North East London NHS Foundation Trust

Inspection report

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

Date of inspection visit: 21 and 22 June 2022
Date of publication: 26/08/2022

Ratings

Overall trust quality rating	Good
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Our findings

Our reports

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.

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.

Overall summary

What we found

Overall trust

We inspected North East London Foundation Trust as part of our continual checks on the safety and quality of healthcare services. We also inspected the well-led key question for the trust overall.

We carried out short notice announced inspections of acute wards for adults of working age and psychiatric intensive care units and mental health crisis services and health-based places of safety. We also carried out a short notice announced focused inspection of specialist community mental health services for children and young people in Kent.

We chose these three core services to see if there had been improvements since our last inspection in June 2019.

The trust provides the following mental health services, which we did not inspect this time:

- 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
- 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

The trust also provides the following community health services, which we did not inspect at this time:

- Community end of life care

Our findings

- Community health services for adults
- Community health services for children, young people and families
- Community inpatient services
- Urgent Care

Our overall rating of the trust improved. We rated the trust as good overall because:

Our rating of well led improved; we rated the trust as good. Our rating of effective, caring and responsive stayed the same; we rated the trust as good. Our rating for safe also stayed the same; we rated the trust as requires improvement.

Our ratings for the acute wards for adults of working age and psychiatric intensive care units and mental health crisis services and health-based places of safety core services core services improved, we rated both as good overall. We did not re-rate specialist community mental health services for children and young people following our focused inspection in Kent. In rating the trust, we took into account the current ratings of the mental health and community health services which were not inspected this time.

The core service inspections and well-led review took place at a challenging time for the trust. In terms of the leadership there was an interim chair and chief executive in place. The trust was managing the recovery from the pandemic and learning to live with COVID-19.

Despite these challenges we found the trust had made significant progress since the last inspection:

- The culture of the organisation was much improved. Throughout our inspection we heard from staff who spoke positively about the changes which had taken place and the move away from a culture of blame. The previous interim chief executive was described as a ‘breath of fresh air’ who led this cultural shift. The current leadership including the interim chair and chief executive had continued to embed this approach. The trust was working to promote a ‘just and compassionate culture’. There was a recognition that there was still much more to do but the progress was evident.
- Staff felt more confident to ‘speak up’. The speaking up arrangements were working well. Themes were being appropriately reported through to the board so improvements could be made. Whilst many of the services delivered by the trust were under extreme pressure, staff from different professions felt able to escalate concerns about patient safety.
- The senior executive leadership team was working together in a cohesive manner. There had been some significant changes in the team including a new executive chief nursing officer, new executive director of people and culture and promoted executive director of finance). The executive team were benefitting from ongoing external facilitation to support team building. All the members of the senior leadership team described healthy and productive working arrangements. This had also led to improved working with the non-executive directors and the effective operation of the board.
- The representation of allied health professionals in the senior leadership team had improved. The executive chief nursing officer was also the executive director for allied health professionals and psychological professionals. We heard from a range of professionals throughout the inspection who felt this arrangement was working well.

Our findings

- The governance arrangements had been strengthened since the last inspection. The people & culture and finance & investment sub committees of the board had been developed. There had been a review of all the trust committees with the aim of ensuring these were operating effectively. There was a recognition that there was still more to do and that the number of internally facing committees could be further slimmed down to avoid duplication and reduce the amount of time operational staff spent in meetings.
- Staff working for the trust put people who used services at the forefront and were committed to providing the best service possible. There was tremendous enthusiasm, commitment and pride in the work of the trust.
- The trust had really 'stepped up' during the pandemic delivering services to meet the needs of local communities including vaccination services, step-down beds to support acute hospital discharges, the development of the Nightingale Hospital site and long-covid clinics. The trust had also worked effectively to ensure the appropriate guidance, equipment and new ways of working were implemented in order to keep patients and staff as safe as possible. The ongoing digital transformation and use of mobile equipment had supported ongoing flexible working arrangements which were well received by staff.
- The trust had delivered high levels of engagement and was learning from what went well in order to deliver ongoing effective communication. Throughout the inspection we heard about the visibility and accessibility of senior leaders and the board.
- The trust has continued its commitment to promoting equality, diversity and inclusion. The board was more diverse. The networks had strengthened and actively contributed to decisions about the strategic direction of the trust. The leadership programme for Black, Asian and minority ethnic staff was supporting good career progression.
- The trust was fully embracing its work with external partners in systems and place. The trust was located across five integrated care systems. It also worked closely with provider collaboratives. The non-executive directors were aligned to geographical areas. The trust had appointed to new roles to increase capacity for this work including an executive director of partnerships. Operational staff working in the directorates were participating in a range of meetings, taking leadership roles where appropriate. This work was challenging as systems were at different stages in their development and so they were having to identify where their contribution would deliver the most.
- We saw increasing use of data in accessible formats to inform day to day care and management decisions. Staff displayed a range of ability in using this data and the trust knew that for some further support was needed to develop their confidence.
- We also found significant improvements in the mental health acute and crisis core service inspections. Many more patients in a mental health crisis received the right care at the right time. The trust had designed and implemented an innovative, bespoke integrated crisis assessment hub which was available to a wide range of people, including self-referrals or those signposted by emergency services. Premises were specially designed and staffed by a dedicated staff team. People in crisis could access timely support at the hub to assess their needs. Work had taken place to improve the standards of care and treatment on the acute inpatient mental health wards.

There were some areas where there was more work to do, but the trust was fully sighted on this and had plans in place. These areas included:

- Clinical leadership at a directorate level needed to embed further. The trust had established a triumvirate leadership structure with operations, nursing and medical input for each directorate. Other allied health professionals were also being aligned to this leadership team. The medical staff had two sessions (one day) available each week but a number said they were having difficulties covering their clinical work so they could focus on their leadership responsibilities. Other consultants said that whilst they were kept informed of changes, they were not always actively involved in decision making even where this directly impacted their area of work.

Our findings

- Co-production work was developing with an involvement register linking up people with lived experience to paid and voluntary opportunities to support the work of the trust. The introduction of an advisor with lived experience to the board meetings was working well. In addition, people with lived experience or carers were participating in a number of key committees across the trust. There were also people with lived experience regularly participating as members of recruitment panels. The trust recognised that the COVID-19 pandemic had delayed the rollout of people participation committees in each geographical area. These groups were scheduled for implementation later in 2022.
- Quality improvement had slowed down during the pandemic with members of the team redeployed to frontline services. Large numbers of staff had been trained and a new QI lead was coming into post in September 2022. During our core service inspections, staff across the trust only occasionally referred to quality improvement and so further work was needed to embed this approach.
- Recruitment was an ongoing challenge, but a range of initiatives were in place including oversees recruitment, working with universities to attract professional graduates and extending apprentices. However, there were still pockets where recruitment was a particular challenge. One of these areas was medical staff recruitment for CAMHS in Kent. The trust recognised the need to improve medical staff recruitment but there was more to do.

How we carried out the inspection

During our inspection of the three core services, the inspection teams:

- reviewed records held by the CQC relating to each service
- visited seven wards at Sunflowers Court. We looked at the quality of the ward environment, management of the clinic rooms, and observed how staff were caring for patients
- spoke with seven ward managers and three matrons covering the wards we visited
- spoke with two assistant directors in the acute and rehabilitation directorate and one director for Kent community CAMHS
- visited four team hubs, in the Dartford, Canterbury, Maidstone and Medway localities; we looked at the quality of the environment for patients and staff, and management of the clinic rooms
- spoke with seven community CAMHS team managers
- visited three home treatment teams, the integrated crisis assessment hub and health-based place of safety and observed the environment and how staff were caring for patients
- spoke with the home treatment teams, the integrated crisis assessment hub and health-based place of safety managers
- spoke with 81 patients and carers
- reviewed 37 comment cards young people and carers
- spoke with 84 staff members, including, doctors, nurses, healthcare assistants, occupational therapists, psychologists, pharmacists, a physical health consultant, a ward administrator and a home treatment team liaison worker
- completed a review of medication management on four wards, three community CAMHS teams and the home treatment team clinic room
- observed a range of meetings and activities including safety huddles, ward round reviews, multidisciplinary handover meetings, occupational therapy groups, team meetings, handovers, an anxiety and depression session and community meetings

Our findings

- reviewed 130 patient care and treatment records
- looked at a range of policies, procedures and other documents relating to the running of each service.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

In the services we inspected, feedback from patients and carers was overwhelmingly positive. On the acute and PICU wards, patients told us that staff were empathetic, went out of their way, and kept on trying. In community CAMHS services we heard that staff were quick to respond in a crisis and that young people responded positively to the interventions delivered. Patients told us that home treatment teams involved them in their care and supported them through periods of crisis.

There were however some areas for improvement identified by people who used the service. On the acute and PICU wards, some patients would like to be able to access one-to-ones with their named nurse more regularly. In community CAMHS, young people and their carers felt they waited too long to access some services. In the home treatment teams, patients would like to see the same staff during their time with the team.

Outstanding practice

We found the following outstanding practice:

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

The Trust had embraced the use of technology to greatly improve the standards of practice across the entire hospital site for prescribing and medicines administration. This led to a direct positive impact on patient safety and increasing staff confidence when administering medicines.

Mental health crisis services and health-based places of safety

Since we last inspected this service in June 2019, the trust had significantly improved their crisis pathway. The Integrated Crisis Assessment Hub (ICAH) had been set up to meet the four-hour guideline of having a management plan in place for patients presenting in a mental health crisis.

Staff in the ICAH provided patients with transport home or to other mental health and physical health services upon completion of their assessment.

The trust had recently started a pilot with the London Ambulance Service (LAS) to better support patients at the start of a mental health crisis. A staff member from the trusts ICAH team had been seconded to work in the LAS ambulance control rooms to improve telephone triage and support.

In Barking, Dagenham and Havering HTT staff were piloting the use of an electrocardiogram (ECG) foot machine. This attached to the patient's foot and synchronised with a device application for the results. This allowed for staff to carry out ECG on patients easily in their homes.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, 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. This action related to one core service.

Specialist community mental health services for children and young people

- The trust must ensure that staff complete all mandatory training **(Regulation 12(2)(c)).**
- The trust must ensure that systems to identify and address changes in risk for young people who are waiting are consistently applied across all teams **(Regulation 12 (1)(2)(a)(b)).**
- The trust must continue work to improve initial assessment and treatment times for young people waiting to access the neurodevelopmental and learning disability pathway **(Regulation 17 (1)(2)(a)(b)).**

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that medical leaders have appropriate support and cover for their clinical roles to release them for their leadership roles
- The trust should ensure that all staff are supported to engage in transformation programmes that affect their teams
- The trust should ensure that an appropriate team is in place and able to appropriately support medical staffing
- The trust should ensure that all staff receive regular supervision and appraisal and that they are able to record these on the trust system
- The trust should continue to review its governance structure to reduce the burden of the number of meetings some leaders are attending
- The trust should ensure that all staff are trained and supported to utilise the new performance platform
- The trust should continue its work in developing new patient participation structures in each locality
- The trust should ensure that governors are appropriately supported with equipment and IT skills to enable them to access and engage in virtual meetings
- The trust should ensure that following the pandemic, QI is reinstated across the trust

Specialist community mental health services for children and young people

- The trust should continue its work to ensure that young people waiting to be assessed or start treatment are kept up to date about when this will happen.
- The trust should ensure that work continues to recruit permanent staff to reduce vacancy levels.
- The trust should ensure that all staff are confident and capable in accessing the trusts new performance platform.

Our findings

- The trust should continue work to embed the improvements made to the single point of access to ensure that all referrals are triaged and signposted in a timely fashion.
- The trust should ensure that individual risks, risk management plans and changes in risk are consistently recorded across the service.
- The trust should continue to monitor caseloads to ensure they are manageable.

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

- The trust should ensure planned works to develop Picasso Ward into a separate male and female wards are progressed. The trust should also ensure that planned works to extend the patient call alarm system are progressed.
- The trust should ensure that all wards promote a therapeutic environment by maintaining good standards of decoration, cleanliness and maintenance.
- The trust should continue its work to recruit to vacant posts.
- The trust should ensure that identified risks and their management plan pull through from progress notes to the risk assessment and management tool.
- The trust should ensure that the reasons for administering a 'when required' PRN medicine and its efficacy are recorded in patient care and treatment records.
- The trust should ensure that recognised ratings scales are used to help assess patient outcomes.
- The trust should ensure that sufficient activities are available for patients on all wards.
- The trust should ensure that staff on all wards receive regular supervision.
- The trust should ensure that all informal patients are aware of their rights.
- The trust should ensure that all staff are trained and supported to be able to access the trusts new performance platform.

Mental health crisis services and health-based places of safety

- The trust should ensure that the environmental risks identified in the Health-Based Place of Safety and the home treatment team premises are adequately assessed.
- The trust should ensure that patient care plans are personalised and holistic and patients are provided with a copy.
- The trust should ensure that all staff are able to access 'STEPS' to accurately record supervision.

Is this organisation well-led?

Our rating of well-led improved. We rated it as good.

Leadership

Since our last inspection in 2019, significant changes had taken place to the board, with over half its membership changing. The interim chief executive appointed in 2019 had completed his term of office and a further interim appointment to this role had been made. The interim chief executive was well established within the trust, having worked as the executive director of integrated care for many years. Their substantive post was vacant and being covered

Our findings

by members of the senior leadership team. The chief nurse and director of people and culture were both new appointments since the last inspection. The finance director was an interim at the last inspection and subsequently been permanently appointed. A new post of executive director of partnerships had been created and appointed to since the last inspection.

There had also been significant changes amongst the non-executive directors. The long-standing chair of the trust had retired, and the vice chair of the trust was the acting chair. Discussions regarding the appointment of a joint chair with a neighbouring trust were ongoing. Three non-executive directors had joined the board since the last inspection.

The non-executive directors continued to have well defined areas of responsibility. In addition to chairing and attending sub-committees, they were aligned to geographical areas and the integrated care directorates. They also had specific areas of interest. These were publicised on the trust website. Board members attended each other's committees to understand their work and ensure issues that extended across more than one committee were considered in a joined-up manner.

The non-executive directors continued to feel well supported with their learning and development. Newly appointed non-executive directors had completed an induction process. There was also access to a range of external and internal training. Learning was also promoted through board development sessions and away days. Non-executive directors had regular supervision with the chair and an annual appraisal.

Non-executive directors regularly visited services. For a time during the pandemic, these had been virtual. They were now returning to face to face visits. These visits took place with the quality improvement team. Visits were mostly announced, and the non-executive directors said they felt able to speak to staff and patients and hear about the challenges they were experiencing. These visits were written up and any areas of concern were followed through by managers across the trust and discussed at board development sessions. Staff across the trust were positive about the visibility of the board and other members of the senior leadership team.

Appropriate checks had taken place for board members. We saw the trusts spreadsheet for managing and recording fit and proper person checks. In addition, we randomly sampled three records, this included two board members who had joined the trust since our last inspection. This showed that all the necessary checks had been completed including financial solvency, checks for disqualification of company directors or trustees from charities, occupational health clearance and reference checks, which was appropriate for people meeting patients and having access to confidential information. Appropriate DBS checks at an enhanced level had also been completed. The trust used an audit tool to track whether checks had been completed and that annual declarations of interest had been made by each board member. The results of this audit were reviewed on an annual basis by the board as part of its cycle of business.

The senior leadership team had a good knowledge of the trust. A new post of director of partnerships had been created since our last inspection in 2019. Other executive director posts were executive medical director, executive director of finance, executive director of people and culture, executive director of integrated care and a combined post of executive chief nursing officer/ executive director allied health professionals & psychological professions. There had been a mix of internal and external appointments to executive posts that had been vacated since our last inspection.

At the previous inspection there were concerns about the capacity of the executive leadership team and their ability to work cohesively. External facilitation to support the development of the executive team was in place. During this inspection we received extremely positive feedback from all the executive team on their cohesion, capacity and ability to lead the trust. A team compact, outlining how leaders would work together, had been signed by each executive director.

Our findings

Changes to portfolio, a review of executive posts and the creation of some additional posts reporting directly to the executive team, had led to clearer roles that supported improved decision making in relation to operations and governance matters. For example, the chief operating officer function for Essex and Kent had moved from the chief nurse portfolio and now sat with a newly created director of operations for Kent and Essex, who reported to the director of partnerships at executive level.

At the previous inspection there had been lengthy discussions about the relative benefits and challenges of having two chief operating offers for the trust, each covering a separate geographical area. At this inspection it was clear that consideration was being given to having one chief operating officer in the future. It was recognised that having one post could improve consistency and learning across the trust.

Since the last inspection we saw that the representation of all professionals at senior leadership level within the trust had been reviewed and improved. For example, we heard how psychology representation at senior level had been strengthened. As part of a refresh of the clinical leadership for each integrated care directorate, a triumvirate approach was being introduced. This meant that medical, nursing, psychology, allied health professionals and pharmacy were all represented in the clinical leadership of each directorate. Recruitment to fill additional psychology posts in these leadership roles had been completed. The model was still being embedded throughout the trust and some medical staff spoke about the challenges of finding time to carry out their leadership roles when they found it hard to find cover for their clinical roles.

The trust had retained an experienced team of integrated care directors. The trust covered a very wide geographical area across four London boroughs, Essex and for child and adolescent mental health services across Kent and Medway. The trust services fell into seven integrated care directorates. Five of these related to geographical areas, one provided the leadership for inpatient mental health services and the final covered corporate matters. Each was led by an integrated care director.

The trust was working to a five-year plan to develop a just and compassionate culture across the organisation. This workstream was represented at all levels of the trust, including staff networks. The trust was planning that this workstream would include QI pieces that would deeper dive into the challenges around delivering a just and compassionate culture across the different geographies and settings the trust operated. We saw that this work was still in its early stages at the time of this review, but that staff throughout the trust were aware of and excited by it.

Leadership development opportunities were available for staff at different levels of the organisation linked to their appraisals and personal development plans. This included training for first line managers, middle managers and senior leadership development.

The trust was engaged in succession planning, recent senior and executive appointments had been made from the trust's internal talent pool. The executive lead for people and culture acknowledged there was more to do for the trust to formalise its programme of succession planning at all levels within the trust. There were talented staff across the organisation who could be potential senior leaders in the future. Staff were encouraged to take opportunities to support future promotion, such as applying for acting up roles to extend their skills, secondments, shadowing and mentoring.

Vision and Strategy

The trust continued to have a clear mission and values which were known and understood by staff. The mission of the trust was to deliver 'the best care by the best people'. The five core values of 'people first, prioritising quality, being progressive, innovative and continually improving, professional and honest and promoting what is possible: independence, opportunity and choice' were recognised by staff and embedded in trust literature.

Our findings

Since our last inspection, the trust strategy had been refreshed. Key priorities were well known to service users and staff at all levels of the organisation. A delivery plan was in development at the time of our review. The trust was sighted on the need to align its plans with the wider integrated care system and other strategic partners. This collaboration with other providers was leading to positive outcomes, for example, an alliance with Essex Partnership University Trust (EPUT) had led to joint work on the development of virtual wards. A collaboration with East London NHS Foundation Trust (ELFT) had led to a significant reduction in the use of out of area beds, the only exception being female psychiatric intensive care beds.

The trust had a good knowledge of the populations they served. They worked within a complex commissioning environment with active involvement by senior leaders across five integrated care systems in North-East London, Essex and Kent. In other geographical areas they participated in a range of partnerships with other statutory and third sector providers to meet the health needs of local people.

Culture

Whilst the trust had achieved positive NHS staff survey results and most staff we spoke to were positive about working for the trust, there were still some pockets of less happy staff. For example, some consultants felt that were informed but not actively engaged in transformation programmes in services where they worked. We noted that junior doctors reported some improvements in culture and working relationships on mental health inpatient wards. During our inspection activity we saw that all staff groups spoke positively in relation to changes in leadership since 2019. In the lead up to our inspection, we carried out our own survey, to which 1640 trust staff responded. This CQC survey showed a mixed picture, with 35% of respondents stating that they did not have confidence in the senior leadership. In the CQC survey, the trust performed well in relation to staff feeling able to raise concerns.

The trust had performed well in the NHS 2021 staff survey when compared with trusts. NELFT had achieved six of the top scores when compared with similar trusts in London. There were strong responses in the ‘people promise’ area of results, with all indicators at the national average or above. There were some areas of notable improvement. In these areas there was a 2% or greater increase or reduction in scores.

Increases in scores included:

- the organisation acting fairly with regard to career progression and promotion
- staff feeling secure to raise concerns about unsafe clinical practice
- staff having frequent opportunities to show initiative
- staff receiving encouragement from an immediate line manager
- managers asking for opinions when making decisions that affect roles
- staff feeling valued during the appraisal process
- Positive reductions in scores included:
- staff feeling pressured by managers to come to work
- reporting of physical violence
- staff feeling unwell as a result of work-related stress

NELFT achieved the best score nationally for staff feeling that they were trusted to do their job.

Our findings

There were however areas for improvement. The response rate of 52% was down on the previous two years from 59%. Whilst staff engagement and morale remained above average, both had reduced since 2020. The fall in morale was statistically significant and was attributed to the ongoing waves of the COVID-19 pandemic. Other areas of notable decline, with a 2% or greater fall in scoring included:

- sufficient staff
- sufficient materials
- ability to meet conflicting demands on time
- recognition for good work
- the extent to which the organisation valued individuals work
- levels of pay
- coming to work whilst not feeling well enough
- looking forward to going to work
- enthusiastic about job
- recommending the trust as a place to work
- recommending the trust as a place to be treated.

The trust was in the process of developing directorate and trust wide action plans in response to the staff survey. At the time of our inspection the equalities and diversity corporate team were working with staff networks to develop action plans in relation to the workforce race equality standard (WRES) and workforce disability equality standard (WDES).

In relation to WDES, scoring for the trust showed that staff with a long-term condition or illness continued to have a worse experience than those without. The trust also received negative scores in relation to experience and reporting of harassment and bullying from colleagues. There were also negative scores in relation to staff being able to access necessary adjustments to their role.

The trusts 2021 survey results indicated that:

- Black and minority ethnic (BAME) staff continued to be more likely than their white counterparts to report being harassed or bullied by patients, relatives and colleagues
- BAME staff were more likely to experience discrimination from their manager or colleague
- BAME staff were less likely to believe that there were equal opportunities for career progression.

However, the response for each of these indicators had improved on the 2020 score and all were better than the national average for BAME staff. The trusts annual WRES submission data had most recently been presented to the board in July 2021. This showed that the percentage of staff shortlisted from BAME backgrounds was 48.8% (down from 49.7% in 2019) and the percentage of white staff shortlisted was 45.8% (down from 50.3% in 2019). The percentage of BAME staff appointed was 45.5% (down from 51.1% in 2019) compared to 44.1% of white staff (down from 48.9% in 2019). The relative likelihood of white staff being appointed compared to BAME staff was 1.4. The trust needed to score below 1 for this metric to be viewed as positive for BAME staff. It should be noted however that the trust was performing above the national average of 1.61.

Our findings

The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff was 2.6 (down from 2.9 in 2019). This indicator was of concern as it had shifted little over the previous three years and was above the national average of 1.6. To address this concern the trust had developed panels where HR, staff networks and staff side were represented. Each disciplinary case had been reviewed through the lens of this panel.

At band 8a and above, BAME representation had grown year on year since 2017 and was at 31%. At very senior management level, 28.6% of staff were from BAME backgrounds, significantly above the national average of 6.8%. During the inspection staff commented very positively on the visibility of BAME staff at senior and executive levels within the trust.

The trust continued its strong track record in terms of its equality and diversity achievements. The trust had a well-established equality and diversity team. They provided support and budgets to each of the staff networks. Each network reported to the people and culture committee regularly and to the board annually. Some of the larger networks had their own strategy. At the time of our inspection, the following networks were active within the trust:

- Ethnic minority network (EMN)
- Disability network
- Dyslexia network
- Hearing impairment network
- Religion and belief staff network
- Lesbian, gay, bisexual and transgender network
- Mental health staff network
- BAME male inpatient nurse's network
- Parent and carer staff network
- WoMens staff network.

In addition to their support for the trust's networks, the equality and diversity team were developing some specific cultural training in relation to the Roma community. They were also developing and rolling out cultural intelligence training, with the aim of improving how staff worked with others from outside of their culture.

The trust had developed an inhouse development programme for BAME staff called 'LEAP'. Cohorts of BAME staff from bands 3 to 8b had been able to complete the programme. Fifty percent of those who had completed the inaugural LEAP programme had progressed within the trust.

NELFT was an earlier adopter of the Patient and Carer Race Equality Framework (PCREF). PCREF is a practical tool to help mental health trusts work with ethnic minority communities and understand what steps they can take to achieve practical improvements in terms of their access, experience of services and outcomes.

In 2022, the trust appeared in the Stonewall index top one hundred list. The trust had also won the recruitment industry disability initiative (RIDI) overall winner for the recruitment of people with a disability category in 2022. Feedback from

the network groups was mostly positive. Each aimed to cover the whole trust geography. During the pandemic meetings had been moved online. Each network group was being consulted about equality and diversity action plans and WRES and WDES action plans. The larger network groups such as EMN and disability, continued to have ambassadors in each directorate to increase their spread and reach.

A steering group made up of operational leads, frontline healthcare professionals, corporate staff, IT staff, and equality and diversity representatives had been set up to oversee the implementation of the Accessible Information Standard (AIS) at the trust. A briefing was being developed for operational leads on how the AIS should be embedded in services and how the trust would support staff and people who use services to access information in the formats they required.

The trust was continuing to strengthen the role of the freedom to speak up guardian (FTSUG). The trust freedom to speak up strategy had recently been refreshed following consultation. The key strategic objectives underpinning the refreshed strategy had not changed. The trust aimed to measure the efficacy of the strategy going forward using staff survey results. The trust had recently reviewed the role of the FTSUG and as a result increased the role to a band seven, in line with other trusts and reflective of the nature of the work undertaken. Additionally, the appointment of a deputy FTSUG had been approved.

At the time of our inspection there were 15 FTSUG champions across the trust. It was hoped that BAME representation to these champion roles could be increased, to this end, discussion with the trusts network leads was in progress. During our core service inspections, we found that staff were aware of the FTSUG and their role within the trust. The FTSUG was working hard to maintain their profile within the trust, they were represented at induction, on some committees and workstreams and attended individual team meetings on request The FTSUG told us they met regularly in private with the CEO and chair to update them on their work. They felt the role had secured a higher profile, as they were now invited to several senior and executive team meetings regularly, as well as being plugged into several current trust workstreams, for example those promoting respect and civilities.

The FTSUG had presented their annual report to the board in May 2022. This showed that November 2021 had seen the highest number of contacts with the FTSUG at 20. More contacts with FTSUG were made by staff working in the trust's mental health inpatient wards. They were most likely to raise concerns in relation to policies and procedures. The other most frequent theme raised with the FTSUG by all staff was bullying and harassment. The report noted that staff were more confident to disclose their ethnicity when raising concerns with the FTSUG, which was seen as positive. In the previous 12 months, 150 staff had completed FTSU training. This included 13 managers. The trust had identified that these training figures needed improving and the FTSU training modules along with e-learning relating to bullying and harassment were being promoted.

Arrangements for the trust to have a guardian of safe working hours (GOSWH) were in place. This role was carried out by a consultant psychiatrist, the current incumbent had been in post for two years. They attended the junior doctors' forum and encouraged junior doctors to complete exception reports. The GOSWH told us that more recently there had been changes to rotas to ensure a five-hour rest period for junior doctors. There had also been a programme of work schedule reviews which had led to the appointment of some additional locums. A recent visit by Health Education England had found improved workloads for junior doctors. Since the last inspection a guardian's fund had been introduced and monies from this had been used to purchase books, equipment and furniture for trainees.

The guardian of safe working hours reported quarterly to the board. We were told that exception reports had decreased from a high point of around 40 in 2019, this was attributed to the successful introduction of the five-hour rest period. There had been seven exception reports in the quarter preceding our inspection. All seven exception reports related to breaches in higher doctors' rest periods and had resulted in fines. There were no exception reports from junior doctors.

Our findings

There were some challenges at present with the rota, specifically out of hours child and adolescent mental health service (CAMHS) cover. The trust was considering the introduction of specialist psychiatric liaison services along with the expansion of current CAMHS provision to address this. Feedback from junior doctors was generally positive, although some did comment there was more work to do in developing the right culture between different staff disciplines on some inpatient wards.

Workforce issues continued to be a challenge for the trust. Particular recruitment challenges were identified in relation to consultant psychiatrists for children's services in Kent, in community health services, particularly district nursing and throughout inpatient services across a range of disciplines and bandings. The trust acknowledged that further work was needed to address workforce issues. Work to ensure an improved level of performance from the medical staffing team was still in progress. As well as recruitment, the trust acknowledged retention, staff resilience, wellbeing and use of bank and agency as the most challenging workforce risks.

The trust had developed a three-year nursing recruitment plan. This aimed to address the high vacancy levels across the nursing workforce. A detailed business case to achieve 'Zero Nurse Vacancies' by 2024 had been prepared. At the time of our inspection this plan was being reviewed by the executive management team.

The trust had also introduced 58 'kickstart' placements and 44 of these had been filled. The scheme aimed to give 16–24 year-olds, who were at risk of long term unemployment and in receipt of universal credit, opportunities to develop new skills via a 6-month placement.

Data reported to the board in February 2022 showed that vacancy levels had reduced slightly to 16.25%, which although higher than the Trust KPI of 10% remained within the trust's tolerance levels. When current employment offers as a result of recent recruitment were taken into account, the trust overall vacancy rate fell to 12.61%. The associated risks were on the corporate risk register and board assurance framework. Data for March 2022 indicated that staff turnover was slightly higher than the trust target at 10.81%. The top reason for leaving the trust in the same month was retirement, which could have been impacted by NHS pension changes due to take effect from April 2022. Data reported to the trust board in February 2022 showed that the sickness rate was 4.74%, slightly above their target of 3.7%. However, sickness absence was on a downward trajectory. The most common reason for absence was COVID-19, followed by cold, cough, flu and influenza related sickness. Teams within Essex and Kent were noted as having the highest levels of sickness absence.

The trust was making good progress with the completion of mandatory training. Compliance for mandatory and statutory training courses at March 2022 was 94%. The trust's mandatory training courses were:

- basic life support (all clinical)
- clinical risk assessment (advanced level)
- clinical risk assessment (foundation level)
- e-Infection prevention and control level 1 (non-clinical)
- equality and diversity
- fire safety
- health and safety awareness
- immediate life support

Our findings

- infection prevention and control level 2 (clinical staff)
- information governance
- manual handling (non-clinical)
- manual handling of people (clinical)
- MCA/DoLs
- Mental Health Act
- PREVENT 1
- PREVENT 2
- prevention and management of violence and aggression
- safeguarding adults (enhanced)
- safeguarding adults recognition and referral
- safeguarding adults strategic
- safeguarding children level 1
- safeguarding children level 2
- safeguarding children level 3

As of March 2022, the trust had attained an overall compliance rate of 94%. In the same month, trust wide compliance with supervision was 54%. The trust had introduced a new 'STEPS' system to support supervision and this was still being embedded which was impacting upon compliance figures. During our core service inspections, we heard from staff that they were receiving regular supervision. For the same period, trust wide compliance with appraisals was 71%. Some appraisals had been suspended during the pandemic, but this was now being addressed.

The trust was working hard to promote staff wellbeing and had introduced wellbeing ambassadors. Staff had access to an occupational health service which provided counselling services and access to assistance with physical health needs such as physiotherapy. In line with national guidance, the trust had revised its flexible working policy for such requests to be automatically approved from the start of employment, unless there were specific reasons not to do this. It was hoped that this would give some staff the opportunity to improve their work life balance. The trust had made a one-off payment in addition to salary recognising the cost of living crisis. The trust was considering whether some food items might be made available in some work bases for staff who may have missed meals at home because of the cost of living crisis. Thank you days had taken place across the trust. Wellbeing hampers had been made available to some teams. Break out rooms had been improved and some staff listening events had taken place. At the time of our inspection, the trust was hosting WELNEL for the local integrated care board. Trust staff could access counselling, support and schwarz rounds through this resource.

Prior to COVID-19 the trust had organised their 'Make a difference' staff awards ceremony annually. In 2021 the trust took a different approach, making nine staff awards that were presented during surprise ceremonies at their place of work. Most staff told us they felt valued by the trust.

Our findings

The trust complied with guidance on duty of candour. We looked at six serious incident investigation reports to see if duty of candour had been applied in practice. We saw that families and carers had contributed to deciding the terms of reference for the incident investigation. The trust shared the outcome of the investigation with families and carers. We also saw that families and carers had an explanation of what had happened and where appropriate, an apology.

Trust response rates to the friends and family test had remained consistent. During the pandemic the majority of responses were received via text messaging. Overall satisfaction rates to the question 'Overall, how was your experience of our service?' averaged at 84% for good or above. The percentage of respondents reporting a poor or very poor experience had remained consistent at 8%. The trust resumed its 5x5 survey in February 2022. Each team contacted five people who had used services and asked them five questions about their experience. Feedback from the friends and family test and 5x5 was shared on a monthly basis for cascade to all team members. Teams shared good practice and acted upon any areas for improvement.

Governance

The trust had structures, systems and processes in place to provide assurance and deliver the trust's key programmes.

The board operated effectively. The board met six times a year and was well attended. The agenda was well structured, and a rolling programme ensured all the necessary reports were received throughout the year. We saw improvements in the quality and consistency of papers being presented to board and to sub committees. Statistical process control (SPC) charts were used in all reports to board, replacing the previous red, amber, green (RAG) rating systems. SPC charts are simple graphical tools that enable clearer performance monitoring and identification of outliers. Meetings were well chaired and board members provided constructive challenge. Governors regularly attended sub committees and the board.

Since our last inspection in 2019, there had been a review of governance frameworks. Two new sub committees to the board had been introduced; people & culture and finance and investment. There were also sub committees of the board addressing quality & safety, audit & remuneration and charitable funds. The review of governance structures ensured that all working groups and other committees reported to a sub-committee of the board. During the COVID-19 pandemic a clinical professional advisory group had been established to manage guidance related to COVID-19. This group was found to be so helpful it has been maintained for the development and review of all trust clinical policies and guidance.

As part of our inspection, we observed the quality and safety committee. Both non-executive and executive directors were represented, as were governors and service users. The agenda reflected current and long term priorities. Reports to the committee bought together a range of information. The meeting included robust exchanges aimed at seeking assurance. Where strategic challenges, for example workforce, were being addressed across more than one sub-committee, updates were provided to ensure committee members had the necessary information. Feedback from senior leaders within the trust was that there needed to be a better balance between operational delivery, governance meetings and external facing work. Many felt that they spent too much time in meetings. This was acknowledged by the board, who advised that further adjustments to the governance structure to reduce the number of internal meetings were required. We noted that all committee meetings now included the question 'what would our patients and staff think of the meeting today?'

The trust was organised into seven directorates. Five of these related to geographical areas, one related to corporate affairs and the final one related to adult mental health inpatient wards. Beneath the quality and safety committee the quality governance structure included systems to hold the directorates to account looking at their quality and performance. Representatives of each directorate attended the quality and safety committee. This was also replicated at a ward and team level to provide accountability at different levels of the organisation.

Our findings

The executive management structure and portfolios had been revised. This supported transparent and effective decision making within the trust. The chief nurse's group had been removed from the governance structure.

During our core service inspections, we saw that governance systems had been improved and were working effectively. Breaches of regulation and best practice recommendations had been systematically addressed and improvements made. Where some issues remained outstanding the trust was well sighted on these. There was a clear rationale on why the issue had not yet been resolved and what was happening to drive improvement. An example of this was waiting times child and adolescent neurodevelopmental assessment in some parts of Kent. The trust was working with commissioners to bring down waiting times.

The trust continued to have structures in place to monitor the delivery of physical healthcare to patients with mental health needs. Patients physical health needs were assessed when inpatient services started and reviewed periodically, or as physical health needs changed. Patients were supported to access specialists when needed. Ward staff reviewed the effects of medication on patients' physical health regularly. Physical health care in mental health setting was reported annually to the board as part of 'harm free care'. Quarterly reports were provided to the quality and safety committee.

There were robust arrangements in place to ensure that the trust discharged its powers and duties under the provisions of the Mental Health Act 1983 (MHA) and Mental Capacity Act 2005 (MCA). Following a governance restructure, the use of the MHA was now overseen by the Mental Health Legislation Committee (MHLC), which met quarterly and was chaired by a non-executive director with representation including the chief nurse, who was the executive lead for the MHA and MCA on the board, executive and operational staff, the lead associate hospital manager (AHM) and service users. The board received monthly exception reports and an annual report on the MHA and MCA via the committee from the head of mental health legislation (HMHL), including restrictive practice and seclusion reporting now required under the Mental Health Units (Use of Force) Act 2018.

The HMHL was the lead for both the MHA and MCA and managed the mental health law team, which had a dedicated member of staff responsible for the MCA and Deprivation of Liberty Safeguards (DoLS). The trust was actively preparing for the introduction of the Liberty Protection Safeguards due to replace the DoLS process and this had partly driven the transfer of MCA responsibility to the mental health law team from the adult safeguarding team.

The number of staff working within the mental health law team had been significantly impacted by long-term sickness and staff departures. A programme of recruitment was underway to increase the size of the team overall. At the time of our review, three full-time and one part-time staff members were covering all essential administration. The team also produced an electronic weekly MHA reminder list for multidisciplinary teams on all wards and in the community. There were robust processes in place to ensure that all core work was being done and that senior staff were aware of the situation. There were 49 recorded unlawful uses of the MHA in 2021-2022.

A mix of agile working, flexible hours and both home and on-site working had enabled the team to cope well with the demands of the COVID-19 pandemic. Incremental improvements to procedures and processes were being achieved, including the replacement of paper-based processes with electronic ones, making the introduction of an MHA dashboard possible. An application to assist with the identification of available section 12 doctors was also being launched. The trust had service level agreements for MHA administration with Barts Health NHS Trust for Whipps Cross Hospital and with Barking, Havering and Redbridge University Hospitals NHS Trust for Queen's Hospital and King George Hospital.

Our findings

MHA and MCA training was mandatory for all clinical staff with a requirement for an annual refresher. There was a 95% compliance rate. Training was via e-learning. The trust provided initial and update MHA training for approved clinicians and section 12 doctors. Some training had been disrupted by the COVID-19 pandemic, but the situation was improving and it was hoped that face-to-face training might resume in due course. The team had responsibility for MHA policies and legal advice and could seek advice from external solicitors if required.

Bed pressures remained a significant challenge for the trust. The trust had more community treatment order (CTO) patients (152) than detained patients (144), leading to a large number of CTO recalls needing to be processed by the mental health law team, which was also processing a very high number of Mental Health Tribunal and associate hospital manager panel appeals. There was a bi-monthly police liaison group which included discussion of section 136 issues, as well as a quarterly police strategic liaison meeting, with senior trust, Metropolitan Police and British Transport Police representation.

There was a mix of 20 associate hospital managers (AHMs) in post, with a good balance of age, gender and ethnicity. Chairs and panel members were paid a fee for hearings and to attend quarterly meetings, which were chaired by a non-executive director and combined with training. Hearings were still taking place remotely but AHMs were keen for face-to-face hearings to be reinstated as soon as possible. An AHM lead had recently been appointed, which was reported to be working well. Uncontested hearings were processed as paper reviews.

Eight subjects for audits for 2022 had been identified, but only one had been commenced due to staffing pressures. A significant amount of information that the team would previously have audited was now available as part of the MHA dashboard on the trust's new performance platform.

CQC MHA monitoring visit reports were received and distributed for responses by the chief nurse's office. Recent themes included recording assessments of capacity and competence, patient involvement in care planning and the documentation of patient rights advice. The trust had responded appropriately through the creation of new forms on the electronic patient record and bespoke clinical staff training.

A new approved mental health professional (AMHP) lead had recently been appointed for the London borough of Waltham Forest and several new AMHPs had been recruited, with 16 AMHPs now on the rota. This number of AMHPs was comparable to Redbridge and Barking & Dagenham, while Havering had 12. There was excellent communication and effective local agreements in place between the AMHP teams. Being able to obtain section 135 warrants online was identified as a beneficial consequence of the COVID-19 pandemic. Challenges identified included high demands on the service, bed availability and delays involving the execution of warrants due to police procedures.

Management of risk, issues and performance

The trust had systems in place to report risks and ensure these were being addressed. The trust had risk registers at team and directorate level. These were brought together in a corporate risk register. The board were aware of the priorities and challenges facing the trust. Executives and senior leaders spoke with insight about the pressures faced by the trust including; recruitment and retention; recovery from the pandemic; increased demand for many services and the challenges of working in increasingly integrated ways. Changes to team or directorate risk registers were discussed and reviewed at the quality and safety committee.

There had been further work to refresh the board assurance framework (BAF) since our last inspection. The number of risks on the BAF and areas of overlap had been reduced significantly. Seven areas of risk were addressed through the BAF, these were: quality of services, influenza & Covid-19; financial objectives; workforce; culture; systems & partnerships and digital. Each BAF risk was accompanied by a summary of the challenges, how they were being

addressed, what was going well, the current risk score and the projected risk score trajectory. There was also an indication of the boards risk appetite, current control measures and any gaps in assurance. During the board meeting we observed there was discussion on whether further revisions were needed to the BAF to ensure its efficacy. Areas of risk were discussed during board workshops.

During our core service inspections, we saw positive examples of how teams and wards assessed and managed risk.

The trust participated in a range of local and national audits. Many audits had been suspended during the pandemic. The trust had adjusted its annual audit programme to ensure all audits were completed over a three year period. The trusts audit team had reviewed their programme and reported to the quality and safety committee on their plans for staff training and delivery of the audit programme. In May 2022, there were 54 clinical audits confirmed to take place over the period 2020/23. Of these, 28% had been completed, 57% were in progress and on target with completion dates, three percent were ongoing and on target with an extended completion date. Six percent had not yet started and a further six percent were waiting to be registered. Internal and external auditors had been appointed and reported on their progress regularly to the audit and risk committee.

Appropriate staff recruitment checks were in place. The trust ensured staff did not start working until all the necessary checks had been completed. This was checked for seven randomly selected members of staff. Systems were thorough and working effectively. However, five of the seven staff employment files we reviewed did not contain notes from the employee job interview. This had been picked up by the HR and the notes had been chased.

The trust had appropriate measures for safeguarding in place. There was a dedicated trust wide safeguarding team. The team ensured policies and procedures reflected current best practice and provided trust wide child and adult safeguarding advice. The trust participated in the relevant external committees in each borough. The safeguarding advice service had maintained a business as usual approach throughout the pandemic, offering advice and support each weekday between 9am and 5pm.

Staff were able to access child safeguarding supervision and take up of this was also monitored. With the shift to predominantly remote safeguarding supervision, there was a need for additional supervisors to be trained, which had been facilitated. A quarterly safeguarding report was presented to the quality and safety committee, with an annual report to the board.

The most recent safeguarding report presented to the board was dated May 2021. This showed that enquiries to the trusts safeguarding adult advice service remained constant at 3426 contacts between April 2020 – March 2021, compared to 3412 in the previous 12 months. The top enquiries to the service were domestic abuse, patient on patient abuse, pressure care and staff education or advice. Similarly, enquiries to the safeguarding children advice service remained constant with 2283 contacts over the same period compared to 2245 in the previous 12 months. Domestic abuse, children's mental health and parental mental health were the top three enquiries. In addition, several emerging safeguarding themes were identified. These were digital safeguarding issues with the use of IT to support remote contacts and increases in serious youth violence in relation to county lines. The safeguarding team initiated a thematic review exploring this area further.

The trust had a dedicated emergency preparedness, resilience and response manager (EPRR). To support its major incident plan and business continuity plan, the trust maintained a suite of threat specific plans including influenza, severe weather and fuel disruption. As well as developing its own procedures, the trust also contributed to a number of

multi-agency plans. The trust had in place an EPRR annual work programme that ensured that all plans were regularly monitored, reviewed and updated. A review meeting, which included NHSE/I and other stakeholders was held in October 2021. The review concluded that all appropriate EPPR measures and plans were in place. An annual report on EPPR had been presented to board in November 2021.

The estates strategy was being refreshed at the time or our review and was yet to be approved by the board. The refreshed strategy aimed to ensure estates were in good condition, fully utilised, sustainable and offered shared opportunities with partners. Since we last inspected the trust they had improved and streamlined the way maintenance issues were reported, with all queries going through one team, regardless of whether the building was trust owned, leased or subject to other arrangements. An external review of estates early in 2022 had resulted in an action plan to further improve how estates issued were managed within the trust.

Some large building projects which the trust was leading for the integrated care board were in train or had started. These included the development of the St Georges site in Havering and the Corringham integrated medical centre. During the pandemic, the trust had undertaken significant estates work, opening 250 stepdown COVID-19 beds at the Goodmayes and Brentwood Hospital sites. They had also provided the London Nightingale Hospital in early 2021 and set up and operated three COVID-19 vaccination centres. After the transfer of inpatient child and adolescent mental health services to the trust in 2020, a significant programme of works had been undertaken to improve the Kent and Medway Adolescent Hospital.

Financially, the trust had a reasonable track record of delivering against its plan with small surpluses recorded in both 2020/21 and 2021/22. However, the trust under-achieved against its 2021/22 planned cost improvement plan of £12.5m, achieving £7.8m. A recent integrated care system 'Drivers of Financial Strategy' report indicated a system wide challenge of circa £207m, with the trust element being of the order of £14m.

For the past two-years the trust had been operating under an emergency financial regime put in place during the pandemic. The trust's financial position was stable with a projected breakeven position in the current financial year, albeit with an underlying deficit which would need to be addressed. However, the operating financial environment had reverted to a more normalised position for the 2022/23 financial-year, and the trust would need to achieve efficiencies through its cost improvement plan (CiP) and through its broader transformation plans. The trust will need to identify opportunities to improve services while also delivering financial improvement and realising recurrent savings. In support of this, the trust should continue to develop its quality improvement programme and ensure that it has the right capacity and capability to deliver transformation and CIP programmes.

The trust's workforce issues were highlighted as a key risk and required the use of high-cost agency to fill gaps. While it was clear the trust had tried many initiatives, a clear strategy to improve this position was required. It was important that trust strategies were aligned and reflected within its financial plans. The trust estates strategy was a critical part of delivering the trusts financial plans as the organisation operated from a large number of buildings across a wide geography.

The trust had effective processes in place to manage the investigation of serious incidents. Serious incidents were reported and an initial incident report completed within 72 hours. The procedures determined whether the incident would be investigated within the directorate or met the threshold a root cause analysis investigation. A small centralised team of staff were trained to carry out and report root cause analysis investigations. These reports included an executive summary for presentation to the board. The trust was preparing for the national transition from the current serious incident framework to the patient safety incident response framework. The trust had received feedback on the new framework from system partners who had been early adopters.

Our findings

The integrated performance update report was presented to board bi-monthly. This included data in relation to serious incidents (SIs). The most recent report presented to board in May 2022 indicated that the most common SIs related to pressure care, at 80%. Most SIs were reported in community health services. Ten percent of recent serious incidents had occurred in both community mental health services for adults and mental health crisis services.

The May 2022 integrated performance update report showed that the top four categories of incident most recently reported across the trust were pressure ulcer present on admission (12%), pressure ulcer developed or deteriorated on caseload (9%), disclosure of abuse (6%) and physical assault, abuse or violence (5.5%). Incident information was reported within the trust using Datix. The trust reported incidents to national databases such as the strategic executive information system (STEIS) and national reporting and learning system (NRLS) as required.

During our core service inspections, we saw that improvements had been made in how patients physical health was monitored after they had received intramuscular rapid tranquilisation. We also saw that the board were kept sighted on this issue with regular reports to the quality and safety committee through the positive and proactive (respect) group update. As well as rapid tranquilisation and restrictive interventions, this report provided data and commentary to the committee related to violence and aggression and use of seclusion.

The trust had appropriate systems in place to monitor and learn from pressure care incidents. A bi-monthly trust wide pressure ulcer quality assurance group was in place. This group took forward recommendations from geographical serious incident panels where all pressure care incidents were reviewed. A working group was reviewing the trusts 'I love great skin' booklet as well as the training provided for staff in relation to pressure care across the trust. A standard operating procedure in relation to pressure care was being developed to operationalise the trust pressure ulcer policy.

Pressure care was reported to the board regularly through the 'harm free care' report. The latest report to board demonstrated that between April 2020 and March 2022 the number of pressure care incidents noted when a patient was admitted to hospital had fluctuated, but remained within control limits. The trust was also involved in some system wide work with Barts Health NHS Trust to improve pressure care.

The trust had appropriate measures for infection prevention control (IPC) in place. There was a dedicated trust wide IPC team and an IPC lead. The annual report to board in September 2021 showed that the infection prevention control (IPC) team had been working at reduced numbers during the pandemic, due to staff departures. However, we noted that staffing levels had improved. During the pandemic the team completed 150 reviews of hospital acquired COVID-19 infection to identify themes and any areas for learning and improvement. In 2020/21 there were 484 IPC related incidents reported compared to 86 incidents during 2019/20. This increase was attributed to COVID-19. Incidents were investigated within 24 hours of receipt by the IPC team. The most common theme was the reporting of COVID-19 in staff and patients.

A small number of aseptic technique audits were also undertaken, they identified inconsistencies in practise and understanding. A trust wide QI project to address these issues was subsequently implemented. During 2020/21, there were 1540 enquiries to the IPC duty nurse function, an increase on the 1343 contacts in 2019/20 and 548 in 2018/19. The trust flu vaccination programme had its highest recorded take up at 78%. The annual IPC audit programme was suspended due to the pandemic but was replaced by COVID-19 focused audits based on the national IPC COVID-19 checklist and IPC COVID-19 Board Assurance Framework.

The trust continued to undertake post infection reviews on all identified cases of clostridium difficile infection, methicillin resistant staphylococcus aureus (MRSA), meticillin-sensitive staphylococcus aureus (MSSA) and escherichia coli (E.coli) bloodstream infections. One case of MRSA bloodstream infection was reported. The case was not attributed

to NELFT and the investigation showed meticulous documentation having been maintained by the care team. In June 2020 the IPC team supported Public Health England (PHE) in investigating a cluster of four cases of invasive group A streptococcus (iGAS). The investigation findings did not link NELFT staff to the cases, but some learning was identified and cascaded in relation to the decontamination of equipment.

At the time of the report to board, two current IPC risks had been identified, with plans in place to mitigate or manage these. They were inability to access vaccination records for some patient facing staff and the need to develop a business as usual approach to fit testing for FFP3 face masks.

Medicines optimisation had been strengthened within the trust. The pharmacy team had been through a period of development. More staff roles, including technicians, rotational pharmacists and support staff had been employed and trained to undertake patient facing roles. This had allowed the team to be more involved in medicines optimisation at a patient level, including medicines reconciliation and de-prescribing. A lead pharmacist for each directorate had been appointed and they were part of the leadership team with medicines as a standing item on all directorate leadership meetings. Pharmacy had impact at quality and safety meetings and visibility at board level. The medicines strategy for the trust, produced by the pharmacy team was signed off by the board. Two key priorities were interoperative electronic systems for medicines and staff team development.

The chief pharmacist had oversight of the contract for the medicines supply from an external partner which had recently been re-tendered. Improvements in this contract were underway, including enabling connection between the electronic supply and prescribing systems, and a co-location on the trust site. There was a medicines optimisation group chaired by a medical director and attended by senior pharmacists. This multidisciplinary group aimed to ensure a shared responsibility for the safe and effective use of medicines across the trust. Since our last inspection the trust had deployed automated medicines dispensing cabinets across all inpatient wards and implemented wireless temperature monitoring across the trust.

Medicine recalls and alerts were managed appropriately, including liaison with the supplying pharmacy. The pharmacy had an audit programme and also investigated specific incidents for example rapid tranquilisation occurrences. The pharmacy team held their own risk register which was suitably populated and updated. This contained risks relating directly to the provision of pharmacy services and medicines management risks in all areas of the trust. Risks were escalated to directorate and trust level risk registers. The chief pharmacist was the controlled drug accountable officer (CDAO) and produced annual reports for the quality and safety committee and quarterly incident reports to the controlled drug local intelligence network (CDLIN). Pharmacy staff had access to summary care records and East London care records which enabled accurate medicines reconciliation and therapeutic drug and safety monitoring information. The pharmacy team were involved in all aspects of clinical training. Analysis of incidents had shown the team that a dedicated medicines induction for staff would be beneficial.

Information Management

Use of technology continued to be a strength for the trust. Staff had been supported with the technology they needed during the pandemic to work flexibly and remotely. Staff were able to access and complete patient records whilst working away from an office, which meant staff could work in a more agile manner. Staff spoke positively about the equipment issued to them to support them in their day to day roles. Since our last inspection, front line staff had been issued with smartphones. Work was underway to make improvements to the trusts electronic care and treatment record for patients, including the ability to access these on tablet devices. Virtual smartcards to facilitate access to trust databases were also being developed.

Our findings

The trust had invested in a new platform to manage performance data. This meant that a comprehensive range of data was available in one place. We saw this data being live accessed during some of the meetings we observed, for example the mortality review group. During our core service inspections, we saw varying levels of proficiency, with some staff and managers needing further support to feel comfortable using these systems.

The trust had recently refreshed its digital strategy. It identified four aims; providing the best staff experience with excellent connectivity, fit for purpose devices and fast intuitive platforms; development of digital pathways to access care for those patients who wanted them, including a single digital point of access; improved cybersecurity and 24-hour support for staff; additional training to upskill staff and patients.

Engagement

The trust board always included hearing from a patient, carer or staff about their experience. Since our last inspection, the trust had commissioned a major external review of its patient and carer engagement, with the findings published in a July 2020 report entitled 'Everyone's responsibility'. As a result of this review a new, centralised, strategic patient and carer engagement panel (SPCEP) had been established and was operational from October 2021. The panel reported to the people and culture committee on a regular basis. Further work was needed to embed the new patient and carer engagement structures in at locality and team level, as this had been delayed due to COVID-19. To support this, a task and finish group had been established to set up the new locality integrated patient and carer engagement panels (IPCEP). The trust aimed that once established, IPCEP would meet monthly to represent the patient voice in the locality and to report back to the centralised strategic SPCEP. In addition, a young person's panel was also planned, with the aim of ensuring a stronger younger person's voice and representation within the trust. The trust were members of the NHSE/I head of patient experience network (HoPE).

Patient participation data presented to the board in early 2022 showed that the majority of patient participation (76%) had been in supporting recruitment. Patient participation at meetings and on quality visits were the next biggest categories respectively in terms of patient participation hours spent.

Since our last inspection a new patient participation advisor to the board and co-production lead had been appointed. This was a person with lived experience. In their role they attended board meetings and the people and culture committee. A recent programme to recruit involvement representatives had been successful. Two-hundred and six representatives had been appointed at the time of our inspection. The trust had identified that involvement representatives were mainly from a mental health background and targeted recruitment to attract people with lived experience of end of life care and physical health issues was underway. Involvement reps were able to access QI training and support.

In addition, the trust had developed the expert patients programme (EPP). This was a free course for people living with long term health conditions and their carer's. The aim of the course was to increase participant confidence so they could better manage their life and health condition. Some participants who have completed the course also delivered EPP graduate group meetings, where support and skills could be consolidated.

The trust had made good use of volunteers. Significant achievements included thirty volunteers who had been recruited and trained to work at the Nightingale Hospital operated by the trust during the pandemic. A further 180 volunteers were recruited over a six-week period to support with the COVID-19 vaccination programme. A telephone befriending service was also set up and staffed by volunteers during the pandemic. The trust was aiming to build upon the success of its volunteer programme by developing a proposal to support volunteers into careers within the NHS.

Our findings

The governors told us how improvements in the culture of the trust and changes within the senior leadership team had reinvigorated their relationship. We observed the governors meeting which was well attended by executive and non-executive directors. The agenda had been developed in line with governor's requests. There was robust challenge with regard to assurance and discussion regarding the level of detail governors required in the papers they received. As governors were aligned with specific geographies, they requested that papers and data presented to them reflected this geographical alignment. This would better support governors in representing the interests of trust members and the public and holding the non-executive directors to account. The lead governor regularly attended the board, the board meeting agenda allocated specific time to address any questions from governors.

During the pandemic, meetings had moved online. Some governors commented that this had been particularly challenging for them as they did not have appropriate equipment or skills to support this move. They noted that other governors had been particularly supportive in this area, but that the trust had not always ensured that governors were appropriately supported with equipment or skills to support this transition. This was something that the trust recognised and was now picking up.

New governors received an induction and training to support them in their role. In addition to their geographical alignment, some governors had been identified as regular observers to board sub committees.

The trust managed complaints effectively. The complaints process was overseen and managed by a central complaints team. The investigation of complaints was led by appropriate locality managers with support from the central team. Information on how to complain was on the trust website. During our core service inspections, we saw that information on how to make a complaint was available locally. Since our last inspection, the trust had established a central PALS service.

During the early stages of the pandemic, advice from NHS England was to suspend complaint investigations. This had led to a backlog in the number of complaints being dealt with. At the time of our review this backlog had mostly been cleared. Themes from complaints were analysed and provided to directorates and teams to provide opportunities for learning and improvement.

In 2020/21 the trust received 240 complaints which was a 39% decrease in the number of complaints received when compared to 2019/20. This was attributed to the pause in dealing with complaints as a result of the pandemic. Trust analysis of complaints showed that the top three themes for complaints were; All aspects of clinical care (48.5%); Appointments (19%) and communication (9.5%). In 2020/21, one complaint was referred to the public health service ombudsman, compared with seven in 2019/20.

The trust had well established arrangements in place to engage and work with trade unions. We heard about improved culture across the trust, positive feedback about flexible working and improved visibility in relation to freedom to speak up. Representatives were well engaged with workstreams linked to the development of a just culture; For example, looking at areas such as reducing bullying and harassment. Staff side did also comment that further improvements could be made to ensure estates issues are addressed quickly and that internal job vacancies run for a suitable period to allow all potential candidates to apply.

During our core service and well led inspection activities we heard about the improved visibility of senior and executive leaders. The trust had made good use of webinars during the pandemic; These had proved so successful they were continuing to be used. The trust worked hard to engage effectively with staff. Staff described how they accessed the trust intranet and how good use was made of social media to communicate with staff. In addition, there was the trust

newsletter. Visits took place to services by members of the senior leadership team. During the pandemic, these had taken place remotely, but were now happening in person. The trust had carried out a consultation with district nursing staff over the trust to greater understand the challenges of their role. Comprehensive feedback from this consultation along with the actions taken, was fed back to the quality and safety committee.

External stakeholders told us that they had developed open, positive relationships with the trust. Kent and Medway commissioners told us they would like to see further improvements in some of the performance data the trust shared with them, particularly in relation to safeguarding supervision. This was being addressed through regular stakeholder meetings.

We heard from leaders how the trust had moved away from working in competition with other providers to working in partnership to meet the needs of local communities. Whilst there was some variation across the geography, we heard about well-established system working in Essex, with a commitment to further developing this across north east London and Kent.

Learning, continuous improvement and innovation

The trust was now halfway through its ten-year quality improvement (QI) programme. The pandemic had impacted on the trusts programme of QI and there was more to do to ensure that QI was embedded throughout the trust. The QI team had been redeployed, coming back together in October 2021. At the time of our inspection a new lead for the QI team had been appointed but had yet to take up their post. A bank of around 40 QI mentors had been depleted to 12. Prior to the pandemic 270 QI programmes were registered, at the time of our inspection this had reduced to 142. There had however been successes, including the commissioning by external stakeholders for NELFT to deliver QI training.

The QI team last reported to board in May 2021. Three work streams were identified around re-establishing audit programmes, re-establishing core QI programmes, for example, training and QI clinics and establishing key strategic priorities for QI as agreed with the executive management team. These were around supporting the transformation plan within adult mental health inpatient wards and the development of a digital roadmap for a blended way of working post pandemic. During this inspection we heard how the team were progressing the trust wide QI programme looking at blended ways of working. We noted that during our core service inspections and well led review staff did not speak often about quality improvement projects they knew about or were involved in.

The trust had a well-established research team. Income generated through grants funded the research the trust had conducted. The research team managed between three and eight studies at any one time. These studies ranged in length from 6 months to several years. In addition, approximately 12 masters and PhD projects were also supported. Some examples of research being carried out at the time of our inspection included an occupational therapy study in the community for people with dementia to see if this support could reduce the need for other interventions. An employment support and coaching programme to empower patients with mental health or learning disability needs to find and maintain work. After successfully piloting open dialogue, this was being rolled out across the trust. The trust had also trained staff from other providers in the use of open dialogue. A mindfulness project for staff and patients on a secure ward had led to a decrease in violence and aggression and an increase in feelings of wellbeing.

The trust had a research strategy in place. The team recruited patients and service users to individual studies and ensured they were engaged in their evaluation. A patient and service user panel oversaw each study. The trust was eager to pursue more research collaborations. The research team reported to the quality and safety committee.

Since we last inspected the trust in 2019, it has been nominated for or won the following awards:

Our findings

- Nigerian Healthcare Professionals UK (NHCPUK) award advocacy
- Met Black Police Association Award Celebrating work in the field of equality and diversity
- Ministry of Defence Award Employer Recognition Scheme - silver
- IPC Link Practitioners Conference Award IPC Special Award/IPC Excellence Award
- Zenith Global Healthcare Awards outstanding team of the year
- CCQI Ranked 1st forensic quality network
- Queens's Nursing Institute Academic Award - The Dora Roylance memorial prize
- Nursing Times Awards for innovation
- Dementia Care Awards outstanding dementia care innovation
- Royal College of Psychiatrists Fellowship
- Our Health Heroes Gold award apprentice of the year
- Women in IT Excellence Awards woman of the year
- Kingston and St George's University award practice educator
- ENEI awards joint overall winner in the public sector disability confident award
- ENEI awards highly commended in the inclusive culture and innovative ways of working category
- ENEI TIDEmark gold standard
- RCNi finalists child health category
- Ministry of Defence armed forces employer recognition scheme
- HSJ value awards highly commended mental health service redesign initiative
- HSJ value awards system or commissioner led service redesign initiative
- RCN BAME rising star award
- UKeIG and K&IM Information manager of the year
- HSJ award partnership
- Essex Police certificate of merit
- Working Families top family-friendly employers in the UK
- National Association of Psychiatric Intensive Care audit poster award
- Chartered Governance Institute UK and Ireland company secretary of the year
- HSJ military and civilian partnership award
- College of Mental Health Pharmacy original research poster award
- RIDI Award public sector: Making a difference
- Stonewall gold award
- Veteran Aware accredited

Our findings

- Platinum Champions Awards commitment to volunteering
- University of Essex alumni volunteer of the year
- Carer Confident accreditation
- Royal College of Podiatry award winners

Since we last inspected the trust in 2019 a number of wards and teams had either been accredited or were working towards accreditation:

- Royal College of Psychiatrists national accreditation programme (MSNAP)
- Royal College of Psychiatrists AIMS accreditation
- UNICEF UK baby friendly initiative stage 3 reaccreditation
- ECT accredited
- Monet, Kahlo, Woodbury and Knight Wards awaiting AIMS accreditation decision.
- Picasso Ward AIMS accredited
- Redbridge HTT, Waltham Forest memory clinic and Waltham Forest perinatal services AIMS accredited
- Waltham Forest HTT and Barking & Dagenham HTT awaiting AIMS accreditation decision
- Barking & Dagenham EIP accredited by national clinical audit for psychosis
- Barking & Dagenham type 1 diabetes service accredited by DAFNE
- Barking & Dagenham type 2 diabetes service accredited by DESMOND

The trust had a well-established mortality review group (MRG), chaired by the medical director. This reported to the board each quarter. The MRG reviewed all unexpected deaths that did not meet the criteria for investigation as a serious untoward incident (SUI) or other review. The MRG also did an initial screen of all learning disability deaths (LeDeR). The MRG used scoring tools recommended by the confidential enquiry into stillbirth and infant deaths (CESDI) and considered whether a death was avoidable or preventable. These reviews aimed to identify good practise and potential learning.

From July to Sept 2021, there had been 20 child deaths and 15 LeDeR deaths trust wide. Over the same period, 18 cases were reviewed by the trust mortality review group. No overarching themes were identified, however there were several individual areas where potential for improvement was noted. These included:

- record keeping
- access to equipment
- signposting for complex cases
- early carers assessment.

The trust recognised its responsibilities to investigate and report on the deaths of patients with a learning disability. The trust had staff who were trained to use the review process for people with a learning disability.

The trust had robust and varied systems in place to learn from incidents. A range of thematic reviews had been completed looking at inpatient falls, pressure ulcers, unexpected deaths and suicides. Learning form these deep dives

was collated and shared across the organisation. Learning could be shared through the patient safety learning group, for cascade to teams, through learning champions in each team, through trust wide learning events and themed learning months. During themed learning months there would be information cascades, targeted training and round up articles. Recent trust wide learning events included sexual safety and the deteriorating patient. Information in relation to learning from incidents was also shared on the trust intranet.

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 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ↑ Aug 2022	Good ↑ Aug 2022

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
Mental health	Requires Improvement	Good	Good	Good	Good	Good
Community	Requires Improvement	Good	Good	Good	Good	Good
Overall trust	Requires Improvement ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ↑ Aug 2022	Good ↑ Aug 2022

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.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Trust Head Office, CEME	No action Jul 2022	No action Jul 2022	No action Jul 2022	No action Jul 2022	No action Jul 2022	Good Sep 2019
Overall trust	Requires Improvement ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ↑ Aug 2022	Good ↑ Aug 2022

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

Rating for Trust Head Office, CEME

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	No action Jul 2022	No action Jul 2022	No action Jul 2022	No action Jul 2022	No action Jul 2022	Good Sep 2019

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good ↑ Aug 2022	Good →← Aug 2022	Good →← Aug 2022	Good →← Aug 2022	Good ↑ Aug 2022	Good ↑ Aug 2022
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
Forensic inpatient or secure wards	Requires improvement Sep 2019	Good Sep 2019	Outstanding Sep 2019	Outstanding Sep 2019	Good Sep 2019	Good Sep 2019
Child and adolescent mental health wards	Good Nov 2017	Requires improvement Nov 2021	Outstanding Nov 2017	Good Nov 2017	Outstanding Nov 2017	Outstanding Nov 2017
Wards for people with a learning disability or autism	Good Sep 2019	Good Sep 2019	Outstanding Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019
Community-based mental health services of adults of working age	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019
Mental health crisis services and health-based places of safety	Good ↑↑ Aug 2022	Good →← Aug 2022	Good →← Aug 2022	Good ↑↑ Aug 2022	Good ↑↑ Aug 2022	Good ↑↑ Aug 2022
Specialist community mental health services for children and young people	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019
Community-based mental health services for older people	Requires improvement Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016
Community mental health services for people with a learning disability or autism	Good Sep 2019	Good Sep 2019	Outstanding Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019
Long stay or rehabilitation mental health wards for working age adults	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016
Overall	Requires Improvement	Good	Good	Good	Good	Good

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.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Requires improvement Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016	Good Sep 2016
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 end of life care	Good Jan 2018	Good Jan 2018	Good Jan 2018	Requires improvement Jan 2018	Good Jan 2018	Good Jan 2018
Overall	Requires Improvement	Good	Good	Good	Good	Good

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.

Mental health crisis services and health-based places of safety

Good ↑↑

Is the service safe?

Good ↑↑

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

Mental Health Crisis Services

Safe and clean environments

The clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

The three home treatment teams shared premises. This meant that staff from each team shared the same environmental risk assessments and clinic rooms. In 2021, the trust created a new team, the integrated crisis assessment hub (ICAH) that was based in a separate building nearby. This space had been purpose built to allow 'walk in' patients to wait safely and to receive an assessment of their needs.

Staff completed and regularly updated thorough environmental risk assessments of all areas and removed or reduced any risks they identified. Risks associated with fire were assessed and regular fire alarm testing took place. The premises had also been assessed for potential ligature anchor points. During the inspection we found a potential ligature risk in a communal toilet. This was flagged to staff who took action to address this.

All interview rooms had alarms and staff available to respond. All staff had personal alarms for use in an emergency. Staff made checks to ensure the alarms were working and practised how to respond to an alarm. This meant that staff could summon support in an emergency.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. Staff made sure equipment was well maintained, clean and in working order. This included weighing scales and blood pressure monitors. Teams had access to equipment for use in the event of a medical emergency.

The premises were clean, well maintained, well-furnished and fit for purpose. Staff ensured cleaning records were up to date and the premises were visibly clean and tidy.

Staff followed infection control guidelines, including handwashing. Staff disposed of used sharps in sharps bin which were appropriately labelled and sealed.

Safe staffing

The service had enough staff, who received basic training to keep people safe from avoidable harm. 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.

Mental health crisis services and health-based places of safety

Nursing staff

The service had enough nursing and support staff to keep patients safe. Managers adjusted their staffing levels to meet the needs of the patients. In Waltham Forest home treatment team (HTT) and Redbridge HTT, the managers had recruited extra staff to help with increased demand for the service.

The service had reducing vacancy rates. We looked at data for this core service for the period November 2021 to April 2022. The showed a staff vacancy rate of 1% as of April 2022. This was lower than the 13% rate reported at the last inspection.

The service employed crisis workers and team managers to keep patients safe. Each HTT had social work posts embedded in the teams, although in Redbridge HTT and Barking, Dagenham and Havering HTT these posts were vacant.

Managers were able to access bank and agency staff to cover unfilled shifts. They requested staff familiar with the service. Each HTT had a pool of regular bank and agency workers who were familiar with the services and the communities they served. Managers made sure all bank and agency staff completed an induction and understood the service before starting their shift.

The Integrated Crisis Assessment Hub (ICAH) acted as the gate keepers for all the crisis referrals potentially requiring a hospital admission. Teams did not have a maximum caseload number and assessed their ability to accept new referrals based on the acuity and needs of the caseload at the time of referral. The shift coordinator reviewed the entire caseload during daily handovers to allocate visits and appointments to clinicians for the day. At the time of the inspection the three teams held caseloads between 63 and 70. Staff said the caseloads were manageable. Staff said they had improved the interface with other mental health services within the trust to increase the throughput of patients being supported by the teams in line with the care pathway.

Levels of staff sickness were low. The sickness rate for the service was 4% between 1 May 2021 and 30 April 2022. The average over the 12-month period prior to the inspection was lower than the sickness rate of 5.7% reported at the last inspection.

Managers supported staff who needed time off for ill health. If there were long periods of absence managers reallocated caseloads to other team members or appointed bank or agency staff to cover the post.

The number and grade of staff matched the provider's establishment at the time of the inspection. Each HTT was undergoing a change in the composition of their teams, either increasing staffing levels or changing structures. For example, Waltham Forest HTT and Redbridge HTT had received funding to recruit three additional band 6 nurses to meet the increasing demand for crisis support. Barking, Dagenham and Havering HTT was in the process of a transition, splitting into two localities and recruiting an additional manager and multi-disciplinary team.

Medical staff

The service had enough medical staff. Each team had a consultant psychiatrist providing medical reviews to patients. In addition, specialist doctors worked in the teams.

Since our last inspection, in June 2019, the trust had recruited additional medical staff to work across the crisis pathway. One of the new teams, the integrated crisis assessment hub (ICAH) had an out of hours specialist doctor and a consultant working 9am-5pm embedded in the team.

Mental health crisis services and health-based places of safety

Some medical staff working in the home treatment teams were locums. They had worked in the teams for some time, ensuring consistency of care. Locum medics received a comprehensive induction.

The service could access support from a psychiatrist quickly when they needed to. Consultants responded quickly to patients who needed urgent medical review. For example, the consultant from Redbridge HTT assessed a patient in the nearby emergency department during the inspection. Staff used the on-call medical staff if consultant psychiatrists were required out of hours.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The average compliance for mandatory training courses across the home treatment teams in April 2022 was 89%.

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training included safeguarding vulnerable adults and children, health and safety, basic life support and clinical risk assessment. The trust could not provide data for compliance rates in relation to conflict resolution and breakaway training. This was due to a technical error with their online training system. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

At the previous inspection, in June 2019, the trust did not ensure patients and staff were kept safe at night whilst patients were waiting unsupervised for their assessment with the acute crisis assessment team (ACAT) at Sunflowers Court. At this inspection, we found this had been addressed and a new hub had been developed with staff available.

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

We reviewed 24 patient risk assessments across the three teams during the inspection. Staff assessed and managed risks to patients and themselves**.** Staff completed a risk assessment for each patient when they were admitted and reviewed this regularly, including after any incident. The risk assessments included a risk history and assessment of risks associated with patients' mental and physical health. Each patients risk summary addressed risk from and to others, factors affecting risk and a brief risk management plan.

Staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff had developed a safety plan template with patients. This plan was included in the patients' welcome pack. Staff recorded clearly in crisis plans the patients relapse indicators and what to do when these signs were spotted. Crisis plans included a list of telephone contacts, including the mental health direct line and home treatment team, the crisis hub and national crisis helplines. Patients and carers confirmed that they knew who to contact if their mental health or their family members' mental health deteriorated.

Management of patient risk

The trust had created a hub where patients in the community could be assessed. The hub was purpose built with a dedicated staff team. The trust created this bespoke model of care so patients could be assessed by staff in a safe, dedicated space during a mental health crisis. This meant that community patients in crisis no longer attended at Sunflowers Court to access an assessment.

Mental health crisis services and health-based places of safety

Staff responded promptly to any sudden deterioration in a patient's health. We observed the daily multidisciplinary handover meeting in Barking, Dagenham and Havering HTT. Staff used low, medium, high or very high indicators to highlight patients' risks. Staff recorded patient information including risk, staff engagement plans, and patients' mental health, social, cultural and personal circumstances onto a team electronic white board. This could be accessed by the whole team and was used to support discussions and handovers.

Staff continually monitored patients for changes in their level of risk and responded when risk increased. We observed areas of good practice in relation to recognising and responding to changing risks. Staff updated risks and the rationale for change in patient care and treatment records. The multidisciplinary team discussed each patient on the team caseload weekly during clinical review meetings. Staff put management plans in place to mitigate individual patient risks. Actions included increasing the frequency of visits to a patient, for example, when a patient had been identified as needing access to inpatient care due to a deterioration in their mental health. We saw another patient where staff had safeguarded them after an incident of domestic violence.

Staff followed clear personal safety protocols, including for lone working. Staff completed a template linked to the electronic wipe board before going on a home visit. The electronic wipe board contained live information on home visits taking place. These were updated when staff returned to the office from visits. Staff were aware of the safety protocols and knew at which point to contact colleagues if staff had not contacted the team.

Safeguarding

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 could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We observed staff discussing potential safeguarding concerns in their weekly multidisciplinary meeting. For example, staff discussed patients who could potentially be sexually or physically exploited/harmed by someone else.

Staff knew how to recognise adults and children at risk of, or suffering harm and worked with other agencies to protect them. We saw examples in patient care and treatment records where potential child safeguarding issues had been identified, discussed and appropriately referred to the local authority safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns**.** Each team had an internal safeguarding lead to advise and support team members with safeguarding concerns. These leads were local authority social workers. The safeguarding leads in the HTTs tracked and monitored all safeguarding referrals to the local authorities and followed up concerns.

Managers took part in serious case reviews and made changes based on the outcomes. In one HTT, staff told us how they had been part of a serious case review. Social workers attended multi-agency public protection arrangement meetings and shared this information with their colleagues.

Staff access to essential information

Staff working for the home treatment teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Staff kept comprehensive patient notes and could easily access these. In addition, staff maintained an electronic white board, which included core patient information. This included: date of risk assessment; date of care plan and frequency of visits.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff were able to access records of patients visits to their GP and local hospital services directly from their electronic record. Discharge summaries from other services were easily accessible through this portal. Staff kept records stored securely to maintain patient confidentiality.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff working for the home treatment teams regularly reviewed the effects of medications on each patient's mental and physical health.

Staff used electronic systems to prescribe and record the administration of medicines. Staff could access advice from a clinical pharmacist each day in person. An external organisation dispensed and delivered medicines to the home treatment teams. Staff were able to access a store of frequently used medicines to ensure patients did not go without their medicines when they were first seen by the teams.

Staff appropriately restricted access to medicines storage areas. Staff had access to emergency equipment that was checked regularly. Staff had access to medicines disposal facilities and any disposed of medicines were recorded appropriately.

Each patient's medicines were regularly reviewed. Staff took appropriate action to safeguard patients and monitor the effects of their medicines on them. Staff provided advice to patients and carers about their medicines. Pharmacy staff attended the home treatment teams daily where patients' needs, including prescribed medicines, were discussed with a multidisciplinary team. Staff working out of hours could access the trust on-call pharmacy service for medicines advice or additional supplies. The pharmacist accessed blood results and other physical health monitoring records to ensure that medicines such as clozapine or lithium were being used safely. They conducted regular reviews into the use of benzodiazepines for individuals every month and those people prescribed high dose anti-psychotic treatments.

Since our last inspection, automated medicines dispensing cabinets had been introduced. These helped ensure that the correct medicine was dispensed for each patient. Access to this was limited by biometric security measures or a lock and key system. Temperatures for the room, cabinets and medicine fridges were monitored by an electronic system which would alert staff and the pharmacist immediately if there was a temperature excursion. Teams also continued to monitor temperatures manually as the system was newly installed in this service.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff reconciled patients' medicines when they were admitted to the home treatment teams. This ensured staff supported patients with their medicines holistically. When a patient was transferred to the HTT from an inpatient ward, staff could access their medicines records from the trusts electronic prescribing system. Staff informed patients' GPs when they were discharged from the service. Staff also supported patients with specialist medicines on discharge to ensure continuity of care. This ensured there were no delays for patients in getting the correct medicines when they were moved between services.

Mental health crisis services and health-based places of safety

Staff learned from safety alerts and incidents to improve practice. Medicines incidents were reported using an electronic system. The pharmacist reviewed incidents related to medicines. The trust had a system to manage and act on medicines safely alerts. Staff regularly carried out medicine's audits. These included prescribing, controlled drugs, POMH-UK (Prescribing Observatory for Mental Health) and medicines reconciliation audits. They also reviewed benzodiazepine prescribing, physical health medicines, clozapine, lithium and valproate prescribing and monitoring.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE (National Institute of Health and Social Care Excellence) guidance. Staff in the HTTs monitored the effect of patient's medicines on their physical health during their daily home visits. Staff understood how patients' medicines could impact their physical health.

Track record on safety

The service had a good track record on safety.

Between 1 June 2020 and 31 January 2022 there were 17 serious incidents reported by this service. In June 2020 the trust had reported a death in the community whilst under the care of Redbridge HTT. The investigation concluded with actions and learning for staff. Actions included the trust updating their standard operating policy.

Reporting incidents and learning from when things go wrong

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.

Staff knew what incidents to report and how to report them. For example, staff reported incidents such as medicines errors, violence and aggression and safeguarding concerns. Staff were aware of recent serious incidents. Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made because of feedback. Staff gave examples of when they had learnt lessons from incidents. Team meeting minutes showed staff discussing incidents and the learning from them. In Redbridge HTT, staff clearly discussed the learning that had resulted from a serious incident. Changes included an addition to the HTT operating policy for missed appointments when staff visited patients at home.

When things went wrong, staff apologised and gave patients and their families honest information and suitable support. For example, in Waltham Forest HTT, a staff member apologised to a patient after they missed an appointment with them. Staff understood their responsibilities under the duty of candour.

Managers debriefed and supported staff after any serious incident. Staff told us they attended debriefing meetings, and these were normally held soon after an incident, in many cases on the same day. For example, in the ICAH team, staff received a debrief after an incident of violence and aggression had occurred on the premises.

Staff received feedback from incident investigations of across the trust. Team managers from all the HTTs attended a monthly directorate leadership business meeting monthly where senior staff discussed incidents. The managers then fed back to their teams any themes, actions and learning from these discussions. In Barking, Dagenham and Havering HTT, staff had created a flowchart for patients that missed appointments. This flowchart was shared across the three home treatment teams.

Health-based place of safety

Mental health crisis services and health-based places of safety

Safe and clean environments

The clinical premises at the health-based place of safety where patients received care was mostly safe, clean, well equipped, well furnished, well maintained and fit for purpose. A few items of damage to one suite were addressed immediately. The physical environment met the requirements of the Mental Health Act Code of Practice.

The physical environment met the requirements of the Mental Health Act Code of Practice. Staff controlled access and entry to the health-based place of safety (HBPoS). The two suites for patients, each comprised a room with a bed, a wet room and toilet. The suites allowed clear observation and two-way communication. Staff were able to clearly observe the patient to ensure they were safe. The service was in the process of installing a children and young people's suite with garden access and a lounge area for patients and family members and carers to access while they were at the service.

Staff completed and regularly updated risk assessments of all areas and reduced any risks they identified. The services ligature risk assessment was accurate and up to date. Staff reviewed each suite after each patient use. However, at the time of the inspection, staff had been delayed in reviewing one of suites where a patient had left the night before. A review of this suite was on the team task list but had not been carried out. This suite had exposed wiring in the ceiling from a small alarm cover that had been removed, a small access panel keylock was exposed in the ceiling as the cover had been removed and the toilet roll holder was damaged creating a sharp edge. These each posed a potential self-harm risk for patients. These issues were highlighted to the team and they took immediate action. In one of the suites there was a blind spot in the wet room. Staff mitigated this risk by ensuring the wet room door remained open while patients were using it. Staff were not able to physically see patients while they used the wet room. Staff said they often talked with patients while they could not see them to ensure patients safety. Whilst staff were aware of this blind spot it was not included in the service's environmental risk assessment. Staff reported that the service was looking at physical options to address this such as viewing panels and convex mirrors.

Staff had personal alarms and staff were available to respond in an emergency. Staff checked the alarms were working at the start of each shift. Patients were under constant observation while using the service.

The service had recently finished installing a clinic room. The clinic room had all the necessary equipment for patients to have thorough physical examinations except for an examination bed, and window blinds. Therefore, all physical examinations were conducted in the suites. These items had been ordered. Staff made daily checks of physical health equipment to ensure it was clean and fit for purpose. Labels on the equipment showed it had been serviced appropriately.

All areas were clean, well maintained, well-furnished and fit for purpose. Staff and said that any faults or repairs were swiftly addressed. Staff made sure cleaning records were up-to-date and the premises were visibly clean. Staff followed infection control guidelines, including handwashing and the use of personal protective equipment where required.

Safe staffing

The health-based place of safety service had enough staff, who received basic training to keep people safe from avoidable harm.

Nursing staff

The HBPoS had enough nursing and support workers to keep patients safe. There were always three staff on duty in the HBPoS. A member of staff was always available to act as section 136 co-ordinator and point of contact for the police. Staff could request support from the rapid response team in an emergency. Staff were extremely experienced and knowledgeable in mental health support and crisis care.

The service had no vacancies. The team had consisted of one matron, five clinical lead nurses, three nurses, one nursing associate, and four support workers. All these posts were filled with permanent staff, many of whom had worked in the service for several years. The service manager was aware of upcoming vacancies due to planned staff retirement and promotions and these posts were currently being advertised in advance of ensure a smooth transition. The service used very few temporary staff. Regular bank staff who were familiar with the service covered any leave and sickness. Agency staff were not used. Managers made sure all bank staff had a full induction before starting their shift. Staff said managers supported them when they needed time off for ill health.

Medical staff

The service had quick and easy access to medical staff. The psychiatric consultants from the adjacent assessment unit, Picasso ward, supported the HBPoS. The duty doctor for the site supported the HBPoS. Out of hours there were two duty doctors available and a consultant and specialist registrar on-call. Staff reported this worked well. Staff said they could easily obtain medical support to conduct initial assessments, Mental Health Act assessments and to respond to emergencies.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The compliance rate for mandatory training was 95%. The mandatory training programme was comprehensive and met the needs of patients and staff. This included the prevention and management of violence and aggression which had a compliance rate of 85%. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

The health-based place of safety staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on arrival using a recognised risk assessment tool. We reviewed 12 patient care and treatment records. These showed staff carried out appropriate risk assessments of every patient on admission. Staff clarified risks with the police during the referral process.

Staff confirmed the reasons for the section 136 or section 135, details of the patient's current behaviour, including their level of disturbance and potential violence or self-harm risks and any known physical health risks or injuries. They also checked if there was any suspected drug or alcohol misuse and any degree of intoxication, details of any medical assessments and whether the police had used a taser on the patient.

All records reviewed showed a strong focus on physical health observations. Staff said if a patient appeared severely intoxicated, had been tasered or needed medical assessment or treatment, they advised the police to take the patient to emergency department for medical review. Staff checked the trust's database and with the GP for information on the patient's risk history. This information was used to create an initial risk assessment. Police escorted the patient to the HBPoS. Staff went out to the vehicle to check the patient was physically well. Staff said that if there were any concerns about the patient's physical health, they asked the police to take the patient to the emergency department. Staff would also confirm all the pre-admission data provided by the police was correct. If staff confirmed the admission was appropriate, the police then escorted the patient into one of suites. Once the patient was admitted into one of the suites staff reviewed risks and updated the initial risk assessment.

Risks were also reviewed during the Mental Health Act assessment. Staff in the nurses' station maintained continuous observation of patients whilst they were in the HBPoS. Staff reviewed risks at the start of each shift in handovers. Staff

also risk assessed whether it was safe for the patient to have use of a mobile phone and whether the door to the suite could remain open, so the patient could walk around the immediate area outside their suite. Staff escorted the patient home or liaised with ward staff to support them to a suitable ward when they were discharged from the service. Records also showed patients were supported through the 136 suites and seen and initially assessed by the service's staff very quickly

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. Staff monitored and maintained the safety of patients whilst they were using the HBPoS. Staff continually observed the patients from the nurses' station and were alert to any new risks to the patient.

Staff followed clear observation and personal safety protocols. Staff also followed trust procedures in relation to searching patients and removing banned items.

Staff reviewed and discussed risks at the start of each shift in handover meetings. Staff were trained in 'safewards' interventions and understood the trust's policies on reducing restrictive interventions. Staff were able to explain the way they communicated with patients to reduce the patient's stress, minimise and de-escalate the risk of violence and aggression. Staff said that rapid tranquilisation by intramuscular injection was very rarely used in the service with staff unable to recall the last incident of its use. Staff were aware of trust procedures on rapid tranquilisation. Staff were trained in national early warning score (NEWS2), which is a tool to monitor a patient's vital signs to alert them of a clinical decline in physical health. There was a protocol in place for who to contact in the event of a medical emergency.

Safeguarding

Staff at the health-based place of safety understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff at the health-based place of safety received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. The compliance rate for mandatory training in safeguarding level two and three was 100%. All patients were seen by an approved mental health practitioner (AMHP) during the assessment processes. The AMHPs were able to check the local authority database for safeguarding information about the patient and those they were in contact with. Staff knew how to recognise adults and children at risk of or suffering harm and knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Staff at the health-based place of safety kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient records and notes were clear, and all staff could access them easily. Staff used the trust's electronic database to record and store information. Information about the patient's previous contact with trust services was readily available. Progress notes were detailed and easy to follow. Staff used a specific section 136/135 electronic form that included information on contact with the police, ambulance services, emergency departments, AMHPs and section 12 of the Mental Health Act appointed doctors. We reviewed 15 section 136/135 electronic forms. These showed that staff were recording the appropriate data and information that included details of when patients stayed in the HBPoS for more than 24 hours. Of the 15 records reviewed there was one occasion where a patient remained in the HBPoS over 24 hours. The records showed that this individual waited at the HBPoS while a bed on an inpatient ward was being prepared. This was managed appropriately in discussion with the patient.

Mental health crisis services and health-based places of safety

Medicines management

The health-based place of safety used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Staff said doctors seldom prescribed medicines to a patient whilst they were in the HBPoS. Medicines were not stored in the HBPoS, but staff could access the emergency medicines cabinet or standard medicines cabinet on Picasso Ward to administer medicines. They made good use of the integrated prescribing system and automated cabinets to ensure patients received required mental health and physical health medicines in a timely manner.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. In the suites 'when required' (PRN) medicines were used very rarely. The staff on the unit were experienced and aware of the risks of using sedative medicines for people who they were unsure what other medicines might already be in the system. Staff followed trust and national guidance on the management of violence and aggression.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence (NICE) guidance. While patients were in the service, they were monitored continually for any deterioration in physical health presentation and staff were knowledgeable about the risks that people's medicines could have on their physical health.

Track record on safety

The service had a good track record on safety.

There were no serious incidents in the HBPoS between April 2021 and April 2022.

Reporting incidents and learning from when things go wrong

The health-based place of safety service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

Staff knew what incidents to report and how to report them. Staff reported Staff said they were aware of the rust's incident reporting procedures and could easily report incidents. Staff understood the duty of candour. Staff said that managers would debrief and support staff after any serious incident. Staff stated that managers shared learning about incidents from across the trust and other NHS trust. Staff demonstrated knowledge of serious incidents and how learning from these incidents improved their care and support for patients.

Is the service effective?

Good ➔➔

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

Mental Health Crisis Services

Mental health crisis services and health-based places of safety

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the home treatment teams worked with patients and families and carers to develop individual care plans and updated them when needed.

However, improvements were needed to ensure that care plans were more personalised and reflected their needs.

We reviewed 24 care plans across the teams. Staff working for the home treatment teams worked with patients and families and carers to develop individual care plans and updated them when needed.

Most staff developed a comprehensive care plan for each patient that met their mental and physical health needs. For example, care plans were up to date and recorded the patients physical and mental health needs. For one patient, staff had recorded that a patient needed support with their medicines and ensuring this was monitored. Another patient had a care plan addressing their social circumstances.

Whilst staff regularly reviewed and updated care plans when patients' needs changed, some care plans were generic and lacked details of the patients' needs. Patient goals were often not specific or time oriented and reduced to very generic statements. For example, 'I will work with HTT on my goals' and 'I want to get better.'

Whilst staff supported patients to be discharged from the crisis service and planned for patient's discharge, this was not always reflected in patients care plans. For example, for a patient whose discharge was delayed whilst they were waiting for housing, this had not been included in their care plan. Housing issues had some impact on caseloads in Waltham Forest HTT and Barking, Dagenham and Havering HTT as discharges were being delayed whilst patients were suitably housed.

Staff carried out physical health assessments. Most physical health checks could be carried out within patient's homes, except for an electrocardiogram. In Barking, Dagenham and Havering HTT staff were piloting the use of an electrocardiogram (ECG) foot machine, that could be used within patients' homes. For those patients receiving anti-psychotic medicines, staff ensured additional blood tests were completed.

Best practice in treatment and care

Staff working for the home treatment teams used recognised rating scales to assess and record severity and outcomes. Staff working for the home treatment teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Staff assessed patient need for psychological interventions and made referrals to the team clinical psychologist where appropriate. Staff worked closely with the psychologist in the team to provide patients with psychological interventions such as cognitive behavioural therapy and family therapy. Psychology staff provided training and reflection sessions to the wider team. In Redbridge HTT the psychologist had provided training to staff on social systems, a model of care recognising the importance of social relationships in creating and maintaining good mental health.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Patients were referred to specialist health services when needed. We observed staff discussing patients' physical health concerns in the team's daily multidisciplinary meeting.

Mental health crisis services and health-based places of safety

Staff supported patients to live healthier lives by encouraging them to take part in programmes or giving advice. Staff referred patients to smoking cessation support and healthy lifestyle groups. Staff also supported patients with alcohol or other substance misuse issues by referring them to specialist services.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. The lead clinical psychologist for the crisis pathway used a range of psychological tools to measure patient outcomes and progress to determine a treatment plan. These included the CORE outcome measure (CORE-10) and DIALOG for patients to assess their health status.

Managers used results from audits to make improvements. The trust had an audit programme that collected data on care planning, risk assessment and physical health investigations each quarter. Managers received the performance scores for their teams against this data and this was reviewed and discussed in team meetings.

Skilled staff to deliver care

The home treatment 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 the range of skills needed to provide high quality care. Managers provided an induction programme for new staff.

Whilst staff reported they received regular supervision to further develop their skills, the figures for supervision rates were low linked to the accurate recording of supervision sessions.

The service had a full range of specialists to meet the needs of patients. This included nurses, social workers, psychologists and doctors, including consultant psychiatrists. In Barking, Dagenham and Havering HTT, newly created occupational therapist (OT) posts were in the process of being recruited to.

Managers gave each new member of staff a full induction to the service before they started work. New starters received a two-week induction on joining the service. This included shadowing staff on visits and completing all mandatory training.

Managers supported staff with regular supervision and opportunities to further develop their skills. Staff told us that they received monthly supervision where they discussed areas such as issues affecting work, caseloads, training and development, and wellbeing at work. Staff stated that they found this helpful in managing their roles.

However, the figures for supervision rates were low. As of April 2022, only 31% of staff in Redbridge HTT had received supervision. The manager said this figure was not correct and attributed this to the supervisory staff being unable to access the trust's performance dashboard to enter the supervision rates. We were advised that this issue had been escalated for action.

In Barking, Dagenham and Havering HTT 53% of staff had received supervision during April 2022. The manager in Barking, Dagenham and Havering HTT said that supervision had recently been low due to staff taking their annual leave after the pressures of COVID-19. Staff reported that they received their supervision regularly.

Staff received yearly appraisals from their line managers. During the COVID-19 pandemic appraisals had been suspended and were now being reintroduced. As of April 2022, the average appraisal rate across the three teams was 74%. The teams with the lowest appraisal rate were Barking, Dagenham and Havering HTT (62%) and Redbridge HTT (67%).

Managers made sure staff attended regular team meetings or received information from those they could not attend. These meetings discussed matters relating to service delivery and performance such as safeguarding, serious incidents, health and safety, and patient experience. Meeting minutes were shared with all staff to ensure those that did not attend were updated. The teams also received regular reflective practice meetings facilitated by psychologists. This meant staff had protected time to discuss complex cases and share learning.

Managers made sure staff received any specialist training for their role. Staff received training in open dialogue, a model of mental health support using family therapy and related psychological skills. Staff received training in suicide prevention as part of their induction. The psychologist trained staff in dialectical behavioural therapy (DBT) to support patients with difficulties in emotional regulation.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers discussed professional development with staff during supervision and appraisal sessions. Staff told us they were given responsibility for specific areas of work and these opportunities developed their skills and competencies. For example, leadership and mentoring training.

Managers recognised poor performance, could identify the reasons for this and dealt with them. Managers sought advice from human resources and their manager to support them managing poor staff performance.

Multi-disciplinary and interagency teamwork

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. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff in each team attended handovers twice a day to manage patient risk and plan for the day. Staff discussed high risk patients, the plan for the mornings and afternoons and the current bed state on the inpatient units.

Staff held twice weekly multidisciplinary meetings to discuss patients and improve their care. These meetings were dedicated to discussing patients. Staff discussed new referrals and reviewed existing patients and their risk ratings. Staff reviewed the treatment and support plan for each patient. Whilst these meetings were effective in discussing patients care and treatment, the meetings we observed in Redbridge HTT and Barking, Dagenham and Havering HTT over ran and involved lengthy discussions., which could impact upon the efficacy of these meetings and the time available to see patients.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. Staff carried out a joint visit with the care coordinator at the patients' home at the point of discharge from the team. A representative from the HTT attended the inpatient wards every day, on a rota basis. This facilitated the discharge process and provided continuity of care for the patient.

Staff had effective working relationships with other teams in the trust. They attended bed management meetings with representatives from the inpatient wards, community mental health teams and early intervention teams to discuss patients from the catchment area and any barriers to their progress and/or discharge. Managers attended the acute and rehabilitation directorate high level risk meeting. This meeting discussed the most complex and high-risk patients and young people that were under the care of this directorate.

Mental health crisis services and health-based places of safety

Staff had effective working relationships with external teams and organisations. For example, staff could attend police liaison group meetings. Staff discussed complex cases with appropriate external organisations to effectively address any delays for Mental Health Act assessments.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff could describe the Code of Practice guiding principles. The trust provided staff with training in the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The trust had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local MHA policies and procedures and to the Code of Practice, which were readily available on the staff intranet.

Patients had easy access to information about independent mental health advocacy. Staff gave patients information leaflets that included the contact details for independent mental health advocacy during patients' first contact with the HTTs.

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed.

Staff completed regular audits to make sure they applied the Mental Health Act correctly. Staff in the Integrated Crisis Assessment Hub (ICAH) team kept a log of each patients' Mental Health Act status on their white boards, so they could review at the daily meetings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff had a good understanding of at least the five principles of the Mental Capacity Act (MCA). The trust provided training in the MCA.

There was a clear policy on the MCA, which staff could describe and knew how to access. Staff knew where to get accurate advice in relation to the MCA.

Staff gave patients all support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. For example, if a patient was intoxicated, staff waited until the patient was able to decide about their care and treatment.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. In Waltham Forest HTT we identified a capacity assessment that was time and decision specific for the patient based on the patient's living situation. In addition, staff recorded that patients consent to visits from the HTT.

Mental health crisis services and health-based places of safety

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Staff knew how to make decisions in the best interests of the patient. For example, in Redbridge HTT, staff discussed a patient's capacity and who they would need to involve in their care to decide in their best interests.

Health-Based Place of Safety

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients.

Staff at the health-based place of safety (HBPoS) completed a comprehensive mental health assessment of each patient. A duty doctor and a nurse conducted a mental health and physical health assessment shortly after admission to the service. This included an assessment of the patient's mental state, their vital signs and any physical health issues including consideration of any level of intoxication. Further assessments were then carried out by a section 12 of the Mental Health Act approved doctor and an AMHP. Following this assessment, a decision was made about the outcome for the patient. For example, either being discharged to their home or being admitted into an inpatient acute or assessment ward under section 2 of the Mental Health Act.

Best practice in treatment and care

Staff working in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

Staff delivered care in line with best practice and national guidance. The trust attended a quarterly joint police mental health strategic review group meeting to review the section 136 pathway and the operation of the HBPoS. The service's data was collected in line with best practice. Staff were recording key data and information from the use of the HBPoS and the section 136 pathway. This included the number of section 136 and 135 detentions, the average time between the section 136 detainee's arrival at the place of safety and the completion of the assessment; section 12 doctor compliance, AMHP assessment compliance, admission to the trust inpatient service outcomes, episodes over 24 hours and 36 hours, repeat users and a breakdown of use of section 136 by ethnic category. However, the service did not yet have a system to record the number of section 136 detainees that were supported through adult and children emergency departments. The trust was aware of this gap in their data and were planning to participate in a NHSE London wide project in Autumn 2022 to digitise and record data of section 136 detainees that were supported through emergency departments.

Staff took part in clinical audits and benchmarking initiatives. The HBPoS audited its practice in respect of section 136. Staff participated in clinical audits, which helped to assure the quality of the service provided to patients. Staff completed audits on the use and application of the Mental Health Act and ligature risks.

Skilled staff to deliver care

The health-based place of safety 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 the range of skills needed to provide high quality care. They supported staff with supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The HBPoS service had access to a full range of experienced specialists to meet the needs of the patients in the service. This included medical doctors, qualified nurses, AMHPs, support workers and pharmacists.

Mental health crisis services and health-based places of safety

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff said they found their colleagues to be skilled and experienced in working with people experiencing a mental health crisis. Managers gave each new member of staff a full induction. Staff confirmed they had received an induction to the service before they started work. This included training on section 136 and section 135 of the Mental Health Act MHA, and training from the AMPH teams.

Managers supported staff through regular, constructive clinical supervision of their work. The supervision compliance average for April 2021 and April 2022 was 85%. Supervision records showed staff discussed a range of areas such as wellbeing, workload, personal and professional development and to reflect on and learn from practice. Staff also reported they were happy with the overall quality of the support provided by their managers.

Managers made sure staff attended regular team meetings. Staff attended regular business meetings. Staff said these were helpful. They discussed areas such as incidents from across the trust and at other trusts, triage, pathway and service developments. Staff could also raise any concerns they had. Managers worked with staff to identify any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff said the trust provided them with a range of specialist training to maintain and develop their professional competence.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff made sure they shared clear information about patients and any changes in their care, including during transfers of care. The HBPoS team held a monthly team business meeting for staff. The team had effective working relationships with other teams in the organisation such as the teams in the assessment ward and inpatient wards. The team had effective working relationships with external teams and organisations. staff demonstrated good multiagency working in the application of section 136. Records showed staff liaised well with other agencies involved in the patient care pathway. This included the police, ambulance services, emergency departments and local authority.

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

Staff in the health-based place of safety understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. The team compliance rate for this training was 100% at April 2022. Staff fully understood their responsibilities in relation to the use of section 136, section 135 and the HBPoS. A member of staff was always available by phone to give advice to the police on whether they should use section 136 or not. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Staff at the service informed patients of their legal status and rights on admission to the service. All records reviewed showed a strong focus on ensuring patients were told their rights. Staff completed regular audits to make sure they applied the Mental Health Act correctly.

Good practice in applying the Mental Capacity Act

Staff understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Mental health crisis services and health-based places of safety

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The team's compliance rate of training in this area was 100% at April 2022. There was a clear policy on the Mental Capacity Act, which staff knew how to access. Staff knew where to get accurate advice on Mental Capacity Act. Records included details of assessments of the patient's mental capacity to make decisions about their care and treatment. These covered the patient's level of insight and their ability to weigh up information to make decisions.

Is the service caring?

Good  

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

Mental Health Crisis Services

Kindness, privacy, dignity, respect, compassion and support

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.

Staff were discreet, respectful and responsive when caring for patients. We spoke to 15 patients and four carers and relatives who used the crisis service. Patients described staff as caring, kind and respectful. Patients said staff treated them with dignity and were non-judgmental. One patient said that staff had helped them, and they really appreciated it and were now out of crisis. Eight patients said that they felt listened to and involved in their care.

Whilst patients and carers said that staff were caring, we received mixed feedback about accessing the service. Four patients said that at times the service could be difficult to contact, with phone calls not being responded to. A further three patients and carers gave negative feedback about the consistency of staff. They preferred to have the same crisis worker attending their home where possible. One patient said that the out-of-hours crisis line was 'not so good', but that the home treatment was very good.

Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. We observed staff discussing patients in their daily handovers and clinical risk meetings. Staff spoke about patients in a respectful, empathic and understanding manner. In Redbridge HTT, staff discussed a patient they knew very well in a holistic way and ensured that the treatment was in their best interests. Staff demonstrated care and compassion in the way they spoke about patients. Staff directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients. Staff raised any concerns they had with their teams and managers and their concerns were acted upon.

Staff followed policy to keep patient information confidential. Staff had undertaken information governance training and understood how to protect patient confidentiality. Patient records were stored securely.

Involvement in care

Staff in the mental health crisis teams did not always involve patients in care planning and risk assessment.

However, staff sought patient feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed. Staff informed and involved families and carers appropriately.

Involvement of patients

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

Whilst staff said they prepared care plans with patients and made sure they received a printed copy, patients and relatives did not always concur with this. Six patients and relatives reported that they did not know what their care plan meant, or they had not received a copy of their care plan. A further four patients and carers said they did not find their care plans helpful. Staff recorded patients' views in care plans.

Staff provided specific advice to patients and carers about their medicines. Staff discussed patients' feedback about their medicines during weekly clinical review meetings. Staff gave patients information about medicines typical for mental health in the crisis service welcome packs.

Staff involved patients in decisions about the service. Staff had involved patients in the creation of the crisis services' welcome pack.

Patients could give feedback on the service and their treatment and staff supported them to do this. Each HTT collected feedback from at least five patients per month. Each team had a staff member taking responsibility for this. Staff called patients by telephone to seek their views and recorded this information.

Staff made sure patients could access advocacy services. The service displayed notices about advocacy services in their group room and included advocacy details in the service welcome packs.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed, and involved families or carers. As a result of feedback from carers in Redbridge HTT, staff decided to create a welcome pack for carers. Carers and relatives had input into the pack as they wanted to be able to understand more about the crisis service and to access help and support themselves. The welcome pack included information about the carer's forum, self-help, complaints and what to do when your family member is in a crisis.

Staff helped families to give feedback on the service. Redbridge HTT had set up a fortnightly carers support group. This group was run by the psychologist and social worker and provided support to carers and relatives when their loved one was in a crisis. The group gave practical advice on how they could receive support in the local area.

Staff gave carers information on how to access a carer's assessment. We observed staff discussing the need for a carer's assessment during the weekly clinical risk meetings. Staff also recorded in patient notes where they had signposted relatives for a carer's assessment.

Health-Based Place of Safety

Mental health crisis services and health-based places of safety

Kindness, privacy, dignity, respect, compassion and support

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.

Staff spoke about patients in a kind and respectful way. Staff could explain how they reduced the patients' stress and anxiety when they were brought to the service by explaining why they were in the service and the assessment process. Patients were able to access the service through a discreet entrance. Staff had a supply of toiletries available to use. If a patient was returning to their own home and for transport and an escort if needed. Staff followed policy to keep patient information confidential.

Involvement in care

Involvement of patients

Staff made sure patients understood their care and treatment. Staff said they explained to patients why they were in the HBPoS and how their needs would be assessed. Staff told us that they often had to repeat information for patients who were extremely unwell. Records showed that, where possible, patients were involved in planning their care after they left the HBPoS. For example, community services and aftercare options were explained to patients if they were going home.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Records showed that, when appropriate, staff worked closely with the patient's family and carers, involving them in information gathering and discharge planning.

Is the service responsive?

Good ↑↑

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

Mental Health Crisis Services

Access and discharge

The trust had worked hard to develop a new pathway for patients in crisis to access services through the integrated crisis assessment hub, in an innovative and timely way. However, patients who could not attend at the hub would still go to an emergency department (ED) in a local acute hospital where they received support from the psychiatric liaison teams. Some experienced long waits in the ED but this data was not routinely available. Some patients found it hard to contact the home treatment teams by phone.

The mental health crisis services were available 24-hours a day and were easy to access, including through a dedicated crisis telephone line. The referral criteria for the home treatment teams did not exclude patients who would have benefitted from care. Staff assessed and treated people promptly. Staff followed up people who missed appointments.

Mental health crisis services and health-based places of safety

The mental health crisis services were available 24-hours a day and were easy to access, including through a dedicated crisis telephone line. Referrals for patients needing crisis support all came through the Integrated Crisis Assessment Hub (ICAH). The hub had been operational since 2020. Patients in crisis could attend at the hub where they would be assessed, and appropriate services provided. The implementation of this service meant that patients no longer reported to or waited at Sunflowers Court to be assessed when in crisis. The hub was housed in a purpose-built environment and had its own stand-alone staff team. Its premises and model of care were innovative and met the needs of a range of people who needed to access crisis services.

The trust provided a dedicated 24-hour crisis line for patients and carers. Staff providing this service arranged for callers to speak with mental health professional who signposted callers to appropriate support.

The crisis teams had skilled staff available to assess patients 24 hours a day, seven days a week. Since our last inspection, staffing had been reviewed to include medical cover in the integrated crisis assessment hub (ICAH).

The crisis team staff worked shifts throughout a 24-hour period. Staff from the home treatment teams provided cover at night for the trusts' gatekeeping team (ICAH) on a rota basis.

The referral criteria for the mental health crisis services did not exclude patients who would have benefitted from care. Referrals to the hub came from GPs, inpatient wards, community mental health teams, London Ambulance Service, the police and accident and emergency departments. The hub provided an open-access service so that patients and their families could self-refer. This made it easier for those patients that were not already known to mental health services.

We looked at the data collected by the trust for the hub for the period 1 January to 30 April 2022. This showed that 249 patients had been assessed at the hub during this period. The data also showed that 94 patients were referrals from the local accident and emergency departments. The second highest number of referrals was from patients 'walking in' (80) and seeking support in a mental health crisis.

During the same period, most patients at the hub were referred to the home treatment teams for support with their crisis. A total of 39% of patients were supported this way, after this the second largest referral outcome was patients either being admitted informally (15%) or discharged back to their care coordinators (15%). This indicated that most patients assessed by the hub received the least restrictive intervention.

Staff at the hub assessed and treated people promptly. Staff triaged referrals within 90 minutes and aimed to complete a full assessment of the patients' needs and a treatment plan within 4 hours. This allowed patients in a crisis to be seen and assessed promptly at all times of the day.

Staff assessed patients in a crisis promptly and patients were admitted to a mental health inpatient bed in a timely way. The manager overseeing the hub kept data on the length patients stayed there. During April 2022, a total of 60 patients attended the hub for assessment. Of these 60 patients, 10 went on to be informally admitted to the trust's inpatient unit, with a further two patients being admitted formally. Amongst these patients, most fell within the 4-hour timeframe to be assessed and admitted to an inpatient bed. We found two incidences where patients waited 4.5 hours from the end of their assessment to be transferred to the trust's mental health inpatient service. However, most patients attending the hub for an assessment did not stay for long periods and never waited more than six hours to be admitted to an inpatient bed after their assessment.

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. The trust had been working on a project with London Ambulance Service (LAS) for two years to better support

patients at the start of their mental health crisis. A staff member from the trusts ICAH team had been seconded to work in the LAS ambulance control rooms to improve telephone triage and support. This avoided conveyance to the local acute trust's emergency department ED where appropriate. The ICAH staff worked closely with the police in their street triage team to provide advice and assistance, so patients received the appropriate care.

Staff encouraged patients to access other important organisations such as drug and alcohol services. This ensured patients could be supported with their drug and alcohol needs during their crisis.

Staff followed up people who missed appointments, either by phone or in person.

Patients had some flexibility and choice in the appointment times available. Staff attempted to see patients at a time of day that was suitable for them. In addition, staff worked with patients' families (where appropriate) to ensure they could attend the appointment.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. Appointments ran on time and staff informed patients when they did not. Patients told us that staff contacted them by telephone to arrange appointments. Patients said this helped and they appreciated the telephone call. Some patients told us it was hard to contact the home treatment teams by phone.

Staff supported patients when they were referred, transferred between services, or needed physical health care. When a patient required medical attention for their physical health needs whilst they were in the hub being assessed, staff would arrange for them to attend the nearby emergency department.

Staff transported patients where they needed to go when their assessment was complete. Staff accompanied them to either their home or to the inpatient unit.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

Where staff met with the patients on the premises, they had a full range of rooms and equipment to support treatment and care. Interview rooms in the service had sound proofing to protect privacy and confidentiality.

In some instances, the trust provided accommodation to patients who had no fixed abode, at the point of access to the home treatment teams.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

The social workers in each home treatment team held regular surgeries to support patients with their housing needs and benefits. The teams had recently created a dedicated staff member to link in with the local authority to support patients with their housing applications. Staff said this had helped and was an improvement to supporting patients with housing needs.

Staff helped patients to stay in contact with families and carers. Staff involved carers in patients' care and treatment where they consented. Redbridge HTT had developed a welcome pack for carers that provided information on consent to information sharing about the person they were supporting.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community**.** Redbridge HTT included information about the local LGBTQ networks in the welcome packs that patients received.

Meeting the needs of all people who use the service

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 could support and make adjustments for disabled people and those with communication needs or other specific needs. The premises could be accessed via a lift for patients with mobility needs.

The trust had a good understanding of the make-up of the local population and tried to recruit staff to better match that of the communities they served. This meant that some staff could speak languages other than English. Managers facilitated patients requests when they preferred a male or female visiting them at home.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The service provided information in a variety of accessible formats. Each team gave patients a welcome pack that included information such as how to complain, local services, medicines, treatment and contact details for the team. The service had information leaflets available in languages spoken by the local community.

Managers made sure staff and patients could access interpreters or signers when needed. Staff tried to rapidly organise interpreters when they had assessments to complete and used alternative means of interpretation when a patients first language was not English. Staff used internet-based tools to support interpretation when they needed to communicate with a patient in an emergency.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients knew how to complain or raise a concern. Information was provided on how to complain in the waiting area of the premises where staff met patients. For those patients who did not meet staff on the premises, they used the information contained in the welcome packs for making complaints.

A patient said they had complained before and received a resolution. Other patients explained they felt able to raise a complaint with staff informally if they needed to. Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff understood the policy on complaints and knew how to handle them. Staff gave patients their manager's contact details if the patient had a concern or informal complaint that the staff member could not address. For formal complaints staff directed patients toward the trust's formal complaints procedure. When the service received a complaint, they sent the complainant a letter of acknowledgement. The service appointed a member of staff to lead the investigation. Patients were interviewed as part of investigations. When services upheld complaints, the complainant received an apology. Patients received feedback from managers after the investigation into their complaint.

Staff received feedback from managers after investigations. Managers discussed learning from complaints with staff in team meetings. For example, in Barking, Dagenham and Havering HTT, a patient complained about not receiving their medicines on time after they were discharged from the trusts' inpatient unit. As a result, staff created a new process to ensure that patients received their medicines on time.

Mental health crisis services and health-based places of safety

Health-Based Place of Safety

Access and discharge

The health-based place of safety was available 24-hours a day. The admission criteria for the health-based place of safety did not exclude patients who would have benefitted from care.

The service had clear criteria to specify which patients they would offer services to. People detained by the Metropolitan Police or British Transport Police and subject to section 136 and section 136 of the Mental Health Act had access to the HBPoS 24 hours a day, seven days a week. The service was available to patients under 18 and for out of area patients if the police brought them to the service, for example if the HBPoS in their home area was full. The service did not exclude people if they had committed a criminal offence or had consumed alcohol or drugs unless there was a medical risk. In these cases, staff would redirect the police to take the individual to an emergency department. A member of staff was always available to advise police about the use of section 136 and the availability of the health-based place of safety (HBPoS) suites. If the service was full, they made enquiries about other HBPoS and told the police where they could take the patient.

The service aimed to ensure that patients were assessed promptly, and data was collected on the timing of mental health assessments. Staff said most patients were assessed and discharged from the service within 24 hours. If patients stayed more than 24 hours it was usually due to issues related to the patient's specific needs, such as waiting for a bed on a particular ward. Staff at the HBPoS recorded the discharge destination for people discharged from the service. This included formal and informal admissions to inpatient wards, and discharges to people's homes. For all persons discharged from the HBPoS, staff ensured they had means of accessing accommodation, and the individual's GP and any community support they were accessing was notified of the admission within 24 hours via a written discharge summary.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of suites in the health-based place of safety supported patients' treatment, privacy and dignity.

Patients were seen within an appropriate environment, which was secure, calm and discreet. Both HBPoS suites had suitable facilities for mental health patients in a crisis. The service had added a children and young people's suite. This was not operational at the time of our inspection as the garden access and a lounge area for patients, family members and carers were still being developed.

Staff stored patients' property safely and securely at the service. Patients had access to their mobile phones if staff risk assessed this as safe and appropriate. Staff provided drinks, snacks, and hot meals to patients 24 hours a day, seven days a week.

Patients' engagement with the wider community

Staff supported patients with family relationships

Staff helped patients to stay in contact with families and carers while patients were in the service. Patient records show contact with family member where this was appropriate.

Meeting the needs of all people who use the service

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.

Mental health crisis services and health-based places of safety

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Staff assessed a patient's social, cultural, and religious needs and took this into account. The service had suitable access for people with disabilities. Managers made sure staff and patients could get hold of interpreters or signers when needed.

Listening to and learning from concerns and complaints

The health-based place of safety service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team.

Staff gave patients written information about section 136, the service, and how to complain. Staff understood the policy on complaints and knew how to handle them. Staff said most complaints were dealt with informally. Managers investigated complaints and identified themes. Between April 2021 and April 2022, the service received one formal complaint. This complaint was investigated and partial upheld. Managers shared feedback from complaints with staff and learning was used to improve the service. For example, from the formal complaint the service received additional training was provided to the team on equality and diversity with a focus on transgender issues.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Mental Health Crisis Services

Leadership

Leaders had the skills, knowledge, and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The managers had a good understanding of the service they managed and could clearly explain how the teams provided high quality care in a crisis. For example, the home treatment team managers explained the challenges patients faced in the borough and in mental health crisis care.

Senior managers were visible in the service and supported staff to develop their skills and take on more senior roles. Managers had knowledge and experience of working in crisis services and worked closely with the acute inpatient service. Managers knew what the challenges were within the crisis services and acted to address them. Staff told us that their managers were supportive and that they felt positive about local leadership. Consultant psychiatrists had a visible presence within the teams and provided strong clinical leadership.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They were aligned to local plans and the wider health economy. The trusts' new crisis pathway model - the integrated crisis acute hub – started off as a pilot in 2020. Senior managers said this had now become 'business as usual' due to its successful implementation.

Mental health crisis services and health-based places of safety

Staff demonstrated the trust's vision and values. Staff worked hard to ensure that patients received the right care at the right time when they were in crisis. Staff understood the pressures they faced and the impact this had on patients.

Some home treatment teams had been reconfigured. Redbridge HTT split into two localities to support with the increasing demand on the service. Since our inspection, Barking, Dagenham and Havering HTT had also split into two teams with an increase in staff numbers.

Culture

Staff felt respected, supported, and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt respected, supported, and valued. Staff reported the culture had improved in the trust in the last two years, especially around incident reporting and blame culture. Staff felt able to raise concerns and report incidents when harm had come to a patient and not feel blamed.

Managers dealt with poor performance appropriately. Managers gave staff time to discuss work issues before using formal performance management processes.

Staff felt the service promoted equality and diversity and provided opportunities for career development. The trust had staff networks for lesbian, gay, bisexual, transgender plus (LGBT+) and black and minority ethnic (BAME) communities. Staff in the home treatment teams engaged in the trust wide BAME network group. Redbridge HTT had a BAME ambassador who could support staff at a local level to promote equality and diversity. The trust facilitated BAME leadership training for staff to be equipped and feel valued to promote career progression.

Staff could raise concerns without fear. Staff knew how to use the whistle-blowing process and the role of the Freedom to Speak Up Guardian. Staff gave examples of where they had raised concerns before and felt supported by the trust when they had done.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

At the last inspection in June 2019, the trust did not ensure leaders listened to feedback from staff and took appropriate action to address the safety, risk, and multidisciplinary working issues in the acute crisis assessment team. At this inspection, improvements had been made.

Leaders ensured there were structures, processes, and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities. The trust had a clear framework of what must be discussed at a ward, team, and service level to ensure essential information was shared and discussed. Staff attended monthly business meetings. Staff followed a standard agenda which included complaints, audits, incidents, and training.

The service managers attended clinical governance meetings and senior management meetings. Managers fed information from these meetings back to their teams at monthly meetings. The managers also attended bed management meetings and met with other service managers within the acute care directorate to support a smooth pathway for patients in crisis.

Mental health crisis services and health-based places of safety

Staff implemented recommendations from reviews of deaths, incidents, complaints, and safeguarding alerts at the team level. The home treatment teams implemented a protocol for staff to use when patients missed appointments, after a serious incident investigation recommendation

Staff in the HTT participated in clinical audits. The audits provided assurance and staff acted on the results when needed. Clinical leads within each team peer reviewed patient records for quality. Staff addressed concerns with their colleagues where needed.

Staff understood arrangements for working with other teams, both within the provider and externally, to meet the needs of the patients. Staff understood the structure and function of other services and teams in other parts of the care pathway. Staff attended interface meetings with other teams such as inpatient and community mental health teams to support smooth patient movement through the pathway. Staff understood how safeguarding teams, the police and emergency services in their boroughs provided support.

Management of risk, issues, and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Managers understood the issues, priorities and challenges the service faced and managed them. Senior managers held weekly multidisciplinary team meetings with staff across the acute and crisis pathway to discuss patients considered to be high risk. Managers within the home treatment teams could escalate a high-risk patient to this meeting so that senior managers were aware of these patients.

Team leaders ensured risks were dealt with at the appropriate level. Staff added to local risk registers. The risk register contained pertinent risk issues to staff and patients within their teams. These included risks such as staffing and caseloads.

However, the trust could not provide the data of compliance rates for conflict resolution and breakaway training. The trust's online training system was unable to generate a report for this training and had only been picked up recently. The trust had put this on their organisational risk register due to the importance of this essential training.

Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care. The consultant psychiatrists and psychologists provided input into the effective running of the service. For example, providing training to staff and input into learning from serious incidents.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. Since our last inspection, the trust had moved to a new platform to collect, collate and share key performance information. However, there was varying confidence and competence amongst staff in using the platform. A new 'STEPS' system had been introduced to monitor supervision compliance. Further work was needed to ensure that all staff could input into this system.

Mental health crisis services and health-based places of safety

Staff analysed data in the hub to check outcomes and measure performance over time. Data collected included waiting times, referral sources, and referral outcomes. This data allowed for the trust to successfully put forward a business case to move the hub from a pilot project to 'business as usual.'

The service used systems to collect data from the teams and frontline staff did not find these systems over-burdensome. Staff had laptops to assist with their record keeping when out on visits. Some managers found the new dashboards useful.

The information systems were integrated and secure. Information governance systems included confidentiality of patient records. All patient's records were kept electronically in a password-controlled database that only trust staff could access. Staff used laptops to support patients in their homes and record their visits. This ensured staff could work flexibly in the community.

Engagement

There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. 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 experienced a mental health crisis.

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. For example, staff had access to the trust intranet that contained up-to-date information on trust news. Staff provided patients and carers with a welcome pack when they were referred to the crisis teams. This included information about how to contact staff, local community groups and how to make a complaint.

Staff in Waltham Forest HTT were engaged with executive leaders to improve the service for their staff and improve patient outcomes. Waltham Forests HTT current base was too far for staff to travel between the office and visits in the community. The manager was working with the executive chief nurse to look for satellite sites in Waltham Forest, so staff were not travelling long distances every day.

Staff collaborated with partner organisations to help improve services for patients within the trust. The team managers worked actively with partner agencies. This included the police, and the London ambulance services. The ICAH staff worked closely with the police in their street triage team to provide advice and assistance, so patients received the appropriate care.

Staff collected feedback from patients and carers on an on-going basis. In Redbridge HTT, staff sent recently discharged patients a text message so they could provide feedback. The results of the feedback were discussed in monthly team meetings to ensure improvements were made. Some of the feedback received included lack of consistency of staff and a lack of information for carers and relatives.

Learning, continuous improvement and innovation

Staff were committed to continually improving services. Since we last inspected this service in June 2019, the trust had significantly improved their crisis pathway. The Integrated Crisis Assessment Hub (ICAH) had been set up to meet the national four-hour guideline of having a management plan in place for patients presenting in a mental health crisis.

For the previous two years the trust had been working with the London Ambulance Service (LAS) to better support patients at the start of their mental health crisis. In Barking, Dagenham and Havering HTT staff were piloting the use of an electrocardiogram (ECG) foot machine.

Mental health crisis services and health-based places of safety

The teams participated in accreditation schemes. All home treatment teams had recently been accredited by the Home Treatment Accreditation Scheme (HTAS).

Health-Based Place of Safety

Leadership

Leaders had the skills, knowledge, and experience to perform their roles. They had a good understanding of the health-based place of safety, were visible in the service and approachable for staff.

The service manager and clinical leads had a good understanding of the HBPoS. They could explain how the team was working to provide good quality care. Staff said the service manager was regularly at the service and operated an open-door policy. Shift leaders were registered mental health nurses with extensive experience of working with patients experiencing mental health crises.

Vision and strategy

Staff at the health-based place of safety knew and understood the provider's vision and values and how they were applied to the work of their team.

Staff understood the trust's vision and values and how they applied to their work with patients. Staff were fully updated on developments within the service and were positive about the additional suite and lounge areas.

Culture

Staff at the health-based place of safety felt respected, supported, and valued. They could raise any concerns without fear.

Staff were positive about the way they were supported by their managers and colleagues. They were extremely proud of the way they carried out their work and supported one another. Staff were positive about the performance of their team and said they felt both physically and psychologically safe in the work environment. Staff also felt positive and proud about working for the trust. Staff were confident that they could raise a concern without fear of retribution. They knew how to use the whistleblowing process and the Freedom to Speak Up Guardian function.

Governance

Our findings from the other key questions regarding the health-based place of safety demonstrated that governance processes operated effectively at team level and that risk was managed well.

Governance arrangements were effective. The HBPoS was in a suitable location and well-staffed. There had been improvements to the premises since our last inspection and further developments were due to take place. Staff were recording key information about the patient's section 136 pathway. The trust attended a multi-agency police liaison group that co-ordinated the operation of the section 136 care pathway and the use of the HBPoS. This group met quarterly to review this data.

Management of risk, issues, and performance

The health-based place of safety team had access to the information they needed to provide safe and effective care and used that information to good effect.

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. The service manager could escalate and discuss risks with senior managers.

Mental health crisis services and health-based places of safety

Information management

The health-based place of safety staff collected data about outcomes and performance.

The team managers had access to information to support them with their management role through the trust's data management system. This included information on the performance on staffing and mandatory training. Staff said the IT (Information Technology) systems and telephones worked well to support care. Staff had access to the equipment and systems needed to do their work.

Engagement

There were effective, multi-agency arrangements to agree and monitor the governance of the health-based places of safety. 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 experienced a mental health crisis; regardless of the setting.

Managers and staff engaged with external stakeholders, such as the police, acute care, approved mental health practitioners and commissioners via forums such as the joint police mental health strategic review group meeting.

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

Good ↑

Is the service safe?

Good ↑

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

Safe and clean care environments

Most wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Ward layouts were safe, but not all bedrooms had access to nurse call alarms. Plans to upgrade the call alarm system were in progress

Safety of the ward layout

Staff completed and regularly updated risk assessments of all ward areas. They removed or mitigated any risks they identified. For example, ensuring rooms with ligature points were used under staff supervision and ensuring staff were in communal areas. Ward ligature risk assessments stated access to garden areas needed to be supervised due to ligature points.

Staff were aware of the environmental risks present on each ward and described how they worked to mitigate these risks. For example, staff on the wards explained how they used regular observations, convex mirrors and closed-circuit television (CCTV) to monitor blind spots on the ward. CCTV was installed in all areas of the ward except for patient's bedrooms and bathrooms. It was not possible to monitor the CCTV live from the nursing office. Managers instead retrospectively reviewed CCTV following any incidents or concerns

In addition to general observations relating to patient safety, staff carried out daily environmental checks of the wards. This was to identify any new environmental risks or maintenance issues. Once any concerns were identified, they would be reported via the trust electronic system to the maintenance team.

The hospital had a detailed fire risk assessment which included evacuation procedures. Each ward had a copy of the fire risk assessment. Yearly fire drills occurred on each ward, with most wards maintaining records of past fire drills. Staff completed training in fire safety, compliance rates across wards varied from 68% on Monet Ward to 92% on Picasso Ward. According to individual patient need, personal emergency evacuation plans (PEEP) for fire emergencies could developed. We saw that for one patient who was a wheelchair user, a PEEP was included in their electronic patient care and treatment record.

The service complied with the Department of Health and Social Care guidance on eliminating mixed-gender accommodation as most wards were single gender. The exception was Picasso Ward, a mixed gender clinical decision unit. Male and female patients were nursed in separate parts of the ward and staff had been trained in sexual safety. Building plans to split the ward in two along gender lines were being developed.

Staff on the wards carried alarms. Staff were able to call for assistance from other wards through the hospital alarm system. Some bedrooms on each ward had been fitted with a call alarm. Patients who were identified as being at higher risk were nursed in these rooms. Plans were being developed to expand the call alarm system to all patient bedrooms, although timescales for this were not available at the time of our inspection.

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

Maintenance, cleanliness and infection control

Staff made sure cleaning records were up-to-date. We saw housekeeping staff cleaning ward areas throughout the day. Some ward areas appeared tired and were in need of refreshment. For example, some painted walls on Kahlo Ward were peeling. On Ogura Ward there was some graffiti and a broken door hinge meant the door closed with a loud bang which could be distressing to some patients. There was also room for improvement in standards of cleanliness on Ogura Ward. We noted a damp smell in one bathroom, a dirty toilet and an overflowing bin in the garden area.

Staff followed infection control principles including appropriate handwashing techniques, use of personal protective equipment and hand sanitiser was readily available. We observed all staff wearing face coverings in all parts of the hospital.

Seclusion room

The seclusion room was located on Titian Ward, the male psychiatric intensive care unit.

This seclusion room had recently been renovated. It allowed clear observation, two-way communication, had a visible clock, and patient access to a toilet and shower.

When this room was in use staff were stationed in an adjoining observation office and could observe patients in the seclusion room with ease. Whilst a physical health monitoring system which helped staff to detect any deterioration in patients' was installed, staff still took manual physical health observations.

There had been 50 incidents where the seclusion room had been used between November 2021 and April 2022. Of those instances, 32 were patients from Titian Ward. The seclusion room was based on a male ward and was only used for male patients. When a female patient required nursing in seclusion there had been occasions when they had been nursed in the empty section 136 suite, whilst a suitable female psychiatric intensive care unit bed was located. Patients being nursed in seclusion were subject to appropriate authorisations and regular reviews in line with the Mental Health Act.

Clinic room and equipment

Clinic rooms were fully equipped. Staff checked, maintained, and cleaned equipment. Cleaning records were maintained. Clean stickers were used in clinic rooms to easily show staff when equipment was last cleaned. Clinic rooms had accessible resuscitation equipment and emergency drugs that staff checked regularly.

At our last inspection in 2019, we identified found that clinic room temperatures exceeded the acceptable range on some occasions, jeopardising the efficacy of the medications being stored. During this inspection we found improvements. Temperatures for the room were monitored by an electronic system which would alert staff and the pharmacy department immediately if temperatures exceeded acceptable ranges.

Safe staffing

With the use of regular bank and agency staff, the wards had enough nursing and medical staff who knew the patients. Most staff had completed basic training to keep people safe from avoidable harm.

Nursing staff

Wards had enough staff on each shift to keep patients safe and to carry out any physical interventions safely. Staff said there were enough staff on each shift.

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

The numbers of staff required on each shift varied between wards. Ward managers were responsible for reviewing the number of registered nurses and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the ward and patients. For example, if ward-based activities had been scheduled or if patients required escorted leave. The number of staff was also increased when more than one patient was being nursed on one-to-one observations.

The trust had recently introduced matrons to work night shifts, this provided extra support and guidance to ward staff out of hours.

Staffing vacancies varied across the wards. For example, Knight Ward had seven registered nurse vacancies and Ogura Ward had one registered nurse vacancy. There were ongoing recruitment drives to recruit staff. This included recruitment of newly qualified nurses and an overseas nursing programme.

The service monitored staff turnover. From April 2021 to April 2022, the turnover for all wards was 6.26%. Of these wards Titian Ward and Ogura Ward had the highest rates, at 10.05% and 14.29% respectively.

Managers used bank and agency staff to cover vacant shifts. They requested staff who were familiar with the service.

Bank and agency usage for registered nursing staff was high across wards. From November 2021 to April 2022 bank usage for registered nurses was highest on Picasso Ward at 52%. Picasso Ward also had the highest use of agency nurses during this period at 15%. Monet, Ogura, Titian and Turner Wards did not use any agency nurses during this period.

For non-registered nurses, bank usage ranged from 62% on Ogura Ward to 36% on Kahlo Ward. Agency usage of non-registered nurses was highest on Kahlo Ward at 35%. Monet Ward did not use any agency non-registered nurses during this same period.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The wards had an induction checklist which ensured important information such as policies, alarms and ward procedures were discussed.

Whilst the service attempted to fill vacant shifts with bank and agency staff, there were shifts which could not be filled. In April 2022 there were 84 unfilled registered nursing shifts across all wards. In this same month there were 68 unfilled non-registered nurse shifts. Ward managers aimed to cover unfilled shifts with staff from other grades. The hospital held safe care meetings each morning where senior leaders and nurses in charge came together to report on their staffing levels. If a ward required support to maintain minimum safe staffing levels, staff could be redeployed from another ward.

Between October 2021 and March 2022 staff sickness level was 8.6% across all wards. Knight Ward had the highest sickness level during this time at 12.57% followed by Kahlo Ward at 11.97%. Managers supported staff who needed time off for ill health. Staff reported their managers contacted them when they were off sick, which they found supportive. A psychologist who ran reflective practice for staff also met with staff on their return to work to discuss their wellbeing.

Patients rarely had their escorted leave or activities cancelled, but leave could be delayed or rescheduled when wards were short staffed.

Staff shared key information to keep patients safe when handing over their care to others. Registered nurses held handovers at the start of their shifts. A multidisciplinary team handover occurred each weekday morning.

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

Medical staff

The service had enough daytime and night-time medical cover.

Each ward had their own medical team which included a consultant psychiatrist and junior doctors. An out of hours duty rota was in place for medical staff to ensure there was 24-hour medical support available to the wards.

Managers could call locums when they needed additional medical cover. At the last inspection in 2019 we highlighted the trust's high use of locum doctors. Locum doctors remained in some positions in the hospital, with most having worked at the service for some time. Managers were aware of the importance of consistent medical support for their patients. Managers made sure all locum staff had a full induction and understood the service.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. It included topics such as risk assessment, health and safety, infection control, safeguarding and intermediate life support training. As of April 2022, over 85% of staff across all wards had completed their mandatory training. This included Titian Ward, where 95% of all staff had completed their mandatory training.

Managers monitored mandatory training and alerted staff when they needed to complete refreshers or other updates.

Assessing and managing risk to patients and staff

Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. In most cases, staff worked with patients to assess and manager risk, although the recorded risk assessments were not always updated.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool. Staff reviewed risk regularly including after any incident. For some patients we saw that risks were recorded in their progress notes and these had not pulled through into the risk assessment. Risk was discussed at handover and multidisciplinary team meetings. Staff demonstrated a good understanding of individual patient risks.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. The staff we spoke with had a good understanding of the patients on the ward, the associated risks and risk management plans.

Staff identified and responded to any changes in risks to, or posed by, patients. The multidisciplinary team reviewed the risks presented by patients daily in handover meetings and safety huddles. Plans to manage or mitigate individual patient risks were in place, although these were not always recorded consistently in the risk assessment.

All patients were checked once per hour. Some patients were on continuous observations which meant a member of staff was allocated to be with the patient at all times, for their safety or the safety of others. Other patients were on intermittent observations, which involved staff checking in with them four times per hour.

Staff followed procedures to minimise risks where they could not easily observe patients. For example, by ensuring staff were situated in the different areas of the ward. CCTV was available on the ward, and body cameras were being trialled

on some wards to reduce incidents and support investigations. Body-worn cameras were part of a pilot project. Patients had been involved in discussions and reviews regarding their use. The cameras were usually switched off, and only turned on when needed. The trust also had two anti-ligature doors installed on each ward. These doors had a sensor on top of the bedroom door to alert staff when pressure was applied to the top of the door frame.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff had recently had refresher training on how to effectively search patients following incidents of prohibited items being brought onto the wards.

Staff reported an increase in acuity and risk within the female acute wards. Some staff felt, as the trust did not have a female PICU ward, it meant there was more pressure on the female acute nursing teams to support these patients.

Use of restrictive interventions

Staff followed the National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Between November 2021 and April 2022, there were 388 incidents across all wards where medication was administered to patients by rapid tranquilisation. Of these incidents, 121 occurred on Picasso Ward, 80 on Titian Ward and 79 on Kahlo Ward.

At our last inspection in 2019, we found staff did not always monitor the physical health of patients who had received medication by rapid tranquilisation. During this inspection, we saw improvements. The trust had a robust system in place to ensure that all instances of rapid tranquilisation complied with trust policy regarding post dose monitoring. We found that for one patient there was a risk of over medication following an instance of rapid tranquilisation. This was escalated to the trust at the time of our inspection for investigation and learning.

Staff made every attempt to avoid using restraint by using de-escalation techniques. Staff restrained patients only when these failed and it was necessary to keep the patient or others safe. Between November 2021 and April 2022 there had been 298 incidents of restraint across all wards. Of these incidents, 85 occurred on Picasso Ward and 78 occurred on Titian Ward. Prone restraint, where a patient is in a face down position, occurred 50 times across all wards. Twenty of these restraints occurred on Titian Ward. Managers said that where a patient may need to be restrained in the prone position initially, staff would move to less restrictive holds as soon as safely possible. Wards were focused on reducing the use of restraint; a quality improvement project was in progress, data was regularly reviewed to look at trends and the reasons for them.

Staff on all wards received training on prevention and management of violent and aggression. Compliance rates ranged from 64% on Picasso Ward to 80% on Titian Ward.

Staff recorded episodes of restraint on the trust's electronic incident reporting system. Staff also completed a separate restraint form, which included detailed information on the holds used, staff involved and duration of the restraint.

Staff participated in the provider's restrictive interventions reduction programme, which was part of the providers 'respect' workstream. Staff received training in reducing restrictive interventions, the use of safety huddles and relational security. Managers had also introduced some 'safewards' initiatives, such as getting to know you staff boards and the use of soft words with patients. Restraint data was reviewed every two weeks to look at trends and issues in relation to restrictive interventions.

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

The trust regularly reviewed blanket restrictions on the wards. Subject to an individual risk assessment, patients were able to use their own mobile phone and have access to their headphones whilst on the wards. Managers had introduced charging cabinets for patient's mobile phones. This meant that patients could charge their phone without having to use a charging cable, which may present a ligature risk. Patients spoke positively about being able to use their own phones and have access to charging cabinets.

Whilst cold refreshments were freely available on the wards, hot drinks were not**;** patients needed to ask staff for these. Some wards had recently introduced tea times, where hot drinks and snacks were served to patients in between meals.

Quiet rooms on some wards had been locked as ligature anchor points had been identified in them. This meant that patients were reliant on staff being available for them to access these quiet rooms. Staff and patients on Knight Ward reported they were not able to use their garden area as there had been concerns of illicit substances being thrown over the fence. This ward did however have access to a balcony area with seating.

When a patient was nursed in seclusion, staff kept clear records and followed best practice guidelines.

Safeguarding

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 up-to-date with their safeguarding training for children, adults and PREVENT. Across the core service, there was a compliance rate for 88% for all mandatory safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had an internal safeguarding team who could be contacted for advice.

Appropriate procedures were in place to safeguard children who visited. A family room, which was booked in advance and away from the ward environments, was available for young visitors to see their relatives.

Staff access to essential information

Staff had easy access to clinical information and could maintain high quality clinical records.

Patient notes were comprehensive, and all staff could access them easily. Care and treatment records were stored on the trusts electronic record keeping system.

When patients transferred between wards, or to trust community services, there were no delays in staff accessing their records as the trust uses the same record keeping system across these teams.

Records were stored securely. All staff required an individual username and password to access the electronic patient record system.

Medicines management

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 recording of the reasons for using 'as required' medication were not always in place.

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff used an electronic system to prescribe and record the administration of medicines.

The pharmacy department provided expert clinical advice to prescribers and staff daily during ward rounds. They also ensured additional monitoring and safety considerations were being followed prior to a medicine being administered. These actions were all recorded on the electronic prescribing and medicines administration system (EPMA).

Medicines were dispensed by an external organisation and delivered to each ward daily. If medicines were required out of hours there were emergency drugs cabinets in two locations that could be accessed with the authorisation of the site officer and the pharmacy.

The staff on each ward made use of automated dispensing cabinets which improved patient safety by ensuring the correct medicine for each patient was dispensed. This system was linked to the EPMA and they co-ordinated to ensure all prescribed medicines were available for a patient when needed. Paper prescriptions were stored in the emergency medicines cabinets. Access to this was limited and required two members of staff to authorise use.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Pharmacy staff were able to attend daily ward rounds where patient's needs, including prescribed medicines, were discussed in the multidisciplinary team. Staff working out of hours could access the trust on-call pharmacy service for medicines advice or additional supplies.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacy technicians would attend the ward and complete a full medicines reconciliation within 24 hours of admission to a ward. This was documented on a patient's EPMA record and a copy given to the prescriber to support informed prescribing decisions. If a patient was prescribed a medicine on one ward and was then transferred it was still possible to access their medicines records via the EPMA and automated dispensing cabinets without delay.

Use of 'when required' (PRN) medicines to manage agitation and aggression on the wards was consistent with the acuity of the patients being treated. Whenever possible, de-escalation techniques were used before PRN medicines were considered. We saw that for some patient's records were not always completed showing why a medicine was needed and if it was successful in achieving the desired outcome. This could have an impact on making informed decisions when patient's medicine treatment regimens were being reviewed.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff ensured each persons' physical health was monitored regularly. They made use of the National Early Warning Scores (NEWS2) to improve detection of and response to clinical deterioration. Any medicines or treatment regimens that required additional monitoring had these carried out within the required timeframe.

The pharmacists would access blood results and other physical health monitoring records to ensure that medicines such as clozapine or lithium were being used safely. They also conducted regular reviews into the use of benzodiazepines for individuals every month and those people prescribed high dose anti-psychotic treatments.

Staff took appropriate action to safeguard patient's safety and monitor the effects of their medicines on them.

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

Track record on safety

The service had a good track record on safety. Staff discussed serious incidents that had happened across the wards within team meetings and shared lessons learnt. Senior staff met regularly to review incidents and share learning across each ward.

Reporting incidents and learning from when things go wrong

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.

Staff knew what incidents to report and how to report them. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff were able to tell us about recent incidents and the learning from them.

Staff understood the duty of candour. When things went wrong, staff apologised and gave patients honest information and suitable support.

Managers debriefed and supported staff after any serious incident. Staff reported debrief meetings occurred after any incident or restraint, but these were not always recorded. Reflective practice sessions on the wards allowed staff a space to discuss their thoughts following incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Investigations routinely involved the review of CCTV footage. Changes had been made as a result of investigating incidents. For example, following sexual safety incidents on two wards, the trust implemented actions such as, ensuring staff received specific training, ensuring posters were visible which highlighted key points. Staff told us they now spoke more openly with patients about how safe they felt on the ward. Staff on all wards were aware of these incidents and the learning. Staff also received training on how to effectively communicate information in an emergency following a medical emergency on the ward.

Is the service effective?

Good

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans with patients which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. When patients were admitted they were reviewed by a doctor for an initial assessment, as well as a nurse who completed base line physical health observations and oriented the patient to the ward.

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

Staff developed individual care plans for patients, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs and were written together with the patient. Most care plans included specific, measurable, achievable, relevant, and time-bound goals for patients to work towards.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. This included blood tests and electrocardiograms (ECGs) where needed.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. They participated in clinical audit and benchmarking but did not use recognised rating scales to assess and record severity and outcomes.

Staff provided a range of care and treatment suitable for the patients in the service and it was consistent with national guidance on best practice. Treatments were delivered in line with guidance from the National Institute for Health and Care Excellence (NICE). Doctors prescribed medicines appropriately with input from clinical pharmacists to ensure that national guidance was followed. Psychologists provided assessments and therapy for patients and occupational therapists provided a timetable of activities and support with activities of daily living.

Staff identified patients' physical health needs and recorded them in their care plans. For example, we saw patients with diabetes care plans and nutritional support care plans.

Staff made sure patients had access to physical health care, including specialists as required. The wards had access to a physical health specialist and a substance misuse team that visited when needed.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Smoking cessation service leaflets were available on the wards, as well as access to nicotine replacement therapy. We saw patients being given information on nutrition and healthy eating.

In all patient records we reviewed, staff did not use recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, the Health of the Nation Outcome Scales was not used to record the severity of patient symptoms on admission and discharge.

Staff took part in clinical audits. Across the service there were regular audits to check the quality of record keeping, for example care plans, risk assessment and physical health. These audits were completed by another ward within the hospital. The results and actions were then shared with the ward mangers and matron, who shared the findings with staff in team meetings or individual supervision.

Skilled staff to deliver care

The ward teams had access to a range of specialists required to meet the needs of patients. Whilst managers made sure they had staff with the range of skills needed to provide high quality care, some staff felt more occupational therapy and psychology input would be beneficial. Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. However, the recording of supervision discussions could further improve. Managers provided an induction programme for new staff.

The service had access to a range of specialists to meet the needs of the patients on the ward. For example, nurses, doctors, psychologists, occupational therapists and a physical health specialist. Each ward had access to a psychologist for two days per week. Each ward also had an assistant psychologist for two to three days per week. Some staff and managers reported having a full-time psychologist on their wards would be more beneficial to the patients.

Some staff commented that they would benefit from specialist training to be able to better support patients in their care who were autistic or diagnosed with a personality disorder.

Ward staff also said they needed more occupational therapy input. For example, Titian Ward had one senior occupational therapist, who also had managerial responsibilities. Staff felt this ward could benefit from having another occupational therapist to run the sessions on the ward. Some patients told us they did not feel there were enough activities, particularly those on Ogura Ward. Wards had been in the process of requesting an additional member of staff, an activity coordinator, who would specifically work to support the activity timetable. This role had not yet been agreed by the senior team.

Managers gave each new member of staff a full induction to the service before they started work. New staff had a trust induction before starting work on their ward. Once on their wards they had a local induction to orient them to their place of work. New starters were supernumerary for two weeks to allow them to shadow other staff members. The wards also operated a buddy system where new staff worked closely with experienced staff to support their learning.

Managers supported staff through regular, constructive clinical supervision of their work. Supervision for clinical staff was held monthly. The service had recently moved to a new online programme for recording supervision. Some of the supervision records we sampled did not include case discussion or mandatory training. In April 2022 monthly supervision compliance ranged from 68% on Kahlo Ward to 88% on Titian Ward.

Managers supported staff through constructive appraisals of their work. During the COVID-19 pandemic appraisals had been suspended. Teams were now getting back on track with these. At the end of April 2022 Knight Ward had completed 47% of appraisals and Titian Ward had completed 54%. All other wards had completed over 79% of their staff appraisals. Ogura ward had completed 100% of staff appraisals.

Managers made sure staff attended regular team meetings or gave information to those that could not attend. Wards had monthly team meetings, these meetings had a standard agenda to ensure they discussed safeguarding, incidents, learning and risks at all meetings. Records were kept following these meetings and shared with staff who did not attend. These minutes were also saved on the ward's shared drive.

Managers recognised poor performance, could identify the reasons for this and dealt with these. Ward managers and matrons gave examples of recognising and managing poor performance, for example, ensuring staff did not work excessive hours and having staff remain supernumerary until they were assured their practice was safe.

Multi-disciplinary and interagency teamwork

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 teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary team meetings took place every weekday morning on all wards. Staff felt they could contribute equally to the discussions at these meetings. Staff made sure they shared clear information about patients and any changes in their care. Nursing handover meetings took place between shifts.

Ward teams had effective working relationships with other teams in the organisation. For example, all ward managers across the hospital met weekly to discuss risks, incidents and share learning. Wards worked well with community mental health teams. Care co-ordinators were invited to ward rounds to discuss treatment and discharge planning.

Staff could access a physical health specialist for advice and support. They also provided training to staff on physical health issues, such as a refresher on how to complete the NEWS2 charts.

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

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, but improvements were needed to make sure informal patients on all wards understood what their rights were.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. One hundred per cent of staff required to complete training in the Mental Health Act had completed this over the core service.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. They knew to contact the Mental Health Act administrators for support.

Most patients had easy access to information about independent mental health advocacy. On Ogura Ward, advocacy information was not displayed in the main ward areas. Advocates visited the wards weekly and for other events requested by patients, such as ward rounds. Patients were also able to contact the advocate for advice outside of these meetings. Whilst posters were available on the wards, not all patients we spoke with knew what an advocate was and how to speak with them.

Staff explained to patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it in the patient's notes. However, some informal patients were not always clear on their rights to leave the ward.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. When patients needed a member of staff to escort them on leave, plans for allocating a member of staff were agreed at the morning mutual help meetings.

Managers received support from Mental Health Act administrators and were informed of upcoming important dates, such as section expiry dates.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

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

Staff received training in the Mental Capacity Act and had a good understanding of its principles. All wards had completed training in the Mental Capacity Act with a compliance rate over 90%; which included 100% of staff on Titian and Picasso Ward.

Staff knew who to speak with for advice on the Mental Capacity Act and deprivation of liberty safeguards. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff assessed each patient's capacity to consent to treatment on admission and at weekly ward rounds.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. When staff assessed patients as not having capacity, they made decisions in the best interest of patients.

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

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.

Staff were respectful and responsive when caring for patients. We saw staff had good relationships with patients and interacted with them in a kind and caring way. Most patients spoke positively about their experiences on the wards and said they felt safe. Patients said staff treated them well and behaved kindly. Most patients commented staff knew how to support them and were approachable.

Staff gave patients help, emotional support and advice when they needed it. Most patients reported having one to one time with nursing staff, but some patients said one to one time was not always offered as regularly as they would like. Two patients on Monet Ward reported staff told them they were too busy to have one-to-one meetings with them when they asked.

Staff supported patients to understand and manage their own care treatment or condition. Most patients told us they received advice in relation to their medication and possible side effects**.**

Staff directed patients to other services and supported them to access those services if they needed help. For example, patient's on Knight Ward were referred to Mother and Baby Units when needed.

Staff followed policy to keep patient information confidential. Over 83% of all staff had completed information governance training.

Involvement in care

In most cases, staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had access to independent advocates.

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

Involvement of patients

Staff introduced patients to the ward as part of their admission. Staff told us they provided welcome packs to patients upon their admission. Welcome packs contained information such as, what to expect from the team, search policy, complaints and compliments process, mobile phone policy and advocacy services. Four patients told us that they did not receive a welcome pack upon their admission to the ward.

Most patients reported being shown around the ward on admission. Others reported they had been on the ward before, so felt this was not needed. Patients views were included in their care plans using their own words where possible. Care plans enabled the patients to describe themselves and their thoughts.

Most patients reported being involved in their care and treatment and had copies of their care plans. Some patients did not have copies of their care plans and felt less involved in their care and treatment.

Staff made sure patients understood their care and treatment. Multidisciplinary staff met with patients weekly to discuss their care and treatment. Staff found ways to communicate with patients who had communication difficulties. Staff were able to access easy read care plans and documents for those who needed it.

Patients could give feedback on the service and their treatment and staff supported them to do this. Suggestion boxes had been introduced on all wards. Weekly community meetings took place on each ward where patients met with staff to discuss ward updates and provide feedback. Meeting minutes were displayed for patients to review on the ward notice board. Actions taken following community meetings were displayed on 'you said, we did' boards. For example, patients were wanting a basketball hoop in the garden on Titian Ward, which was provided, magazines were supplied for patients on Monet Ward, and pampering activities were introduced on Kahlo Ward.

Mutual help meetings occurred with patients every morning. These meetings were spaces for patients to discuss ways in which staff could support them. Staff involved patients in decisions about the service, when appropriate. Managers told us they had discussions with patients prior to introducing body cameras to seek their opinions and answer any questions. Titian Ward also involved patients in the designing of the artwork around the ward.

Involvement of families and carers

Staff informed and involved families and carers appropriately. Staff supported, informed and involved families or carers. Welcome packs were available for carers and staff made efforts to involve carers in line with patients' wishes. Relatives and carers were invited to attend ward rounds and discharge planning meetings where patients had given consent for them to attend. Family members could attend these meetings either in person or using video-conferencing facilities.

Staff and patients informed us visitors were allowed, but these needed to be booked in advance. Visitors were required to meet patients with the doors open or supervised due to the risk of illegal substances entering the wards. Patients on Picasso Ward were not able to have visitors, however these admissions tended to be between three and five days. Carers were able to have virtual and phone contact with patients.

Wards ran carer groups to support families and carers. These were mostly remote groups where carers were able to speak with the staff team and receive updates on the service. Carers were able to provide feedback to the service in these meetings.

Carers were able to call the ward with any queries or concerns. Carers also had a dedicated email address to contact, which was monitored daily by staff.

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

Is the service responsive?

Good 

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

Access and discharge

Beds were well managed; a bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

From November 2021 to April 2022 bed occupancy across the acute wards ranged from 80% to 100%. Although bed occupancy was high, staff reported beds were available for patients in their catchment area. Since our last inspection, the trust had developed closer links with their immediate neighbour and were able to access beds there should they have no capacity. This meant over the last 18 months, patients had rarely been sent out of area to access inpatient care.

Bed occupancy on Titian Ward, the hospital's PICU ward, ranged from 55% to 76%, meaning there had been a male PICU bed available whenever a patient needed it. There was no female PICU located within the trust. When a female required more intensive care they were referred out-of-area to a neighbouring trust or private mental health ward.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. When patients went on leave there was a bed available when they returned. On Monet Ward a patient's bed was being used whilst they were on leave. The patient returned once per week to be reviewed at ward round with a view to discharge.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. Patients would usually first be admitted to the assessment ward. Patients would then move to the appropriate male or female pathway.

When patients moved between wards, staff did not move or discharge patients at night or very early in the morning. Patient transfers to acute and PICU wards were planned and at times that were appropriate for the patient and team.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Patients did not have to stay in hospital when they were well enough to leave. Over the past six months one patient on Knight Ward and one patient on Monet Ward had their discharge delayed. These patients were awaiting appropriate supported accommodation and residential placements.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Community care coordinators were invited to all ward rounds. They were able to attend in person, or via video conferencing facilities.

Home treatment team coordinators worked across the wards. They attended multidisciplinary team meetings and worked closely with the ward team, community mental health teams and local authorities to ensure that there were no barriers for when the patient was ready to be discharged.

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

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom. There were quiet areas for privacy. The food was of good quality. Patients had access to a programme of therapeutic activities although on some wards we heard that people would like more activities.

Each patient had their own bedroom, which they could personalise. Not all of these bedrooms had en-suites. There were communal toilets, baths and showers for patients to use on each ward. We found some toilets were locked, which meant patients relied on staff to unlock these for them. Communal bathrooms were also locked, staff reported this was due to the potential ligature risks in these rooms.

Most patients had a secure place to store personal possessions. Patient rooms had a locker to secure possessions, but on some wards these were not in use. Patients were able to leave their valuables in their bedroom which could be locked by nursing staff. The ward provided additional storage space for larger items in a separate room, which was also locked.

Wards had a range of rooms and equipment to support treatment and care. For example, activity rooms, TV lounges and quiet rooms. Staff mentioned a dedicated sensory room would be helpful for their patients. Monet Ward had the equipment for a sensory room on the ward and were awaiting the removal of ligature points and installation of the sensory equipment in the designated room.

There was limited space on Kahlo ward, however the trust had planned to move some of the offices off ward to allow additional rooms for patients to use. At the time of inspection, the ward had a dining room, one locked quiet room and a tv lounge with seven chairs for a ward of 21 patients. The ward planned to introduce a further quiet room, an activity room and an additional room for visitors.

Patients could make phone calls in private. Patients were able to use their own mobile phones following individual risk assessments. These could then be used in their own rooms. Ward phones were also available for patients to use. Patients were also able to use hospital computers to access the internet if they did not have their own device.

Each ward had a garden or balcony area. All patients were also able to access a central courtyard, which had gym equipment. One female patient commented they felt uncomfortable using this area as males also have access to the courtyard.

Most patients we spoke with said the service offered a variety of good quality food.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships. The wards offered weekly programmes of activities provided by the occupational therapists. These included arts and crafts groups, mindfulness and a budgeting group. Patients also had access to games consoles, films and computers on the wards.

Staff helped patients to stay in contact with families and carers. This included supporting patients to have visits from family members and giving patient's access to the ward's video conferencing technology to speak with their family and friends. On some wards patients told us they would like to have access to more activities.

Meeting the needs of all people who use the service

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 could support and make some adjustments for disabled people and those with communication needs or other specific needs. For example, the wards had rooms with wider doors which were more accessible for those in a wheelchair and easy read information was available if needed. Managers made sure staff and patients could get help from interpreters or signers when needed.

Whilst most wards had artwork and pictures on the walls, Kahlo Ward and Ogura Ward could have had more decoration to ensure it was a therapeutic environment for patients.

The service provided a variety of food to meet the dietary and cultural needs of individual patients, for example, halal and vegetarian options.

Patients had access to spiritual, religious and cultural support. For example, staff had recently supported patients to observe Ramadan.

We saw evidence of staff respecting the wishes of transgender patients and placing them in the ward with the gender that they identified with. The trust was drafting a policy around caring for LGBT+ patients. Staff also liaised with an external service who provided advice on how to care for transgender patients. Staff were respectful in supporting patients and ensured they use the correct pronouns when referring to them.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously. They investigated them and learned lessons from the results, which they shared with the whole team and wider service. Patients, relatives and carers knew how to complain or raise concerns. The service displayed information about how to raise a concern in patient areas. Some patients reported not knowing the exact procedure to raise a complaint, but all felt able to approach staff and raise a concern when needed.

Patients and carers were able to raise any concerns with the trust's patient advice and liaison service (PALS). Any concerns raised through this service were sent to the relevant ward manager for investigation.

Patients could also raise any issues in weekly community meetings. As part of the transformation project, the service had introduced a weekly 'inpatient voice' meeting to obtain feedback from patients. This was a service wide meeting held with managers and two patients were invited virtually from each acute inpatient ward to share their views about their care and treatment on the ward. This allowed managers to listen to patient views as to how the wards could be improved.

Managers investigated complaints and identified themes. They understood the policy on complaints and knew how to handle them. Serious complaints were investigated by a manager from another ward to ensure objectivity. Once the investigation was complete the outcome and learning was shared with the relevant teams.

Managers shared feedback from complaints with staff and learning was used to improve the service. Suggestions that had been made by patients were displayed in the form of 'you said, we did' boards, on each ward. The service used compliments to learn, celebrate success and improve the quality of care. Cards containing compliments were also displayed on some of the wards.

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

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Many of the managers had moved wards within the last 12 months as part of the trusts transformation project.

The ward managers and matrons were present on the wards. They had a good understanding of the service they managed, as well as their patients' needs, risks and circumstances. The hospital had recruited matrons to work on night shifts to offer more support to staff out of hours.

Staff said they found their managers to be visible and approachable. They could get support from them when they needed it.

Many of the staff in leadership positions had been supported to develop into these posts throughout their time within the trust.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The trust had a range of vales. For example, putting people first, prioritising quality, continuous improvement, and being professional and honest.

Staff reported senior managers visited the wards. Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff had been consulted on the changes being implemented as part of the transformational project. Staff felt these changes had been managed well.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt respected, supported and valued. Staff said the transformational project had led to improvements at the hospital. Staff felt the ward culture had benefitted from the movement of staff and said their new teams worked well together. Staff also told us new training had been implemented, specifically around customer care, which had improved the culture.

Staff knew about the role of the trust's Freedom to Speak Up Guardian and knew how to contact them. Information about the Freedom to Speak Up Guardian was displayed on the wards.

Staff had access to support for their own physical and emotional health needs through an occupational health service. A psychologist also provided reflective spaces and followed up on staff wellbeing following sick leave.

Managers dealt with poor staff performance when needed. Managers gave clear examples of the process they would follow to manage poor performance. This included allowing staff more time as supernumerary, providing additional training and support, and disciplinary action when necessary.

Staff said they had opportunities for further development within the trust, for example the mentorship programme.

The wards recognised staff success within the service, for example, through the trusts recognition awards and ward based 'making a difference' awards. Patients were asked to vote for the staff employee of the month in the weekly community meeting. This enabled staff to receive recognition and positive comments from patients.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. Governance arrangements were in place that supported the delivery of the service.

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear framework of what must be discussed at team or directorate level to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Quality and patient safety meetings occurred once per month where senior staff discussed patients risks and incidents. Matrons from all wards met twice per week to share information and learning between wards. Ward managers met once per week.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at service level. The transformational project was created in response to incidents that occurred on the wards. As a response the trust increased the amount of closed circuit television (CCTV) cameras across the hospital, invested in a trial of anti-ligature doors, ensured staff were adequately trained and ensured a wider staff and patient awareness of sexual safety.

Staff participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. Audits were carried out on areas of care such as care planning, risk assessments, physical health observations and infection control. Wards peer reviewed each other's record keeping and shared the outcomes. However, the ward's audit system did not pick up on an occasion where the rapid tranquilisation policy was not followed.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level.

Staff maintained and had access to a ward-level risk register. Staff working on the wards could escalate concerns via ward managers. Staff concerns in the service matched those on the risk register, for example the potential for illicit substances to be thrown over the garden fences.

Bank and agency usage across wards was high. However, the wards, where possible, were requesting staff familiar with the service. They also had ongoing recruitment initiatives to focus on recruiting staff, such as through universities or overseas programmes.

Ward staff told us that safety huddles were an effective way of ensuring all staff were aware of the current patient risk and had reduced the number of incidents of violence and aggression. Staff also reported that increased CCTV, the trial of body cameras and a review of blanket restrictions had helped reduce the number of incidents on the wards.

The hospital had reviewed patient safety following incidents. This resulted in installing two anti-ligature doors on each ward for high risk patients and updating their staff emergency alarm system.

The trust held a weekly high-risk report meeting. At this meeting senior staff reviewed the high-risk cases throughout the directorate.

The service had a business continuity plan which covered a range of possible incidents and recovery plans. Plans included emergency contact details and actions staff should take in the event of an emergency.

Information management

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. However not all managers were confident in the use of the information management systems.

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. The trust had recently moved to a new performance platform where managers were able to access timely information on areas such as incidents and restrictive practices.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. All managers had access to this platform. There were however inconsistencies in managers abilities to be able to find and extract the information they needed. This was raised with seniors who reported training was available to all staff, including one to one sessions.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure worked well and helped to improve the quality of care. Some staff reported the WiFi was not always working which led to delays in patient observations being updated via a tablet. Staff also reported there was limited mobile telephone signal on some wards. Staff on Monet Ward reported having a specific phone to be used in an emergency as mobile phone signal was not always available.

Information governance systems included confidentiality of patient's records. Training in information governance was included in the trusts mandatory training. At the time of inspection at least 83% of staff across all wards had completed this training.

Engagement

Patient, carers and staff were able to provide feedback to the service. Managers used this feedback to make improvements.

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used, for example, through the intranet, community meetings and carer meetings.

Feedback was encouraged, and people were supported to provide feedback in a way that was best for them. Feedback could be given in community meetings, the suggestion box on the ward, direct to staff, or through the patient advice and liaison service.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. For example, introducing a patient property checklist form to be completed on admission, after a patient reported their possession was missing and adding activities to the weekly plan based on patient interests.

Patients and carers were involved in decision-making about changes to the service. For example, wards involved patients in discussions around the introduction of body cameras on some wards. The trust runs a patient and carer involvement programme. Through this programme patients and carers could be involved in interview panels for new staff, representing patient views in a variety of meetings and consulting on trust policies as part of reading panels.

Learning, continuous improvement and innovation

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. For example, implementing new technology for dispensing medicines and managing temperatures.

Monet Ward was part of a well-established quality improvement project, working with a London university and other trusts, to reduced restrictive interventions. All other wards participated in the trusts respect approach, which aimed to reduce restrictive interventions by conducting mutual help meetings, safety huddles, and by monitoring data on restrictive interventions.

Staff on other wards were not able to identify or explain any other quality improvement projects on their wards.

Acute wards were members of the quality network for inpatient working age mental health services with the Royal College of Psychiatrists and were working towards Accreditation. The PICU ward was a member of the quality network for psychiatric intensive care units with the Royal College of Psychiatrists, also working towards Accreditation