcomes of MHA review visits were discussed with the relevant ward managers, approved mental health professionals (AMHPs) and consultants. Lessons learned were disseminated across the trust.

- There had been little change in the overall number of detentions over the past two years which did not follow the national trend. However, in keeping with the national picture, there was a marked increase in the number of applications for section 2 as opposed to section 3.

- The number of CTOs had increased and as of 31 October 2017, stood at 167, more than the total number of detained patients on the wards at any one time. We were told that this reflects the relatively low bed base, a short average length of stay and the utilisation of CTOs as the 'least restrictive' option. Approximately half of the trust's CTOs were for patients from the London Borough of Waltham Forest.

- There were 20 associate hospital managers. The lead for the associate hospital managers was the trust chair. Hospital managers held a quarterly meeting which included training. All Mental Health Tribunals for inpatients were held at Goodmayes Hospital. Overall the number of applications and references to the tribunal was increasing.

Are services effective?

- From September 2016 to October 2017, CQC conducted three visits to review the implementation of the MHA. CQC made actions with regards to access to the MHA electronic records system on one occasion, staff explanation of rights on one occasion, capacity on one occasion, Deprivation of Liberty Safeguards on one occasion and care plans on one occassion.

- The mental health Law manager had started a quality improvement initiative based on integrated working with South Essex Partnership Trust in the development of a single overarching MHA policy with a suite of procedures that cross reference directly into the Code of Practice.

- The trust maintained regular contact with external stakeholders, including approved mental health professionals (AMHPs).

- On all of the wards we found that people had access to independent mental health advocacy (IMHA) services and information on IMHA services was provided to patients. Patients and staff knew how to access IMHA services appropriately.

- At this inspection, we found staff followed the MHA and its code of practice for most patients and that this had improved since the previous inspection.

- There was good staff take up of MHA training. Staff understood the requirements of the Act, the code of practice and its guiding principles. Staff knew how to access trust policy relating to the Act and how to seek advice from the MHA office. Both informal and detained patients were made aware of their rights in a way they could understand. Copies of Section 17 leave forms were kept on wards. All the wards displayed a notice to tell informal patients that they could leave the ward freely.

- At the April 2016 inspection we found there was poor take up of Mental Health Act training on wards for older people with mental health problems. During this inspection, we saw improvement. All staff on the wards had received training in the Mental Health Act.

- At the inspection in April 2016, on acute wards for adults of working age and psychiatric intensive care units, some records had no further explanation recorded when patients had not understood their rights. During

this inspection we saw this had improved. Staff explained to patients their rights under the MHA in a way they could understand and recorded this in their care and treatment records.

- At the inspection in April 2016, on acute wards for adults of working age and psychiatric intensive care units, documents relating to detention were not available on the ward. During this inspection we found this had improved.

Good practice in applying the Mental Capacity Act

- The trust had an up to date policy on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

- The MHA office provided support to staff regarding the MCA.

- The trust monitored adherence to the MCA through a programme of audits. On the PICU ward a quality improvement project had been introduced to improve capacity assessments.

- The trust provided mandatory training in the MCA and DoLS. Staff take up rates for this training were generally high.

- Overall, staff demonstrated a sound knowledge and application of the MCA . Most staff were confident in applying the MCA, but on the PICU ward some staff were not.

- Where decision specific MCA assessments had been carried out and the patient lacked capacity, best interests meetings were held to make decisions. At end of life services, we saw prompts for staff to follow in relation to best interest decisions for patients who did not have capacity to make decisions about care and treatment, including in relation to nutrition and hydration.

- Staff in services working with children considered Gillick competence and Fraser guidelines. Gillick competence is a test in medical law to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge. Whilst staff at specialist community mental health services for children and adolescents, demonstrated a sound understanding of

Are services effective?

capacity isues, where decision specific capacity assessments were made, these were not recorded in patients' records and there was no system to monitor the appropriate use of the Mental Capacity Act.

- During this inspection we saw improvements had been made at child and adolescent mental health wards,

issues of capacity were promptly assessed. Where a patient's capacity to make a specific decision had been assessed, this was documented appropriately in their care records.

- Staff made DoLS applications when required and monitored the progress of applications to supervisory bodies. Records showed that ward staff monitored the progress of deprivation of liberty safeguards applications with the local authority.

Are services caring?

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

Summary of findings

Please see overall summary

Our findings

Kindness, dignity, respect and support

- Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients and carers with help, emotional support and advice at the time they needed it. When staffed supported patients, they promoted their privacy and dignity.

- Staff supported patients to understand and manage their care, treatment or condition.

- Most patients said staff treated them well and behaved appropriately towards them.

- At end of life services, feedback from people who used the service was positive. We saw that staff were motivated to meet patient's needs. Staff demonstrated compassionate care to patients and their families. Relationships between people who used the service, those close to them and staff were caring and supportive. These relationships were valued by people and their families.

- At community services for children, young people and families, we observed staff providing care with kindness and compassion. Staff supported patients and families they worked with, and provided patient-centred support in clinics and in homes.

- At community services for adults, during our observations and home visits we saw staff treated patients with care, compassion and kindness.

- At specialist community mental health services for children and young people, staff were compassionate,

demonstrated an in-depth knowledge of the young person's circumstances and were respectful towards them. Children and young people were treated in age appropriate way and were involved in their treatment.

- At wards for older people with mental health problems, staff treated patients with respect and kindness. Staff understood how to communicate with patients who may have memory problems or communication difficulties.

- At child and adolescent mental health wards, reports from patients and families were very positive about the service, they said they received excellent care.

- At the previous inspection, patients gave mixed feedback on how they were treated by staff at acute wards for adults of working age and psychiatric intensive care units. During this inspection the majority of patients on Ogura, Turner and Monet wards reported the service was good and that staff were caring and supportive. However some patients gave negative feedback regarding their care on Hepworth and Kahlo wards, commenting that some staff could be disrespectful and rude and did not always spend enough time with them. Managers were aware of this issue and were actively trying to improve this.

- At the April 2016 inspection, patients gave mixed feedback on how staff promoted their privacy and dignity at acute wards for adults of working age and psychiatric intensive care units. Some patients said that staff did not knock on their bedroom doors before entering and some that they were disturbed when asleep by staff carrying out general observations. During this inspection we found this had improved.

- Prior to the inspection, we placed comment card boxes throughout the trust. We received 96 responses. Of these, 77 gave feedback on the quality of the service: 48 recorded positive feedback, 27 negative feedback and 3 mixed feedback.

- Staff understood the individual needs of patients, including their personal, cultural, social and religious

Are services caring?

needs. At end of life services we observed care that focused on meeting the emotional, spiritual and psychological needs of patients as well as their physical needs. There was a visible person-centred culture.

- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

- Staff maintained the confidentiality of information about patients. Electronic records systems were password protected. Where teams and wards used paper records, these were securely stored. At teams and wards where patient information was displayed on wipeboards, covers had been fitted to maintain confidentiality. At sites where teams hot desked, a clear desk policy was in operation to maintain patient confidentiality.

- At the April 2016 inspection we found that at wards for older people with mental health problems, recording of patient information on boards in communal areas could compromise patient confidentiality. During this inspection we saw that this had improved.

- The trust's overall score for privacy, dignity and wellbeing in the 2016 PLACE survey was 82%.

Involvement in care

Involvement of patients

- Staff used the admission process to inform and orient patients to the ward and to the service.

- At acute wards for adults of working age and psychiatric intensive care units, staff introduced newly admitted patients to the ward and to other patients. Staff also gave patients information leaflets about the ward. When staff admitted a new patient, they spent time with them to understand their needs and to develop a good relationship.

- Prior to agreeing to informal admission, young people could visit child and adolescent mental health wards with their parent or carers. This visit allowed young people and their parents/carers to meet with the staff and see the ward environment. The inpatient ward had an admission pack and admission suite at the front of the building. Staff would go through admission issues and give new patients a tour of the ward.

- Staff on wards for older people with mental health problems, used the admission process to inform and orientate patients to the ward and to the service. Patients and carers told us a member of staff showed them around the ward when they were admitted. They said they were also introduced to staff and patients and told about mealtimes and activities on the ward. Staff also gave a 'welcome pack' to new patients which explained how the service operated.

- Staff involved patients in care planning and risk assessment. Care and treatment records included information on how staff had involved patients in discussions about risks and care planning as much as possible.

- At the last inspection of acute wards for adults of working age and psychiatric intensive care units, we found that not all patients felt involved in their care plan development or that care plans captured their views. Some patients told us they did not have access to their care plan. During this inspection we found there had been improvements. Staff involved patients in care planning and risk assessment. The majority of care plans we reviewed reflected this. Patients participated in ward rounds where they had the opportunity to discuss their care and treatment.

- At the last inspection of child and adolescent mental health wards in October 2016, we found that although staff recorded the views of young people it was brief with limited information. During this inspection, we found that the recording on care plans had improved. The care records were comprehensive and detailed and showed that staff had in depth discussions with young people. Staff recorded the views of the young people in the words of the young person.

- Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties.

- Staff had a range of pictorial tools they could use when communicating with patients. On wards for older people with mental health problems staff assessed patients hearing and sight and made sure that patients

Are services caring?

wore their glasses and hearing aids. At community services for children, young people and families, easy read care plans were in place for children with learning disabilities.

- Patients at child and adolescent mental health wards had access to the 'My Mind app' which provided interactive, confidential advice and support for those who were receiving care and treatment. The app also gave access to on-line resources, appointments and care plans. This app had won an NHS digital pioneer award.

- Staff involved patients when appropriate in decisions about the service. At specialist community health services for children and adolescents, the service had coproduced a revised care plan format with patients' that was being trialled. On all mental health wards, regular community meetings were held where patients could participate in day to day decision making about the services. Patients were involved in the recruitment of staff at community and inpatient mental health settings.

- Staff enabled patients and carers to give feedback on the service. The trust used various surveys to obtain feedback on the service provided. These included the 5x5 survey, the friends and family test, a 'your views count' survey, the 'voice of the child' and patient experience data. Whilst patient feedback varied between services, the majority of feedback was positive with patients and carers stating they would recommend the service they had used.

- Staff enabled patients to make advance decisions when appropriate. At end of life services, we saw advanced wishes were discussed with patients and their relatives and recorded within the care plan.

- Staff ensured that patients could access advocacy services. At community and inpatient mental health settings information regarding advocacy services was displayed and patients and staff knew how to access them.

The involvement of families and carers

- Staff informed and involved families and carers appropriately and provided them with support when needed.

- Staff at end of life services undertook an assessment of the emotional needs of family members using a pre-bereavement checklist.

- At wards for older people with mental health problems, staff gave carers information and support. Carers were made welcome on the wards. Staff involved them in planning the patient's care, treatment and discharge from the ward.

- At community services for children and young people, staff worked in partnership with families and carers.

- Carers were provided with information about how to access a carer's assessment.

Are services responsive to people's needs?

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

Summary of findings

Please see overall summary

Our findings

Access and discharge

Access and waiting times

- The services had clear criteria for which patients would be offered a service and, if waiting lists were used, who could be placed on them. However, at end of life services, staff at Mayfield Community Hospital said they had not been fully prepared for the palliative care remit.

- At community health services for children, young people and families, the trust had a vulnerable children initiative in place, aimed at children who did not meet the threshold for referral to social services.

- At the last inspection, at community health services for children, young people and families, we found inconsistencies in how services applied referral procedures. During this inspection we saw this had improved. The trust had carried out an audit and found procedures were now fully embedded and consistently applied.

- The trust had set targets for time from referral to assessment and from assessment to treatment, but within some services was not meeting these.

- At specialist community mental health services for children and young people, referral rates were increasing. Services were not meeting their target times for referral to assessment of 12 weeks. Teams were working hard to ensure children and young people were seen as quickly as possible. However, 92% of children and young people were starting treatment within 18 weeks of referral, although this was below the trust target of 95%.

- At community health services for adults, district nurse referral times for urgent cases had increased in Basildon and Brentwood and Thurrock. The trust was aware of this and had implemented strategies to address it.

- The Waltham Forest eating disorders service, part of community services for adults, met the national referral to treatment time target of 100% for urgent cases.

- At the last inspection, we found that at community health services for children, young people and families, within paediatric services, waiting times were being breached. During this inspection, we saw that whilst waiting times had improved, these still did not meet national targets of 18 weeks. The services had increased staffing establishments for occupational therapy, speech and language therapy and dietetics, but were finding it challenging to recruit to these posts.

- The teams could see urgent referrals quickly and most non-urgent referrals within an acceptable time.

- Support was available seven days a week from end of life services. Urgent referrals were often seen the same day.

- At community health services for adults, rapid response assessment teams in London saw 96% of urgent referrals within two hours. In Essex, response times had increased significantly over the previous 12 months.

- Skilled staff were able to assess patients rapidly.

- At specialist community mental health services for children and young people, referrals were screened daily and young people could gain quick access into the service with urgent referrals being seen within 14 days. Children and young people could be easily referred to specialist crisis services that supported patients at home and operated out of hours.

- At child and adolescent mental health wards, the young persons' home treatment team ensured that referrals were triaged and in an emergency, patients could be seen the same day.

- Teams responded promptly and adequately when patients telephoned the service.

Are services responsive to people's needs?

- At community health services for children, young people and families, health visiting and school nursing teams operated a duty system to enable a timely response to patients needing support and advice.

- Patients who received care at home from district nurses from community health services for adults, told us the service was easy to access and that they received prompt responses to out of hours telephone calls.

- Staff cancelled appointments only when necessary and when they did, they explained why.

- Appointments usually ran on time and staff informed patients when they did not.

- At some community health services for adults' teams, staff used text messages to remind patients of their appointments.

- The teams tried to make follow-up contact with people who did not attend appointments.

- Staff supported patients during referrals and transfers.

- At the last inspection, at community services for children, young people and families, we found inconsistent transition arrangements from paediatric to adult services. During this inspection we found improvements. The trust had implemented a transition policy and appointed a transition lead. However, not all services had transition arrangements in place because of local commissioning arrangements.

Bed management

- Bed occupancy across all acute wards for adults of working age and psychiatric intensive care units was high. In July 2017 all wards had occupancy levels including patients on leave, exceeding 100%, ranging from 107% for Ogura to 122% for Kahlo ward. Using a mean average, occupancy levels excluding patients on leave were 97%. Average occupancy at psychiatric intensive care units was lower, at 91% for July 2017.

- At acute wards for adults of working age and psychiatric intensive care units, robust processes were in place to manage beds. In addition to regular bed management meetings, the trust had recently introduced twice daily patient flow meetings. Both these meetings identified

any potential or actual delayed discharges and developed strategies to address these. Patients placed out of area were reviewed at bed management meetings.

- At child and adolescent mental health wards, the average bed occupancy on the inpatient unit was 55% since reopening in September 2016. Patients were able to access the young persons' home treatment jointly commissioned and co-located at Brookside to prevent admission and support discharge.

- From June 2016 to June 2017, the average bed occupancy levels at wards for older people with mental health problems were Woodbury 84%, Stage 91%, and Cook 91%.

- There had been no out of area placements at wards for older people with mental health problems and child and adolescent mental health wards in the previous 12 months. At acute wards for adults of working age and psychiatric intensive care units, there had been eight out of area placements in the service within the last 12 months.

- Beds were available when needed for patients living in the catchment area.

- At wards for older people with mental health problems and child and adolescent mental health wards there was always a bed available when patients returned from leave. However, at acute wards for adults of working age and psychiatric intensive care units some patients did not have access to a bed on the ward when they unexpectedly returned from leave.

- At wards for older people with mental health problems and child and adolescent mental health wards, patients were not moved between wards during an admission episode unless it was justified on clinical grounds. However, at acute wards for adults of working age and psychiatric intensive care units there were three occasions between 1 January and 31 March 2017 where patients were subject to non-clinical moves between wards. Three patients were admitted to older people wards and transferred to an acute ward within 48 hours, when a bed became available.

- When patients were moved or discharged, this happened at an appropriate time of day.

Are services responsive to people's needs?

- A bed was always available in a psychiatric intensive care unit (PICU) if a patient required more intensive care. Male patients could be admitted to Titian PICU at the Goodmayes Hospital site. Female patients who required intensive nursing were referred to the independent health sector and an available bed was not always close to friends and family.

Discharge and transfers of care

- At wards for older people with mental health problems, between June 2016 and June 2017, there were 36 delayed discharges.

- At child and adolescent mental health wards, between June 2016 and June 2017, there were 22 delayed discharges.

- At acute wards for adults of working age and psychiatric intensive care units, between June 2016 and June 2017, the discharge of 43 patients was delayed for non-clinical reasons. Monet ward had the highest number of delayed discharges with 12, closely followed by Hepworth ward and Turner ward with 10 delays each.

- At all mental health inpatient wards, where patients discharge was currently delayed, staff had oversight of this and actions were in place to progress these. Delayed discharges occurred for a number of reasons, for example, waiting for housing in the community or delays in transfers to other services.

- Staff planned for patients' discharge, including good liaison with care co-ordinators. On most wards, discharge planning commenced at the point of admission. Professionals, including care co-ordinators and family members were invited to planning meetings.

- Staff supported patients during referrals and transfers between services, for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit.

The facilities promote recovery, comfort, dignity and confidentiality

- At wards for older people with mental health problems, environments were dementia friendly. On Cook ward there was an internal garden room which could be used by patients and carers for relaxation. The nurse

consultant and staff team won a national award for patient safety in the care of older people July 2016 for the development of this room and dementia friendly signage.

- On most wards patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. However, on wards for older people with mental health problems, some patients were accommodated in shared bedroom areas which compromised their privacy and dignity.

- Patients could personalise their bedrooms.

- At the April 2016 inspection we found that at wards for older people with mental health problems, bedrooms were not personalised. During this inspection we found this had improved.

- Patients had somewhere secure to store their possessions. At acute wards for adults of working age and psychiatric intensive care units, small personal items could be securely stored in a lockable safe in patient bedrooms. Larger personal items could be stored in a locked property room. A small number of patients who had not used these storage facilities reported that items of clothing had gone missing from their bedrooms.

- At the April 2016 inspection we found that at wards for older people with mental health problems, patients did not have an appropriate space to secure their belongings. During this inspection we saw that patients continued to have access to a key pad safe in their bedrooms. Patients could lock their room. However, because many of the patients on the wards had memory loss they often forgot to do so. We saw that staff were mindful of the need to secure patients personal possessions and discussed with patients and their families how their personal possessions could be kept as safe as possible whilst they were on the ward.

- Staff and patients had access to the full range of rooms and equipment to support treatment and care at most services.

- At community services for children, young people and families and at specialist community mental health

Are services responsive to people's needs?

services for children and adolescents, waiting rooms were child friendly. They were equipped with toys, books and other resources appropriate for different ages.

- At child and adolescent mental health wards, a family suite for relatives or carers who wished to stay overnight was available.

- At acute wards for adults of working age and psychiatric intensive care units, some wards were not therapeutic. Whilst access to activity rooms on Kahlo ward had improved since the previous inspection in April 2016, during this inspection we saw that the activity rooms on Monet and Kahlo wards were bare and contained a desk and a table with little evidence of activities.

- At specialist community mental health services for children and young people, some team sites children and young people's privacy and dignity were compromised as height and weight measurements were taken in a corridor.

- During the previous inspection in October 2016, we found that patients at child and adolescent mental health wards did not have facilities to hang their towels when using the bathroom. During this inspection, we saw that this had improved.

- There were quiet areas on most wards and a room where patients could meet visitors. However, at acute wards for adults of working age and psychiatric intensive care units, at Hepworth ward, there was no visitors' room on the ward. Visitors could meet with the patient in an interview room on the ward. Patients and carers told us that it was difficult to have visits in this room due to interruptions from staff and patients and the door not closing properly.

- Most patients could make a phone call in private, but at acute wards for adults of working age and psychiatric intensive care units, patients without access to a mobile phone were not able to make phone calls in private. This had not improved since the inspection in April 2016.

- Patients had access to outside space, but at acute wards for adults of working age and psychiatric intensive care units, at Turner and Hepworth wards the outside spaces were not therapeutic.

- The food was of a good quality on most wards.

- At a previous inspection in October 2016, we found that at child and adolescent mental health wards, some meal choices were not available in sufficient quantities. During this inspection this had improved, but patients said that the quality of food was poor. Managers and staff were working to improve the quality of meals.

- Patients could access hot drinks and snacks at all times.

Patients' engagement with the wider community

- Staff ensured that patients had access to education and work opportunities.

- At child and adolescent mental health wards, staff supported patients to attend school in the community.

- At specialist community mental health services for children and young people, we saw that children and young people were encouraged to engage with education. This was supported by the schools "in reach" programme.

- Staff supported patients to maintain contact with their families and carers. However, staff at end of life services in Waltham Forest needed to improve to ensure that patients received end of life care at their preferred place.

- Patients were encouraged to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

- Staff at community services for children, young people and families, sign posted patients and carers to relevant community support groups and other local resources.

Meeting the needs of all people who use the service

- Transgender young people were well supported and placed in areas of child and adolescent mental health wards that reflected their gender identity. Staff had accessed training and had worked with a young person to formulate a list of preferred pronouns. Staff had supported a patient to attend PRIDE and there was information on the ward for young people who were lesbian, gay, bisexual or transgender. The ward sought to promote positive images of women and their achievements and had celebrated international women's day in March 2017.

Are services responsive to people's needs?

- Work was in progress at end of life for a conference to showcase and share staffs expertise in providing pathways for minority groups. This included travelling communities, homeless people, LGBT people and people detained in secure units.

- Community health services for adults had a dedicated equality and diversity team that looked at how services could be adapted to meet specific patient needs. Teams had also developed the service to meet the needs of an aging patient group living with HIV.

- The service made adjustments for disabled patients. Inpatient wards had rooms that had been adapted to meet the needs of disabled patients.

- Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain.

- When child and adolescent mental health wards were inspected in October 2016, we found that there was also a lack of information relevant to young people on display on the ward. During this inspection this had improved. For example, there was information specifically aimed at young people regarding mental health.

- Information was also available in accessible formats, such as easy read.

- Staff made information leaflets available in languages spoken by patients.

- At the previous inspection in October 2016, we found that information in other languages was not displayed at child and adolescent mental health wards. During this inspection, we saw that for patients and their carers whose first language was not English, staff provided information in different accessible formats.

- Staff and patients had easy access to interpreters and these could be organised quickly. The trust's partner interpreting service provided translation for 36 different languages. Staff and patients reported good links to interpreter services. The trust was in the process of rolling out devices to some community teams so they could access mobile online translation services.

- At the previous inspection in April 2016, at acute wards for adults of working age and psychiatric intensive care units, patients on Ogura ward and Monet ward told us they experienced difficulties accessing an interpreter. During this inspection we found that this had improved.

- Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. A choice of foods to meet patients' cultural or spiritual needs was available on all inpatient wards, which included halal and kosher foods.

- Staff ensured that patients had access to appropriate spiritual support.

- Staff at end of life services ensured that the wishes, choices and beliefs of patients were incorporated into care plans.

Listening to and learning from concerns and complaints

- We checked eight randomly selected complaints. For all of the complaints staff had contacted the complainant and advised them how the complaint would be investigated and how long this would take.

- Where investigations took longer than expected, staff kept the complainant updated. Complaints were dealt with through an easy to understand process. Complaints were assessed and rated for risk. Five complaints included documentation showing a thorough investigation and clear feedback to the complainant on the outcome of their complaint and actions taken. Two complaints were annotated 'dealt with informally' and no investigation details, outcomes or actions were held centrally.One was closed as the complainant did not engage with the investigator.

- Where complaints had been managed centrally, copies of outcome letters that had been sent were available. Where complaint investigations identified learning, this was shared at team meetings and directorate level performance quality and safety groups.

- Most patients knew how to complain or raise concerns. At community health services for adults, patients we spoke with did not know how to make a complaint, but all said that they felt confident to raise any concerns they had about the service.

Are services responsive to people's needs?

- Staff knew how to handle complaints appropriately, and patients who raised concerns were protected from discrimination and harassment.

- At community health services for children, young people and families, complaint investigation records did not always includes information about risk and lessons learnt.

Are services well-led?

Good ●

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

Summary of findings

Please see overall summary

Our findings

Leadership

- The trust board had no vacant posts. It consisted of the chair, chief executive, six non-executive directors and five executive directors. One non-executive director was reaching the end of their term in December 2017. The chair was working to recruit a replacement with strong financial experience and extending the tenure of the current director until a replacement was found. The chair was also keen to promote succession planning through the role of associate non-executive directors and was meeting some potential candidates.

- The chair had been a non-executive director for the trust since 2013 and the chair for the last year. Just prior to the well-led review the chair had also been appointed as the chair for the local acute trust Barking, Havering and Redbridge University Hospitals. This will promote opportunities for collaborative working. Potential conflicts of interest had been considered and where needed the vice chair would lead board discussions.

- The non-executive directors had the appropriate range of skills, knowledge and experience. They all had experience as senior leaders in a range of organisations and brought skills such as finance, strategic development, IT, working in partnership and transforming services. There had been careful consideration to ensure the right skills were in place to support the ongoing work of the trust. During the previous year, there had been three new non-executive directors. One had brought experience of working in the healthcare sector and another had been a borough commander in the police. Their appointment had also responded to the need to improve the diversity of the board.

- The non-executive directors were supported with their learning and development. Three of the non-executive directors who had joined in the previous year had completed an induction process. They felt this had given them a good understanding of the work of the trust. In addition each person had an annual appraisal, there were board development days and board workshops also attended by integrated care directors to allow topics to be explored in greater detail. Examples of topics discussed at board workshops included recruitment, fire safety and quality improvement.

- Appropriate checks had taken place of board members. A random selection of trust board member fit and proper person checks were reviewed. This showed that all the necessary checks had been completed including disclosure barring checks which was appropriate for people meeting patients and having access to confidential information.

- The senior leadership team had been very stable and had a good knowledge of the trust. They consisted of an executive director of finance and commercial development, executive medical director, executive director of nursing and integrated care, executive director of integrated care and executive director of workforce and organisational development. All of the leadership team had been in post at the previous inspection two years previously.

- The trust was continuing to grow and there were concerns about the capacity of the senior leadership team. The chief executive acknowledged that the delegation of responsibilities had evolved as the trust developed and a review of the roles and responsibilities of the executive team had not systematically taken place. This particularly related to the executive director of nursing portfolio. The post-holder provided nurse leadership across the trust, had chief operating office responsibilities across two of the seven integrated care directorates, was providing the executive leadership for the newly acquired CAMHS teams in Kent and was about to start working one day a week for another provider to support them in a director of nursing role. Whilst the

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executive director of nursing was supported by four directors of nursing and integrated care directors in each of the divisions, this was a particularly extensive remit. The potential conflict from the role with another provider had been recognised and conditions were being put into place.

- The trust had an experienced team of integrated care directors. The trust covered a very wide geographical area across four London boroughs, Essex and more recently for CAMHS services across Kent and Medway. The trust services fell into seven integrated care divisions. Six of these related to geographical areas and the final one provided the leadership for most of the mental health services. Each was led by an integrated care director who was supported by associate medical directors and deputy or assistant directors dependent on the services in that division. Directors of nursing were also aligned to the divisions.

- The trust board also carried out a programme of board visits, however there was scope for these to be co-ordinated better and for feedback systems to be embedded. For non-executive directors, they were all carrying out visits, although the numbers of visits and destinations were not sufficiently co-ordinated to ensure that different types of services across the wide geographical area were reached. Non-executive directors described undertaking and writing up these visits using a range of tools including the new internal inspection methodology. They also said they would feedback urgent concerns and raise any issues at relevant points in the board meeting as needed. It was however, evident that the non-executive directors were approaching this work slightly differently and there was scope to review this to ensure these visits were taking place as effectively as possible. For executive directors, planned visits took place once a month to a range of services in a geographical area. Most staff commented on the approachability of senior leaders in the trust, although a few said they were not visited regularly.

- Non-executive directors had portfolio areas, although these were at varying levels of development and needed to be promoted further. For example, one of the recently appointed non-executive directors was taking the lead on end of life care, children's services and mortality review work. Governors and some staff throughout the trust were not yet sighted on these portfolio roles.

- Leadership development opportunities were available for staff at different levels of the organisation linked to their appraisals and personal development plans. This included training for first line managers, middle managers and senior leadership development. Much of the leadership development for first line managers was provided internally. There was also access to some external leadership development opportunities. Managers throughout the organisation were positive about their access to these leadership development opportunities. They also welcomed the leadership development opportunities linked to the quality improvement work.

- In terms of succession planning, the chief executive felt confident that there were talented staff across the organisation who could be potential senior leaders in the future. Staff were encouraged to take opportunities to support future promotion, such as applying for acting up roles to extend their skills, secondments, shadowing and mentoring. For staff wanting to be promoted, there was access to a 'talent pod' which offered additional training opportunities.

Vision and strategy

- The trust had developed a clear vision and set of values. The vision of the trust was to deliver 'the best care by the best people'.

- The five core values of 'people first, prioritising quality, being progressive, innovative and continually improving, professional and honest and promoting what is possible' were recognised by staff and embedded in trust literature. At the new trust head-quarters they were clearly displayed in the main reception area.

- The trust did not have a formally developed strategy to guide its organisational development in the short and longer term to provide good quality and sustainable care. The leadership team described how sitting beneath the trust vision and values were a number of key strategies. These included strategies for the workforce, estates, IT and a clinical strategy. When asked about the trust strategy, senior leaders gave a variety of responses. This meant that while they were broadly sighted on the priorities facing the organisation and how some of these were being addressed, they could not connect these to a longer term strategy linked to

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wider external developments. The trust had previously heard through external consultants who had reviewed their trust leadership and governance arrangements that this was an area for improvement.

- Whilst the trust consulted with staff, patients, carers and external providers, there was scope for this to take place more extensively. For example the recently developed clinical strategy, approved by the board in July 2017, had been designed to stimulate innovation by providing the opportunities to review care pathways at a local level. Each locality was now looking at how this could be implemented in their area. Whilst this strategy offered many positive opportunities for development, it had been developed with very limited contributions from staff, patients and carers. Only around 200 staff had taken part in workshops in four localities and consultation had taken place with the governors and through the trust patient experience forum. This was a low level of engagement for such a significant strategy in a trust of this size. Other examples of consultation and engagement tended to be related to specific pieces of work. For example there was consultation about how the trust should implement the 'smoke free' policy and patients also helped with evaluating the process.

- The trust was actively involved in three sustainability and transformation plans in North-East London, Essex and Kent, with staff attending a range of meetings and contributing information as needed. This was leading to a number of initiatives to develop sustainable care. For example Barnet, Enfield and Haringey were continuing to commission the procurement services provided by North East London Foundation Trust.

Culture

- The overall culture of the trust was patient centred. Staff were highly motivated by wanting to provide the best possible care for patients. Staff said they felt proud to work for their team and were able to articulate the contribution made by themselves and their service.

- 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 and team.

- In the NHS Staff Survey 2016 the trust had a very low response rate of 38%. Staff had raised doubts about the confidentiality of their completed surveys and how long

this took. The trust senior executives found this did not reflect the positive feedback they received from meeting staff across the trust. The trust response to the staff survey was to work to improve the response rate. Other developments included reviewing appraisal and feedback mechanisms to ensure they are completed to a high standard and recognise good performance; promote the communication skills of managers especially when undertaking supervisions; prioritise the response to when staff are experiencing stress at work; improve the reporting of bullying and harassment. In addition localities had local initiatives. The trust was also concerned about the results of the staff friends and family test. This indicated that only around 50% staff who completed the survey would recommend the trust as a place to work or feel safe reporting incidents.

- The trust had a very strong track record in terms of its equality and diversity achievements. The trust had an equality and diversity strategic group monitoring the progress of the equality and diversity action plan. This covered the requirements of the workforce race equality standards (WRES), accessible information standards, disability confident champion and planned to engage more with Stonewall, including its LGBT workplace equality index. Equality and diversity groups met in London and Essex to implement actions locally and each of the integrated care directorates had an ethnic minority ambassador. Three networks were in place: for ethnic minority staff, disabled staff and LGBT staff. Each one was championed by a member of the executive team. There were strong links with a wide range of third sector organisations and charities. The trust had won a number of national awards for its equality and diversity work.

- The trust was very positive about their workforce race equality standard results from 2016 whilst recognising there was more to do. In the previous year ethnic minority staff appointed to band 8 and 9 positions had risen from 25% to 36%. Although the responses from BME staff were significantly worse than white staff to the NHS staff survey questions on the experience of discrimination and on experiencing bullying and harassment from other staff, there had been a decrease in ethnic minority staff experiencing harassment and bullying from other staff from 36% in 2015 to 30% in 2016.There were also significant differences in the responses between staff groups in relation to believing

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that the organisation provided equal opportunities for career progression or promotion (74% of BME staff believed this compared with 87% of white staff) although this had slightly improved for BME staff from the previous year. Two new non-executive directors on the board were from a BME background. Examples of other support to ethnic minority staff included the implementation of reverse mentoring, coaching programme for bands 5, 6 and 7 staff and expanding the representation of ethnic minority staff in interview panels.

- The trust provided a range of opportunities for staff to raise concerns. Most staff said that they felt able to raise concerns with their line manager without fear of retribution. Staff also knew about whistle-blowing and had access to a whistle-blowing email.

- There had been slow progress with the development of the Freedom to Speak up Guardian (FSUG). At the time of the review two people had taken on the role of the FSUG but had not been given time to carry this out. It had been recognised that the role did require dedicated time and so a part-time post had been advertised. The inspection of services found that staff had limited awareness of the FSUG.

- The average staff sickness rate had reduced from 4.38% in March to 3.56% in July 2017.

- 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 had access to an occupational health service which provided counselling services and access to assistance with physical health needs such as physiotherapy. The trust was finding it challenging to meet its target for staff having the flu vaccine.

- The trust recognised staff success. There was a 'make a difference' staff award scheme. Most staff said that they did feel the trust valued staff.

- We looked at five serious incidents to see how the trust applied 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. They had also been asked to give their views on the incident and to contribute to the terms of reference for the enquiry.

Governance

- The trust had governance structures in place although work was taking place to strengthen some of the processes. For example at the time of the inspection the board assurance framework was being reviewed and updated. This meant it was not possible to see if this reflected the challenges being faced by the trust and whether the actions being taken to mitigate the challenges were robust. The board assurance framework was discussed in part 2 of the board meeting and the reasons given were that it could include commercially sensitive material. However, it also meant that significant concerns might not be made available to the public.

- The trust board had three sub-committees which were audit, remuneration and quality and safety. They each had a clear remit and non-executive directors chaired the board sub-committees.

- There was a framework in place including meetings with set agendas to ensure all the necessary topics were discussed at different levels of the organisation. Each of the integrated care directorates had their own quality safety group and these were replicated below this level so that wards and teams could attend. The meetings followed a rolling programme of agenda items covering quality, performance, strategy and corporate issues. This was welcomed as previously staff felt there had been too much focus on performance. These meetings made good use of data available through live dashboards. This enabled inaccurate data to be identified and addressed immediately. Managers used these meetings to discuss learning from incidents and complaints in their directorate and the action that was needed.

- Exceptions from the integrated care directorate quality safety groups were escalated to a trust wide quality safety leadership team. This quantitative and qualitative data was discussed and exceptions escalated to the quality report for the quality and safety sub-committee of the board and then through to the board.

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At the time of the review the quality report and quality dashboard had been reviewed and a new format presented at a couple of board meetings. Positively the dashboard information was displayed in a more accessible format and showed trends. However, whilst the trends were described the report did not explain how areas for improvement were being addressed and some areas of the quality dashboard were still in development. It was also noted that the trust wide quality and safety leadership team was chaired by the executive director of nursing, who was also the chief operating officer for two of the integrated care directorates. This meant that the executive director of nursing was leading the assurance process for services that they were operationally responsible for and deciding which exceptions should be escalated to the quality and safety committee.

Six of the integrated care directorates were linked to geographical areas. This helped to facilitate joint working with clinical commissioning groups and local authorities. There were a number of examples of how the trust was working closely with primary care, local authorities, acute trusts and the third sector to promote good patient care.

At a ward and team level front line managers were also clear about their responsibilities and felt they were given sufficient autonomy and also support to perform their roles. There was good access to relevant data and use of dashboards to inform decision making.

The trust had structures and procedures for monitoring the implementation of the Mental Health Act. All but one of the trust's inpatient wards was located at the Goodmayes site, enabling a centralisation of Mental Health Act administration at this location. One of the directors of nursing was the executive lead for mental health law and oversaw the work of the Mental Health Act team. They reported to the executive director of nursing. The mental health law manager provided quarterly and annual reports and presented them to the acute and rehabilitation directorate leadership team and to the directorate performance, quality and safety groups. They provided assurance that the use of the Mental Health Act was monitored and reported annually to the trust board. This annual report was of a high quality. Whilst it was recognised that mental health

services are only part of the trusts service provision it was noted that this essential role was only reviewed by a trust sub-committee if concerns were escalated as an exception and only reviewed once a year by the board.

Management of risk, issues and performance

Further work was needed to ensure there were clear arrangements in place for identifying and managing risk. Staff had access to a risk register at a team and directorate level and were able to add and escalate concerns. The risk register was reviewed at the quality and safety meeting. Whilst the summary paper said that recruitment and retention was the main risk it did not clearly identify other key risks or describe how these were being managed. Senior leaders when asked about the main risks for the trust all identified staffing challenges, but beyond that listed a range of other potential areas. The format of the board assurance framework was being amended and so it was not yet possible to see this linking up with the risk register.

Areas of potential risk were discussed in board workshops, such as recruitment and retention of staff. This was positive as it enabled topics to be explored in greater depth. The challenge was that the outcomes were not recorded or always reported back to formal board meetings which meant there was not always a clear audit trail for decision making. In addition some complex topics were only given a short time, usually five or 10 minutes, for discussion at the formal board meeting.

It was reported that some regular executive director to non-executive director meetings, also outside the formal meeting structure, provided some risk assurance. Again, the outcomes were not recorded or always reported back to formal board meetings which meant there was not always a clear audit trail for decision making.

The trust recognised the importance of having a strong programme of quality assurance. There were 77 clinical audits taking place in the current financial year. This included 31 national and other 'must do' audits. There were an additional 46 audits reflecting trust priorities. The summary of results and associated actions were reported quarterly to the quality safety committee.

The trust performance report was being reviewed at the time of the inspection. Previous reports had shown the

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trust was meeting most targets and where needed actions were identified. It was not possible to tell if the revamped performance dashboard would cover hidden waiting lists, such as waits for psychological therapies once initial assessments and treatment had been delivered.

- The trust had introduced a system of mock inspections as a way of being assured about the performance of services. The feedback was used to improve services. Additionally if staff vacancies in a service were above 30% this triggered an inspection by a director of nursing to assess the safety of the service.

- The trust also carried out some intensive reviews. Examples of this included looking at unexpected suicides, or where there had been clusters of serious incidents.

- The emergency planning & business continuity plan was reviewed on an annual basis by the board. In the latest plan for 2016/17 the trust was compliant with 54 out of the 55 indicators across core standards. The trust recognised changing treats and hazards, for example the rise in threats from terrorism and was continuing to work to improve the trusts resilience in partnership with other stakeholders.

- At the time of the inspection the trust was anticipated to achieve a surplus at in 2017-18. However, this was dependent on achieving cost improvements of just over £19 million. At the time of the inspection 36% of these cost improvements were identified as being at risk of not being achieved, which was similar to the previous year's under-achievement of cost improvements. These cost improvements plans were developed and reviewed at a directorate level and also approved by the executive nursing and medical directors to ensure they did not compromise patient care.

Information management

- Use of technology was a strength for the trust. They had made significant progress in supporting their workforce to have access to mobile technology. This enabled them to access and complete patient records whilst working away from an office. It meant staff could work in a more agile manner which was important for many of the services provided by the trust.

- Like all trusts, their staff needed to use a range of different IT systems. They had developed a platform to support staff to access these systems. They recognised that staff had varying levels of proficiency and many needed further support to feel confident in using these systems.

- The IT systems were able to generate live data which supported the ongoing monitoring of the trusts performance. This enabled staff at different levels of the organisation to generate live dashboards. It also helped to identify when data was incorrect so it could be addressed immediately. The non-executive directors felt confident about the quality of the data at a board level. They said it was reliable, accurate and timely.

- The trust had developed technology to directly support patients to manage their own care. At the time of the inspection the trust won the Nursing Times technology and data in nursing award. This was for the My Mind App co-produced with young people to help them support themselves with their mental health.

- The trust also used technology to promote communication. For example since the trust moved to their new headquarters they were able to live stream the board meetings. After the board meeting the chair and chief executive would send out a recorded message to staff sharing what areas had been discussed.

- The trust was taking cyber security very seriously. They had a dedicated cyber security compliance manager in place and were working to ensure all their IT systems were sufficiently protected. The trust was not affected by the virus outbreak in May 2017.

Engagement

- The trust had examples of positive engagement with patients, carers and staff although this could be developed further especially in terms of peer workers and volunteers.

- The trust board always included hearing from a patient, carer or staff about their experience.

- The trust had a strategic patient experience partnership which held regular meetings. There are also meetings in each locality chaired by patients and carers. A patient and carer experience strategy had been approved by the executive management team in 2016. There was a centralised patient experience department overseen by

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a director of nursing. An annual update on patient and carer engagement was provided for the board. Around 112 people were registered for involvement activities with the trust and were paid for their input. The total numbers of hours of involvement equated to just over a full time post. Examples of the involvement activities were helping with interviews, staff training, PLACE assessments, attending participation meetings and other events.

- A number of initiatives took place across the services where patients and carers were engaged. Good examples of this were the involvement of young people in the CAMHS teams to help produce a website and app for the service.

- At the time of the inspection there were very few peer workers and they only worked where the 'open dialogue' model of care was being delivered. The trust was also starting to encourage the use of volunteers with a non-executive director championing this work.

- The trust was working to implement the accessible information standard which came into force in July 2016. There was a steering group overseeing its implementation across a range of trust communication and information systems.

- Governors felt their engagement with the trust could be improved. The council of governors was made up of 22 public, staff and appointed governors and there were three formal meetings a year. In between there were monthly meetings providing information and also they could meet with the chair individually which they found very helpful. The trust was providing an externally facilitated development programme for the governors and the first session had taken place. The trust had 10,000 public members. The governors said that the meetings were supporting them to feel better informed although they would have liked more involvement in deciding the agenda. The governors were also encouraged to attend and ask questions at the board meeting. They recognised that their role was to hold the non-executive directors to account but said they did not get many opportunities to meet with them, although the chair was very accessible. They reflected that usually only one non-executive director in addition to the chair would attend the formal council of governors meetings. They spent more time with the executive directors.

- Patient and carer feedback was gathered using the friends and family test. They trust was also collecting 5X5 survey data. This method involved a senior member of staff from each team contacting five randomly selected patients or carers and asking them five questions about their experience of care. This yielded at least 1000 responses a month. The learning from this feedback was shared at each level of the trust including feedback to the board with actions to address areas for improvement. The trust also promoted on their website the opportunity for people to raise concerns or leave suggestions using a 'you said; we did' email address.

- The trust used complaints to identify themes and areas for improvement. In 2016-17 the trust received 316 complaints and 84% of these were responded to within timescale. Ten complaints were randomly checked as part of the inspection. This found that the final responses were comprehensive and written in an appropriate manner.

- The trust worked hard to engage effectively with staff. Staff described how they accessed the trust intranet and how good use was made of social media to communicate with staff. In addition there was the trust newsletter. The chief executive attended all the inductions to welcome new staff. He also had breakfast meetings across the different localities that staff were invited to attend. Visits took place to services by members of the senior leadership team. Staff also said how much they appreciated social events. It was apparent though that staff generally felt more engaged with their locality or service rather than with the trust as a whole.

- The trust had arrangements in place to work with staff including a joint staff committee with trade unions. Senior executive staff described the positive joint working.

- External stakeholders fed back about the trusts engagement and said that whilst communication with the trust had become more open, they would like to see this developed further.

Learning, continuous improvement and innovation

- In 2016 the trust joined the UK Improvement Alliance. They were using Institute for Healthcare Improvement methodology and had set up a quality improvement programme. The trust had a quality improvement

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steering group. A central team of seven staff were in post to focus on quality improvement. Four levels of training were provided for staff across all grades and around 450 people had attended the initial taster session. At the time of the inspection there were 90 projects actively happening across the trust. In some areas, there was a focus on specific topics. For example, in the mental health services there were projects looking to improve the quality of care planning and assessing patient risks. Staff were very enthusiastic about the quality improvement work. It was recognised that there was scope to improve the shared learning across the projects.

- The trust was widely recognised for some of its innovative work. For example, the trust was leading on a national multi-centre open dialogue pilot. This aimed to transform the model of care to patients with major mental health problems. It involved working with the whole family of patient network rather than just the individual. Another example was PUSH which stood for 'pressure ulcers should be history' which was an educational programme.

- To stimulate innovation, the trust had a fund and staff could pitch ideas to obtain funding for projects to improve services.

- The trust had won a number of awards. In July 2017 the trust won the patient safety in the community award (national patient safety awards) for the development of a training package to help staff in care homes recognise when a resident was deteriorating. In April 2017 the trusts medical education department won four awards at the UCL Partners post-graduate medical education awards.

- The trust participated in clinical research studies. The trust was an implementer site for dementia research and patients could sign up to volunteer for research studies. The trust hosted more than 60 research studies and over the previous year had produced several international publications in peer reviewed journals and presented at international conferences. The trust was part of UCL Partners who supported work to translate research into practice.

- The trust had a number of accredited services. This included seven services accredited with the Royal College of Psychiatrists' centre for quality improvement. These were three memory services, one ECT service, one CAMHS inpatient service, one forensic service and one psychiatric liaison service. Also the Thurrock health visiting team were accredited for the full 'baby friendly initiative'.

- The medical director was the trust lead on learning from deaths and there was also a non-executive director lead. The trust had a weekly incident review group with representatives from teams covering patient risk, health and safety, safeguarding and infection control. This identified any unexpected deaths. These went to a separate weekly group chaired by the executive director of nursing and attended by the directors of nursing and head of allied health professionals. They would ask for additional information where needed and using a framework decide on the level of the investigation. In addition to investigations into individual unexpected deaths, themed reviews also took place for example to review clusters of deaths. The trust had a central investigation team and they would liaise with relatives to determine the terms of reference for the investigation. The trust mortality review group was chaired by the medical director and looked at the data and themes from the reviews of unexpected deaths and reported these to the quality and safety committee. The trust recognised its responsibilities to investigate and report on the deaths of patients with a learning disability. A mortality assurance framework was also in place to monitor the trusts progress with meeting the recommendations as set out in the Mazars independent review.

- The trust provided opportunities for learning from serious incidents including deaths. There had been two learning events in the last year that had been well attended.

- Opportunities were available for shared learning. There were a number of cross directorate meetings to support this. Examples included meetings for the associate medical directors, district nurse forum and an associate director forum.

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Acute wards for adults of working age and psychiatric intensive care units (PICU)** • The provider had not done all that was practicably possible to mitigate the risk of safe care and treatment following the administration of rapid tranquillisation**.** • Staff did not consistently record or monitor patient's vital signs after the administration of rapid tranquilisation. • Some patients returning from leave did not have a bed on their return to the ward. • Some patients on acute wards experienced moves between wards for non-clinical reasons. **Specialist community mental health services for children and young people** • The trust did not ensure that staff had a call system or alarms in place that would enable them to call for assistance in an emergency. **This was a breach of Regulation 12 (1)(2)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Good governance**

Treatment of disease, disorder or injury

Trust wide

- The trust did not have a strategy, which had been produced in consultation with patients, carers and other stakeholders, to guide its organisational development in the short and longer term to achieve its priorities and develop good quality sustainable care.

Acute wards for adults of working age and psychiatric intensive care units (PICU)

- The provider did not ensure systems to assess, monitor and improve the quality and safety of services, mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.
- The provider did not ensure governance processes and systems were applied consistently across all wards to monitor safety and performance.

This was a breach of regulation 17 (1)(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Community health services for adults** - Staff were not consistently or regularly given clinical supervision or appraisals. **This was a breach of regulation 18(2)(a)**

Action we have told the provider to take

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