North East London NHS Foundation Trust

Inspection report

Trust Head Office, CEME, West Wing
Marsh Way
Rainham
Essex
RM13 8GQ
Tel: 08446001200
www.nelft.nhs.uk

Date of inspection visit: 14 May to 26 June 2019
Date of publication: 06/09/2019

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

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

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

North East London NHS Foundation Trust became a foundation trust in 2008. With an annual budget of £338 million in 2018/19, the trust employs around 6,000 staff. Sixty percent of the workforce identify themselves as white, whilst just under 40% identify as BME.

The trust provides combined mental health and community health services, with community health services constituting approximately 70% of the work of the trust. The trust serves a diverse population of 4.3 million and in the 12 months to 31 October 2018, had contact with approximately 65,000 service users.

The service provides the following core services:

Mental health core-services:

- Acute wards for adults of working age and psychiatric intensive care units (PICUs)
- Child and adolescent mental health wards
- Forensic inpatient/secure wards (low secure)
- 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

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

PMS core services:

- Urgent Care

The trust operates from 11 registered locations including seven hospitals.

- Foxglove Ward
- Woodbury Unit
- Trust Head Office, CEME
- Waltham Forest Rehabilitation Services
- Phoenix House

Summary of findings

- Brentwood Community Hospital
- Thurrock Community Hospital
- Sunflowers Court
- Grays Court Community Hospital
- Brookside
- Meadow Court

Community health services (CHS) are provided over the county of Essex and the London boroughs of Redbridge, Waltham Forest, Barking and Dagenham and Havering and, from September 2018, Barnet. Adult mental health services and child and adolescent mental health services (CAMHS), both in the community and in hospital, are provided by the trust in Redbridge, Waltham Forest, Barking and Dagenham and Havering. Community CAMHS services are provided by the trust in Essex and Kent.

The trust provides inpatient CHS over five locations in Waltham Forest and Essex. Ten of its 12 mental health inpatient wards are based at the Sunflowers Court site at Goodmayes Hospital, with the exception of its CAMHS inpatient unit (Brookside) which is situated very close by and the Woodbury Unit, which is located in the London borough of Waltham Forest.

The trust provides urgent care services at three sites, these are urgent care at Whipps Cross Hospital, minor injuries at Orsett Hospital and a walk-in centre service at Barking Community Hospital.

The trust has been inspected four times since 2016.

We conducted a comprehensive inspection of the trust in April 2016. At that inspection we rated the trust as requires improvement overall. We rated it as requires improvement for four key questions (safe, effective, responsive and well led) and good for one key question (caring).

In October 2016, we inspected child and adolescent mental health wards. Following the inspection, the overall rating for child and adolescent mental health wards went up from inadequate to good.

In 2017, we inspected seven core services as part of our ongoing checks on the safety and quality of healthcare services:

- Specialist community health services for children and young people
- Wards for older people with mental health problems
- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health wards
- End of life care
- Community health services for adults
- Community health services for children and young people

At that inspection, our rating of the trust improved. We rated the trust as good overall. We rated one service we inspected as outstanding, five as good and one as requires improvement.

When these ratings were combined with the other existing ratings from previous inspections, one was rated requires improvement, 12 were rated good, one was rated outstanding and one had not been inspected.

Summary of findings

Overall summary

Our rating of this trust went down since our last inspection. We rated it as Requires improvement 

What this trust does

North East London NHS Foundation Trust provides a range of community health services, community mental health services for adults and children and inpatient mental health services for adults and children in four north east London boroughs.

It also provides community health services and community mental health services for adults and children and young people in Essex and community mental health services for children in Kent.

The trust provides urgent care services at three sites, these are urgent care at Whipps Cross Hospital, minor injuries at Orsett Hospital and a walk-in centre service at Barking Community Hospital.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected eight core services as part of our ongoing checks on the safety and quality of healthcare services:

- Acute wards for adults of working age and psychiatric intensive care units
- Community-based mental health services for adults of working age
- Forensic inpatient/secure wards (low secure)
- Wards for people with a learning disability or autism
- Mental health crisis and health-based places of safety
- Community-based mental health services for people with a learning disability or autism
- Specialist community mental health services for children and young people
- Urgent Care

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed 'Is this organisation well-led'.

Summary of findings

What we found

Overall trust

Our rating of the trust went down. We rated it as **requires improvement** because:

- We rated safe and well led as requires improvement. We rated effective, caring and responsive as good. In rating the trust we took account of the ratings of the seven services inspected previously.

The inspection of North East London NHS Foundation Trust was one of great contrast. On the one hand we inspected some outstanding services that were going the extra mile to meet the needs of every patient. On the other hand, we saw services where the care was unsafe. The services for adults who needed acute inpatient mental health treatment were under extreme pressure and this was impacting on the safety and quality of patient care. The trust recognised that they needed to open another acute adult inpatient mental health ward but could not recruit enough nursing staff to enable this to happen.

- The inspection found some unsafe practice for patients coming at night to Sunflowers Court, the main mental health inpatient base on the Goodmayes Hospital site. They were waiting for variable lengths of time, either for an assessment or admission by the acute crisis assessment team (ACAT) without clinical staff available to provide support and in an unsafe environment. The arrangements for the acute crisis assessment team to work with other professionals and teams in the trust was adversely affecting the responsiveness of the service to meet the needs of patients. Junior doctors and consultants told us of many occasions when they had encountered difficulties working with ACAT; whose role was to be the out of hours 'gate-keeper' for acute admissions. They described complex and lengthy escalation processes. They had examples of where delays resulted in potential harm to patients. They also described the impact of this process on their morale, often feeling a lack of respect or professionally under-mined. We took enforcement action to ensure improvements take place in a timely fashion.
- Staff engagement was mixed, and some staff described an unhealthy culture. Whilst the trust had achieved positive staff survey results and most staff we spoke to were very enthusiastic about working for the trust, there were still some pockets of unhappy staff who did not feel adequately engaged. The most significant examples were the junior doctors and some consultants working in the mental health services. They described how they had tried to escalate concerns but had not received a timely or adequate response. They explained how their professional views were not adequately respected and how when things went wrong there was a culture of blame rather than learning.
- The senior executive leadership team was not working together in a cohesive manner. This was having an impact on the safe delivery of services. For example, whilst an action plan was in place in response to the junior doctor concerns it required collaborative work across the leadership team to make the improvements. Whilst some work had taken place, other significant concerns relating to the admission process to the acute mental health inpatient beds and the broader culture of the inpatient services had not been resolved. Some members of the leadership team recognised the difficulties in working together and expressed a sense of frustration that this was hampering their ability to do their jobs well.
- The trust continued to have significant workforce challenges and did not have enough medical or other professional staff in some services to provide consistently safe and high-quality care. Whilst the trust was aware of these short-falls and was working to address them, this had not yet resulted in the necessary improvements. In Kent CAMHS the number of staff available, including bank and agency, was below the agreed establishment levels. Half of the medical posts in Kent were vacant. This was having an adverse impact on the trust's ability to deliver the service. In acute and PICU services, further work was needed to reduce the use of locum consultant psychiatrists and have more

permanent staff in post to improve clinical leadership and the provision of high-quality care and treatment. Early intervention team caseloads were above the numbers recommended by best practice guidance. This could prevent them from giving individual patients the time they needed. In some community mental health teams for adults, there was a high turnover and staff reported feeling 'burnt out'.

- The current governance processes may not provide adequate assurance for the board on workforce and finance. At present, safer staffing data was discussed at each board meeting and a six-monthly workforce report was presented to the Quality Safety Committee and then key points reported to the board. The trust was addressing many complex workforce issues, and this might not provide adequate opportunity for assurance to be gained. Whilst the trust had a positive track record of delivering its financial performance, there were some areas of potential risk identified in financial governance. The trust had a 'finance matters' meeting with the non-executive directors which was not a formal sub-committee of the board. There was a potential risk that financial performance might not receive adequate board oversight and that emerging risks and issues may not get escalated appropriately.

However:

- The trust had made progress with most of the areas identified at the last inspection. This included extensive consultation and the launch of the trust strategy which was now embedded into the ongoing work of the organisation. It was also good to note the progress with visits to services by non-executive directors including arrangements for sharing feedback; increasing the inclusion of governors to provide them with more opportunities to undertake their role; improving how the trust considers risk and strengthening the board assurance framework; and strengthening the arrangements for patient and carer engagement.
- The trust continued to progress its work on equalities, diversity and human rights championed by the current chief executive. This included the ongoing development of staff networks and work to improve the trust's performance in relation to the Workforce Race Equality Standard.
- The trust's use of technology to support mobile working was impressive, along with the increasing innovative use of digital technology to meet the needs of patients and staff.
- It was positive to see the extended reach of the trust's programme of quality improvement and the impact this was having on staff engagement in improving services.
- We were also really interested in the work of the trust in promoting partnership working to achieve greater integration to meet the needs of populations especially across North-East London. On a smaller scale we also heard about how specific services were working innovatively in partnership with other health and third sector providers to meet patient needs.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- At this inspection we rated safe as requires improvement in four of the eight core services. We rated safe as inadequate in one core service and good in the other three core services. When these ratings were combined with the other existing ratings from previous inspections, seven of the trust services were rated requires improvement, one as inadequate and seven were rated good.
- The trust was not always adequately managing risks to patients and staff. The arrangements in place for the acute crisis assessment team (ACAT) to assess and admit patients to an inpatient bed was unsafe. Patients attending out of hours at Sunflowers Court for assessment by the ACAT or waiting to be admitted to wards after their ACAT assessment, were not appropriately supervised. There was a risk that the patient could cause harm to themselves or others whilst unsupervised, particularly in secluded areas of the building.

Summary of findings

- The trust had not yet ensured that patients were kept safe following the use of rapid tranquilisation. In the previous calendar year rapid tranquilisation was used on 322 occasions. Staff did not always complete post-dose physical health monitoring after patients had received medication by rapid tranquilisation. This meant there was a risk of not identifying a deterioration in a patient's physical health. The same concern was identified at the previous inspection and whilst the trust had implemented systems to try and address this matter, they were not yet embedded.
- The trust had not ensured the wards provided a safe environment to care for patients. On the forensic wards, whilst a need for call alarms in patient bedrooms had been identified, no dates for these works had been set. Staff did not describe how they were managing this risk until the alarms were installed. This meant that patients might not be able to call for help in an emergency.
- The trust did not have enough medical or other professional staff in some services to provide consistently safe and high-quality care. Whilst the trust was aware of these short-falls and were working to address them this had not yet resulted in the necessary improvements. In Kent CAMHS the number of staff available including bank and agency, was below the agreed establishment levels. Half of the medical posts in Kent were vacant. This had an adverse impact on the trust's ability to deliver the service. In acute and psychiatric intensive care unit (PICU) services, further work was needed to reduce the use of locum consultant psychiatrists and have more permanent staff in post to improve clinical leadership and the provision of high-quality care and treatment. Early intervention team caseloads were above the numbers recommended by best practice guidance which could prevent them from giving individual patients the time they needed. In some community mental health teams for adults there was a high turnover and staff reported feeling 'burnt out'.
- The trust was working to reduce restrictive interventions on mental health inpatient wards but ward teams did not have access to data on their use of interventions, so they could monitor their progress.
- The recording of potential risks for patients was not always completed and stored in a robust manner. In acute and PICU services, although changes in patient risk were discussed and understood amongst staff, patient risk assessments were not always updated to reflect these changes on Ogura ward. In community mental health services for children and young people, improvements were needed in how staff assessed and managed risk in Waltham Forest. Thirty percent of the care and treatment records we looked at in this team did not include an assessment of risk or management plan. In community mental health adult teams, there were inconsistencies in where risks assessments were recorded in patients records. This meant that staff may not find this information in a timely manner.
- The trust had not ensured that the equipment used for emergency first aid was in good order. In Maidstone some of the emergency first aid equipment had not been checked including adrenaline and some dressings.
- Some improvements were needed to ensure medicines were safely prescribed, administered, recorded and stored. The room used to store medicines at Waltham Forest community recovery team experienced high temperatures which could impact the efficacy of medicines stored there. In the same team, allergy information was not always recorded on patients' medicines charts. In inpatient settings, some clinic room temperatures also exceeded the acceptable range on some occasions. The trust was in the process of considering how to address this problem when we inspected. At Barking Community Hospital, patient group directives for medicines were not regularly reviewed to ensure they were up to date. Staff did not always review the effects of medications on each patient's physical health. Staff in the Redbridge community recovery team did not have a process to identify and regularly review the effects of high dose anti-psychotic medications on each patient's physical health.
- Staff did not always manage risks to themselves. For example, staff in the Waltham Forest community recovery team did not follow trust protocols for lone working which could put them at risk.

However:

Summary of findings

- Inpatient wards and community bases were clean, well equipped, well furnished, well maintained and fit for purpose.
- The trust had systems in place to safeguard patients from abuse and the services worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The trust managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support. Incidents were investigated in a timely manner and the reports were completed to a high standard. Pressure ulcers were the most frequently reported incident and the trust had a range of measures in place to try to reduce their incidence. However, there was still scope to improve the learning from incidents, particularly across geographically spread teams providing similar services.

Are services effective?

Our rating of effective stayed the same. We rated it as good because:

- At this inspection we rated effective as good in all eight core services. When these ratings were combined with the other existing ratings from previous inspections, all of the trust services were rated good.
- Staff assessed the physical and mental health of patients on admission to a service. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were mostly personalised, holistic and recovery-oriented.
- The trust provided a range of care and treatment interventions suitable for the patient groups and mostly consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- 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. During the inspection we saw improvements being made in response to audit findings.
- The trust had systems in place to induct and deliver ongoing training to ensure staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. However, further work was needed to ensure consultants received an appropriate induction. Also, a business information system was being implemented to ensure that staff received regular supervision.
- The trust ensured that staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff explained patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Some mental health staff and teams within the trust were not working together effectively to meet the needs of the patients. An example of this was between medical staff in community mental health teams and liaison psychiatry and the acute crisis assessment team (ACAT) which operated as the out of hours gate-keeper for acute inpatient mental health beds. We heard about the frustrations of trying to work together, not feeling that professional skills were respected and of lengthy escalation processes.

Summary of findings

- In some teams there was not access to the range of specialists needed to meet the needs of the patients. In the three community mental health teams for adults with learning disabilities and autism, there were vacancies for speech and language and occupational therapists. Challenges in recruiting to the posts permanently and in the interim, meant there was a risk that individual teams may not always include, or have access to speech and language therapists or occupational therapists.
- In some adult community mental health teams there were long waits for specific types of individual psychological therapies. Patients were offered alternative services such as attending groups facilitated by psychologist's whilst waiting for the treatment.

Are services caring?

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

- At this inspection we rated caring as good in five core services. We rated caring as outstanding in three core services. When these ratings were combined with the other existing ratings from previous inspections, 11 of the trust services were rated good, and four were rated outstanding.
- In some services we received extremely positive feedback about the caring approach of the staff. On the forensic ward, learning disability ward and learning disability community services we heard how staff went the extra mile and the care and support exceeded expectations. Patients and those close to them were active partners in their care and staff were fully committed to this partnership approach.
- In these three services, patients' individual preferences and needs were always reflected in how care was delivered. There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.
- Across all services, staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Across most services, staff involved patients in planning their care and the development of their risk assessments and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates. However, in some areas patients and carers did not feel so well involved. For example, feedback from patients using acute and PICU mental health services about their involvement in their care was mixed. Some patients did not feel they were adequately involved in developing their care plans. Some acute and PICU patients also reported they did not know how to provide feedback about the service.
- The trust promoted the involvement of patients. They had a strategic patient experience partnership which held regular meetings. There were also meetings in each locality chaired by patients and carers. There was a centralised patient experience department promoting involvement across the trust. Examples of the involvement activities were helping with interviews, staff training, PLACE assessments, attending participation meetings and other events. Patients and carers were involved in many of the quality improvement projects.
- Staff informed and involved families and carers appropriately. They supported carers to complete a carers assessment. They provided opportunities for carers to become better informed or participate in the service such as through carers groups. There were some good examples of co-production work with carers.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

Summary of findings

- At this inspection we rated responsive as good in five of the eight core services. We rated is as requires improvement in one core service, inadequate in one core service and outstanding in one core service. When these ratings were combined with the other existing ratings from previous inspections, 11 of the trust services were rated as good and one as outstanding. One of the trust services was rated inadequate and two of the trust services were rated requires improvement.
- The design, layout, and furnishings of the wards and team bases supported patients' treatment, privacy and dignity. On inpatient wards each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. However, we did hear from some community team staff about the lack of space for them to work in the office.
- The food on inpatient wards was generally of a good quality and patients could make hot drinks and snacks at any time. However, patients on the learning disability ward said the food was unappetising but were working with the caterers to suggest improvements.
- The services met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy, cultural and spiritual support.
- The trust continued to manage responding to concerns and complaints well. They largely responded to complaints within the appropriate timescales. The responses were of a good standard. The trust used the themes from complaints to make improvements.
- Referral criteria for community mental health services for adults and children and young people did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly. Staff followed up patients who missed appointments.
- The service ensured that patients, who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the patient's care.
- There were some excellent examples of working with other providers or in an innovative manner to ensure people received the range of services needed to promote their recovery. For example, the forensic ward maintained excellent links with the community and engaged patients in a range of activities seven days a week. This included local college attendance, work experience on a farm and attending a 'coping through football programme' with the local professional football team. Since the last inspection the ward had developed one of its gardens to provide an innovative programme where patients looked after a range of small livestock, including chickens and rabbits.

However:

- The trust was not adequately monitoring the responsiveness of the health-based place of safety (HBPoS). For example, they did not collect the data to monitor the number of times when the HBPoS was full and patients needed to be taken to another trust. In addition, the trust did not routinely gather data to show the number of patients who had stayed in the HBPoS for more than 24 hours, or the reasons why.
- The community mental health services for children and young people in Kent still had some significant waiting lists. Across Kent, there were 4143 young people at the end of May 2019 who had been waiting over 16 weeks for treatment following referral. Of these, 3372 were waiting for treatment through the neuro-diverse pathway and 771 were waiting for treatment through the other pathways available. Some families in Kent, fed back that they had been frustrated by some of the waits and that they were not consistently given information about the length of time they would be waiting for services to start. The trust was working with local commissioners to continue to make improvements.

Are services well-led?

Summary of findings

Our rating for well led went down. We rated well led for the trust overall as requires improvement because:

- Staff engagement was mixed, and some staff described an unhealthy culture. Whilst the trust had achieved positive staff survey results and most staff we spoke to were very enthusiastic about working for the trust, there were still some pockets of unhappy staff who did not feel adequately engaged. The most significant examples were the junior doctors and some consultants working in the mental health services. They described how they had tried to escalate concerns but had not received a timely or adequate response. They explained how their professional views were not adequately respected and how when things went wrong there was a culture of blame rather than learning.
- The senior executive leadership team was not working together in a cohesive manner. Whilst some external support had been sought to promote an improved working relationship there was still more to do. This was having an impact on the safe delivery of services. For example, whilst an action plan was in place in response to the junior doctor concerns it required collaborative work across the leadership team to make the improvements. Whilst some work had taken place, other significant concerns relating to the admission process to the acute mental health inpatient beds and the broader culture of the inpatient services had not been resolved. Some members of the leadership team recognised the difficulties in working together and expressed a sense of frustration that this was hampering their ability to do their jobs well.
- Many staff described a trust where they believed decision making was 'nurse dominated'. The Chief Nurse Group caused the greatest confusion with people describing its role in a variety of ways. There was a lack of clarity in how this group related to the Communities of Practice. We had ongoing concerns about the split Chief Operating Officer role. These related to variations in how the role was carried out by the two post-holders; the impact of this arrangement in terms of staff perception of the unity of the trust and the potential for a lack of clarity in terms of decision making on operational issues.
- The current governance processes might not provide adequate assurance for the board on workforce and finance. At present, safer staffing data was discussed at each board meeting and a six-monthly workforce report was presented to the Quality Safety Committee and then key points reported to the board. The trust was addressing many complex workforce issues, and this might not provide adequate opportunity for assurance to be gained. Whilst the trust had a positive track record of delivering its financial performance, there were some areas of potential risk identified in financial governance. The trust had a 'finance matters' meeting with the non-executive directors which was not a formal sub-committee of the board. There was a potential risk that financial performance might not receive adequate board oversight and that emerging risks and issues may not get escalated appropriately.
- The trust did not have a separate financial strategy other than delivering the annual financial plan. There was a risk without an overarching financial strategy the trust did not have in place suitable arrangements to deliver a medium and long term, financial plan.
- Learning and development for team and ward managers did not equip them with the skills to effectively manage staff. Whilst managers were offered training, there had been around 60 contacts this year with the Freedom to Speak Up Guardian to raise concerns relating to the application of trust HR processes. The trust recognised that further leadership development was needed to put this into place. The trust also needs to further reduce the number of disciplinaries and make increased use of mediation. Grievance processes needed to be concluded in a timely manner.
- The effective use of feedback from the Freedom to Speak Up Guardian needed to be further improved. It was positive to see that a full-time post had been created and growing awareness of staff across the trust of the role. However, feedback tended to focus on numbers of contacts and themes rather than how the issues raised could be addressed. In addition, the feedback gathered had not always been used in a timely manner by the executive team to make improvements such as those raised by the junior doctors.

However:

Summary of findings

- The trust had made progress with most of the areas identified at the last inspection. This included extensive consultation and the launch of the trust strategy which was now embedded into the ongoing work of the organisation. It was also good to note the progress with visits to services by non-executive directors including arrangements for sharing feedback; increasing the inclusion of governors to provide them with more opportunities to undertake their role; improving how the trust considers risk and strengthening the board assurance framework; and strengthening the arrangements for patient and carer engagement.
- The trust continued to progress its work on equalities, diversity and human rights championed by the current chief executive. This included the ongoing development of staff networks and work to improve the trust's performance in relation to the WRES.
- The trust's use of technology to support mobile working was impressive, along with the increasing innovative use of digital technology to meet the needs of patients and staff.
- It was positive to see the extended reach of the trust's programme of quality improvement and the impact this was having on staff engagement in improving services.
- We were also really interested in the work of the trust in promoting partnership working to achieve greater integration to meet the needs of populations especially across North-East London. On a smaller scale we also heard about how specific services were working innovatively in partnership with other health and third sector providers to meet patient needs.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in four services we inspected:

- Forensic inpatient/secure wards (low secure)
- Wards for people with a learning disability or autism
- Community-based mental health services for people with a learning disability or autism
- Specialist community mental health services for children and young people

For more information see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including breaches of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that the trust must put right: Regulation 12 Safe care and treatment; Regulation 17 Good governance. There were 22 things the trust must put right in relation to breaches of these two regulations. In addition, we found 35 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information see the areas for improvement section of this report.

Summary of findings

Action we have taken

We issued requirement notices in respect of the two regulations that had been breached within five core services. We issued a warning notice in relation to one regulation that had been breached in one core service.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

Forensic inpatient/secure wards (low secure)

- Carers had coproduced with staff an information leaflet about psychosis.
- Innovative plans to develop and staff a professional kitchen were in hand and capital funding had been applied for.
- Since the last inspection the ward had developed one its gardens to provide an innovative programme where patients looked after a range of small livestock, including chickens and rabbits. This therapeutic activity supported patients' recovery.
- The ward continued to maintain excellent links with the community and engaged patients in a range of activities seven days a week. This included local college attendance, work experience on a farm and attending a 'coping through football programme' with the local professional football team.

Wards for people with a learning disability or autism

- The ward had a quality improvement project on daily activity planning with patients. The ward had a daily planning meeting with activities and the activities were patient led. This activity planning utilised various communication methods and was patient centred. This meant that patients had opportunities to participate in and make choices about the care they receive.
- Carers were actively participating and involved in the planning of care in ward rounds following the introduction of a quality improvement project. Carers were involved in improving their involvement in patient care and jointly reviewing the effectiveness of interventions.

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

- The Havering team had built robust relations with their internal and external stakeholders to ensure that proactive patient care was provided. Their commitment to enabling patients to access care and treatment in the community had prevented any mental health related hospital admissions for 18 months.
- Staff had a key focus on physical health for patients with learning disabilities. They worked with and provided training to local GPs, housing providers and care homes around physical health and had significantly improved their statistics around the uptake of annual physical health checks.
- The Waltham Forest team had introduced a phlebotomy clinic just for patients with learning disabilities. The Redbridge and Havering teams had introduced databases to monitor the annual health check completion for their patients.

Summary of findings

- The Havering team consultants had a meeting with neurologists on a quarterly basis to discuss cases in which patients presented with epilepsy and learning disabilities. This was done to gain expert perspective on the situation and to ensure that the patient's health was managed without deterioration in their mental or physical health.

Specialist community mental health services for children and young people

- The service had developed effective specialist crisis services for children and young people across the London boroughs, Kent and Essex. In Essex the service was rolling out a specialist intensive support pathway which was focussed on avoiding hospital admission and attendance at emergency departments. This was available to children and young people in Essex over 24 hours, seven days a week.
- The service was committed to agile working and had developed technology which ensured that members of staff were able to work 'on the move' and this ensured that staff worked more productively.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with legal requirements. These 18 actions relate to five core services. An additional four actions are trust wide.

Trust wide

- The trust must take steps to ensure the senior executive leadership team work together in a cohesive manner to ensure they work together to address issues that impact on the safety of patients and staff. **Regulation 17 Good governance (1)(2)(a)(b)(e)(f)**
- The trust must ensure that the culture of the trust is improved so that medical staff, particularly in the mental health services, can raise concerns without a blame culture and feel confident that staff will work together to make the necessary changes. **Regulation 17 Good governance (1)(2)(a)(b)(e)(f)**
- The trust must ensure that staff understand the decision processes within the trust especially the role of the Chief Nurse Group. They must also review the split chief operating officer role. **Regulation 17 Good governance (1)(2)(a)(b)(e)(f)**

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

- The trust must ensure post-dose physical health monitoring takes place after patients have received medication by rapid tranquilisation in line with the trust's rapid tranquilisation policy. **Regulation 12 Safe care and treatment (1)(2)(a)(b)**
- The trust must develop a governance system to effectively monitor the use of restrictive interventions across the wards. **Regulation 17 Good governance (1)(2) (a)(b)**
- The trust must work to address the concerns raised by junior doctors to ensure a good working relationship and safe care. **Regulation 17 Good governance (1)(2)(e)(f)**

Community-based mental health services for adults of working age

Summary of findings

- The trust must ensure that governance processes are strengthened to ensure consistency quality and safety across the geography. **Regulation 17 Good governance (1)(2)(a)(b)**
- The trust must ensure that staff are appropriately supported to raise concerns without fear of reprisal and that these concerns are listened to and acted upon. **Regulation 17 Good governance (1)(2)(a)(b)(e)(f)**
- The trust must ensure that systems and processes to safely store, prescribe, administer, transport and record medicines are consistent across teams. **Regulation 12 Safe care and treatment (1)(2)(g)**
- The trust must ensure that all staff understand and follow safe lone working practices, in line with trust policy. **Regulation 12 Safe care and treatment (1)(2)(a)(b)**

Forensic inpatient/secure wards (low secure)

- The trust must ensure that a completion date for planned works to install call alarms in patient bedrooms is fixed. In the meantime they must complete a risk assessment showing how they will manage the potential risks for patients until alarms are available. **Regulation 12 Safe care and treatment (1)(2)(d)**

Mental health crisis and health-based places of safety

- The trust must ensure that patients attending out of hours at Sunflowers Court for assessment by the acute crisis assessment team (ACAT), or waiting to be admitted to wards after their ACAT assessment, are appropriately supervised and cared for. A policy and procedure to govern this process must be developed. **Regulation 12 Safe care and treatment (1)(2)(a)(b)(c)(d)**
- The trust must ensure that effective arrangements are in place for the acute crisis assessment team to work with other professionals and teams, especially medical staff, to ensure patients receive comprehensive assessments and where clinically required an inpatient admission in a timely manner. **Regulation 12 Safe care and treatment (1)(2)(a)(b)(c)**
- The trust must ensure that leaders of all levels listen to feedback from staff and take appropriate action to address the safety, risk and multidisciplinary working issues in the acute crisis assessment team. **Regulation 17 Good governance (1)(2)(a)(b)(e)(f)**
- The provider must ensure that all staff complete mandatory training in the prevention and management of violence and aggression. **Regulation 12 Safe care and treatment (1)(2)(c)**

Specialist community mental health services for children and young people

- The provider must continue to work to ensure children and young people in Kent have access to treatment within 18 weeks of referral to the service. **Regulation 17 Good governance (1)(2)(a)(b)(e)(f)**
- The provider must ensure that the systems in place to identify and address changes in risk for young people waiting to be assessed or start treatment are robust, consistent and effective. **Regulation 12 safe care and treatment) (1)(2)(a)(b)**
- The provider must ensure that governance systems are strengthened to provide assurance that services are safe and effective; that learning from incidents is shared across the geography; that good practice is shared across the geography. The provider must also ensure that managers and leaders have access to accurate data to monitor their performance. **Regulation 17 good governance (1)(2)(a)(b)(e)(f)**
- The provider must ensure that work to improve the Kent single point of access continues. The provider must also ensure that all referrals in Kent are screened in a timely fashion and prioritised for follow up by the correct team. **Regulation 12 safe care and treatment (1)(2)(a)(b)(c)**

Summary of findings

- The provider must ensure that staff complete all mandatory training. **Regulation 12 Safe care and treatment (1)(2)(c)**

Community-based mental health services for older adults (from inspection in April 2016)

- The trust must ensure that the premises used by staff and patients are safe (fire escape was out of a window). **Regulation 12 (2)(d) Safe care and treatment**
- The trust must ensure safety alarms work and are present in interview rooms. **Regulation 12 Safe care and treatment (2) (d)**

Community health services for adults (from inspection in 2017)

- The trust must ensure staff are given regular supervision, including clinical supervision, and appraisal. **Regulation 18 (2)(a) Safe staffing**
- The trust must ensure agency staff, including agency nurses, have documented evidence of their clinical competencies. **Regulation 18 (2)(a) Safe staffing**

Community health inpatient services (from inspection in 2016)

- The trust must ensure that equipment at the Alistair Farquarson Centre is appropriately stored and therapy equipment properly maintained. **Regulation 15(1)(c)(e)(f) Premises and equipment**
- The trust must ensure that equipment such as blood pressure machines, beds and bed pan macerators are properly maintained. **Regulation 15(1)(c)(e)(f) Premises and equipment**
- 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. **Regulation 18(1) Safe staffing**

Action the trust SHOULD take to improve

We told the trust that it should take action to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement in future or to improve service quality. These are the 35 actions related to the whole trust and eight core services.

Trust wide

- The trust should review the governance processes to ensure workforce and finance are given enough access to the appropriate assurance.
- The trust should ensure that the feedback from the Freedom to Speak up Guardian receives sufficient consideration so that issues raised can be addressed in a timely manner.
- The trust should continue to review the leadership development for first time managers to ensure they are confidently and capably using the HR policies and procedures.
- The trust should continue to implement the business information system so that the completion of supervision and appraisals can be monitored.
- The trust should continue to review the board assurance framework to reduce the number of items and overlaps in the content.
- The trust should ensure that potential risks associated with lack of pharmacy support in community teams are reviewed and appropriate action taken.

Summary of findings

- The trust should ensure it has a financial strategy in place. This should link to the trust's strategic objectives and risk management arrangements. There was a risk that without an overarching financial strategy, the trust would not have in place suitable arrangements to deliver a medium and long-term financial plan.

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

- The trust should continue to work towards maintaining clinic room temperatures within an acceptable range.
- The trust should ensure that changes in patient risk and the strategies used to manage risk are recorded consistently across the wards.
- The trust should formalise a strategy to reduce restrictive interventions.
- The trust should ensure a consistent programme of audits is used across the wards.
- The trust should complete its work on Turner and Knight wards to enable patients to access the ward gardens.
- The trust should consider improvements to the general environment of Monet ward and its garden.
- The trust should reduce the reliance on locum consultant psychiatrists to improve clinical leadership and the consistency of treatment for patients.

Community-based mental health services for adults of working age

- The trust should ensure that all staff receive regular supervision and that managers are able to access appropriate systems to monitor the frequency of staff supervision.
- The trust should continue its work to improve waiting time for individual psychology in the Barking and Dagenham access, assessment & brief intervention team.
- The trust should ensure that caseloads are in line with best practice guidance.
- The trust should ensure that learning is shared from serious incidents that are related to unexpected deaths from physical health issues.
- The trust should continue work to strengthen and improve the referral and decision-making process when referrals are made to ACAT.

Forensic inpatient/secure wards (low secure)

- The trust should ensure that the identified staff training need to support the accurate identification and recording of rapid tranquilisation is met.
- The trust should ensure that where patients require physical health checks after receiving rapid tranquilisation these, including refusals, are consistently recorded in patient care and treatment records.

Wards for people with a learning disability or autism

- The trust should ensure that improvements are made to meal choices for patients.

Mental health crisis and health-based places of safety

- The trust should ensure that appropriate data that assures the efficacy of the HBPoS is gathered. For example, information on the percentage of occasions when the heath-based place of safety was full and Police/LAS conveyed the patient elsewhere. In addition, data to show the number of patients who had stayed in the HBPoS for more than 24 hours and the reasons why.
- The trust should ensure that HTTs have access to feedback from patients, family members and carers to enable them to assess, monitor and improve the quality and safety of their services from a patient and family perspective.

Summary of findings

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

- The trust should ensure that all patients referred to the service are seen within the 18-week referral to treatment target times set by the trust.
- The trust should continue its efforts to recruit permanently to occupational therapy and speech and language therapy posts within the teams.

Specialist community mental health services for children and young people

- The provider should ensure that equipment used in an emergency is regularly checked.
- The provider should ensure that young people in Waltham Forest have robust and comprehensive up to date risk information and management plans recorded. The provider should also ensure that risk assessment and risk management information is recorded consistently in patient electronic records.
- The provider should ensure that documentation regarding care planning is consistent and that young people are involved in care planning discussions and have copies of their care plans.
- The provider should ensure that young people waiting to be assessed or to start treatment are kept up to date about when this will happen.
- The provider should ensure that where learning from incidents is to be shared in a specific learning forum, these are convened in a timely fashion.

Urgent Care

- At Barking Community Hospital the trust should ensure that patient group directives are reviewed to make sure they remain up to date.
- At Orsett Hospital the trust should consider revising the system in place for recording patients who attend the service prior to the opening time of 10am.
- At Orsett Hospital the trust should review the way that patients with the greatest need are identified when they attend the service.

Community-based mental health services for older adults (from inspection in 2016)

- The trust should ensure risk assessments are monitored and updated when needed.
- 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 that team managers have access to information systems to support their management of the team.
- The trust should ensure managers had sufficient authority and resources to make decisions about their service.

Wards for older people with mental health problems (from inspection in 2017)

- 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.

Summary of findings

Community health services for children and young people (from inspection in 2017)

- 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.

Community health services for adults (from inspection in 2017)

- 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.

End of life care (from inspection in 2017)

- 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).

Child and adolescent mental health wards (from inspection in 2017)

- 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.

Community health inpatient services (from inspection in 2016)

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

All 'musts' and 'shoulds' outstanding from inspections in 2016 and 2017 will be followed up at the next inspection of the relevant core services.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating for well led went down. We rated well led for the trust overall as requires improvement because:

- Staff engagement was mixed, and some staff described an unhealthy culture. Whilst the trust had achieved positive staff survey results and most staff we spoke to were very enthusiastic about working for the trust, there were still some pockets of unhappy staff who did not feel adequately engaged. The most significant examples were the junior doctors and some consultants working in the mental health services. They described how they had tried to escalate concerns but had not received a timely or adequate response. They explained how their professional views were not adequately respected and how when things went wrong there was a culture of blame rather than learning.
- The senior executive leadership team was not working together in a cohesive manner. Whilst some external support had been sought to promote an improved working relationship there was still more to do. This was having an impact on the safe delivery of services. For example, whilst an action plan was in place in response to the junior doctor concerns it required collaborative work across the leadership team to make the improvements. Whilst some work had taken place, other significant concerns relating to the admission process to the acute mental health inpatient beds and the broader culture of the inpatient services had not been resolved. Some members of the leadership team recognised the difficulties in working together and expressed a sense of frustration that this was hampering their ability to do their jobs well.
- Many staff described a trust where they believed decision making was 'nurse dominated'. The Chief Nurse Group caused the greatest confusion with people describing its role in a variety of ways. There was a lack of clarity in how this group related to the Communities of Practice. We had ongoing concerns about the split Chief Operating Officer role. These related to variations in how the role was carried out by the two post-holders; the impact of this arrangement in terms of staff perception of the unity of the trust and the potential for a lack of clarity in terms of decision making on operational issues.
- The current governance processes may not provide adequate assurance for the board on workforce and finance. At present, safer staffing data was discussed at each board meeting and a six-monthly workforce report was presented to the Quality Safety Committee and then key points reported to the board. The trust was addressing many complex workforce issues, and this might not provide adequate opportunity for assurance to be gained. Whilst the trust had a positive track record of delivering its financial performance, there were some areas of potential risk identified in financial governance. The trust had a 'finance matters' meeting with the non-executive directors which was not a formal sub-committee of the board. There was a potential risk that financial performance might not receive adequate board oversight and that emerging risks and issues may not get escalated appropriately.
- The trust did not have a separate financial strategy other than delivering the annual financial plan. There was a risk without an overarching financial strategy the trust did not have in place suitable arrangements to deliver a medium and long term, financial plan.

Summary of findings

- Learning and development for team and ward managers did not equip them with the skills to effectively manage staff. Whilst managers were offered training, there had been around 60 contacts this year with the Freedom to Speak Up Guardian to raise concerns relating to the application of trust HR processes. The trust recognised that further leadership development was needed to put this into place. The trust also needs to further reduce the number of disciplinaries and make increased use of mediation. Grievance processes needed to be concluded in a timely manner.
- The effective use of feedback from the Freedom to Speak Up Guardian needed to be further improved. It was positive to see that a full-time post had been created and growing awareness of staff across the trust of the role. However, feedback tended to focus on numbers of contacts and themes rather than how the issues raised could be addressed. In addition, the feedback gathered had not always been used in a timely manner by the executive team to make improvements such as those raised by the junior doctors.

However:

- The trust had made progress with most of the areas identified at the last inspection. This included extensive consultation and the launch of the trust strategy which was now embedded into the ongoing work of the organisation. It was also good to note the progress with visits to services by non-executive directors including arrangements for sharing feedback; increasing the inclusion of governors to provide them with more opportunities to undertake their role; improving how the trust considers risk and strengthening the board assurance framework; and strengthening the arrangements for patient and carer engagement.
- The trust continued to progress its work on equalities, diversity and human rights championed by the current chief executive. This included the ongoing development of staff networks and work to improve the trust's performance in relation to the WRES.
- The trust's use of technology to support mobile working was impressive, along with the increasing innovative use of digital technology to meet the needs of patients and staff.
- It was positive to see the extended reach of the trust's programme of quality improvement and the impact this was having on staff engagement in improving services.
- We were also really interested in the work of the trust in promoting partnership working to achieve greater integration to meet the needs of populations especially across North-East London. On a smaller scale we also heard about how specific services were working innovatively in partnership with other health and third sector providers to meet patient needs.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement ↓ Aug 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Requires improvement Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
Mental health	Requires improvement →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement ↓ Aug 2019

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
Community health services for children and young people	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
Community health inpatient services	Requires improvement Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Community end of life care	Good Jan 2018	Good Jan 2018	Good Jan 2018	Requires improvement Jan 2018	Good Jan 2018	Good Jan 2018

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good ↑ Aug 2019	Requires improvement →← Aug 2019	Requires improvement →← Aug 2019
Forensic inpatient or secure wards	Requires improvement ↓ Aug 2019	Good →← Aug 2019	Outstanding ↑ Aug 2019	Outstanding →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019
Child and adolescent mental health wards	Good Nov 2017	Good Nov 2017	Outstanding Nov 2017	Good Nov 2017	Outstanding Nov 2017	Outstanding Nov 2017
Wards for older people with mental health problems	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017	Good Nov 2017
Wards for people with a learning disability or autism	Good →← Aug 2019	Good →← Aug 2019	Outstanding ↑ Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019
Community-based mental health services for adults of working age	Requires improvement →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement ↓ Aug 2019
Mental health crisis services and health-based places of safety	Inadequate ↓↓ Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Inadequate ↓↓ Aug 2019	Requires improvement ↓ Aug 2019	Inadequate ↓↓ Aug 2019
Specialist community mental health services for children and young people	Requires improvement ↓ Aug 2019	Good ↑ Aug 2019	Good →← Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement ↓ Aug 2019
Community-based mental health services for older people	Requires improvement Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Community mental health services for people with a learning disability or autism	Good ↑ Aug 2019	Good →← Aug 2019	Outstanding ↑ Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for primary medical services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent Care	Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019

Wards for people with a learning disability or autism

Good ➔➔

Key facts and figures

North East London NHS Foundation Trust has one inpatient ward for people with learning disabilities or autism, Moore Ward. Moore Ward is based in Sunflowers Court in Goodmayes Hospital. Moore Ward is an assessment and treatment unit, which provides a specialist assessment and treatment service for adults with a learning disability that present with mental illness or disorders and/ or challenging behaviours. This is a mixed gender ward with 12 beds.

The CQC last inspected Moore Ward in September 2016. At that inspection the service was rated 'Good' for all five key questions and 'Good' overall.

There were no outstanding breaches of regulations arising from the last inspection.

This was a comprehensive inspection, which was announced to ensure that everyone we needed to talk to was available.

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?

During the inspection visit, the inspection team:

- spoke with two patients who used the service and two carers
- spoke with a ward manager and modern matron
- spoke with five staff members, including consultant psychiatrist, deputy ward manager, registered nurse, non-registered health care assistant and assistant psychologist
- observed an activity planning meeting
- conducted a tour of the ward environment
- conducted a tour of the clinic room
- observed a ward round meeting
- observed a ward handover meeting
- observed a community meeting
- reviewed three patients' care records
- looked at a range of policies, procedures and documents related to the services we visited.

Wards for people with a learning disability or autism

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Feedback from patients and those who are close to them was continually positive. Staff went the extra mile and their care and support exceeded expectations. Patients and those close to them were active partners in their care and staff were fully committed to this partnership approach. Patients' individual preferences and needs were always reflected in how care was delivered. Between April 2018 to March 2019, the ward received 58 compliments, which accounted for 1% of all compliments received by the trust as a whole.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promotes people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.
- Staff encouraged patients to have a voice and be actively involved in decisions about their care. The consultant psychiatrist encouraged patients to take a central role in their ward round, listened to their views and took these into account when reviewing changes in care and treatment. Patients could submit a written document completed with the help of staff or a relative prior to the ward round outlining what they wanted to discuss.
- Patients were able to give feedback about the ward at community meetings. For example, patients discussed issues such as the ward being too hot, limited mealtime options and activities to do in the summer. Staff were proactive in providing possible solutions such as speaking to maintenance department about the heating, the catering company about the food and suggesting activities for the summer to include gardening and a summer sports day. Minutes were available to patients in easy read format.
- There were high levels of satisfaction across all staff. There was strong collaboration and team-working and a common focus on improving the quality and sustainability of care and people's experiences. Some staff had lived experience that added real value. Quality improvement methodology was embedded on the ward. Staff were empowered to lead and deliver change. Quality improvement projects involved patients and carers.
- Governance arrangements were robust, and incidents and risks were reported, analysed and shared. Leaders had high quality management information, which showed trends and risks in the service. They were able to use this information to manage risks and improve the service. We were given examples of learning from incidents that had led to changes to improve the service.
- The service provided safe care. The ward environment was safe and clean. The ward had enough nurses and doctors. Managers ensured that staffing levels were adjusted to reflect the fluctuating needs of patients and the risk levels present at that time. Any potential impact of staffing vacancies was mitigated by the use of bank and agency staff familiar with the ward and its patients. Staff assessed and managed risk well, managed medicines safely, followed good practice with respect to safeguarding and minimised the use of restrictive practices. Staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment; they also engaged carers in the planning and reviewing process. They provided a range of treatments suitable to the needs of the patients cared for in a ward for people with a learning disability and autism and engaged in clinical audits to evaluate the quality of care they provided.

Wards for people with a learning disability or autism

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers ensured that these staff received training, supervision and appraisal. The ward manager had actively recruited learning disability nurses. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare. The ward proactively referred all patients to speech and language therapists from community teams.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

However:

- Two patients and two carers felt that there did not have much choice at mealtimes and food was unappetising when it was served.

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good because:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. ward layout enabled staff to easily move around to observe patients. The mixed-gender environment was well managed and met best practice guidelines. The ward also had a clean and fully equipped clinic room and had evidence of appropriate environmental risk assessments.
- The service had enough nursing and medical staff, who knew the patients. Staff also received additional training that was specific to their patient group. Some of this training was delivered by staff on the ward. Staffing levels were adjusted to reflect the fluctuating needs of the patients. The potential impact of staffing vacancies was mitigated by the use of bank staff familiar with the ward and its patients.
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. All staff had completed safeguarding training and were able to explain what do if any concerns were identified.
- Staff had easy access to clinical information on and it was easy for them to maintain high quality clinical records.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The ward had a good track record on safety. The ward managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team through meetings, supervision and directorate meetings. Lesson were shared in team meetings. There was one recorded serious incident occurring within the last 12 months, and staff demonstrated awareness in the lessons learnt from this incident.

Wards for people with a learning disability or autism

- Staff used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- Staff kept detailed records of patients' care and treatment, they ensured that key risk assessment and risk management documents were up to date. These documents were always accurate in relation to the patient's current circumstances or risks.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic, identified patient strengths, recovery-oriented and involved patients and carers. Each patient also had an easy-read personal profile and had a communication passport, which contained a wide variety of information about them and their needs and preferences.
- Staff provided a range of care and treatment interventions suitable for the patient group, consistent with national guidance on best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills, and to meaningful occupation. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit and quality improvement initiatives to monitor the effectiveness of services provided.
- The ward had access to the full range of specialists required to meet the needs of patients on the ward. The ward manager had actively recruited learning disability nurses. Although the ward did not have its own speech and language therapist (SALT), they had had input from community SALTs who responded promptly and provided the support needed for patients and staff. Managers made sure they had staff with a range of skills needed to provide high quality care
- The service supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. Staff received an appraisal within the last 12 months, and staff received support regular monthly supervision.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.
- The ward had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. Staff focused on best practice and achieving positive outcomes for people using the service.

Wards for people with a learning disability or autism

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- Feedback from patients and those who are close to them was continually positive. Staff went the extra mile and their care and support exceeded expectations. Patient's and those close to them were active partners in their care and staff were fully committed to this partnership approach.
- Patients' individual preferences and needs were always reflected in how care was delivered. Patients' emotional and social needs were seen as being as important as their physical and mental health needs. Staff developed social stories with patients prior an activity. Social stories help autistic people with short and or pictorial descriptions of an event or activity, which include specific information about what to expect in that situation. The staff assisted families by compiling positive behaviour support plans to help to support families and carers to understand how to reduce challenging behaviour.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promotes people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.
- Staff encouraged patients to have a voice and be actively involved in decisions about their care. The consultant psychiatrist encouraged patients to take a central role in their ward round, listened to their views and took these into account when reviewing changes in care and treatment. Patients could submit a written document completed with the help of staff or a relative prior to the ward round outlining what they wanted to discuss.
- Patients were able to give feedback about the ward at community meetings. For example, patients discussed issues such as the ward being too hot, limited mealtime options and activities to do in the summer. Staff were proactive in providing possible solutions such as speaking to maintenance department about the heating, the catering company about the food and suggesting activities for the summer to include gardening and a summer sports day. Minutes were available to patients in easy read format.
- Carers were also actively involved and there were carers meetings where they could set the agenda.

Is the service responsive?

Good ● →←

Our rating of responsive stayed the same. We rated it as good because:

- Patients were not moved between wards during an admission episode unless they needed to be transferred on clinical grounds.
- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The ward had a range of rooms and equipment to support treatment and care, including a sensory room. Patients reported that they aware were given the option to personalise their bedrooms. The ward environment had appropriate adjustments for people with restricted mobility.

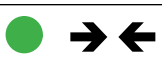
Wards for people with a learning disability or autism

- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- Patients' beds remained open for them to return to following leave from the ward.
- The wards met the needs of all patients who used the service, including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support. The ward had notice boards displaying information on a wide variety of topics in easy-read format and had a wide range of information leaflets also in easy-read formats.
- Patients participated in daily activity planning meetings. All patients were encouraged by staff the participate so as to plan a range of activities and outings each day.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service. Moore ward received 58 compliments in the past year from both patients and carers. Staff received compliments from services users, carers, professionals and other health care providers that worked in liaison with the ward. Carers told us they were confident that they knew how to make a complaint if needed. During the past 12 months, there had been two complaints one withdrawn and one partially upheld.

However:

- Two patients and two carers, patient and carers felt the choices were limited and food was not appetising.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- Leaders demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. They were visible in the service and approachable for patients and staff. Leaders had a deep understanding of issues, challenges and priorities in their service.
- They demonstrated an inspiring shared purpose and strove to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff.
- There was strong collaboration and team-working and a common focus on improving the quality and sustainability of care and people's experiences. Staff on the ward were trained to deliver training. Some staff had lived experience that added real value. Quality improvement methodology was embedded on the ward. Patients and carers were actively involved in this work. Staff were empowered to lead and deliver change.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression.
- Staff were proud of the ward and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns. The service was very responsive to feedback from patients, staff and external agencies.
- Governance arrangements were robust, and incidents and risks were reported, analysed and shared. Leaders had high quality management information, which showed trends and risks in the service. They were able to use this information to manage risks and improve the service.

Wards for people with a learning disability or autism

Outstanding practice

We found examples of outstanding practice in this service: -

The ward had a quality improvement project on daily activity planning with patients. The ward had a daily planning meeting with activities and the activities were patient led. This activity planning utilised various communication methods and was patient. This meant that patients' opportunity to participate in and make choices about the care they receive.

Carers were actively participating and involved in the planning of care in ward rounds following the introduction of a quality improvement project. Carers were involved in improving their involvement in patient care and jointly reviewing the effectiveness of interventions.

Areas for improvement

We found areas for improvement in this service: -

The trust should ensure that improvements are made to meal choices for patients.

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

Requires improvement 

Key facts and figures

North East London NHS Foundation trust provides acute mental health admission wards and a male psychiatric intensive care unit to patients from the London Boroughs of Waltham Forest, Barking and& Dagenham, Havering and Redbridge from its Sunflowers Court hospital site.

We inspected this service as part of our comprehensive programme of inspections. The inspection was announced.

During this inspection we:

- Spoke with 24 patients and three carers
- Spoke with 55 staff members including nursing staff, doctors, psychologists, occupational therapists, pharmacists and administration staff
- Reviewed 23 patient care and treatment records
- Spoke with two matrons
- Spoke with two assistant directors for the trusts Acute and Rehabilitation directorate
- Spoke with the Integrated Care Director for the Acute and Rehabilitation directorate
- Spoke with five ward managers
- Attended three multidisciplinary team meetings
- Attended on multidisciplinary ward round
- Attended three staff handover meetings
- Completed a detailed check of each of the ward environments, the clinic rooms and reviewed the safety of medication management procedures on each ward
- Reviewed other documentation, policies and procedures relating to the way the service operated.
- Attended a focus group with junior doctors

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- In the previous calendar year rapid tranquilisation was used on 322 occasions. Staff did not always complete post-dose physical health monitoring after patients had received medication by rapid tranquilisation. This meant there was a risk of not identifying a deterioration in a patient's physical health. The same concern was identified at the previous inspection and whilst the trust had implemented systems to try and address this matter, they were not yet embedded.
- Cultural challenges were described by the junior doctors where they felt bullied at times by the nursing staff. They also described the difficulties in speaking out when they were concerned about unsafe practice. Whilst the trust had an action plan in place this was not yet adequately addressing their concerns.

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

- Further work was needed to reduce the use of locum consultant psychiatrists and have more permanent staff in post to improve clinical leadership and the provision of high-quality care and treatment.
- Governance processes to monitor the use of restrictive interventions were not adequate. Staff did not have timely access to data on the use of restrictive interventions such as the use of restraint, prone restraint and rapid tranquilisation. This reduced their ability to monitor their progress in reducing the use of restrictive interventions

However:

- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Although the quality of clinical audits varied between the wards staff were engaged in these audits and evaluating the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Although the service was operating under significant bed pressures at the time of the inspection, staff were doing all they could to manage beds well so that a bed was available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this. Out of area placements were sought for patients as a last resort.
- Since our last inspection in August 2017, the service had improved to minimise the likelihood that patients would need to be moved without clinical justification or return from leave with no bed to return to.
- The service was well-led and the governance processes had improved since the last inspection in August 2017 to help ensure ward procedures ran smoothly.

Is the service safe?

Requires improvement 

Our rating of **safe** stayed the same. We rated it as requires improvement because:

- In the previous calendar year, staff used rapid tranquilisation on 322 occasions. Staff did not always complete physical health monitoring after patients had received medication by rapid tranquilisation. This meant there was a risk of not identifying a deterioration in a patient's physical health. The same concern was identified at the previous inspection and whilst the trust had implemented systems to try and address this matter, they were not yet embedded.
- Further work was needed to reduce the use of locum consultant psychiatrists and have more permanent staff in post to improve clinical leadership and the provision of high-quality care and treatment.
- Clinic room temperatures exceeded the acceptable range on some occasions, jeopardising the efficacy of the medications being stored. The trust was in the process of considering how to address this problem when we inspected.

- Although changes in patient risk were discussed and understood amongst staff, patient risk assessments were not always updated to reflect these changes on Ogura ward.
- The trust did not have a clear strategy to reduce restrictive interventions. The use of restrictive interventions was not actively monitored across the wards.

However:

- Since our last inspection in August 2017 some improvements had been made to the safety of the wards. Staff better understood the trusts incident reporting system, mandatory training compliance had improved, staff knew how to safely manage pregnant patients, clinical equipment was safely maintained, actions from fire risk assessments were addressed and there were enough personal alarms for staff and visitors.
- The service had enough nursing staff who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse.
- Staff had easy access to clinical information and it was easy for them to maintain quality clinical records.
- The service used systems and processes to safely prescribe, administer and record medicines.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learnt with the whole team. When things went wrong, staff apologised and gave patients honest information and appropriate support.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare.
- Staff were working to promote healthy lifestyles and were in the process of moving the service to smoke-free status.
- Staff could access a full range of specialists required to meet the needs of patients on their ward. Improvements had been made to the service since our last inspection in August 2017 and staff supervision now took frequently, managers kept track of staff appraisal compliance and staff now accessed specialist training that was relevant to their roles in areas including emotionally unstable personality disorder.
- Staff from different disciplines worked together to benefit patients. Improvements had been made to the way staff supported each other to make sure patients had no gaps in their care since we last inspected in August 2017. Staff had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation including community mental health services and the local authority social services team.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

- Staff supported patients to make decisions about their care and assessed and recorded whether patients had the capacity to consent to specific decisions.

However:

- Audits of care and treatment records and risk assessments were not used consistently across the wards.

Is the service caring?

Good

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

- During our last inspection in August 2017 the trust was working to improve staff attitude towards patients and carers on Kahlo and Hepworth wards. During this inspection this had improved. Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. However junior doctors described how at times they observed nursing staff across several wards speaking to patients in an inappropriate manner such as with a raised voice.
- During our last inspection in August 2017 patients were not always able to make telephone calls or speak with visitors in private. During this inspection this had improved. Patients could now speak with visitors and make telephone calls in private.
- Staff sought feedback on the quality of care provided during community meetings and by issuing surveys when patients were discharged. Staff informed and involved families and carers appropriately and ensured patients had easy access to independent advocates.

However:

- Feedback from patients about their involvement in their care was mixed. Some patients did not feel they were adequately involved in developing their care plans.
- Some patients reported they did not know how to provide feedback about the service.

Is the service responsive?

Good 

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

- Despite ongoing challenges with bed pressures, staff were working hard to manage these pressures as best as possible. The trust was working with commissioners to review its acute bed capacity and was preparing to open an additional female acute ward. Recent guidance had been implemented about using the Mental Health Act at a time of scarcity of beds. This aimed to ensure patients were treated in the most appropriate, least risky environment possible when there was a shortage of beds.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.

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

- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Improvements needed to be made to the quality of the environment on Monet ward. There was also no access to the ward garden areas on Turner and Knight wards during our inspection.

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- We held a focus group for 12 junior doctors who had worked on these acute wards. They described cultural challenges where they felt bullied at times by the nursing staff. They also described the difficulties in speaking out when they were concerned about unsafe practice. Whilst the trust had an action plan in place this was not yet adequately addressing their concerns.
- Governance processes to monitor the use of restrictive interventions were not adequate. Staff did not have timely access to data on the use of restrictive interventions such as the use of restraint, prone restraint and rapid tranquilisation. This reduced their ability to monitor their progress in reducing the use of restrictive interventions

However:

- Local managers had a good understanding of the services they managed and senior leaders were visible in the service and approachable to patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- During the last inspection in August 2017 staff did not have a good understanding of the role of the trust's Freedom to Speak Up Guardian or how to approach them. During this inspection, staff knew how to contact the trust's Freedom to Speak Up Guardian and felt confident to do so. The Freedom to Speak Up Guardian had visited the teams and posters were displayed with information about how to contact them.
- During the last inspection in August 2017 the trust needed to improve the consistency, quality and application of its governance processes. During this inspection managers had access to more information to monitor the performance of the wards.

Areas for improvement

Actions the trust MUST take:

- The trust must ensure post-dose physical health monitoring takes place after patients have received medication by rapid tranquilisation in line with the trusts rapid tranquilisation policy. Regulation 12 Safe care and treatment (1)(2)(a)(b)
- The trust must develop a governance system to effectively monitor the use of restrictive interventions across the wards. Regulation 17 Good governance (1)(2) (a)(b)

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

- The trust must work to address the concerns raised by junior doctors to ensure a good working relationship and safe care. Regulation 17 Good governance (1)(2)(e)(f)

Actions the trust SHOULD take

- The trust should continue to work towards maintaining clinic room temperatures within an acceptable range
- The trust should ensure that changes in patient risk and the strategies used to manage risk are recorded consistently across the wards
- The trust should formalise a strategy to reduce restrictive interventions
- The trust should ensure a consistent programme of audits is used across the wards
- The trust should complete its work on Turner and Knight wards to enable patients to access the ward gardens
- The trust should consider improvements to the general environment of Monet ward and its garden
- The trust should reduce the reliance on locum consultant psychiatrists to improve clinical leadership and the consistency of treatment for patients.

Forensic inpatient or secure wards

Good ➔➔

Key facts and figures

Background to the trust.

The forensic service at North East London NHS Foundation Trust is provided on Morris Ward at the Sunflowers Court site. The service provides low secure services for up to 15 men in a purpose-built location. Morris Ward accepts male patients from the London boroughs of Barking & Dagenham, Havering, Redbridge and Waltham Forest catchment areas.

The previous CQC inspection was in April 2016 and was comprehensive. The service was rated good overall and outstanding in the responsive domain.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive mental health inspection programme.

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 the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

During the inspection visit, the inspection team:

- visited the one forensic ward at the Goodmayes hospital site and looked at the quality of the ward environment
- observed how staff were caring for patients

Forensic inpatient or secure wards

- spoke with six patients who were using the service
- spoke with the manager and matron for the ward
- spoke with nine other staff members; including a doctor, nurses and psychologist
- attended and observed a hand-over meeting
- reviewed eight patient care records and treatment records
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Patients' individual needs and preferences were central to the delivery of tailored services. Patients led their own ward review meetings. The services were flexible, provided informed choice and ensured continuity of care.
- Feedback from patients and those who are close to them was continually positive. Staff went the extra mile and their care and support exceeded expectations. Patients and those close to them were active partners in their care and staff were fully committed to this partnership approach. The service had listened to patient feedback regarding food. Innovative plans to develop a kitchen in the ward, so that food could be prepared on-site were planned and a capital bid made.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. The ward had an elected patient representative who attended staff team meetings. Improvements had been made to the service as a result of feedback. Patients and carers were confident in raising concerns and no complaints had been received. Two percent of all the compliments received by the trust related to Morris Ward.
- The ward continued to maintain excellent links with the community and engaged patients in a range of activities seven days a week. Since the last inspection the ward had developed one of its gardens to provide an innovative programme where patients looked after a range of small livestock, including chickens and rabbits. This therapeutic activity supported patient's recovery.
- The service provided safe care. The ward had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward team included the full range of specialists required to meet the needs of patients. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Forensic inpatient or secure wards

- Staff planned and managed discharge well and liaised with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- Whilst a need for call alarms in patient bedrooms had been identified, no dates for these works had been set. Staff did not describe how they were managing this risk until the alarms were installed.
- The ward manager had identified that staff would benefit from further training to ensure that incidents where patients were administered rapid tranquilisation were accurately identified and reported. Further work was needed to ensure that physical health checks post rapid tranquilisation was consistently recorded, including when a patient declined these.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- Whilst a need for call alarms in patient bedrooms had been identified, no dates for these works had been set. Staff did not describe how they were managing this risk until the alarms were installed.
- The ward manager had identified that staff would benefit from further training to ensure that incidents where patients were administered rapid tranquilisation were accurately identified and reported. Further work was needed to ensure that physical health checks post rapid tranquilisation was consistently recorded, including when a patient declined these.

However:

- All wards were clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Forensic inpatient or secure wards

Is the service effective?

Good  

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and where appropriate, a positive behavioural support plan.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives, such as Safewards.
- The ward team included the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them to plan the patient's discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Outstanding 

Our rating of caring improved. We rated it as outstanding because:

- Feedback from patients and those who are close to them was continually positive. Staff went the extra mile and their care and support exceeded expectations. Patients and those close to them were active partners in their care and staff were fully committed to this partnership approach. Carers had coproduced with staff an information leaflet about psychosis.
- Patients' individual preferences and needs were always reflected in how care was delivered. Patients' emotional and social needs were seen as being as important as their physical and mental health needs.

Forensic inpatient or secure wards

- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promotes people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.
- Patients were actively involved in decisions about their care. This included chairing their own care plan review meetings.
- Patients were actively involved in decisions about the ward. An elected patient representative joined the staff team meeting. There was also a patient on staff interview panels.
- Carers were involved in the ward and were invited to a monthly facilitated carers group where they could set the agenda. They had co-produced an information booklet on psychosis.

Is the service responsive?

Outstanding ☆ ➔➔

Our rating of responsive stayed the same. We rated it as **outstanding** because:

- The ward was tailored to meet the needs of individual patients and care and treatment was delivered in a way to ensure flexibility, choice and continuity of care.
- The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Since the last inspection the ward had developed one its gardens to provide an innovative programme where patients looked after a range of small livestock, including chickens and rabbits. This therapeutic activity supported patient's recovery. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The service had listened to patient feedback regarding food. Innovative plans to develop a kitchen so food could be prepared on site were planned and a capital bid made. In the meantime, a range of local measures had been introduced in partnership with patients to improve mealtimes. Drinks and snacks were available at all times.
- People who use the service and carers were involved in how the service responded to concerns. Patients and carers were able to feedback through a variety of forums. Improvements had been made to the service as a result of feedback. Patients and carers were confident in raising concerns and no complaints had been received. Two percent of all the compliments received by the trust related to Morris Ward. The ward treated concerns seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.
- There was a proactive approach to understanding the needs and preferences of different patients and to delivering care in a way that met those needs, which was accessible and promoted equality. The ward continued to maintain excellent links with the community and engaged patients in a range of activities seven days a week. This included local college attendance, work experience on a farm and attending a 'coping through football programme' with the local professional football team. Staff also helped patients with communication, advocacy and cultural and spiritual support.
- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.

Forensic inpatient or secure wards

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities, for example through Safewards and the national quality network for forensic mental health services.

Outstanding practice

We found areas of outstanding practice at this service:

- Carers had coproduced with staff an information leaflet about psychosis.
- Innovative plans to develop and staff a professional kitchen were in hand and capital funding had been applied for.
- Since the last inspection the ward had developed one its gardens to provide an innovative programme where patients looked after a range of small livestock, including chickens and rabbits. This therapeutic activity supported patient's recovery.
- The ward continued to maintain excellent links with the community and engaged patients in a range of activities seven days a week. This included local college attendance, work experience on a farm and attending a 'coping through football programme' with the local professional football team.

Areas for improvement

We found areas for improvement at this service:

Actions the trust MUST take:

- The trust must ensure that a completion date for planned works to install call alarms in patient bedrooms is fixed. In the meantime they must complete a risk assessment showing how they will manage the potential risks for patients until alarms are available. **Regulation 12 Safe care and treatment (1)(2)(d)**

Action the trust SHOULD take:

- The trust should ensure that the identified staff training need to support the accurate identification and recording of rapid tranquilisation is met.

Forensic inpatient or secure wards

- The trust should ensure that where patients require physical health checks after receiving rapid tranquilisation these, including refusals, are consistently recorded in patient care and treatment records.

Specialist community mental health services for children and young people

Requires improvement 

Key facts and figures

North East London NHS Foundation Trust provide specialist community mental health services for children and young people in the London boroughs of Havering, Waltham Forest, Barking and Dagenham and Redbridge. They also provide emotional well-being mental health service (EWMHS) across Essex and have done since 2015 and in Barking and Dagenham, Havering and Redbridge since 2018. In 2018 they were commissioned to provide community mental health services for children and young people across Kent.

The specialist community mental health services for children and young people offer a wide range of community-based treatment, psychological interventions and support, medication and advice.

During this inspection, we visited 9 teams which offered a range of services across the patient group

- Barking and Dagenham CAMHS
- Redbridge CAMHS
- Waltham Forest CAMHS
- Medway CYPMHS (Gillingham hub)
- Canterbury and Coastal CYPMHS (Canterbury hub)
- West Kent CYPMHS (Maidstone hub)
- Colchester EWMHS
- Chelmsford EWMHS
- Basildon EWMHS

We also visited the specialist crisis teams covering Kent and Essex.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

During the inspection visit, the inspection team:

- looked at the quality of the environment and observed how staff interacted with patients
- spoke with 41 young people or parents/carers who accessed the service
- spoke with the managers or acting managers of each of the services we visited
- spoke with 71 other staff members; including doctors, nurses, clinical psychologists, social workers, family therapists and administrative staff
- attended and observed one multidisciplinary pathway meeting and three zoning meetings where risk was discussed in a multidisciplinary team
- observed one home visit, one duty assessment and one scheduled assessment
- observed two groups running with children and young people including one hosted at a local school
- observed the CAMHS Community of Practice Group meeting

Specialist community mental health services for children and young people

- looked at 55 treatment records of patients
- looked at a range of policies, procedures and other documents.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- In some teams the number of staff in post, including the use of bank and agency, did not match the providers staffing plan. The vacancy rate in the core service (27%) was significantly higher than the trust average (17%). The vacancy rate for medical staff in Kent was 50%. There was a risk that Kent services may be disrupted by the lack of consistent medical input and leadership. In Kent, some clinicians had high caseloads which could prevent them from giving individual patients the time they needed.
- Governance processes needed strengthening to ensure that performance and risk were managed well. Systems to ensure consistency from learning from incidents or to share good practice across the geography were not embedded. Systems were not always in place to ensure equipment was clean and safe to use. Systems were not in place to enable management oversight of supervision within teams or services although this was being implemented. Some performance data was not accurate. In Kent there were operational variations between teams in how young people on waiting lists were monitored with no effective assurance process in place to ensure each was safe and effective.
- There were significant waiting lists for both initial assessment and treatment in Kent. The trust had introduced systems to detect and respond to increases in risk whilst young people waited. However, we saw examples in Kent where these systems had not been effective in identifying changes in risk or ensuring an appropriate response. Across Kent, there were 4143 young people at the end of May who had been waiting over 16 weeks for treatment following referral. Of these, 3372 were waiting for treatment through the neurodevelopmental and learning disability pathway and 771 were waiting for treatment through the other pathways available. We were told by family members that they were not consistently given information about the length of time they would be waiting for services to start.
- Equipment used to monitor physical health or to treat young people in an emergency was not always calibrated or checked. Less than 75% of staff had completed mandatory immediate life support training.
- Improvements were needed in how staff assessed and managed risk in Waltham Forest. Thirty percent of the care and treatment records we looked at in this team did not include an assessment of risk or management plan. In other teams across the geography there were inconsistencies in where risk information was included in patients records.
- The operation of the Kent single point of access was on the directorate risk register. Not all referrals in Kent were screened in a timely fashion and prioritised for follow up by the correct team.
- Whilst incidents were appropriately investigated, learning from these was not consistently shared across the whole geography. Where learning from incidents was to be shared in a specific learning forum, these were not always convened in a timely fashion.
- Some patients and carers in Kent were not clear what treatment and support they should be receiving from the team.

However:

- Clinical premises where patients were seen were safe and clean. Staff followed good practice with respect to safeguarding.

Specialist community mental health services for children and young people

- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood the principles underpinning mental capacity, competence and consent as they apply to children and young people and managed and recorded decisions relating to these well.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.
- Staff assessed and treated patients in crisis promptly.
- The criteria for referral to the service did not exclude children and young people who would have benefitted from care.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- In Kent, the number of staff in post, including the use of bank and agency, did not match the providers staffing plan. The vacancy rate in the core service (27%) was significantly higher than the trust average (17%). The vacancy rate for medical staff in Kent was 50%. There was a risk that Kent services may be disrupted by the lack of consistent medical input and leadership. In Kent, some clinicians had extremely high caseloads which could prevent them from giving individual patients the time they needed.
- There were significant waiting lists for both initial assessment and treatment in Kent. The trust had introduced systems to detect and respond to increases in risk whilst young people waited. However, we saw examples in Kent where these systems had not been effective in identifying changes in risk or responded to them appropriately.
- Less than 75% of staff had completed mandatory immediate life support training. Equipment used to monitor physical health or to treat young people in an emergency was not always calibrated or checked. In Basildon some equipment was not routinely calibrated. In Maidstone some of the emergency first aid equipment had not been checked including adrenaline and some dressings. In Waltham Forest, there was no cleaning schedule for toys available at the time of our inspection.
- Improvements were needed in how staff assessed and managed risk in Waltham Forest. Thirty percent of the care and treatment records we looked at in this team did not include an assessment of risk or management plan. In other teams across the geography there were inconsistencies in where risk information was included in patients records. Inconsistencies in where risk information was recorded meant that there was a risk that all staff may not find this information in a timely manner.
- Whilst we found that the Single Point of Access in Essex was working well, in Kent, improvements were needed. The trust recognised this, and the operation of the SPA was on the directorate risk register. Not all referrals in Kent were screened in a timely fashion and prioritised for follow up by the correct team.

- Whilst incidents were appropriately investigated, learning from these was not consistently shared across the whole geography. Where learning from incidents was to be shared in a specific learning forum, these were not always convened in a timely fashion. In Waltham Forest, learning from an incident in August 2018 had yet to be shared with staff through a learning forum.

However:

- Staff received basic training to keep patients safe from avoidable harm.
- Where staff were actively working with patients, they responded promptly to any sudden deterioration in a patient's health.
- When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.
- Staff kept detailed records of patients' care and treatment that were accessible to all staff providing care.
- Staff regularly reviewed the effects of medications on each patient's physical and mental health. Staff followed a safe and secure process for storing and recording forms used for prescriptions.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Good

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

- Staff assessed the mental health needs of all patients. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for the patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Specialist community mental health services for children and young people

- Staff supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

However:

- Whilst most staff worked with patients and families to develop individual care plans, care and treatment records and feedback from patients and carers showed that this was not always the case. Some patients and carers in Kent were not clear what treatment and support they should be receiving from the team.

Is the service caring?

Good 

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment and condition in a way that focussed on the needs of the young people.
- When appropriate, staff involved families and carers in assessment, treatment and care planning.
- Patients and parents and carers were involved in design and delivery of the service through local user involvement groups.

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

- Patients in Kent had difficulty accessing services. This was because there were waiting lists for treatment which exceeded the target for young people to be seen within 18 weeks. This meant that young people in Kent were not consistently receiving care in a timely manner. We did not identify concerns relating to waiting lists for services in Essex or the London boroughs. Across Kent, there were 4143 young people at the end of May who had been waiting over 16 weeks for treatment following referral. Of these, 3372 were waiting for treatment through the neurodevelopmental and learning disability pathway and 771 were waiting for treatment through the other pathways available.
- Some families in Kent, fed back that they had been frustrated by some of the waits to access the service. Across all the services we were told by family members that they were not consistently given information about the length of time they would be waiting for services to start.

However:

- Crisis teams across the London boroughs, Essex and Kent employed skilled staff who were able to see urgent referrals quickly. Demand for crisis services in Kent was high and staff were not always able to meet the four-hour target for urgent referrals to be seen. Each referral was risk assessed and priority given to assessing young people in the community.

Specialist community mental health services for children and young people

- Services had clear points of access. Referral criteria did not exclude patients who would have benefitted from care. Staff followed up patients they were working with who missed appointments.
- In the London boroughs and Essex patients who did not require urgent care did not wait too long to start treatment.
- The service ensured that patients, who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the patient's care.
- The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- Governance processes needed strengthening to ensure that performance and risk were managed well. Systems to ensure consistency from learning from incidents or to share good practice were not embedded. Equipment was not always calibrated and toy cleaning schedules were not always in place. Systems were not in place to enable management oversight of supervision within teams or services although this was being implemented. Some performance data was not accurate. In Kent there were operational variations between teams in how young people on waiting lists were monitored with no effective assurance process in place to ensure each was safe and effective.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Staff engaged actively in local quality improvement activities.
- Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area.

Outstanding practice

- The service had developed effective specialist crisis services for children and young people across the London boroughs, Kent and Essex. In Essex the service was rolling out a specialist intensive support pathway which was focussed on avoiding hospital admission and attendance at emergency departments. This was available to children and young people in Essex over 24 hours, seven days a week.

- The service was committed to agile working and had developed technology which ensured that members of staff were able to work 'on the move' and this ensured that staff worked more productively.

Areas for improvement

Actions the provider must take to improve:

- The provider must continue to work to ensure children and young people in Kent have access to treatment within 18 weeks of referral to the service. Regulation 17 Good governance (1)(2)(a)(b)(e)(f)
- The provider must ensure that the systems in place to identify and address changes in risk for young people waiting to be assessed or start treatment are robust, consistent and effective. Regulation 12 safe care and treatment) (1)(2)(a)(b)
- The provider must ensure that governance systems are strengthened to provide assurance that services are safe and effective; that learning from incidents is shared across the geography; that good practice is shared across the geography. The provider must also ensure that managers and leaders have access to accurate data to monitor their performance. Regulation 17 good governance (1)(2)(a)(b)(e)(f)
- The provider must ensure that work to improve the Kent single point of access continues. The provider must also ensure that all referrals in Kent are screened in a timely fashion and prioritised for follow up by the correct team. Regulation 12 safe care and treatment (1)(2)(a)(b)(c)
- The provider must continue its work to recruit staff and must ensure that the number of staff on the ground matches the staffing plan. The provider must also ensure that individual caseloads are manageable. Regulation 18 Safe staffing (1)(2)(a)
- The provider must ensure that staff complete all mandatory training. Regulation 12 Safe care and treatment (1)(2)(c)

Actions the provider should take to improve:

- The provider should ensure that equipment used in an emergency is regularly checked.
- The provider should ensure that young people in Waltham Forest have robust and comprehensive up to date risk information and management plans recorded. The provider should also ensure that risk assessment and risk management information is recorded consistently in patient electronic records.
- The provider should ensure that documentation regarding care planning is consistent and that young people are involved in care planning discussions and have copies of their care plans.
- The provider should ensure that young people waiting to be assessed or to start treatment are kept up to date about when this will happen.
- The provider should ensure that where learning from incidents is to be shared in a specific learning forum, these are convened in a timely fashion.

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

Good ➔➔

Key facts and figures

The adult learning disability community service, part of North East London NHS Foundation Trust, provides joint health and social care services. Some of the teams within this core service are integrated. This means that they are provided by the trust but also report to the relevant local authority. Both integrated and non-integrated teams work with two electronic reporting systems covering both providers.

The service offers adults with a learning disability and their carers advice, information and therapeutic support. The teams are also responsible for providing assessment, care planning, specialist health care and purchasing appropriate care packages for people who use the service.

The trust have four multidisciplinary teams: Redbridge, Havering, Barking and Dagenham, and Waltham Forest.

At the last inspection in April 2016, we rated the service as good overall. We rated safe as requires improvement and effective, caring, responsive and well-led as good. We issued a requirement notice for one regulation; Regulation 17 HSCA (RA) Regulations 2014 Good governance.

At this inspection, we visited the Redbridge, Havering and Waltham Forest teams.

The team that inspected this core service comprised of one CQC inspector, two inspection managers, two specialist advisors and one expert-by-experience.

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 the inspection visit, we reviewed information that we held about this service, asked a range of other organisations for information and sought feedback from staff and patients at focus groups.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

During the inspection visit, the inspection team:

- Visited three community teams and inspected the premises
- Spoke with four patients who were using the services
- Spoke with 15 carers and family members of people who were using the services
- Spoke with the managers and service directors for each of the teams
- Spoke with 35 other staff members, including psychiatrists, community nurses, social workers, occupational therapists, psychologists and clinical behaviour specialists

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

- Observed three clinical home visits
- Observed five clinic sessions
- Observed one multidisciplinary meeting
- Reviewed 15 care records of patients who were using the service
- Looked at the policies and procedures of the trust.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service provided safe care. Clinical premises where patients were seen were safe and clean. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff managed waiting lists well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood the principles underpinning capacity, competence and consent and managed and recorded decisions relating to these well.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions. Feedback from people who use the service, their families and carers was continually positive about the way staff treated them.
- The service was easy to access and staff and managers managed waiting lists and caseloads well.
- The criteria for referral to the service did not exclude patients who would have benefitted from care. Staff assessed and initiated care for patients who required urgent care promptly.
- The service was well led and the governance processes ensured that procedures relating to the work of the service ran smoothly. The requirement notice made at a previous inspection in relation to monitoring waiting times from referral to treatment had been met.

However:

- A small number of patients (12) had waited more than 18 weeks to start their treatment at the time of our inspection.
- Across the three teams, there were vacancies for speech and language and occupational therapists. Challenges in recruiting to the posts permanently and in the interim, meant there was a risk that individual teams may not always include, or have access to speech and language therapists or occupational therapists.

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

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- Premises where patents received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The trust had installed safety alarms in interview rooms since the last inspection.
- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm. Mandatory training completion rates had improved since the last inspection. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans.
- Staff monitored patients on waiting lists to detect and respond to increases in level of risk and responded appropriately when these had changed. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Good →←

Our rating of effective stayed the same. We rated it as good because:

- Staff took a holistic approach to assessing the needs of all patients. They worked with patients and with families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care interventions that were informed by best-practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives. For example the Waltham Forest team included a phlebotomy service and the Havering consultants met quarterly with local neurologists to review patients where needed.
- Staff understood and applied NICE guidelines in relation to behaviour that challenges. This included support for families, early identification and assessment, psychological and environmental interventions, medications and interventions for co-existing health and sleep problems.

- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. Staff worked with the patient's support network to ensure best interest decisions were made when relevant.

However:

- Across the three teams, there were vacancies for speech and language and occupational therapists. Challenges in recruiting to the posts permanently and in the interim, meant there was a risk that individual teams may not always include, or have access to speech and language therapists or occupational therapists.

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- Staff treated patients with respect, politeness and genuine empathy. We observed that staff maintained patients' privacy and dignity and spoke to them with kindness during clinics and appointments.
- Feedback from people who use the service, their families and carers was continually positive about the way staff treated them. Patients and carers said that staff often go the extra mile to provide care and support that exceeded their expectations.
- There was a strong, visible person-centred culture. Staff provided individualised care for patients and recognised the totality of patients' needs, including their mental, physical and emotional health. Staff would also work with other providers such as housing providers to support them to understand and meet the individual needs of patients.
- Staff worked to provide patient-led care. Staff at the Havering team had adopted a patient-led conversation model to focus on patients' strengths, communication abilities and long-term planning and outcomes.
- Patients were active partners in their care. For example, staff in the Havering team carried out the 'Partnership Boats' initiative with patients and carers. This was a quarterly patient-led meeting with an agenda to improve quality of care.
- Carers were actively supported. They had access to individual support and monthly carers groups.
- Staff carried out a number of service wide and community initiatives to reach out to new carers, and to support existing carers, in the care that they provided for people who used the service. The staff were active participants in community awareness events often held in partnership with other organisations.

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

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and initiated care patients who required urgent care promptly.
- The teams met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- A small number of patients (12) had waited more than 18 weeks to start their treatment at the time of our inspection.

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Outstanding practice

- The Havering team had built robust relations with their internal and external stakeholders to ensure that proactive patient care was provided. Their commitment to enabling patients to access care and treatment in the community had prevented any mental health related hospital admissions for 18 months.

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

- Staff had a key focus on physical health in patients with learning disabilities. They worked with and provided training to local GPs, housing providers and care homes around physical health and had significantly improved their statistics around the uptake of annual physical health checks.
- The Waltham Forest team had introduced a phlebotomy clinic just for patients with learning disabilities. The Redbridge and Havering teams had introduced databases to monitor the annual health check completion for their patients.
- The Havering team consultants had a meeting with neurologists on a quarterly basis to discuss cases in which patients presented with epilepsy and learning disabilities. This was done to gain expert perspective on the situation and to ensure that the patient's health was managed without deterioration in their mental or physical health.

Areas for improvement

We found areas for improvement at this service:

Actions the trust SHOULD take:

- The trust should ensure that all patients referred to the service are seen within the 18-week referral to treatment target times set by the trust.
- The trust should continue its efforts to recruit permanently to occupational therapy and speech and language therapy posts within the teams.

Community-based mental health services of adults of working age

Requires improvement 

Key facts and figures

Background to the trust

North East London Foundation Trust (NELFT) provides community-based mental health services for adults of working age across four London boroughs, Redbridge, Waltham Forest, Havering and Barking and Dagenham.

Community recovery teams (CRTs), access, assessment and brief intervention teams (AABIT) and early intervention (EI) teams make up the trusts provision of community based mental health services for adults of working age in each borough. CRTs provide ongoing support to patients with severe and enduring mental illness who are subject to the care programme approach (CPA). AABIT provide a single point of access for all adults who present with a mental health need which cannot be met by their GP. They carry out comprehensive assessments of need and offer a range of short term focussed interventions for patients who do not require long term care or treatment. EI provide care and treatment to patients experiencing a first episode of psychosis. All teams are made up of health and social care professionals including psychiatrists, social workers, psychiatric nurses, occupational therapists and recovery workers. Each team is also able to access psychology input.

During this inspection, we visited the following services:

- Redbridge Access, Assessment and Brief Intervention Team.
- Redbridge Early Intervention in Psychosis
- Redbridge Community Recovery Team
- Havering Early Intervention in Psychosis
- Havering Community Recovery Team
- Havering Open Dialogue Team
- Waltham Forest Early Intervention in Psychosis
- Waltham Forest Community Recovery Team
- Barking and Dagenham Early Intervention in Psychosis
- Barking and Dagenham Community Recovery Team
- Barking and Dagenham access and assessment team

Community-based mental health services for adults of working age were last inspected in April 2016 when the overall rating was good, with a rating of requires improvement in safe, good in effective, good in caring, good in responsive and good in well-led. Our most recent inspection of the community mental health teams for adults of working age took place between 14 May and 23 May 2019.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Community-based mental health services of adults of working age

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive mental health inspection programme.

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 the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

During the inspection visit, the inspection team:

- visited 14 teams providing community mental health services for adults of working age and looked at the quality of the environment in which patients were seen
- spoke with 21 patients and four carers
- spoke to 45 staff members including nurses, consultant psychiatrists, social workers and occupational therapists
- looked at 35 patient care and treatment records
- checked 40 prescription charts
- attended and observed seven 'zoning' meetings
- attended and observed one clozapine clinic
- attended and observed one patient assessment
- reviewed policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

Community-based mental health services of adults of working age

- Governance systems required strengthening to ensure they were consistent and that a high quality and safe service was delivered from all locations. We identified isolated pockets of poor practice relating to caseload numbers, lone working practice, medicines transportation, recording of allergy information, identification of patients prescribed high dose anti-psychotics, provision and monitoring of clinical supervision; efficacy of audits and recording of risk information across the geography.
- Some teams did not have effective systems and processes to safely prescribe, administer and record medicines. Staff in the Redbridge community recovery team did not have a process to identify and regularly review the effects of high dose anti-psychotic medications on each patient's physical health. At Waltham Forest community recovery team, the room used to store medicines experienced high temperatures which could impact the efficacy of medicines stored there. In the same team, staff had not been equipped with lockable bags to transport medicines. Allergy information was not always recorded on patient's medicines charts.
- Staff in Waltham Forest community recovery team did not follow trust protocols for lone working which could put them at risk.
- The numbers of patients on the caseload of teams and of individual members of staff was in some cases high. In early intervention teams these were above the numbers recommended by best practice guidance. Staff in some teams with a high turnover of staff reported feeling 'burnt out'.
- Learning from incidents was not always consistently implemented across all teams. When incidents of unexpected death were investigated and underlying physical health issues were found to be the cause, learning from these incidents was not routinely shared with staff, which could mean that opportunities to learn and develop practise were missed.
- Whilst the majority of teams received regular supervision, staff in the Barking and Dagenham community recovery team did not. Managers across all directorates reported that the introduction of a new system to record and monitor supervision had been problematic as it was difficult to use and extract management data from.
- Locality teams were working in partnership to improve their relations with the acute crisis assessment team. Locality teams were frustrated that their multidisciplinary referrals were being rejected without appropriate feedback.
- Not all staff felt respected, supported and valued. A small number of staff felt there was a culture of blame in the team when incidents occurred. They also commented that there was a lack of meaningful consultation when changes were made to the teams and that they did not feel heard, or feared retribution when they raised concerns.
- There were some long waits to access individual psychology in Barking and Dagenham access, assessment and brief intervention team. New referrals were triaged and prioritised and patients were offered groups whilst they waited. The team were actively recruiting psychologists to increase their psychology offer.

However:

- Clinical premises where patients were seen were safe and clean. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training. Staff worked well together as a multidisciplinary team.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Community-based mental health services of adults of working age

- Staff assessed and treated patients who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The criteria for referral to the service did not exclude patients who would have benefitted from care.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- Staff did not prescribe, administer or record medicines consistently across the teams. Staff in the Redbridge community recovery team did not have a process to identify and regularly review the effects of high dose anti-psychotic medications on each patient's physical health. The room used to store medicines at Waltham Forest community recovery team experienced high temperatures which could impact the efficacy of medicines stored there. In the same team, staff had not been equipped with lockable bags to transport medicines. Allergy information was not always recorded on patient's medicines charts.
- Staff in Waltham Forest community recovery team did not follow trust protocols for lone working which could put them at risk.
- The numbers of patients on the caseload of teams and of individual members of staff was in some cases high. In early intervention teams these were above the numbers recommended by best practice guidance. Staff in some teams with a high turnover of staff reported feeling 'burnt out'.
- Learning from incidents was not always consistently implemented across all teams. When incidents of unexpected death were investigated and underlying physical health issues were found to be the cause, learning from these incidents was not routinely shared with staff, which could mean that opportunities to learn and develop practise were missed.

However:

- All clinical premises where patents received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on psychology waiting lists to detect and respond to increases in level of risk.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and mostly shared lessons learned with the team. When things went wrong, staff apologised and gave patients honest information and suitable support.

Community-based mental health services of adults of working age

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for the patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Whilst the majority of teams received regular supervision, staff in the Barking and Dagenham community recovery team did not.
- Managers across all directorates reported that the introduction of a new system to record and monitor supervision had been problematic as it was difficult to use and extract management data from.
- Locality teams were working in partnership to improve their relations with the acute crisis assessment team (ACAT). Locality teams were frustrated that their multidisciplinary referrals were being rejected without appropriate feedback.

Is the service caring?

Good 

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They supported patients to access advocacy services where they were available.
- Staff informed and involved families and carers appropriately.

Community-based mental health services of adults of working age

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- The service referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.
- The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously and investigated them.

However:

- There were some long waits to access individual psychology in Barking and Dagenham community recovery team. New referrals were triaged and prioritised and patients were offered groups whilst they waited. The team were actively recruiting psychologists to increase their psychology offer.

Is the service well-led?

Requires improvement ➔

Our rating of well led went down. We rated is as requires improvement because:

- Governance systems required strengthening to ensure consistency, quality and safety across the geography. There were variations in caseload numbers, lone working practice, medicines transportation, recording of allergy information, identification of patients prescribed high dose anti-psychotics, provision and monitoring of clinical supervision, efficacy of audits and recording of risk information across the geography.
- Not all staff felt respected, supported and valued. A small number of staff we spoke to told us that there was a culture of blame in the team when incidents occurred. They also commented that there was a lack of meaningful consultation when changes were made to the teams and that they did not feel heard, or feared retribution when they raised concerns.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Staff engaged actively in local quality improvement activities.

Areas for improvement

Action the provider MUST take to improve:

Community-based mental health services of adults of working age

- The trust must ensure that governance processes are strengthened to ensure consistency quality and safety across the geography. Regulation 17 Good governance (1)(2)(a)(b)
- The trust must ensure that staff are appropriately supported to raise concerns without fear of reprisal and that these concerns are listened to and acted upon. Regulation 17 Good governance (1)(2)(a)(b)(e)(f)
- The trust must ensure that systems and processes to safely store, prescribe, administer, transport and record medicines are consistent across teams. Regulation 12 Safe care and treatment (1)(2)(g)
- The trust must ensure that all staff understand and follow safe lone working practices, in line with trust policy. Regulation 12 Safe care and treatment (1)(2)(a)(b)

Action the provider SHOULD take to improve:

- The trust should ensure that all staff receive regular supervision and that managers are able to access appropriate systems to monitor the frequency of staff supervision.
- The trust should continue its work to improve waiting time for individual psychology in the Barking and Dagenham CRT.
- The trust should ensure that caseloads are in line with best practice guidance.
- The trust should ensure that learning is shared from serious incidents that are related to unexpected deaths from physical health issues.
- The trust should continue work to strengthen and improve the referral and decision-making process when referrals are made to ACAT.

Mental health crisis services and health-based places of safety

Inadequate ↓↓

Key facts and figures

Background to the trust

We visited the trust's three home treatment teams (HTTs), the acute assessment and crisis team (ACAT) and the health-based place of safety (HBPoS). These teams cover the London Boroughs of Redbridge, Barking and Dagenham, Havering, and Waltham Forest.

The ACAT are the gatekeepers to admit patients on the HTTs' caseloads. The ACAT are also the gatekeepers to all inpatient admissions. Referrals to the ACAT come from wards or teams within the trust, including the psychiatry liaison service at the local acute hospitals, GPs and self-referrals from members of the public.

The HTTs provide short-term treatment in the community as an alternative to hospital admission. This service is available 24 hours a day, 365 days a year. These teams also support patients who are being discharged from hospital and returning back to home or community settings.

The trust provides a HBPoS for up to two people. The service is located adjacent to the adult mental health inpatient wards at Sunflowers Court. Section 136 of the Mental Health Act allows for someone thought by the police to have a mental disorder, and who may cause harm to themselves or another, to be detained in a public place and taken to a safe place. The service operates 24 hours a day.

The mental health crisis service and health-based place of safety was last inspected in April 2016, when the overall rating for the service was good. Safe, caring, responsive and well-led were rated as good, and effective was rated as requires improvement. We issued one requirement notice following the 2016 inspection in relation to the HBPoS; regulation 12 safe care and treatment, as people who were assessed to have a mental disorder were not always seen by an approved mental health professional before being discharged from Section 136 of The Mental Health Act 1983.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive mental health inspection programme.

How we carried out this inspection

Our inspection of the mental health crisis services and health-based places of safety took place between 20 and 23 May 2019.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

Mental health crisis services and health-based places of safety

We undertook an additional unannounced inspection of Sunflowers Court on the night of Thursday 27 June 2019. The inspection team consisted of a CQC inspection manager and a CQC inspector. We carried out this inspection to follow up on concerns raised by trust staff about how the work of the trust's Acute Crisis and Assessment Team (ACAT) was carried out. These concerns were raised during a focus group with junior doctors who worked at Sunflowers Court. The focus group took place as part of the trust's CQC well-led review on Monday 24 June 2019.

Before our inspection, we reviewed information we held about the trust and asked other organisations to share what they knew about the trust.

During the inspection visit, the inspection team:

- Spoke with 15 patients who were using the service, or had recently used the service, and three carers
- spoke with the managers of each HTT and the manager for the ACAT and HBPoS
- spoke with 25 members of staff including nurses, support and recovery workers, social workers, doctors, clinical psychologists, consultant psychiatrists, and prescribing leads
- spoke with the night time lead for ACAT
- spoke with the night time lead nurses on Knight and Ogura Wards
- spoke with the night time receptionist at Sunflowers Court
- spoke with the night time nurse in charge (DNO) of Sunflowers Court
- spoke with the integrated care director for acute and rehabilitation services
- looked at the quality of the environment for the HTTs and HBPoS
- reviewed 17 care and treatment records, 12 at the HTTs and five at the HBPoS
- looked at 18 medicine charts
- observed six handover meetings
- observed one multidisciplinary meeting
- observed two bed management meetings
- observed nine patient home visits, with the patients' consent
- reviewed a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- The arrangements in place for the acute crisis assessment team (ACAT) to assess and admit patients to an inpatient bed was unsafe. Patients attending out of hours at Sunflowers Court for assessment by the ACAT or waiting to be admitted to wards after their ACAT assessment, were not appropriately supervised. There was a risk that the patient could cause harm to themselves or others whilst unsupervised, particularly in secluded areas of the building.
- The arrangements for the acute crisis assessment team to work with other professionals and teams in the trust was adversely affecting the responsiveness of the service to meet the needs of patients. Seeking a doctor to support the assessment process could cause delays and put pressure on medical staff working in other parts of the trusts crisis

services. We also heard multiple examples from junior doctors and consultants about the difficulties of working with ACAT as part of the decision-making process for admitting patients to an inpatient bed. They described complex and lengthy escalation processes. They had examples of where delays resulted in potential harm to patients. They also described the impact of this process on their morale, often feeling a lack of respect or professionally under-mined.

- Leaders of all levels within the service were aware of the operational challenges for the ACAT potentially impacting on the safety of patients. There had not however been a timely response in addressing these, despite the concerns being known for some months. At the time of our inspection appropriate measures to ensure that ACAT provided high quality care to their patients waiting to be seen or admitted to Sunflowers Court were still not in place.
- The trust did not record data recommended by best practice to monitor the work of the health-based place of safety. For example, there was no data relating to occasions when the heath-based place of safety was full to capacity and the police or ambulance service needed to convey the patient elsewhere, such as the nearest emergency department. The trust did not routinely gather data to show the number of patients who had stayed in the HBPoS for more than 24 hours and the reasons why these incidents had occurred.
- Staff did not have access to the feedback from patients, family members and carers. The trust did not share patient survey results and findings with the HTTs. Therefore, the HTTs were unable to assess, monitor and improve the quality and safety of their services from a patient and family perspective.

However:

- Clinical premises where home treatment team (HTT) patients were seen were safe and clean and the physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff followed good practice with respect to safeguarding.
- Staff working for the HTTs developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Managers ensured that staff had completed most mandatory training, although only 75% of staff had completed training on the management of violence and aggression. Staff were supervised and appraised. Staff worked well with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- HTT staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The mental health crisis services were easy to access. Those who required urgent care were taken onto the caseload of the HTTs immediately. Staff and managers managed the caseloads of the mental health crisis teams well. The services did not exclude patients who would have benefitted from care.

Is the service safe?

Inadequate 🔴 ↓↓

Our rating of safe went down. We rated it as inadequate because:

Mental health crisis services and health-based places of safety

- The arrangements in place for the acute crisis assessment team (ACAT) to assess and admit patients to an inpatient bed were unsafe. Patients attending out of hours at Sunflowers Court for assessment by the acute crisis assessment team (ACAT), or waiting to be admitted to wards after their ACAT assessment, were not appropriately supervised. There was a risk that the patient could cause harm to themselves or others whilst unsupervised, particularly in secluded areas of the building. One member of staff reported a recent incident where a member of staff had been assaulted by an unsupervised patient under the care of the ACAT team at Sunflowers Court.
- Take up of mandatory training to prevent and manage incidents of violence and aggression was below 75%.

However:

- Clinical premises where home treatment team (HTT) patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.
- The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high and was closely monitored. Staff take up of most mandatory training was high.
- HTT staff assessed and managed risks to patients and themselves.
- Home treatment teams responded promptly to sudden deterioration in a patient's health.
- When necessary, staff working in the home treatment teams worked with patients and their families and carers to develop crisis plans. HTT staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- Overall, the service used systems and processes to safely prescribe, administer, record and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's physical health. A controlled medicines reconciliation error identified during the inspection was followed up appropriately by the manager.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Staff working for the HTTs worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff working for the HTTs provided a range of care and treatment interventions that were informed by best practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare.
- Staff working for the HTTs and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.
- Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Mental health crisis services and health-based places of safety

- In the HTTs, staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. HTTs had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Good 

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

- HTT staff treated patients with compassion and kindness. We observed staff behaviours and attitudes as discreet, respectful, and responsive when interacting with patients. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff in the HTTs involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Patients we spoke to said they contributed to their care plans and received copies of their care documents. Staff ensured that patients had easy access to advocates when needed.
- HTT staff informed and involved families and carers appropriately.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate because:

- The arrangements for the acute crisis assessment team to work with other professionals and teams in the trust was adversely affecting the responsiveness of the service to meet the needs of patients. Seeking a doctor to support the assessment process could cause delays and put pressure on medical staff working in other parts of the trust's crisis services. We also heard many examples from junior doctors and consultants about the difficulties of working with ACAT as part of the decision-making process for admitting patients to an inpatient bed. They described complex and lengthy escalation processes. They had examples of where delays resulted in potential harm to patients. They also described the impact of this process on their morale, often feeling a lack of respect or professionally under-mined.
- The trust did not record data recommended by best practice to monitor the responsiveness of the health-based place of safety. For example, data was not collected relating to the number of occasions when the heath-based place of safety was full to capacity and the police or ambulance service needed to convey the patient elsewhere such as the nearest emergency department. In addition, the trust did not routinely gather data to show the number of patients who had stayed in the HBPoS for more than 24 hours, or the reasons why.

However:

Mental health crisis services and health-based places of safety

- The mental health crisis service was available 24 hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated patients promptly. Staff followed up patients who missed appointments.
- The health-based places of safety were available when needed. Section 12 approved doctors and approved mental health professionals attended promptly when required.
- The services met the needs of patients who use the service. Staff helped patients with communication, advocacy and cultural support. Staff had a good understanding of the make-up of the local population.
- The HTTs treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

- Leaders of all levels within the service were aware of the operational challenges for the ACAT potentially impacting on the safety of patients. There had not however been a timely response in addressing these, despite the concerns being known for some months. At the time of our inspection appropriate measures to ensure that ACAT provided high quality care to their patients waiting to be seen or admitted to Sunflowers Court were still not in place.
- Staff did not have access to the feedback from patients, family members and carers. The trust did not share patient survey results and findings with the HTTs. Therefore, the HTTs were unable to assess, monitor and improve the quality and safety of their services from a patient and family perspective.

However:

- Leaders were visible in the service and approachable for patients and staff. Staff knew and understood the provider's vision and values. Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity.
- Staff said the information systems and equipment worked well and they could develop care plans with patients and record their visits while in patients' homes.
- Governance systems around the HTTs were more robust.
- Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they needed it.

Areas for improvement

We found areas for improvement at this service:

The trust must ensure that:

- The trust must ensure that patients attending out of hours at Sunflowers Court for assessment by the acute crisis assessment team (ACAT), or waiting to be admitted to wards after their ACAT assessment, are appropriately supervised and cared for. A policy and procedure to govern this process must be developed. Regulation 12 Safe care and treatment (1)(2)(a)(b)(c)(d)

Mental health crisis services and health-based places of safety

- The trust must ensure that effective arrangements are in place for the acute crisis assessment team to work with other professionals and teams, especially medical staff, to ensure patients receive comprehensive assessments and where clinically required an inpatient admission in a timely manner. Regulation 12 Safe care and treatment (1)(2)(a)(b)(c)
- The trust must ensure that leaders of all levels listen to feedback from staff and take appropriate action to address the safety, risk and multidisciplinary working issues in the acute crisis assessment team. Regulation 17 Good governance (1)(2)(a)(b)(e)(f)
- The provider must ensure that all staff complete mandatory training in the prevent and management of violence and aggression. Regulation 12 Safe care and treatment (1)(2)(c)

The trust should ensure that:

- The trust should ensure that appropriate data that assures the efficacy of the HBPoS is gathered. For example, information on the percentage of occasions when the heath-based place of safety was full and Police/LAS conveyed the patient elsewhere. In addition, data to show the number of patients who had stayed in the HBPoS for more than 24 hours and the reasons why.
- The trust should ensure that HTTs have access to feedback from patients, family members and carers to enable them to assess, monitor and improve the quality and safety of their services from a patient and family perspective.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

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

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 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	
Treatment of disease, disorder or injury	

Our inspection team

Jane Ray, CQC Head of Inspection led this inspection. An executive reviewer, John Vaughan and specialist advisor, Gillian Hooper, supported our inspection of well-led for the trust overall.

The well led inspection team included eight further inspectors, including a pharmacy specialist. The well led inspection team also included a Mental Health Act reviewer and a representative from NHSI.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.