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HEALTH SCRUTINY SUB-COMMITTEE

Wednesday, 2 November 2016 at 6.30 p.m.

MP702, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

This meeting is open to the public to attend.

Members:
Chair: Councillor Clare Harrisson
Vice-Chair**:** Councillor Sabina Akhtar

Councillor Dave Chesterton, Councillor Abdul Asad, Councillor Peter Golds, Councillor Abdul Mukit MBE and Councillor Muhammad Ansar Mustaquim

Substitues:
Councillor Danny Hassell, Councillor Amina Ali, Councillor Rajib Ahmed, Councillor Chris Chapman, Councillor Mahbub Alam and Councillor Aminur Khan

Co-opted Members:
David Burbidge   (Healthwatch Tower Hamlets Representative)
Tim Oliver   Healthwatch Tower Hamlets

[The quorum for this body is 3 voting Members]

Contact for further enquiries:
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APOLOGIES FOR ABSENCE

1. ## DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Monitoring Officer.

2. ## MINUTES OF THE PREVIOUS MEETING(S)

To confirm as a correct record the minutes of the meeting of the Health Scrutiny Panel held on 15 September 2016.

3. ## REPORTS FOR CONSIDERATION

4 .1 **Planning and Primary Health Care Infrastructure**

The Health Scrutiny Sub - Committee is recommended to:

1. Note the contents of the presentation to help gain a greater understanding of:
   - The challenges facing General Practice and the plans in place to address them.
   - Planning of healthcare infrastructure to account for population increases.
   - The links between planning and health infrastructure and how this is implemented in LBTH.
   - How the housing needs of elderly residents will be addressed.

4 .2 **TH Clinical Commissioning Groups Commissioning Intentions 2017/18**

The Health Scrutiny Sub-Committee is asked to:

1. Develop an understanding of the CCGs key priorities and commissioning activities;

2. Consider how CCG commissioning at the borough-level fits in with the Transforming Services Together (TST) programme across the sub-region (Tower Hamlets, Newham & Waltham Forest), and the North East London Sustainability and Transformation Plan (NEL STP) footprint;

3. Develop an understanding of Tower Hamlets Together: a 'New Models of Care' Vanguard.

**4 .3   East London Foundation Trust Care Quality Commission Inspection   33 - 108
Response**

The Health Scrutiny Sub-Committee is asked to:

1. Note the outcome of the inspection;

2. Develop an understanding of the performance of East London
    Foundation Trust (ELFT).

5.   ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS
    TO BE URGENT

Next Meeting of the Panel
The next meeting of the Health Scrutiny Panel will be held on Tuesday, 17 January
2017 at 6.30 p.m. in MP702, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent,
London, E14 2BG

DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

This note is for guidance only. For further details please consult the Members' Code of Conduct at Part 5.1 of the Council's Constitution.

Please note that the question of whether a Member has an interest in any matter, and whether or not that interest is a Disclosable Pecuniary Interest, is for that Member to decide. Advice is available from officers as listed below but they cannot make the decision for the Member. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending a meeting.

Interests and Disclosable Pecuniary Interests (DPIs)

You have an interest in any business of the authority where that business relates to or is likely to affect any of the persons, bodies or matters listed in section 4.1 (a) of the Code of Conduct; and might reasonably be regarded as affecting the well-being or financial position of yourself, a member of your family or a person with whom you have a close association, to a greater extent than the majority of other council tax payers, ratepayers or inhabitants of the ward affected.

You must notify the Monitoring Officer in writing of any such interest, for inclusion in the Register of Members' Interests which is available for public inspection and on the Council's Website.

Once you have recorded an interest in the Register, you are not then required to declare that interest at each meeting where the business is discussed, unless the interest is a Disclosable Pecuniary Interest (DPI).

A DPI is defined in Regulations as a pecuniary interest of any of the descriptions listed at **Appendix A** overleaf. Please note that a Member's DPIs include his/her own relevant interests and also those of his/her spouse or civil partner; or a person with whom the Member is living as husband and wife; or a person with whom the Member is living as if they were civil partners; if the Member is aware that that other person has the interest.

Effect of a Disclosable Pecuniary Interest on participation at meetings

Where you have a DPI in any business of the Council you must, unless you have obtained a dispensation from the authority's Monitoring Officer following consideration by the Dispensations Sub-Committee of the Standards Advisory Committee:-
- not seek to improperly influence a decision about that business; and
- not exercise executive functions in relation to that business.

If you are present at a meeting where that business is discussed, you must:-
- Disclose to the meeting the existence and nature of the interest at the start of the meeting or when the interest becomes apparent, if later; and
- Leave the room (including any public viewing area) for the duration of consideration and decision on the item and not seek to influence the debate or decision

When declaring a DPI, Members should specify the nature of the interest and the agenda item to which the interest relates. This procedure is designed to assist the public's understanding of the meeting and to enable a full record to be made in the minutes of the meeting.

Where you have a DPI in any business of the authority which is not included in the Member's register of interests and you attend a meeting of the authority at which the business is considered, in addition to disclosing the interest to that meeting, you must also within 28 days notify the Monitoring Officer of the interest for inclusion in the Register.

Further advice

For further advice please contact:

Melanie Clay, Corporate Director of Law, Probity & Governance & Monitoring Officer, Telephone Number: 020 7364 4800

APPENDIX A: Definition of a Disclosable Pecuniary Interest

(Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012, Reg 2 and Schedule)

Subject	Prescribed description
Employment, office, trade, profession or vacation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by the Member in carrying out duties as a member, or towards the election expenses of the Member. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority— (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to the Member's knowledge)— (a) the landlord is the relevant authority; and (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where— (a) that body (to the Member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either— (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

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LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY SUB-COMMITTEE

HELD AT 6.35 P.M. ON THURSDAY, 15 SEPTEMBER 2016

C1, 1ST FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Clare Harrisson (Chair)
Councillor Sabina Akhtar (Vice-Chair)
Councillor Abdul Mukit MBE
Councillor Muhammad Ansar Mustaquim
Councillor Danny Hassell
Co-opted Members Present:

David Burbidge	(Healthwatch Tower Hamlets Representative)

Other Councillors Present:

Councillor Amy Whitelock Gibbs
Apologies:

Councillor Dave Chesterton
Councillor Abdul Asad
Councillor Peter Golds
Others Present:

Dianne Barham	(Director of Healthwatch Tower Hamlets)
Dr Sam Everington	(Chair, Tower Hamlets Clinical Commissioning Group)
Simon Hall	(Acting Chief Officer, NHS Tower Hamlets Clinical Commissioning Group)
Jenny Cooke	(Deputy Director for Primary and Urgent Care, Tower Hamlets Clinical Commissioning Group)
Moira Coughlan	(North East London Commissioning Support Unit)
Claire Hogg	(Tower Hamlets Clinical Commissioning Group)
Bhavin Patel	(North East London Local Pharmaceutical Committee)

Officers Present:

Joseph Lacey-Holland	(Senior Strategy, Policy &Performance Officer)
Dr Somen Banerjee	(Director of Public Health)
Luke Addams	(Service Head Adult Social Care)

Nasima Patel   (Service Head Children's Social Care,
                                                Children's Services)

Farhana Zia   (Committee Services Officer)

1.   **DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS**

The Chair, Councillor Clare Harrisson welcomed everybody to the Health
Scrutiny Sub-Committee meeting and explained that the running order of the
meeting would change; after the housekeeping items, Item 5 would be taken
first followed by Item 4.

She requested everyone introduce themselves and commenced the meeting.

Apologies for absence were received from Councillor Dave Chesterton,
Councillor Abdul Asad and Councillor Peter Golds. Councillor Danny Hassell
was substituting for Councillor Dave Chesterton.

Apologies were also received from Denise Radley, Corporate Director for
Adult Social Care, Debbie Jones, Corporate Director for Children's Social
Care and Daniel Kerr Strategy, Policy and Performance Officer.

Moira Coughlan representing the North East London NHS Commissioning
Support Unit and invited as a guest for item 5, declared her husband worked
for the National Pharmacy Association, an organisation which represents
community pharmacy businesses.

Members of the sub-committee were appreciative of the declaration however
concurred this would have no bearing on the item for discussion.

2.   **MINUTES OF THE PREVIOUS MEETING(S)**

The Chair referred members of the Sub-Committee to the minutes of the
previous meeting held on the 28th June 2016. She asked members to approve
these as an accurate record of the meeting.

The Members agreed the minutes to be an accurate record of the meeting.

The Chair updated Members of the Sub-Committee on action points arising:

- She had been appointed Chair of the Inner North London Joint Health
  Overview and Scrutiny Committee (INEL JOSC).

- She had visited the new birthing unit at the Royal London Hospital as a
  member of the Maternity Action Partnership, which is overseeing the
  implementation of the Maternity Scrutiny Review completed by this
  Sub-Committee. She had found the visit useful and asked members to
  notify the Strategy, Policy and Performance Officer – Daniel Kerr, if
  they were interested in visiting the facility sometime in the New Year.

- David Burbidge reminded the Sub-Committee there was an outstanding visit to the A&E department at Royal London Hospital as agreed by the former Health Scrutiny Panel.

3.   REPORTS FOR CONSIDERATION

3.1   Health Scrutiny Work Programme

The Chair referred Members to pages 11-21 of the agenda pack and stated the work programme for the Sub-Committee had been formulated taking on board the discussion and comments made at the last meeting.

The Chair stated the focus of Sub-Committee would be on 'Acess to Health and Social Care Services' and the Sub-Committee would explore issues such as the role of community pharmacies as well as examining how increased population demand can impact on health infrastructure and 0-5 healthcare access and provision.

Members made the following comments:

- Could the Chair, as Chair of the INEL JOSC consider patient representation on the INEL JOSC.
- The Sub-Committee ought to consider inviting the GP Care Group to attend the November meeting when looking at access to GP care.
- The Housing Scrutiny Sub-Committee Chair and relevant Portfolio Lead should be invited for the item on health infrastructure in November and the Portfolio Lead for Education & Children's Services Cllr Rachael Saunders be invited to the 0-5 item in January.
- Will the Committee be considering housing for key workers as well as population demand?

The Chair thanked everyone for their input.

The Sub-Committee **RESOLVED** to **AGREE**:

The forward work programme for the Health Scrutiny Sub-Committee

4.   SETTING THE SCENE: FEEDBACK ON ACCESS TO HEALTH AND SOCIAL CARE

4.1   Access to Health Services and Social Care - Community Insight

Dianne Barham, Chief Executive of Healthwatch Tower Hamlets presented the findings of her report entitled "Key Issues to accessing health and social care services in Tower Hamlets".

This report formed part of the 'setting the scene' agenda which aims to inform the Health Scrutiny Sub-Committee to understand and analyse the community

intelligence collated by Healthwatch on patient experience of health and social care services within the borough.

Key findings from the report were:

Access to GP – telephone systems, online appointments, Access to prescriptions, referrals and access to services and information. Some residents being denied registration due to the lack of ID, some booking GP appointments just for signposting (a lack of interest from some front-of-house staff in addressing this.)

Social Services – delays in getting a care package, lack of communication, Older people, Carers, Women and Children.

Hospitals – appointment process, interpreters, follow up appointments, finding services and training of staff.

Members could relate to the issues experienced by patients and made the following comments:

- Long wait at Urgent Care Centres
- GP surgeries still asking for Utility Bills, when patients register at GP surgeries. This is not a requirement.
- Surgery staff not interested in signposting patients.
- Behaviour Change required of reception staff and cancelled appointments.

Dianne invited Sub-Committee members to attend Healthwatch site-visits of 10 GP surgeries being conducted over the next month.

4.2   Access to Health Services

Jenny Cooke, Deputy Director of Primary and Urgent Care, Tower Hamlets Clinical Commissioning Group presented her slides "Setting the scene: access to Health Services."

She outlined the challenges facing the NHS and stated some of the key barriers to access:

Population growth – keeping up with the growing demand, the transient nature of the local population means a high level of un-registered patients using urgent care and A&E services.

Workforce Challenges – recruitment and retention of healthcare professionals, capacity issues within providers particularly Primary Care.

Complex Systems – parts of the NHS systems are too complex especially urgent care where there are multiple access points. It can be difficult to navigate.

Financial Situation – the current financial situation of the health system creates challenges in ensuring sufficient capacity.

She explained to Members the CCG had developed their Primary Care Strategy and whilst for some patients the continuity of care was important, for others access was more important. The challenge is to create a balance between the two and the CCG was scoping new ideas and initiatives.

For example the CCG was developing the "Tower Hamlets Health and Well-being Club" in order to streamline the registration process and promote well-being. The idea is to offer a simple online registration process and to induct patients about the services available and when to use what service.

Video appointments and the re-thinking of outpatient appointments are also being considered.

This was followed by questions from the Members, who stated:

- Organisations such as schools and universities required GP letters for the administration of medicine and/or confirmation of a medical condition; clearly a simple process could be developed to (a) attain a letter or (b) discourage organisations from making this a requirement as it burdens the NHS.

- Members enquired if the 'Health and Wellbeing Club" was linked to the "Health and Wellbeing Board" as it could have universal appeal to other stakeholders who could benefit in encouraging a "One registration" process and introduction to their services /offer.

4.3   Access to Social Care

The final presentation was made by Luke Addams, Service Head for Adults Social Care and Nasima Patel, Service Head for Children's Social Care.

They 'Set out the scene" for Social Care and presented slides showing the number of contacts, assessments and referrals made by the service.

Whilst the number of contacts for Social Care had increased vastly, the majority of contact was a mis-match of other services required. For example often Social Services were contacted however the underlying issue related to Housing, Benefits or Environmental Services.

The Social Services team as a whole was looking to develop integrated teams with Health partners as well as develop single pathways to access services. 75% of the contact required teams to signpost users to other parts of the Council and/or health partners and therefore the Social Services team was looking to develop a wider front door – co-locating services to improve access.

The Chair Councillor Clare Harrisson thanked all the presenters for 'Setting the Scene' and said the information provided was helpful to the Sub-Committee.

The Sub-Committee **RESOVLED** to **NOTE** the presentations.

5.   **COMMUNITY PHARMACY - BRIEFING ON CURRENT ISSUES**

Councillor Amy Whitelock-Gibbs, portfolio lead for Health and Adults Services introduced this item and set out the important role Community Pharmacies play in communities.

She said Pharmacies played a vital role in providing low-level health and social care interventions and were an integral part of the High Street. The Tower Hamlets Public Health team funded programmes such as Smoking Cessation, Sexual Health and Substance misuse and Pharmacies were helping to support these programmes.

In particular she highlighted how the Sexual Health programme had achieved positive outcomes because of the reach local pharmacies had within the communities. Chlamydia screening and contraception advice were offered by pharmacies and patients preferred the anonymity provided as users, especially young people, could avoid going to a formal setting such as a sexual health clinic for advice and treatment.

Dr Somen Banerjee referred Members to Pages 45-58 of the agenda pack and set out the National and Local picture. He stated the prime objective of Pharmacies was to dispense medicines and support prevention.

There are 48 pharmacies in Tower Hamlets supporting 36 GP Practices and pharmacies were the mainstay in supporting quits on the Smoking Cessation programme.

Dr Banerjee stated NHS England had conducted a medicine user review in 2015 which concluded there had been a 20% increase in the use of Pharmacies. He said the review had put forward several recommendations including a 6% reduction in funding and the clustering of pharmacies.

Issues to be noted were
- The Centralising of dispensing
- Delivering medicine to a patients home
- Having a Click and Collect service
- Or Patients going to the Pharmacy to collect medicine.

The Government had not made a decision regarding the reform of Pharmacies but a decision was expected in early December. Dr Banerjee referred members to page 54 and said responses to the Government's proposals had been made by the Pharmaceutical Services Negotiating Committee (PSNC) as well as the Local Government Association which had stated pharmacies were a social and economic asset on the High Street.

Bhavin Patel, of the Local Pharmaceutical Committee was invited to comment further and he thanked the Members for the opportunity to address the Sub-Committee.

Mr Patel explained the Local Pharmaceutical Committee had an ambitious plan with local pharmacies evaluating resources and looking to modernise the services which they provided. The Pharmaceutical Committee had produced a booklet entitled the "High Street Clinic" with the aim to be the 21st century pharmacy service. Some of the principle themes were:

Getting the best out of life – managing patients with Long-term conditions with a view to provide personalised care plans and encourage behaviour change.

Getting the best out of the workforce – providing training for front-desk/reception staff on long term conditions and co-morbidity.

Getting the best out of the Healthcare system – looking to establish pharmacy federations on a hub and spoke model. Supporting local GP surgeries, supporting local care homes, supporting individual patients in their homes and supporting mental health teams

This was followed by questions from Members who made the following points:

- Members accepted that until the Government had made a decision regarding the future of Pharmacies (and their funding) it was difficult to plan and identify where the gaps would be; however they were encouraged the Local Pharmaceutical Committee and the CCG had been working together to identify how to support local pharmacies.

- The Chair stated the importance of making every contact count and understanding how pharmacy can fit into this. How does the local Pharmacy Committee see pharmacy fitting into a local health system so that it supports the integration agenda?

- The Sub-Committee Members concurred it was inevitable funding reduction and cuts would be made but local health stakeholders could influence where these cuts should be. It was suggested that a Quality Framework matrix which measured customer satisfaction, as well as the number of prescriptions dispense would be helpful. Currently the plan to close pharmacies with less than 4000 prescriptions dispensed may not be reflective of the value and customer care a pharmacy provides.

Cllr Clare Harrisson thanked invited guests for their presentations and input and summarised the key question was how local health stakeholders could build systems which truly encouraged local pharmacies to be part of the NHS structure providing useful advice and supporting long-term objectives whilst continuing to be an integral part of the High Street.

The Chair of the CCG mentioned that the following were considered a priority in terms of developing the local pharmacy offer:

- Addressing the lack of 24 hour pharmacy access locally. How could this assist with night time hospital discharge.
- Better, more comprehensive use of pharmacy 'dashboards' in order to help drive up quality and provide a sound evidence base for future decision making.
- Increasing the number of pharmacies with access to GP notes/shared records.

The Sub-Committee **NOTED** the report.

6.   ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

There was no other business discussed.

The meeting ended at 8.40 p.m.

Chair, Councillor Clare Harrisson
Health Scrutiny Sub-Committee

Non-Executive Report of the: **Health Scrutiny Sub Committee** 02 November 2016		TOWER HAMLETS
Report of: Somen Banerjee, Director of Public Health		**Classification:** Unrestricted
Planning and primary health care infrastructure		

Originating Officer(s)	Tim Madelin, Healthy Environments and Communities Lead, Public Health LBTH Jenny Cooke, Deputy Director of Primary and Urgent Care, NHS Tower Hamlets CCG Matthew Pullen, Infrastructure Planning Team Leader, LBTH
Wards affected	All

Summary

The joint presentation produced in response to the health scrutiny sub-committee request, outlines the main issue relating to spatial planning and primary health care infrastructure. It covers the following;

- Key challenges facing General Practice in Tower Hamlets
- CCG and provider plans to support and develop General Practice
- Workforce challenges and programmes to address these
- The local planning framework
- Infra-structure planning for healthcare facilities
- Estates strategy
- Housing needs of elders

Recommendations:

The Health Scrutiny Sub - Committee is recommended to:

1. Note the contents of the presentation to help gain a greater understanding of:
   - The challenges facing General Practice and the plans in place to address them.
   - Planning of healthcare infrastructure to account for population increases.
   - The links between planning and health infrastructure and how this is implemented in LBTH.
   - How the housing needs of elderly residents will be addressed.

1. REASONS FOR THE DECISIONS

1.1 Presentation is for information

2. ALTERNATIVE OPTIONS

2.1 To not give presentation would not enable the committee to gain a greater understanding of this topic.

3. DETAILS OF REPORT

3.1 The link between planning and health has been long established and the Health Scrutiny Sub-committee wanted to understand how this is being maximised to improved access to health care in Tower Hamlets. LBTH has one of the fastest growing and changing populations in the country and this requires services to constantly evolve to match demand. It is important to continue to make new investments in services, equipment and facilities in the community to support the delivery of improved patient care. As the population is increasing at the same time that the resources available to local authorities and public services is decreasing it is important to consider how planning and development can contribute to achieving broader health objectives. .

3.2 The population growth will have a significant impact on GPs who provide vital services and will be subject to unprecedented levels of pressure. The 'General Practice Forward View' was published in April 2016 and this aims to stabilise and transform General Practice, tackling issues of the low number of GPs, the high workload, infrastructure, and aims to redesign the way care is delivered.

3.3 The Health Scrutiny Sub-committee wanted to develop an understanding of the issues facing, the impact of these on residents, and the plans in place to improve provision and manage growing demand.

3.4 The attached presentation which was jointly produced between the local NHS in Tower Hamlets and Tower Hamlets Council (spatial planning, public health and adult social care) address the following areas:
   - Key challenges facing General Practice in Tower Hamlets
   - CCG and provider plans to support and develop General Practice
   - Workforce challenges and programmes to address these
   - The local planning framework
   - Infra-structure planning for healthcare facilities
   - Estates strategy
   - Housing needs of elders

3.5 The purpose of the presentation is to enable the health Scrutiny Committee to:

- Develop an understanding of the challenges facing General Practice and the plans in place to address them.
- Understand how significant increases in the population and number of new homes impacts on demand for health services.
- Understand the links between planning and health and how this is implemented in LBTH.
- Review the Local Plan to help form an understanding of the relationship between housing and health and social care.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 This presentation is for members' information and as such has currently no direct financial implications.

4.2 The Council's 2016/17 to 2018/19 three year capital budget for Public Health includes resources towards the infrastructure for healthcare facilities to a total of £15.885m. This is to be funded from S106 contributions and the Community Infrastructure Levy (CIL).

5. LEGAL COMMENTS

5.1 This report considers the role of planning in the provision of primary health care infrastructure.

5.2 The Council's duties under Sections 1-7 of the Care Act 2014 include a duty to promote integration of care and support with health services and a duty under section 6 to co-operate generally with its partner agencies, including Health relating to adults with needs for care and support.

5.3 The National Planning Policy Framework provides that local planning authorities should set out the strategic priorities for the area in the local plan and that this should include the provision of health (paragraph 156). Further it advises that local planning authorities should work with other authorities and providers to assess the quality and capacity of infrastructure for *inter alia*, health and its ability to meet forecast demands (paragraph 162).

5.4 The Planning Practice Guidance provides that local planning authorities should ensure that health and well-being, and health infrastructure are considered in local and neighbourhood plans and in planning decision making.

5.5 The Council are currently in the process of preparing a new local plan. Through this the Council can seek to identify and safeguard potential sites for infrastructure. The Council's Infrastructure planning Team have prepared an evidence base which analysis growth projections and contains details of the expected primary heath care facilities that will be required to support this growth.

5.6   In terms of funding the provision of health care infrastructure, prior to April 2015 developer contributions towards health were secured through Section 106 agreements. In April 2015, the Council adopted its Community Infrastructure Levy ("CIL") charging schedule, and as a result health and other infrastructure are now funded from the CIL that is paid by developers. The money that the Council collects in CIL can be used to pay for any infrastructure on the Council's infrastructure list (commonly referred to as our "Reg 123 list"), and the monies are no longer ring fenced for a particular type of infrastructure as was the case under the s106 system. There is the ability in legislation for a developer and the Council to enter into an infrastructure agreement whereby a developer may provide infrastructure (such as a new health care centre) on site in lieu of the payment of CIL.

5.7   Decisions on how the Council spends the CIL collected is for the Council's Executive.

6.   ONE TOWER HAMLETS CONSIDERATIONS

6.1   More disadvantaged communities have a heavier disease burden than less deprived sections of the community, it is important for equity to ensure that sufficient primary health care facilities are provided to ensure all sections of the community have equitable access to healthcare.

7.   BEST VALUE (BV) IMPLICATIONS

7.1   Social care and health care are closely inter-related and Tower Hamlets Together seeks to bring health and social care providers. In order to get best value from this process it is important to ensure there is appropriate access to primary healthcare.

8.   SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1   Presentation is for information

9.   RISK MANAGEMENT IMPLICATIONS

9.1   Social care and health care are closely inter-related and Tower Hamlets Together seeks to bring health and social care providers. In order to minimise the risk for the provider partnership it is important to ensure there is appropriate access to primary healthcare.

10.   CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1   Presentation is for information

_____

Linked Reports, Appendices and Background Documents

Linked Report
- None

Appendices
- Presentation

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report
List any background documents not already in the public domain including officer contact information.
- These must be sent to Democratic Services with the report
- State NONE if none.

Officer contact details for documents:
- Tim Madelin, Healthy Environments and Communities Lead, Public Health LBTH, 020 7364 7388, tim.madelin@towerhamlets.gov.uk
- Jenny Cooke, Deputy Director of Primary and Urgent Care, NHS Tower Hamlets CCG, 020 3688 2575, Jenny.cooke@towerhamletsccg.nhs.uk
- Matthew Pullen, Infrastructure Planning Team Leader, LBTH, 020 7364 6363, Matthew.Pullen@towerhamlets.gov.uk

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General Practice in Tower Hamlets : planning and infrastructure

Health Scrutiny Panel – 2nd November 2016

Tower Hamlets CCG
London Borough of Tower Hamlets
Tower Hamlets GP Care Group

Overview

- Key challenges facing General Practice in Tower Hamlets
- CCG and provider plans to support and develop General Practice
- Workforce challenges and programmes to address these
- The local planning framework
- Infra-structure planning for healthcare facilities
- Estates strategy
- Housing needs of elders

We need to redesign primary care to help us meet the increasing pressures on the system

The GP challenge	Our response to the GP challenge
- General Practice in Tower Hamlets is **facing significant challenges** due to: - a growing population - increased demand - changes in contracts resulting in funding changes - challenges around recruitment and retention - This has resulted in **increased pressure and workload** for practices	- Recognising the stress in Primary Care, the CCG wanted to provide **strategic and operational support** to practices - In response to this the CCG is undertaking two key programmes of work: **Operational support to practices & development of a QI focused workforce** **Long term re-design** of primary care services

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We want to empower practices to address these pressures and equip them to be able to take on future challenges without support

TH level project objectives	Practice level project objectives
A. **Empower** TH practices to make **effective strategic, operational and team dynamics changes** in order to address challenges in the short to medium term B. **Develop a QI focused primary care workforce** to ensure that a **culture of QI** is the centre of primary care in TH to help take on today's challenges and those of the future	In order to meet our overall objectives we will help practices meet the following specific aims: 1. Increase **staff satisfaction** 2. Increase **patient satisfaction** 3. Ensure **resource optimisation** 4. Ensure **appointment optimisation** 5. Build **QI capabilities**

Slide 1

Prime Minister's Access Fund in Tower Hamlets

The Vision: For 8-8 access, 7 days a week to urgent and routine primary care for all Tower Hamlets registered patients, which is supported by a range of measures to build the overall resilience of communities and their local health care system

1. Primary Care delivery — Primary Care hubs operating at a locality level to provide innovative and tailored solutions to primary care access

2. Developing partners in care — Community pharmacy partnership | Voluntary sector partnerships to maximise value from GP Premises | Patient and community partnerships

3. Addressing the cycle of demand — Social prescribing scheme across Tower Hamlets | DIY health project developing patient and professional partnership | Introducing the health touch mobile to support self management | Training and education to give staff the skills to work as connectors

Service user feedback:

"Just a line to say 'thanks' to the Hub for prompt care. I went to my surgery, and was offered an appointment at the Hub clinic, at a time comfortable to me. Meaning I did not have to take time off work! Bliss."

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Slide 2

Improving Access: Priorities in 2016-18

- Standardised and centralised registration processes
- Improved digital access: appointment booking, access to notes, online consultations, and long term condition management
- Social Prescribing: supporting people with non-clinical needs to access appropriate support
- Simplifying and streamlining urgent care and extended access
- New ways of working: piloting telephony project across a network

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Slide 3

General Practice Workforce

1615 — patients per WTE GP
3905 — patients per WTE nurse
5920 — patients per WTE HCA /AP

Gender split of GPs – 58% Female and 42% Male
58% | 42%

GP age profile breakdown
No of GP's

partner 46% | non-partner 54%

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Slide 4

Addressing the workforce challenges

Open Doors:
The 2 year high quality training programme which includes a degree or PG Dip at City University London has drawn 50 Nurses into practice posts for training since 2008, 25 are currently working in practices either in training or permanent posts.
Much of the success is due to a team of Clinical Tutors (all experienced PNS) employed by GP Care Group who:
- Assist with a highly effective screening and assessment process for applicants
- Visit weekly in year 1 and fortnightly in year 2 to teach and mentor trainees
- Provide a weekly action learning group that provides clinical teaching of a practical nature and gives people support whilst adapting to the challenges of working in General Practice settings.

Physician Associates:
CCGs in East London have sponsored the development of a PA training programme at Barts and the London School of Medicine and Dentistry (Queen Mary University of London). The development of the PA role within primary care is seen as a vital way of enhancing access to primary care and alleviating the existing burden on General Practice. The two year course will start in January 2017 with 24 places in year 1.

Salaried GP scheme
Recognising the difficulty recruiting and retaining salaried GPs, the GP Care Group and the CCG have designed a salaried GP programme that offers recently qualified GPs an opportunity to develop their leaderships skills and specialist interests whilst receiving regular peer support and mentoring.

Local Plan

- 15 year plan which sets planning policy and subsequently design, scale & location of development
- Identify and safeguard potential sites for infrastructure
- Infrastructure Delivery Plan forms a key part of plan
- Local Plan currently being revised
  - Draft Local Plan formal consultation – Winter 2016
  - Publication of the Local Plan for Submission - Spring 2017
  - Examination by a Planning Inspector – Autumn 2017
  - Adoption by Full Council – Winter 2017/18

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Infrastructure Capacity Planning

- Council needs to ensure sufficient infrastructure to support new development
- Also a need to consider how such infrastructure will be funded
- Infrastructure delivery has evidence base document
  - Contains population projections from Tower Hamlets Growth Model
  - Has health facilities chapter produced in consultation with NHS partners
  - Contains expected primary healthcare facility requirements

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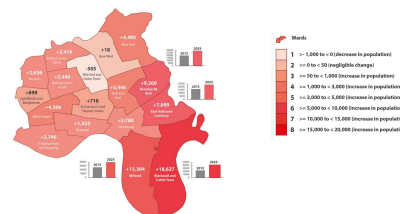**Clinical Commissioning Group**

Developer Contributions

- Public Health in Tower Hamlets worked with Healthy Urban Development Unit to produce model to determine financial impact of development on healthcare
- This model was then incorporated in the Planning Obligations Supplementary Planning Document
- S106 for health systematically collected for developments permitted up to April 2015
- In April 2015 the Community Infrastructure Levy (CIL) was adopted in Tower Hamlets – this replaces S106 in contributing towards key infrastructure including health facilities.
- Key difference between S106 and CIL is that S106 was secured for specific purposes such as health or education, whereas CIL can be used for any infrastructure and it is for the Mayor to decide how he wishes to spend it on infrastructure priorities
- Estimated that CIL is only likely to meet up to 20% of cost of required infrastructure

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Population Growth over next 10 years

Population growth heat map shows projected demographic growth by ward in Tower Hamlets from 2015 to 2025, based on 2013 ward boundaries

Data source: GLA 2013 SHLAA capped AHS

Wards
1. >= 1,000 to < 0 (decrease in population)
2. >= 0 to < 50 (negligible change)
3. >= 50 to < 1,000 (increase in population)
4. >= 1,000 to < 3,000 (increase in population)
5. >= 3,000 to < 5,000 (increase in population)
6. >= 5,000 to < 10,000 (increase in population)
7. >= 10,000 to < 15,000 (increase in population)
8. >= 15,000 to < 20,000 (increase in population)

	Millwall		East India and Lansbury		Blackwall & Cubitt Town		Bromley by Bow		Bow East		Whitechapel	
	5 Years	10 Years	5 Years	10 Years	5 Years	10 Years	5 Years	10 Years	5 Years	10 Years	5 Years	10 Years
TOTAL increase in GP appointments based on Growth	31,954	91,845	37,365	68,280	72,440	115,539	55,762	81,273	14,208	31,553	24,019	38,464
Clinic rooms	4	13	5	10	10	16	8	11	2	4	3	5
Treatment rooms	1	3	1	3	4	2	3	1	1	1	1	1

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Additional Infrastructure Requirements in 2021 and 2026

The following tables show the additional infrastructure requirements in 2021 and 2026 based on a shift in outpatient appointments and the increase of GP appointments based on the population growth as per the Transforming Services Together (TST) model. The additional capacity requirements will be met through a combination of new build and more efficient use of our existing healthcare infrastructure. It is important to note that the planning assumptions for future estates development will continue to be refined to reflect changing models of care and new technologies.

Indicative planning assumptions 2015

Total GP appointments baseline: 1,868,917	Total Appointments 2021	Clinic rooms 2021	Treatment rooms 2021
TST shift in Outpatient appointments	32,554	5	1
TOTAL increase in GP appointments based on Growth	349,706	49	13
Total Appointments in Primary Care	382,260	54	14

Total GP appointments baseline: 1,868,917	Total Appointments 2026	Clinic rooms 2026	Treatment rooms 2026
TST shift in Outpatient appointments	35,116	5	1
TOTAL increase in GP appointments based on Growth	643,902	89	24
Total Appointments in Primary Care	679,018	94	25

Capital Programme and New Developments to 2021 Current

William Cotton Place (£3.2 million) - Provision of new primary care facility to house St Paul's Way Practice, Community Nursing and a Pharmacy. Currently shell & core of practice is being fitted out as primary care practice

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Future

Locality	Estates Development	M²	GP Practice(s)	Consulting Rooms	Treatment Rooms	Additional capacity: consulting rooms/Treatment rooms	Target completion date
North West	Suttons Wharf	940	Globe Town Surgery +	14	3	7	31/12/2017
	Maximising Existing Health Infrastructure	16	Mission Practice	1		1	31/03/2017
	Maximising Existing Health Infrastructure	16	Blithehale Health Centre	1		1	31/03/2017
	Maximising Existing Health Infrastructure	58	Spitalfields Practice	3		3	31/03/2017
						Additional: 12	
South West	Goodman's Field	1250	Whitechapel Health/City Wellbeing +	21	4	17	31/03/2020
	Maximising Existing Health Infrastructure	37.5	Wapping Group Practice	1	1	2	31/03/2017
						Additional: 19	
North East	William Cotton Place	1122	St Paul's Way Medical Centre +	9	3	2	19/12/2016
	Wellington Way	915	Merchant Street/Stroudley Walk +	13	4	5	31/12/2017
						Additional: 7	
South East	Aberfeldy Health Village	1122	Aberfeldy	17	4	16	31/12/2019
	Wood Wharf	1070	Island Medical	18	5	16	31/01/2023
	Maximising Existing Health Infrastructure	32	Limehouse Practice		1	1	31/03/2017
	Maximising Existing Health Infrastructure	77	Barkantine Practice	4		4	31/03/2017
	Maximising Existing Health Infrastructure	18	Island Health	1		1	31/01/2017
						Additional: 38	
	Total additional capacity – Consulting / Treatment					76	

Note: New Facility will be required at South Quay to cater for Opportunity Area Planning Framework (OAPF) growth, details still being finalised led by GLA
Total Capital Investment programme – c.£21m including £2.6m for Existing Health Infrastructure

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Housing mix for older residents

- Ageing Well Strategy (under development) proposes a range of measures;
  - Working with social housing providers to find new ways of identifying and supporting vulnerable older tenants to enable them to remain living in their own homes (over 50% of 65+ population in TH live in social housing)
  - Working with sheltered housing providers to ensure that the right kinds of support are available to tenants at the right time

4

Housing mix for older residents
Continued

– Using telecare and an ever wider range of assistive technologies with to give vulnerable older people and their families confidence that they can stay safe

– Working with providers (extra care, sheltered and residential care home) to find new ways of using assistive technologies to keep residents safe and supported;

– Working with care homes and housing associations to reduce the number of residential care beds in the borough while increasing the number of nursing home beds and extra care sheltered housing schemes in response to changing need locally.

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Committee: Health Scrutiny Sub-Committee	Date: 02/11/2016	Classification Unrestricted	Report No.	Agenda Item No.
Report of: Health Scrutiny Sub-Committee		Title: TH CCG Commissioning Intentions 2017/18		
Originating Officer: Josh Potter Tower Hamlets CCG		Wards: All		

1. SUMMARY

1.1 Clinical Commissioning Groups (CCG) have a statutory duty to ensure quality and sustainability in their local health systems. In order to achieve this, the CCG develops service change and transformation schemes in order to improve the quality of the services provided and reduce cost and spend in the system. The Tower Hamlets health economy needs to identify £10m of system savings per year over the next five years, in addition to the productivity requirements set by NHS England to be delivered by providers of services.

1.2 However, due to additional pressures within the health economy, the requirement for 2017/18 has been revised up to £15m. Tower Hamlets CCG aims to deliver these system savings through schemes that improve quality, seek to change and innovate services, improve productivity and seek to prevent ill health and the need for emergency care. This paper outlines where the CCG feels these opportunities exist, and what plans the CCG have to achieve them.

2. RECOMMENDATIONS

The Health Scrutiny Sub-Committee is asked to:

1. Develop an understanding of the CCGs key priorities and commissioning activities;

2. Consider how CCG commissioning at the borough-level fits in with the Transforming Services Together (TST) programme across the sub-region (Tower Hamlets, Newham & Waltham Forest), and the North East London Sustainability and Transformation Plan (NEL STP) footprint;

3. Develop an understanding of Tower Hamlets Together: a 'New Models of Care' Vanguard.

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Developing and Delivering System Transformation and Sustainability: The CCG's plans for 2017/18 and the Tower Hamlets Together Approach in the future

Introduction and Context

Clinical Commissioning Groups (CCG) have a statutory duty to ensure quality and sustainability in their local health systems. In order to achieve this, the CCG develops service change and transformation schemes in order to a) improve the quality of the services provided and b) reduce cost and spend in the system. The Tower Hamlets health economy needs to identify £10m of system savings per year over the next five years, in addition to the productivity requirements set by NHS England to be delivered by providers of services. However, due to additional pressures within the health economy, the requirement for 2017/18 has been revised up to £15m. Tower Hamlets CCG has always sought to deliver these system savings through schemes that improve quality, seek to change and innovate services, improve productivity and seek to prevent ill health and the need for emergency care. This paper outlines where the CCG feels these opportunities exist, and what plans we have to achieve them.

In addition the CCG is engaged in partnership programmes to deliver system transformation:
- Transforming Service Together: A collaborative programme focusing on the Barts Health footprint (Newham, Waltham Forest and Tower Hamlets). This programme largely focuses on improvements within Barts Health and some system transformation where there are common priorities between the Boroughs. This paper will identify where we expect this programme to contribute to Tower Hamlets' system sustainability in 2017/18
- North East London Sustainability and Transformation Plan: a regional strategy to ensure that opportunities for system sustainability are leveraged across North East London, for example in maternity services, acute mental health and specialist hospital care.
- Tower Hamlets Together: a "New Models of Care" Vanguard site seeking to deliver an improved model of care for adults, children, and to accelerate improvements in population health. This paper will describe how from April 2017 onwards, this will become the vehicle for developing system transformation across Health and Social Care in Tower Hamlets.

Process

The process for developing commissioning intentions and system transformation plans is as follows:
- Data analysis, benchmarking, and best practice: The use of local and national datasets to identify where there may be opportunities for improvements in services, or to identify where current services are providing substandard care. Tower Hamlets CCG is also a wave one site for the NHS England RightCare programme; a suite of improvement tools and data to support local areas. Finally we also review emergent best practice guidance to identify where we can implement evidence based improvements to current services.
- Review of current schemes and services: where the CCG already commissions services, or has delivered previous transformation schemes, we review the performance of these to identify if there are any further opportunities or if the intended benefits are not being fully realised.
- Engagement with members and public: through regular engagement events, or via targeted engagement activities with certain sections of the public and service users, we seek to identify issues with current services that are amenable to a commissioning approach. In addition, through the locality structures within the CCG we seek to get the feedback from our GP membership on current service provision.

Summary of schemes

Below is a summary per CCG programme board or partnership programme. For more detail please see appendix 1. PLEASE NOTE: this is the situation as of 17th October 2016 and is subject to change.

Programme	Areas of Focus	Impact	Estimated Savings (£000s)
Children	Mental Health 0-5s Complex needs	Less emergency care Improved access to care	TBC
Adults	Primary and Urgent Care Pathway redesign	Reduced emergency activity Improved primary care access Reduction in referrals to hospital	£3,841
Complex Adults	Integrated Care LTC management Mental Health	Reduced emergency activity More effective LTC support	£1,019
Transactional/ Productivity Savings	CHS procurement Provider Productivity	Improved productivity and efficiency	£3,383
Transforming Services Together	Pathway development Diagnostics and pathology savings	Reduced referrals More appropriate care	£2573
Total			£10,816
Savings requirement			£15,000
Variance			£4,184

Development of system transformation in the context of Tower Hamlets Together (THT)

Tower Hamlets CCG is a partner in the Tower Hamlets Together Vanguard, a programme seeking to deliver a new model of care for our residents. As a partnership programme consisting of all providers and commissioners of health and social care in Tower Hamlets, it is a unique opportunity to work together to meet the joint challenges we face in terms of population health, system sustainability and quality.

In delivering the Tower Hamlets Together agenda it has become apparent that there has been a certain amount of duplication of effort both in the development of strategy and the delivery of change. In addition, whilst THT is a collaborative programme, it focuses on a discreet portion of the wider transformation agenda in Tower Hamlets. This is despite the fact that all partners are around the table and engaged in the wider agenda elsewhere. We are missing an opportunity to develop a truly integrated and collaborative approach.

Therefore, it is proposed that from April 2017 the Tower Hamlets Together Board takes on the oversight of all transformation activity happening within Tower Hamlets. This would include a shared view and responsibility of system quality and efficiency challenges, including the financial savings required. Commissioning Intentions and transformation agendas will be built jointly with those providers who have to deliver them. The proposed governance for this is outlined in the diagram below:
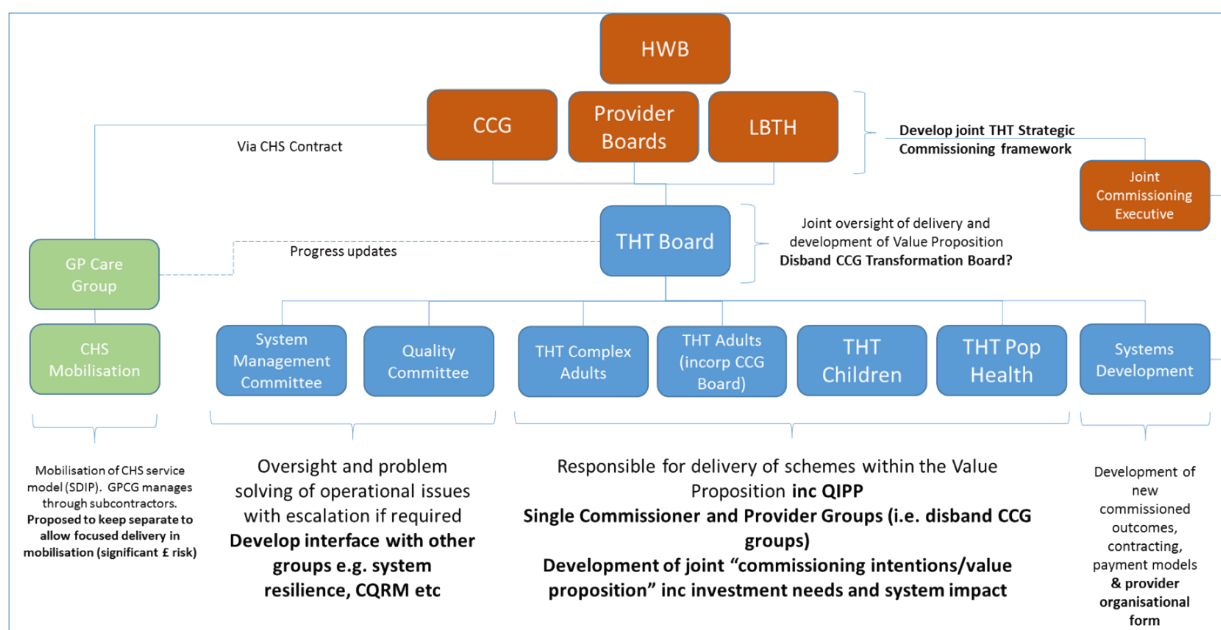
In practical terms this will mean that rather than having separate programme boards and oversight boards between the CCG and THT, there will be a single function under the Tower Hamlets Together Board, with shared leadership of the transformational boards feeding into it. It is believed that this will have significant benefits for the development of plans and delivery of schemes:

- It will better align provider side cost improvement programmes with longer term strategy
- Make more efficient use of the transformation resource within the system
- Potentially allow for economies of scale in support functions such as analytics, commissioning support etc
- Reduce unnecessary delays in the annual contracting round by provider colleagues having a full role in the development of plans that impact upon their operations

Conclusion and Next Steps

For planning for 2017/18, the CCG's commissioning teams will be taking forward this programme as follows:

- Risk assessment of current schemes to further refine deliverability and timescales
- Continue to develop existing schemes where impact projections are not yet available
- Develop further schemes to meet gap through review of existing service budgets
- Development of full business cases for schemes, for sign off by the CCG's Transformation Board
- Plan and commence delivery

The CCG will also be working closely with its partners within THT to refine the governance proposal as outlined above, and work to ensure that we can operate as a single system effectively from April 2017/18 onwards, in order to deliver what is required for the foreseeable future.

Appendix 1: Breakdown of CCG Transformation Programmes

CCG Programme Board	Description	Quality and Productivity Impact	Estimated Financial Impact (£000s)
Children's	CAMHS Transformation: - Crisis response - Improve access and participation - Improve coordination	Improved health and wellbeing Increased access to mental health services Reduction in emergency services use	TBC
	0-5 Years Strategy: - Improve access to perinatal mental health services - Increase choice of birth options - Pre-conceptual care for women with diabetes - Data analysis to inform further priorities	Improved health during and following pregnancy More births in non-obstetric settings	TBC
	Complex Care: - Expand virtual ward for children - Pathway improvements in secondary care - Delivering personal budgets for children - Developing autism pathway	Reduced emergency admissions Reduced referrals to hospital	TBC
Adults	Improved pathways into hospital: Full year effect of schemes for: - MSK and Pain - Gastroenterology - Dermatology	Reduced referrals into hospital Reduction in unnecessary invasive procedures	£1,651
	Provision of data to GPs to inform referral practice	Increase in appropriateness of referrals	TBC
	Primary Care transformation: - Extended access hubs - Building resilience in general practice - Provider development	Reduction in primary care waiting times Improved stability of Primary Care	TBC
	Integrated Urgent and Emergency Care: - System redesign around primary care hub model - SPA via 111 - Ambulatory Care	Reduced A&E attendances Reduced emergency admissions Improved experience	£2,190
Complex Adults	Integrated Care: - Further development of IC community teams - Reablement and community equipment review	Reduced emergency admissions and A&E attends Improved support for people at home	£1,019

	- LTC NIS development		
	Latent TB infection project	Earlier identification	NA
	Mental Health in Primary Care Pilot	Reduction in referrals Improved management of primary care demand	TBC
	Last Years of Life: - Education and training programme - Compassionate neighbours programme - Review 24/7 services	Increase in people dying at home	TBC
	Long Term Conditions: - RightCare Respiratory pathway review, inc prescribing - Falls reduction	Reduction in emergency admissions	TBC
	Mental Health: - Autism review - Dementia service development - Develop crisis care - Improve talking therapies pathway - Suicide prevention	Improved quality and experience Reduction in emergency demand Increase in access to IAPT	TBC
Productivity/ Transactional Savings	Community Health Services Procurement Efficiency	Improved service model	£1,800
	Acute provider productivity	Reduction in unnecessary follow-up appointments	£583
	HEMS	NA	£1,000
Transforming Services Together	Pathway development work: - Specialist advice for GPs - Non face to face appointments - LTC bundles - Community ophthalmology - Community gynaecology - Rheumatology	Reduced secondary care referrals	£653
	Reducing unnecessary testing (pathology and imaging)	Reduction in unnecessary diagnostics	£1,920
Total			£10,816
Savings target for 2017/18			£15,000
Variance			£4,184

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Committee: Health Scrutiny Sub-Committee	Date: 02/11/2016	Classification: Unrestricted	Report No.	Agenda Item No. 1
Report of: Health Scrutiny Sub-Committee **Originating Officer:** Edwin Ndlovu East London Foundation Trust		**Title:** East London Foundation Trust CQC Inspection Response **Wards:** All		

1. **SUMMARY**

1.1   The Care Quality Commission (CQC) undertook an inspection of East London Foundation Trust (ELFT) services in June 2016. The inspection included a visit of 86 services and discussions with over 300 patients, 52 carers, and over 700 members of staff. The CQC rated ELFT as 'outstanding'. This report details the findings of the inspection.

2. **RECOMMENDATIONS**

The Health Scrutiny Sub-Committee is asked to:

1. Note the outcome of the inspection;

2. Develop an understanding of the performance of East London Foundation Trust (ELFT).

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Before the Inspection visit the team

- Requested information from the Trust and reviewed the information received
- Asked a range of other organisations for information including NHSI, NHSE, CCG's, local Authorities, Healthwatch, Health Education England RCP and other professional bodies, user and carer groups
- Sought feedback from patients and carers through attending five user and carer groups and meetings
- Received information from patients, carers and other groups through their website.

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During the announced inspection visit from the 13th June – 24th June 2016
The inspection team:

- Visited 86 wards, team and clinics
- Spoke with 324 patients and 52 relatives and carers who were using the services
- Collected feedback from 406 patients, carers and staff using comment cards
- Joined 14 service user and carer meetings
- Spoke with 754 staff members.
- Attended 19 focus groups attended by 283 staff
- Interviewed 8 Executive team and board members
- Interviewed a further 20 senior staff
- Attended and observed 69 hand-over meetings and MDT meetings
- Joined care professionals on 28 home visits
- Looked at 417 treatment records
- Carried out a specific check of the medication management across a sample of wards and teams
- Looked at a range of policies
- Requested and analysed further information from the Trust to clarify what was found during the visits
- Observed a board meeting and a quality assurance meeting.

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CareQuality Commission

Last rated
1 September 2016

East London NHS Foundation Trust

Overall rating	Inadequate	Requires improvement	Good	Outstanding ☆

	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆
Child and adolescent mental health wards	Good	Good	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
Community health inpatient services	Good	Good	Good	Good	Good	Good
Community health services for adults	Requires improvement	Good	Good	Good	Good	Good
Community health services for children, young people and families	Good	Good	Good	Good	Good	Good
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Good	Good	Good	Good	Outstanding ☆	Good
Community-based mental health services for older people	Good	Good	Outstanding ☆	Requires improvement	Outstanding ☆	Good
Forensic inpatient/secure wards	Requires improvement	Good	Outstanding ☆	Good	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Mental health crisis services and health-based places of safety	Good	Good	Good	Outstanding ☆	Good	Good
Specialist community mental health services for children and young people	Good	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆
Wards for older people with mental health problems	Good	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆
Wards for people with learning disabilities or autism	Good	Requires improvement	Good	Good	Good	Good

CareQuality Commission

East London NHS Foundation Trust

Overall rating	Inadequate	Requires improvement	Good	Outstanding ☆

Are services

Safe?	Good
Effective?	Good
Caring?	Outstanding ☆
Responsive?	Outstanding ☆
Well led?	Outstanding ☆

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East London NHS Foundation Trust

Quality Report

Trust Headquarters
9 Alie Street
London
E1 8DE
Tel: 02076554000
Website: www.elft.nhs.uk

Date of inspection visit: 13 June 2016
Date of publication: 01/09/2016

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Adult Mental Health Services - City and Hackney Directorate	
	Adult Mental Health Services - Newham Directorate	RWK62
	Adult Mental Health Services - Tower Hamlets Directorate	RWK46
	Luton and Central Bedfordshire Mental Health Unit	RWK61
	Weller Wing	RWKY7
	Oakley Court	RWKY4
		RWK2A
Mental health wards for older people	Community Health Services and Mental Health Care for Older Persons Directorate	RWKW2
	Mayer Way	RWKY6
	Bedford Health Village	RWKY8
Community mental health services for older people	Community Health Services and Mental Health Care for Older Persons Directorate	RWKW2
	Bedford Health Village	RWKY8
	Luton & Bedfordshire Community Mental Health Services	RWKW1
Forensic inpatient wards	Forensic Services Directorate	RWK60
Crisis services and health based places of safety	Adult Mental Health Services - City and Hackney Directorate	RWK62
		RWK46

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Summary of findings

	Adult Mental Health Services - Newham Directorate	
	Adult Mental Health Services - Tower Hamlets Directorate	RWK61
	Weller Wing	RWKY4
	Luton and Central Bedfordshire Mental Health Unit	RWKY7
Child and alolescent mental health wards	Children's Services	RWKX9
Specialist community mental health services for children and young people	Children's Services	RWKX9
Community based mental health services for adults	Adult Mental Health Services - City and Hackney Directorate	
	Adult Mental Health Services - Newham Directorate	RWK62
	Adult Mental Health Services - Tower Hamlets Directorate	RWK46
	Luton and Bedfordshire Community Mental Health Services	RWK61
		RWKW1
Community mental health learning disability services	Luton and Bedfordshire Community Mental Health Services	RWKW1
Mental health wards for people with a learning disability	The Glades	RWKY5
Rehabilitation mental health wards for working age adults	Bedford Health Village	RWKY8
	105 London road	RWKY9
Community health inpatient services	East Ham Care Centre	RWKX7
Community health services for adults	Trust Headquarters	RWKGY
Community health services for children, young people and famillies	Trust Headquarters	RWKGY
Primary medical services Newham Transitional Practice	Newham Transitional Practice	RWK98
	Spitalfields Mendical Centre	RWK64

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

Summary of findings

Ratings

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

Overall rating for services at this Provider	Outstanding	☆
Are services safe?	Good	●
Are services effective?	Good	●
Are services caring?	Outstanding	☆
Are services responsive?	Outstanding	☆
Are services well-led?	Outstanding	☆

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

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

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

Summary of findings

Contents

Overall summary

We have given an overall rating to East London NHS Foundation Trust of **outstanding** because**:**

- We have rated four of the fourteen core services that we inspected as outstanding and ten as good.

- The trust is well led with a visionary board and senior leadership team who have created an open culture that welcomes innovation. There are hard working and enthusiastic staff throughout the organisation who enjoy their work and are committed to improving services. Sitting alongside this are clear systems of assurance that enable the trust to get things right.

- The trust has invested over the previous two years in a wide scale quality improvement programme. This has been embraced by staff working in the trust. The methodology has successfully encouraged innovation and improvement which we were able to see throughout the inspection. There was a genuine passion to ensure that the services provided are the best possible.

- Staff worked with patients and their carers to ensure they were partners in their care. Patients were supported to express their wishes. They were active participants in all the meetings where their care was discussed. But more than this, patients were actively involved in the running of the trust. Opportunities were in place throughout the organisation to promote this participation. Examples included patients helping to recruit and train staff. Also patients developed and helped with audits and other quality checks.

- The trust was mindful of the need to provide the safest care possible. This included making the buildings where care was delivered as safe as possible, providing enough appropriately trained staff, ensuring equipment is in good condition and ensuring all staff considered potential risks for people receiving care.

- Staff were genuinely engaged in the work of the trust. Many staff had worked at the trust for a number of years and said they would not want to work anywhere else. They knew the senior staff in the organisation, feel it was non-hierachical and said they could raise concerns or ideas in the knowledge that they would be taken seriously.

- Staff had access to a wide range of opportunities for learning and development, especially leadership training, which had helped many staff to make progress with their career whilst also improving the care they delivered to people using the services. Staff from East London had helped manage the changes in Luton and Bedfordshire which had provided them with opportunities to develop their leadership skills.

- The trust staff understood the importance of supporting patients with their physical as well as their mental health. In Newham this was made easier as the trust provided mental health and community services. There was positive work taking place to facilitate close working with GPs. Innovative work was taking place to promote good physical healthcare for patients, for example arranging health screenings for female patients.

- The trust staff worked well with commissioners and other statutory and third sector providers to make sure the best services were provided and to support patients to access all the services they need.

- The trust recognised and celebrated the diversity of the patients and staff and worked to meet the needs of people using the services. There were a lot of exciting initiatives to meet the needs of people using the trust's services. The trust also had an active department of spiritual, religious and cultural care.

  However:

- Although we have rated the trust outstanding overall, our inspection has identified a number of areas in core services rated good or outstanding where further improvement can be made. We expect the trust to continue its journey of continuous improvement and we will work with the trust to agree an action plan based on the findings of our inspection.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?   **Good** ●

We rated safe as **good** because:

- The trust had an ongoing programme to improve the safety of the buildings where patients received care. In the last year they had invested £12.3m to improve the physical environments especially in Luton and Bedfordshire.
- Equipment used for emergency and physical healthcare was in good order. Staff ensured that the new emergency medical response bags designed by the trust were available when needed. The physical healthcare lead nurse in each directorate delivered monthly emergency drills in each area so staff were able to deliver emergency care to patients when needed.
- In March 2016, 7.2% of staff posts were vacant.This was very low for the London region. The trust had a robust values-based recruitment process in place to maintain the numbers and quality of staff joining the trust. Over 500 staff had been offered posts in Luton and Bedfordshire since the trust took over managing these services.
- The trust maintained safe staffing levels most of the time and staff could access additional temporary staff where needed.
- Compliance with mandatory training was at 92.6% in May 2016. Where there were gaps in the completion of training, additional training was planned.
- Teams across the trust were very aware of the potential risks for patients and had good systems to ensure this information was reviewed and communicated. Quality improvement projects had specifically looked at the risks of violence and aggression and also of patients developing a pressure ulcer. The trust had introduced innovative measures to reduce these risks and was monitoring the improvements closely.
- The trust had a reducing restrictive practices board which was working to ensure that physical interventions were only used as a last resort. This included ensuring staff had received the appropriate training.
- The trust was trying to avoid the use of blanket restrictions. For example patients on acute mental health wards were able to keep and use their own mobile phones.
- The trust supported staff working on their own to keep safe. Many staff were equipped with personal alarms that included GPS so they could be tracked if needed.
- Staff were encouraged to report incidents and knew how to do this. Serious incidents were investigated to a high standard.

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Learning from incidents was shared using a range of communications, for example video podcasts on medicines safety. Duty of candour was being implemented and monitored.

However:

- In the forensic services at the John Howard centre, some patients wore an electronic device whilst on escorted leave. This was decided using a risk based approach.However, the staff had not ensured that the risk assessments incorporated the views of the patients and reflected the patients' care plans.
- Alarms were in place for staff on wards to call for assistance where needed. However, on Clerkenwell ward in the forensic services, the loud noises and flashing lights were causing distress to the patients who had a learning disability or autism.
- Work was taking place to improve the quality of the recorded risk assessments throughout the trust. However, further work was needed to ensure the quality of the records were consistently of a high standard and that they were located where they could be easily accessed.
- Safeguarding arrangements were in place including access to training and support. However, staff were not always clear about the threshold for making a safeguarding alert. In Luton and Bedfordshire they were more confident but further work was needed in the London services.
- Further work was needed to continue to reduce the use of prone restraint which accounted for around 25% of all the restraints.

Are services effective?

We rated effective as **good** because:

- The trust ensured that staff assessed the physical health of all patients. They had developed a single page physical health assessment proforma which included all the key cardio-metabolic parameters. They were also innovative in promoting people's physical health. For example across the community mental health teams in London pods were available where patients could check their weight and blood pressure before their outpatient appointment.
- Patients using an inpatient service had access to good physical healthcare. Examples of this included patients in the forensic services having access to a substance use support service which offered educational and support groups. Also young people at the Coburn Centre had access to sexual health services.

Good 🟢

Summary of findings

- There were a range of services in place to enable patients with mental health needs to receive their treatment from primary care services. GPs were provided with specialist advice where needed.
- The trust as part of their assurance processes undertook a number of audits. These included checking trust procedures were being followed and clinical audits. It was seen that where improvement actions were needed, these were being implemented and their progress was monitored.
- Staff had a wide range of opportunities to access ongoing training. For example staff working in the inpatient and community services for older people with mental health needs had all completed training on dementia awareness. Staff working on the community inpatient wards in Newham had training on tissue viability, catheter care and end of life care.
- Staff were having regular supervision. This was monitored by the trust and at the time of the inspection was in place for 91% of staff. Most teams also had reflective practice sessions. In March 2016, 96% of staff had completed an annual appraisal.
- There was good working within multi-disciplinary teams, across teams within the trust and with external professionals. For example the CAMHS inpatient services maintained regular contact with the community teams supporting the young person. Where there these teams were a long distance away they could arrange from them to join CPA meetings by video link.
- The Mental Health Act and Code of Practice was mostly being used appropriately across the trust. Staff had access to training and support where needed.

However:
- The trust was re-structuring the psychology service in Luton and Bedfordshire to improve access to psychological therapies in line with best practice guidance. Good progress was being made with addressing this area for improvement but it was not yet complete.
- Staff were receiving training in positive behaviour support so they are equipped to use this approach, but this was not going to be completed till October 2016.
- The trust was introducing mandatory Mental Capacity Act (MCA) training in October 2016. Teams that regularly used the MCA had been trained and were confident in their use of the legislation. Staff from other teams were less confident, but could seek advice if needed.
- The trust faced significant challenges with its management of patient records especially in Luton and Bedfordshire where it

inherited three previous systems and was moving these records to the trust wide system. This was still a work in progress. Also in the district nursing services the poor record keeping meant it was not possible to be sure that patients had been thoroughly assessed and had the appropriate risk assessments and care plans in place.

Are services caring?

We rated caring as **outstanding** because:

- Staff provided holistic care and made every effort to get to know and understand people and meet their needs. This was done in a non-judgemental way that respected peoples individual choices.
- Staff delivered care in a considerate manner, for example on some acute wards patients were given a pack when they arrived containing essential toiletries.
- Staff showed a very good understanding of people's diverse needs. An examples of this was on the Coburn unit for young people, where support was provided to young people who were transgender to have their individual needs met and where needed to be referred for additional support from specialist services.
- Patients and carers were very involved in preparing their care plans and different formats were available for patients to complete their own documents. They were also fully involved in ward rounds and review meetings. A patient led audit had been developed to monitor patient involvement in their review meetings.
- The trust was very committed to involving carers. The trust had carer leads and their names and contact details were on the trust website. An example of this was the training provided for carers of patients diagnosed with dementia.
- There were peer workers across the trust. Also patients had opportunities to work in a voluntary capacity and this helped them build up their confidence and skills to return to work.
- Patients and carers were supported to be actively involved in the running of the trust. Many people had completed training and were able to participate in staff recruitment and delivering training. For example patients helped to deliver the induction training and also the training on physical interventions.
- Patients were also involved in wider community work. For example in the community health services for children, young people and families the sickle cell and thalassemia service had

Outstanding ☆

set up a peer support group and this group had arranged a national conference for patients, families and professionals to discuss innovations in care, which was attended by 150-200 people.

Are services responsive to people's needs?

We rated responsive as **outstanding** because:

- Patients needing access to the acute care pathway were receiving an outstandingly responsive service. At the time of the inspection the average bed occupancy on the trust acute mental health wards was 83%.

- The trust was managing bed occupancy to a continuously high standard. Beds were available for patients who needed admission and the focus of work was on supporting patients with their discharge. This work started as soon as they arrived on the ward.

- The home treatment teams acted as the gate-keepers for the acute beds to ensure that all other options had been exhausted before an admission was required. These teams were very responsive and would see urgent referrals within 4 hours (or in Bedfordshire within 2 hours in A&E). The London teams had a target of seeing 80% of new referrals within 24 hours, which they were meeting for 85% of the patients referred. Patients across the trust had access to a crisis line that operated throughout the night and where needed there was a duty emergency team. During the day there was a dedicated line for patients being supported by the home treatment team. This was answered by an experienced nurse who could arrange additional visits if needed.

- The three health based places of safety were very responsive. Patients were not excluded if they were intoxicated due to drugs or alcohol, unless they needed medical attention and an admission to A&E was more appropriate.

- All the community teams including home treatment teams and community mental health teams (CMHT) for adults and older people tried to be flexible with appointment times to meet people's needs. For example the Hackney South CMHT provided an assessment service to homeless people in the evenings at a local shelter. Patients who did not attend their appointments were followed up.

- The Newham CAMHS was working to improve responsiveness through a quality improvement project called the 'front door' initiative to reduce waiting times for assessment and create a safer system. The 'front door' initiative had been in place since

Outstanding ☆

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2015 and there had been significant reductions in young people waiting for their first contact with CAMHS.This had improved attendance rates and young people being allocated the correct clinician at the earliest opportunity.

- The two GP surgeries provided by the trust were very accessible and were available for patients who did not have access to a permanent address. Patients could be seen the same day and offered rapid access to substance misuse treatment if needed.

- Inpatient services had facilities which really tried to meet the needs of people using the services. For example in the Newham mental health unit the patients using the psychiatric intensive care unit had access to a sound proofed music room. On Coral ward an acute ward in Luton and Bedfordshire, patients were able to grow their own vegetables.

- Feedback about food was mostly positive. Staff in some services ate with the patients which was well received.

- Therapeutic activities were available for patients using services. This had been supported by the recovery colleges in London and a newly opened one in May 2016 in Luton and Bedfordshire. In the inpatient wards, the extension of activities had frequently been linked to the quality improvement work to reduce incidents of violence and aggression.

- The department of spiritual, religious and cultural care recognised the effect of each of these on people's mental well-being. They provided a range of training to equip staff and members of faith communities to holistically support people suffering from mental distress. The team also provided one to one visits to wards and groups on wards, acts of worship from different faith traditions, connecting patients to faith leaders and communities, celebration of festivals, provision of religious texts and materials, individual spiritual needs assessments and liaison meeting with staff. We heard about the work that had been done with the mosques in East London and could see that patients who wished to celebrate Ramadan that was happening at the time of the inspection were being fully supported to do so.

- Patients knew how to complain and complaints were taken seriously and investigated thoroughly. Staff had learnt from complaints and made improvements.

However:

- The memory clinics had waiting lists for an initial appointment for assessment and diagnosis. The London services had clear targets of 6 weeks for an assessment and 18 weeks for a

diagnosis. The London and Luton clinics were making progress towards meeting these timescales. In Bedfordshire two out of the three teams still had more work to complete in order to meet these timescales.

Are services well-led?

We rated well led as **outstanding** because:

Outstanding ☆

- The trust had inspiring and approachable leaders who shared a clear vision that was known and understood by staff working across the trust. They welcomed innovation and celebrated success.
- There was a very stable senior leadership team. At the time of the inspection the chief executive had announced his pending retirementbut the deputy chief executive had been appointed as the new chief executive. She was the first female BME NHS chief executive in the country.
- The chair and board were very impressive. The board was diverse and reflected the local communities. The non-executive directors bought with a wide range of professional skills and personal experience. At the board meeting the quality of questions, challenge and debate was a high quality. Board members appropriately held executive staff to account to ensure the trust was meeting the needs of people using the services. There was no complacency and they set high standards and were always thinking about how the trust could improve.
- Senior leaders had managed the transfer of the services in Luton and Bedfordshire to the trust successfully and staff and patients from those services were delighted with the many improvements that had taken place. The massive changes made in these services in just over a year was incredibly impressive.
- The trust had robust governance structures in place. This meant that from ward to board there was a good understanding of the challenges facing the trust. Areas for improvement were recognised and work was done in a timely manner to make these changes.
- There was a clear board assurance framework. This was organised to reflect the three key objectives for the trust: to improve service user satisfaction, improve staff satisfaction and maintain financial viability. Under each of these objectives the main risks were identified and improvement actions identified. Progress was monitored. There was management information available in an accessible format identifying trends and areas for improvement.

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- The trust had an extremely healthy culture. It was in the top 5 trusts in the country in the latest staff survey. Staff said how much they enjoyed working for the trust and felt valued and able to contribute. They also felt able to raise concerns. Staff felt very engaged in the work of the trust and it was recognised that the quality improvement programme contributed significantly to this.
- Staff also talked positively about their opportunities for learning and development and also career development.

Summary of findings

Our inspection team

Our inspection team of **108** people over two weeks was led by:

Chair: Julie Hankin, executive medical director, Nottinghamshire Healthcare NHS Foundation Trust

Team Leader: Jane Ray, head of inspection for mental health, learning disabilities and substance misuse, Care Quality Commission

Other members of the team included:

24 CQC inspectors

three trainee CQC inspectors

two assistant inspectors

one inspection planner

three analysts

seven Mental Health Act reviewers

19 nurses and health visitors

11 psychiatrists

nine social workers

13 allied health professionals

three CQC pharmacists

10 experts by experience and 1 trainee (some were on site and others making phone-calls off site)

three people with governance experience

Why we carried out this inspection

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

How we carried out this inspection

Before the inspection visit the inspection team:

- Requested information from the trust and reviewed the information we received

- Asked a range of other organisations for information including NHS Improvement, NHS England, clinical commissioning groups, local authorities, Healthwatch, Health Education England, Royal College of Psychiatrists and other professional bodies, users and carers groups.

- Sought feedback from patients and carers through attending five user and carer groups and meetings.

- Received information from patients, carers and other groups through our website

During the announced inspection visit from the 13 June – 24 June 2016 the inspection team:

- Visited **86** wards, teams and clinics

- Spoke with **324** patients and **52** relatives and carers who were using the service

- Collected feedback from **406** patients, carers and staff using comment cards

- Joined **14** service user and carer community meetings

- Spoke with **754** staff members, ward and team managers and other directorate staff

- Attended **19** focus groups attended by **283** staff

- Interviewed **8** executive team and board members

- Interviewed a further **20** senior staff in trust wide roles

- Attended and observed **69** hand-over meetings and multi-disciplinary meetings

- Joined care professionals for **29** home visits

- Looked at **417** treatment records of patients

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- Carried out a specific check of the medication management across a sample of wards and teams

- Looked at a range of policies, procedures and other documents relating to the running of the service

- Requested and analysed further information from the trust to clarify what was found during the site visits

- Observed a board meeting and a quality assurance meeting

The team inspecting the mental health services at the trust inspected the following core services:

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

- Wards for older people with mental health problems

- Community-based mental health services for older people

- Forensic inpatient/secure wards

- Mental health crisis services and health-based places of safety

- Child and adolescent mental health wards

- Wards for people with a learning disability or autism

- Community mental health services for children and young people

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

- Community mental health services for people with learning disabilities or autism

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

The team inspecting the community services at the trust inspected the following core services:

- Community health services for adults

- Community health services for children, young people and families

- Community inpatient services

The team also inspected two primary medical services which will have separate reports.

We did not inspect the substance misuse service that the trust provides and a number of other specialist services.

Information about the provider

East London NHS Foundation trust was formed in 2000 and gained foundation trust status in 2007.

The trust was first established as a mental health trust covering East London (City and Hackney, Newham and Tower Hamlets). However, over the years the remit of the trust has broadened. In 2011 it started to provide community health services in Newham. The trust also provides psychological therapies in Richmond and children and young people's speech and language therapy in Barnet. The trust also has a mother and baby unit at the Homerton which receives referrals from across the South-East. In April 2015 the trust gained responsibility for mental health services in Bedfordshire and Luton.

The trust provides services to a population of 820,000 in East London and 630,000 in Bedfordshire and Luton. The trust employs around 5000 permanent staff. The trust has over 800 inpatient beds and provides services from around 100 community and inpatient sites. It has an annual budget of £353 million.

The trust was organised into directorates based on the five geographical areas (City and Hackney, Tower Hamlets, Newham, Luton and Bedfordshire) and also directorates for forensic services, specialist services including children and adolescent mental health services and children's community services, specialist services covering addictions, specialist directorate for older people including the Newham adult community services and specialist directorate for psychology services. Each one has a clinical director and service lead.

The CQC inspected forensic services at the John Howard centre in Hackney in November 2015. We found no areas of non-compliance. We inspected adult mental health services in Tower Hamlets in December 2010 and we had concerns around people receiving medication for which there was no legal authority (consent to care and treatment). This had been rectified when we reinspected in July 2011. We had also carried out a number of other inspections where the trust was found to be fully compliant. These included forensic learning disability

Summary of findings

services in January 2012, community health services in Newham July 2012, forensic services in December 2012, community health services in Newham July 2013, City and Hackney inpatient mental health services December 2013, Newham adult inpatient mental health services December 2013 and Newham CAMHS in January 2014.

What people who use the provider's services say

Before the inspection took place we met with five different groups of patients, carers and other user representative groups as follows:

- CHUMS mental health and emotional wellbeing service for children and young people in Bedfordshire

- Bedford, Luton and Milton Keynes Mind

- Core Arts group in Hackney

- Dementia Café in Newham

- Community options user group in Tower Hamlets

Through these groups we heard from patients and carers. We also received feedback from an independent mental health advocacy service and three Healthwatches who provided us with general feedback and details of their enter and view visits. Hackney Healthwatch arranged a meeting specifically to provide feedback for the inspection. Feedback was also received from three voluntary sector organisations in City and Hackney. These were the Peter Bedford Housing Association, One Hackney and Peoples Network.

During the inspection we spoke to 376 people using services and their relatives and carers, either in person or by phone. We received 406 completed comment cards.

Also also received around 40 individual comments from people through our website or by phone in the three months leading up to the inspection. Of these 12 were specific complaints about the use of the Mental Health Act.

Much of the feedback we received was very positive. Typical comments from people who used the service and their carers was as follows:

- Services really helped to improve their physical and mental health

- Staff, individually and collectively have been kind, supportive, professional and helpful

- Very responsive services – for example the crisis line and crisis café in East London, but these need to be publicised more

- Lots of opportunities for patient involvement

- When service users raise issues the trust actively seeks to make improvements

- Patients are supported to reduce their medication

- Patients have a clear written crisis plan

- The dementia service in Newham provided good support, staff know everyone and there was an excellent users group.

More people made positive comments than negative but some of the challenges we heard about were:

- Communication in Luton and Bedfordshire – they do not keep the patients informed of changes, for example if they are going to relocate or close a service. These changes also may result in longer journeys for patients

- Acute wards – not enough healthy food, named nurse may be working at night and so hard to see them, hard to get toiletries and clean clothes on arrival, staff very busy and not enough time to speak, have to use the phone in the ward office etc

- District nurses – not turning up on time

- Dementia service (Newham) – tests for diagnosis taking a long time

- Patients discharged from inpatient acute services – not well signposted to community services

- Patients (in Bedfordshire) are not sufficiently involved in preparing their care plan and do not always attend the ward round meetings where their care needs are discussed

- Patients supported in the community are not aware of their care plan

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- Some patients not aware of their crisis plan

- Patients feel there is not always enough timely contact after discharge

- Wards do not always give patients a copy of their welcome pack

- CMHTs in Hackney – can be hard to get through on the phone

- CMHTs are discharging patients for non-engagement

- Patients in hospital not offered enough encouragement to access psychological therapies also waiting times for access to these services in the community

- CAMHS Newham – delays in getting appointments (but a good service)

- CAMHS – concerns about patients being discharged too soon

- Brett ward (acute City and Hackney) – cleanliness, access to outside space

- Keats (Bedfordshire acute) – ward short-staffed, patients have access to sharp knives, lack of security going in and out of the ward, concerns about staff attitude

- Fountain Court (Bedfordshire older people) – a couple of examples of medication errors

- Acute and older persons inpatient services in Bedfordshire and Luton – concerns about the numbers of patients assaulting other patients

- Crisis line – hard to get through

- Wards not thoughtful enough about the care of people who are transgender

Good practice

Trust wide:

- The quality improvement programme had led to many improvements in the care for patients and the running of the organisation. It had also encouraged innovation and stimulated staff engagement.

- Pharmacists were integrated into multi-disciplinary teams and this was providing excellent support to staff and patients.

- The patient participation team had leads in each borough and was supporting lots of innovative practice to ensure people using the services were involved in all aspects of their care and the running of the trust.

- The trust had a strong and wide-ranging spiritual, religious and cultural care department which accessed information and assistance for people from many backgrounds and communities in a sensitive manner and also provided advice and support for staff members regarding the cultural and spiritual support which they offered. This was more embedded in London but developing in Luton and Bedfordshire.

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

- There were identifiable positive outcomes for some of the quality improvement programmes, such as extending access to screening for womens' health on Connolly ward and monitoring physical health monitoring after the administration of rapid tranquillisation in Bevan ward.

- Patient engagement was evident through 'hope walls' in the wards which were painted and designed by patients and the roll out of locally based newsletters which updated staff and patients about events and activities on the wards in their local areas but also provided a channel for information to be shared. For example, there was a news item regarding LGTBQ issues in the Bedfordshire newsletter.

- The staff name board in Oakley Court with photos of staff holding promises that they made to patients. For example, to listen to patients and to display kindness.

Summary of findings

Forensic inpatient wards:

- There were many opportunities for patients to earn money and gain experience through contracts of employment on site, as well as through work placements in the community. This was part of an employment pathway which includedtraining and a competitive recruitment process. 30 patients were on employment contracts and 126 patients had benefitted from the work taster and work experience opportunities on site. Off site, there was evidence of partnerships with social enterprises which supported patients to develop confidence and experience. Patients also had a chance to earn money on the ward. There was enthusiasm and pride among staff and patients in the many different employment projects available.

- There was a well integrated substance misuse support service for patients (SUSS). Members of the SUSS team attended multi disciplinary team meetings and other meetings on the request of patients. Group and individual sessions supported patients to overcome their substance misuse both on site and in the community for patients on unescorted leave. The SUSS team also offered training to staff on the wards and kept them updated on new information about substances.

- The quality improvement pilot into violence reduction showed a decrease of 57% in violent incidents in Clerkenwell ward during the previous six months.The use of restraint, rapid tranquilisation and the seclusion room was reduced through the introduction of a sensory room, increased range and frequency of occupational therapy activities and a strong emphasis on positive behavioural support techniques.

- At Wolfson House, each ward had a written philosophy on display which stated staff would support patients to be involved in the planning of their care. This philosophy was reflected in patient care planning which showed the involvement of patients and also recorded where patients did not want to have their comments recorded as quotes in their notes.This philosophy also informed the multi disciplinary team meetings which were patient focussed. Although all disciplines were usually represented in these

meetings, the patient could choose how many people were in the room, or choose to have separate discussions with one member of staff outside of the meeting, yet still have their views considered.

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Crisis services and health based places of safety:

- Staff in the home treatment teams took active steps to engage people with a focus on understanding the individual needs, preferences and context of people's lives. Practical support was offered if this was the patient's priority. When needed staff would support patients to access third sector organisations.

- For patients supported by the home treatment team there was time given to ensure people had active involvement in their care planning, with care plans focused on patients self-defined needs and objectives.

Community based mental health services for adults of working age:

- Community mental health team (CMHT) in Hackney had developed a quality initiative with the input of patients on making care plans more recovery focused.

- At Dunstable CMHT, supervision records were particularly comprehensive covering staff well-being and development needs as well as a detailed caseload review.

- In the East London teams there were arrangements in place for staff to encourage patients to have appropriate physical health checks. At the CMHT sites there were 'pods' which could be used by patients to check their weight and blood pressure prior to their appointment with their psychiatrist.

- Teams where flexible about appointment times when this was necessary to meet people's needs. For example, the Hackney South CMHT provided an assessment service to homeless people during the evenings at a local shelter.

Summary of findings

Specialist community mental health services for children and young people:

- CAMHS services were participating in internal quality improvement projects.For example, Newham CAMHS 'front door' initiative was part of the quality improvement model. The 'front door' initiative had been set up to reduce waiting times for assessment and create a safer system. The 'front door' initiative had been in place since 2015 and there had been significant reductions in young people waiting for their first contact with CAMHS.This had improved attendance rates and young people being allocated the correct clinician at the earliest opportunity.

- CAMHS teams employed cultural consultants and bi-lingual workers to support them in providing services to young people who might have found it difficult to engage with the services.

- Young people were involved in re-designing the care plans and CAMHS micro website. Young people had been nominated for an award by the participation worker in Luton and Bedfordshire and had won third place in the Bedfordshire Young People of the Year Award 2015 competition. Young people contributed to magazines and videos about their treatment in CAMHS and were supported by the participation workers to do so. Young people were involved in the recruitment of new staff.

- Tower Hamlets CAMHS worked in collaboration with the adoption consortium and provided play therapy for looked after children who were moving to a permanent placement.

- All teams offered good support for young people who were looked after and placed out of borough.

- The Bedfordshire team had received training, which had given them a better understanding of female genital mutilation. There was strong working relationship between Bedfordshire CAMHS and the family nurse partnership (FNP). FNP provide a programme for vulnerable young first time mothers.

Child and adolescent mental health ward:

- The frequency of use of physical restraint was reducing as a result of a quality improvement project aiming to reduce incidents of violence and aggression. The service had implemented training in managing challenging behaviours. The managing challenging behaviours ethos was used when writing young people's care plans on the psychiatric intensive care unit.

- Young people sat on staff interview panels and were paid in vouchers for work that they did to help with the running of the service. Young people gave feedback and were consulted about operational decisions such as replacing bed linens.

- The sensory room vas very popular with young people and staff. It was a calm environment with bean bags, interesting lighting and music. Staff told us it helped to ensure the least restrictive practice was followed when de-escalating aroused patients.

- All staff participated in reflection at the end of each shift, where they thought about what had gone well and how to manage challenging situations during subsequent shifts. In the day service, young people also took part.

Wards for older people with mental health problems:

- There was excellent use and implementation of 'this is me' life history documentation to provide person-centred care.

- The service used a comprehensive handover tool to ensure that all important information such as risk and updates related to individual patients was communicated effectively to staff coming onto the shift.

- A carers support group provided carers with support and training so that they had a better understanding of dementia care.

- The refurbishment of Thames ward had been designed using guidance from the University of Stirling, Dementia Services Development Centre and the Kings Fund healing environment assessment to provide a high quality environment for patients living with the experience of dementia.

- The service had developed and implemented the multifactorial falls prevention risk assessment tool. The use of this tool had reduced the number of falls incidents across the service.

Community mental health services for older people:

- City and Hackney staff had produced a welcome pack for patients and carers. It provided information about the service, referral pathways, key contacts and care packages. It provided a glossary which explained the meaning of terms used such as single point of entry. Within the pack were additional leaflets on the Mental Capacity Act, the Mental Health Act, Deprivation of Liberty Safeguards and the teams commitment statement on promoting independence.

- "Breakfast meetings" were held once a month at City and Hackney where professionals were invited to come and speak with staff. A stroke specialist gave a talk at the the most recent meeting.

- Newham staff provided a dementia awareness training session to all new staff as part of their corporate induction to ELFT.

- Tower Hamlets staff had begun piloting a training session on supporting sexual expression in dementia.

- Tower Hamlets staff had developed their own East London cognitive assessment tool and had worked with a dietitian to develop a malnutrition universal screening tool for use with patients in the community.

Summary of findings

Rehabilitation mental health wards:

- 105 London Road had an excellent scheme of patient self-administration of medication with detailed monitoring and assessment in place. This enabled the staff team to make informed decisions about which patients could be independent with their medicines.

- Both wards had excellent links with local third sector organisations. For example, at Cedar House patients accessed a MIND wellness centre which offered courses such as yoga and creative writing. At 105 London Road, another organisation offered support to improve patient recovery by helping patients understand their finances and benefits. Patients were supported to visit local music studios when they expressed an interest in music.

Community mental health learning disability services:

- An event was arranged to celebrate learning disability awareness week. This was a great success and people told us that they enjoyed it immensely.

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Summary of findings

Mental health wards for people with a learning disability:

- The service model for the intensive support team provided support for patients in the community before and after admission to the Coppice and included crisis prevention work and a reduction in acute hospital admissions.

Community Health services for children, young people and families

- The trust's sickle cell and thalassemia team worked in partnership with patients to develop the service and improve ownership and understanding of their care amongst clients. An annual conference took place to share information with people from across the country.

- The team of specialist health visitors improved access and support for particular patient groups. There were specialists in perinatal and infant health, HIV, and sickle cell and thalassemia.

Areas for improvement

Action the provider MUST take to improve

Forensic inpatient wards:

- The trust must ensure that risk assessments for the use of electronic devices relate to individual patient care plans and reflect the views of the patient and that all risk assessments for each patient are easily accessible to the staff who need to use them.

- The trust must make changes to the alarm systems on the learning disability ward to support the needs of patients especially those with an autism spectrum disorder. This should include considering how the use of flashing and noisy alarms could be reduced.

Summary of findings

Community mental health services for older people:

- The trust must ensure that waiting times for patients referred to memory clinics to attend a first appointment and to receive a diagnosis continue to be improved especially across the Bedfordshire services.

Mental health wards for people with learning disability:

- The trust must ensure that as most patients using the service had challenging behaviours that they have care plans reflecting a positive behaviour support approach.

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Community health services for adults:

- The trust must ensure all patient records are maintained appropriately. This is to ensure that patients have the necessary assessments, that assessments have been reviewed at appropriate timescales, that records of physical health observations are available and care plans in place. This is to ensure that district nurses in particular, deliver the appropriate care or recognise when the patients needs are changing and if it is necessary to involve another care professional such as a tissue viability nurse.

Action the provider SHOULD take to improve

Trust wide:

- The trust should continue to reduce the use of prone restraint.

- The trust should continue to implement the changes in its patient record system, especially in Luton and Bedfordshire to promote ease of access for staff to essential patient information and improve the potential information governance risks linked to confidential information being in a paper format or across a number of electronic systems.

Summary of findings

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

- The trust should ensure the seclusion room on Gardiner ward has a fully working two way intercom and a visor to preserve the privacy of patients using the toilet.

- The trust should ensure recorded risk assessments include all the updated information.

- The trust should ensure that the London wards are applying the thresholds for safeguarding alerts consistently.

- The trust should ensure that staff working in the London acute wards are making the most of opportunities to learn from incidents across directorates.

- The trust should ensure that it continues to review the numbers of beds on its wards in Luton and Bedfordshire so they are in line with national guidelines.

- The trust should ensure that it completes the review of psychology services in Luton and Bedfordshire to improve access to services.

- The trust should ensure that it continues to work on reducing the clinic room temperature in the areas where there were high temperatures in the clinic rooms.

- The trust should ensure that it implements the programme of mandatory training on the Mental Capacity Act to support ward staff having a consistently good understanding of the Mental Capacity Act and being able to apply these principles in practice.

- The trust should ensure that staff are recording restraint comprehensively on Keats ward so that accurate numbers can be determined.

Forensic inpatient wards:

- The trust should ensure the mirrors to improve lines of sight on the wards at the John Howard Centre are installed.

- The trust should ensure regular bank staff at the John Howard Centre receive training so they can support patients with their evacuation in the event of a fire.

- The trust should ensure at the John Howard Centre that all the control drugs are included on the control drug registers.

- At the John Howard Centre the trust should continue to try to keep the amount of cancelled leave due to staff shortages as low as possible. At Wolfson House the trust should monitor the amount of cancelled leave.

- The trust should review staffing levels on Shoreditch ward at the John Howard Centre as there are a high number of incidents of physical interventions on this ward.

- The trust should ensure that new staff are introduced to Shoreditch ward as planned in order to provide consistent standards of care.

- The trust should work to reduce the incidents of patients sexually intimidating female staff at the John Howard Centre.

- The trust should ensure at Wolfson House that all equipment used for physical health checks is in good working order.

- The trust should ensure that staff recognise when patients assaulting other patients should be reported as a safeguarding incident and when steps need to be taken to keep people safe.

- The trust should ensure that for patients detained under the Mental Health Act that the record of their authorised medication is attached to their medication administration record.

- The trust should ensure that Clissold ward at Wolfson House displays the full range of information for patients including how to access advocacy services.

- The trust should work with commissioners to ensure patients who are receiving care in a low secure setting are cared for in a more appropriate setting.

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- The trust should ensure it consults with and listens to the views of staff when making decisions about significant changes in how care is delivered, for example the use of electronic devices for patients taking leave.

Crisis services and health based places of safety:

- The trust should ensure there is a consistent approach to recording and storing risk assessments to improve the safe care and treatment of patients.

- The trust should ensure that serious incidents and the lessons from them are discussed in the Tower Hamlets home treatment team similarly to the other teams.

- The trust should ensure that all records relating to patients admitted to health based places of safety are completed in full to ensure that the care of people using this service can be accurately monitored.

- The trust should ensure that records relating the patients admitted to health based places of safety are regularly audited to identify potentially unlawful practice and practice that is inconsistent with the Mental Health Act 1983 Code of Practice and that this is raised where needed at crisis care liaison meetings.

- The trust should ensure that patients receive information about their rights under the Mental Health Act when they are on leave under the care of home treatment team.

Summary of findings

Community based mental health services for adults of working age:

- The trust should ensure that staff fully complete medicines administration charts in all CMHTs to reduce the risks of errors in medicines administration.

- The trust should ensure there are robust arrangements in all CMHTs to ensure there are adequate records on the outcome of referrals to ensure patients receive appropriate follow up.

- The trust should review the systems for the use of alarms at the Luton CMHT premises to keep lone workers safe.

Child and adolescent mental health ward:

- The trust should ensure that the length of time a patient is restrained is recorded and a duty doctor always attends to review patients after episodes of prone restraint.

- The trust should improve the choice of meal options to ensure they are positively received by the young people.

- The trust should ensure that rights are read to detained patients promptly after admission or detention according to section 132 of the Mental Health Act.

- The trust should ensure that details of patient's nearest relative and their address are provided in Mental Health Act applications and leave forms.

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Wards for older people with mental health problems:

- The trust should ensure that recorded risk assessments contain detailed information, so that care and support is delivered safely.

- The trust should ensure that ligature audits detail a timeframe for work completion.

- The trust should ensure that records are maintained so that staff can find information with ease where needed.

- The trust should review the composition of the multi-disciplinary team on Cedar Lodge to ensure patients receive appropriate occupational therapy support to meet their needs.

- The trust should ensure that at Fountains Court staff engage with patients to promote their wellbeing.

- The trust should ensure that service user meetings take place on Leadenhall ward to provide a forum for patients to express their views.

- The trust should ensure that ward level risk registers are in place, as one was not completed.

Community mental health services for older people:

- The trust should ensure all first aid boxes are fully stocked, as one was missing some items.

- The trust should ensure there are clear timescales in place for the migration of the patient electronic records to the new system.

Summary of findings

Rehabilitation mental health wards:

- The trust should ensure that staff carry out and record risk assessments of detained patients before they take agreed section 17 leave. They should also ensure that staff record clearly the limits of section 17 leave for detained patients and this is adhered to.

- The trust should ensure that all patients have clear recovery goals and that outcomes of care and treatment can be measured.

- The provider should ensure that patients are referred for evidence based psychological therapies when this is appropriate.

Mental health ward for people with learning disability:

- The trust should ensure that recorded

- The trust should continue to implement the changes to enable improved access to psychology and therapy staff.

- The trust should ensure that the planned training on positive behaviour support is fully delivered to the staff team to inform their approach with patients.

- The trust should ensure that improvement in the documentation of best interest decisions for people who are unable to consent to care and treatment.

- The trust should ensure that a choice of more activities is provided to patients at the Coppice, and these should be monitored and reviewed. These should include support with activities of daily living to ensure that people maintain or develop their independence skills.

Summary of findings

Community mental health learning disability services:

- The trust should review if all members of the multi-disciplinary team would benefit from having a portable alarm to take with them when visiting patients, to protect them during lone working.

- The trust should ensure that all relevant staff receive training relating to the Mental Capacity Act (2005).

- The trust should continue to implement the changes to enable improved access to psychology and therapy staff.

- The trust should ensure that the training on positive behaviour support is provided to the staff team to inform their approach with patientsand this is always used in care planning for patients with challenging behaviour.

- The trust should ensure that a strategic lead is recruited for the learning disability teams to give the service direction and support the care of people with learning disabilities across the trust.

Specialist community mental health services for children and young people:

- The trust should ensure that staff are clear about the lone working protocols and ensure that staff undertaking home visits have breakaway training.

- The trust should ensure that staff keep records of when toys are cleaned.

- The trust should ensure that the physical health monitoring equipment in the Luton and Bedfordshire CAMHS is calibrated regularly.

- The trust should ensure that the fridge used to store medicines at the Tower Hamlets CAMHS office is fit for purpose and is regularly checked to ensure that the medicines stored in it are in date.

- The trust should ensure that BME staff are supported as part of their diversity action plan.

- The trust should ensure that the administrative staff receive ongoing support during the period of their roles being reviewed.

- The trust should ensure that staff complete training in safeguarding children levels 2 and 3 as planned.

Summary of findings

Community health services for children, young people and families:

- The trust should ensure that staff are all familiar with the term, 'duty of candour' and their responsibilities, even though they were applying this in practice.

- The trust should ensure staff know how to respond to potential incidents of domestic abuse.

- The trust should continue to take steps to improve client transition from paediatric to adult community services to ensure continuity of care and access to timely and appropriate provision for all clients.

- The trust should provide communication skills training to ensure practitioners communicate with all clients clearly and appropriately.

- The trust should work with the organisations that are responsible for the health centre buildings, where the clinics are provided to improve their safety for children and make them more child-friendly.

- The trust should develop and document standardised operating procedures for referrals to ensure consistency across services.

- The trust should continue to promote staff engagement and consultation, particularly around service and estates redesign.

Community health services for adults:

- The trust should ensure that staff are all familiar with the term, 'duty of candour' and their responsibilities, even though they were applying this in practice.

- The trust should ensure that staff have greater clarity of the thresholds for making safeguarding alerts.

- The trust should ensure that staff working in the community health services for adults have an improved confidence in using the Mental Capacity Act.

- The trust should ensure that staff working in the community health services for adults make more use of outcome measures to monitor the progress made by patients using the service.

- The trust should aim to provide patients with more information about the time of their district nursing appointment.

- The trust should continue to improve the waiting times for a wheelchair service.

- The trust should ensure staff all have opportunities to attend team meetings on a regular basis.

East London NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

The trust's systems supported the appropriate implementation of the Mental Health Act 1983 (MHA) and its Code of Practice. The mental health law department managed the trust's responsibilities in relation to the MHA and related legislation and case-law. The executive lead was the director of nursing and quality. The department was managed by the associate director of mental health law with support from the clinical nurse specialist in mental health law (the designated lead for the MCA).

There were thirty-nine associate hospital managers who considered the power to discharge under section 23 of the MHA. This function was directly managed by the associate director and overseen by the trust board Mental Health Act sub-committee which was chaired by a non-executive director.

The department had a programme of audits during the year which covered the use of the MHA in community settings and the use of the MHA in in-patient settings.

There were seven mental health law offices which administered the MHA and provided legal advice/support to clinical teams. An additional two band 7 posts had been created to oversee the administration of the MHA in East London and Luton and Bedfordshire.

MHA training was provided on a variety of subjects available to all staff through classroom sessions advertised on the intranet and bespoke sessions as requested by individual teams. The trust considered the training needs of three different groups: Mental Health Law department staff, hospital managers and clinical staff. While MHA training was not mandatory it was considered essential for certain clinical staff. MHA courses available included and overview of the MHA, receipt and scrutiny of statutory forms and consent to treatment.

The Trust had reviewed all its policies and procedures to make them compatible with the Code of Practice. MHA activities were seen as integral to all other policies and procedures.

During this inspection we completed nine Mental Health Act review visits pursuant to the CQC's duty under section 120 of the Act. We found evidence that detention paperwork was completed correctly, was up to date and was stored appropriately. However in the forensic service there was one instance noted of the use of concurrent sections as there were concerns that impending court hearings might not lead to hospital orders being made. This was not compatible with the principle of least restriction. On one acute ward there were some examples of the record of detention in hospital form (H3) not being signed.

We found evidence that there was adherence to consent to treatment and capacity requirements overall. Copies of consent to treatment forms were mostly attached to medication charts where applicable. However on one ward some assessments of capacity for consent to treatment were very brief and on three wards there was no evidence of discussions with patients about the nature and effects of medication.

There was evidence that most people had their rights under the Mental Health Act explained to them. However on two of the wards we visited it was not clear that all patients had been regularly reminded of their rights and on one of the wards we visited patients were not aware of the availability of the independent mental health advocacy service. When patients were on leave and being supported by the home treatment teams, not all patients were being reminded of their rights.

A majority of the care plans we reviewed were comprehensive and individualised with evidence of patient involvement. On a children and adolescent mental health (CAMHs) ward we noted that one informal patient had been moved to the psychiatric intensive care unit (PICU) without a review of legal status. At each of the health based places of safety that were visited there were a number of section 136 applications where it appeared that the patients had been taken by police to the health based place of safety from their own homes, rather than from a public place.

On a CAMHs ward patients and staff in conjunction with the Royal College of Psychiatrists had developed a special patient friendly leaflet to explain what happened at Mental Health Tribunals

Mental Capacity Act and Deprivation of Liberty Safeguards

The mental health law department managed the trust's responsibilities in relation to the Mental Capacity Act 2005 (MCA) and related legislation and case-law.

Administration of the MCA and the Deprivation of Liberty Safeguards was supported by a trust-wide MCA officer.

The department had a programme of audits during the year which covered capacity to consent to informal admission and Deprivation of Liberty Safeguards.

MCA training was available to all staff through classroom sessions advertised on the intranet and bespoke sessions as requested by individual teams. Whilst MCA training was not mandatory it was considered essential for certain clinical staff. MCA courses available included an overview of the Mental Capacity Act and Deprivation of Liberty Safeguards. There were plans in place to make this training mandatory by October 2016.

From August 2015 – February 2016 there had been 116 applications for an authorized Deprivation of Liberty Safeguard mostly on wards for older people with mental health problems.

The inspection found that where staff were regularly using the MCA. For example in services for older people with dementia and in services for adults with a learning disability, staff had completed bespoke training and had a good understanding and were appropriately using the MCA. In other services, staff often lacked confidence about applying the act in practice, although they knew where to access support when needed. Staff in services for young people had a good understanding of Gillick competency and how this was applied in practice.

Are services safe?

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

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

Summary of findings

Our findings

Safe and clean environments:

- The trust provided care from a varied range of physical environments. In East London there were six main inpatient sites. These were on sites adjacent to Mile End Hospital, Homerton University Hospital, Newham University Hospital, the East Ham Centre, the John Howard Centre and Wolfson House. In Bedfordshire and Luton there were a number of sites providing inpatient services of which more were stand alone locations. These environments were managed through a number of different ownership and maintenance arrangements.

- The trust had an estates strategy which identified the priorities for each directorate. In the last year the trust spent £12.3m on capital investment. Some of the priorities had included ligature reduction work and improving seclusion facilities. There were also a wide range of other environmental improvements. The most significant changes that had taken place were in Bedfordshire and Luton with major projects such as the refurbishment on the Weller Wing located on the Bedford Hospital site. This replaced previous dormitory accommodation with individual bedrooms. There was still a significant programme of work to be completed for the services in Luton and Bedfordshire. Whilst the inspection team found a number of services where the environment needed to improve, it was noted that plans were place.

- The board assurance framework had highlighted that some premises needed more work to improve their safety. This included providing additional security at the John Howard Centre (forensic services in Hackney) and addressing fire alarm issues at the East Wing at the Homerton (acute services Hackney). Action plans were in place for this work to be undertaken.

- The inspection team did not have concerns about the impact of the environment on the immediate safety of patients. The only partial exceptions to this were that in the community health services for children, young people and families the health visitors held clinics in health centres that we not owned by the trust. It was noted that these were not always safe for children. For example at the Lord Lister health centre, there were automatic doors opening onto a main road and children were seen running in and out of the building. It was suggested that the trust liaises with the landlord to consider how safety can be improved.

- The trust had carried out a full ligature point review on all the mental health wards. High risk ligature point reduction work had been completed. Some more work was taking place in a few wards but staff did not always know the timescales for this. They had developed ligature maps to ensure ward staff were aware of where the risks were. They had also provided training for staff on how to identify and support patients where there was a risk of suicide. We saw that the risks to patients of self-harm using a ligature point was mitigated through individual patient risk assessments, identifying patients who needed higher levels of observation and providing patients who were at higher risk of self harm with bedrooms nearer to the nurses station.

- Most of the wards in the trust were single gender with only a few services having mixed gender wards. Where wards had patients of different genders there were separate bedroom and bathroom accommodation to maintain their privacy and dignity. Patients also had access to single gender lounge areas.

- Equipment used in emergencies and for physical health checks was in good order and was regularly checked. New medical response bags had been rolled out that had been designed by the trust. They were clearly laid out and brightly coloured. The trust had employed a senior A&E nurse on secondment to roll out the bags and deliver training on how to respond to an emergency. The physical health care lead nurse in each borough delivered monthly emergency drills in each

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Are services safe?

area. Equipment for physical health checks had been reviewed, with a few minor exceptions and each ward had an EEG machine which had been upgraded where needed.

- The trust had robust procedures in place for infection control. There was a trust lead for infection control and an infection control committee reporting to the trust quality committee. Regular hand hygiene audits were carried out and had a result of around 80%. There had been no cases of MRSA or C Difficile. Staff were seen maintaining standards of infection control when providing clinical care.

- In relation to cleanliness, the latest patient-led assessment of the caring environment score was 99.3%. This was around two percentage points above the national average. The environments that were inspected were all clean. The exception to this was the CAMHS team base in Luton, but this was thoroughly cleaned during the inspection.

Safe Staffing:

- Whilst the trust was doing well with recruitment and retention of staff this was still an ongoing challenge, especially for qualified nurses. In March 2016 the trust vacancy rate was 7.2%. The turnover in the year up to January 2016 was 17%. There were also 12% of the staff who were on fixed term contracts or secondments. These arrangements were in place to support London staff to develop services in Bedfordshire and Luton. They were also enabling staff to progress in their personal development and use their leadership skills. The trust had started to move staff onto permanent contracts.

- Across the trust safe staffing levels were being achieved most of the time, with levels of combined qualified and unqualified staff over 90%. Where the wards were unable to access qualified staff they would book additional unqualified staff or the other way round. Ward staff said they were able to book additional staff based on the patient need. The challenge was being able to access high quality bank staff, especially at the last moment. We heard that in the forensic services patient leave was occasionally cancelled as there were not enough staff to escort the patient.

- The trust had a number of measures in place to promote safe staffing. This included measures to promote recruitment and retention and also measures to manage the roster and daily staffing levels.

- On a daily basis staffing levels were closely monitored. Managers could book additional staff where needed. There was a decentralised bank and agency service within the trust which enabled ward managers to book bank staff directly where they had on-going relationships with them, to promote continuity of care. All inpatient bank staff bookings were recorded in the electronic staff rota. Last minute shift requests were handled through text messaging of bank staff by ward managers and there was a protocol in place to book agency staff where bank staff were unavailable which was done online. The trust was in the process of scoping alternative methods of procuring agency staff. The trust had rated the performance of agencies and ensured the top ranked agencies were contacted first.

- The trust had worked to improve the quality of bank staff. This included the use of values based recruitment, ensuring bank staff completed induction and mandatory training, increased bank payment rates and the introduction of a rewards scheme, providing bank staff with supervision and including bank staff in the staff survey. Some staff said the quality of bank staff was variable and the trust acknowledged there was more work to do.

- The trust recognised that it had certain recruitment hot-spots. These included staff in the Luton and Bedforshire services, district nursing in Newham and recruiting care co-ordinators for community mental health services in London. The trust had a formal recruitment and retention project in place to address this. Recruitment strategies included partnership work with local universities and in Bedforshire 26 newly qualified nurses were joining the trust in September 2016. The trust had also had ongoing extensive recruitment campaigns including a 'refer a friend scheme'. New matron and band 7 posts had been developed to promote opportunities for career progression. A band 5 apprenticeship scheme had been implemented to accelerate promotions to band 6.

- The positive effects of this work were evident. In Luton and Bedfordshire the trust had inherited services with high use of temporary staff. The trust had made

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Are services safe?

employment offers to around 500 staff since taking over the management of these services. Fountains Court (older peoples inpatient ward in Bedford) had the highest number of shifts filled by bank or agency staff.

- The recruitment of district nurses was on the board assurance framework. But latest reports showed that vacancies had reduced from around 30% to 7%. The development programme for band 5 nurses had contributed to the reduction in the turnover. Other measures to improve consistency of staff included ongoing recruitment, trying to use agency on medium term contracts, seconding a second tissue viability nurse to the team from Colombia ward and providing the team with additional support to manage incidents and complaints.

- Throughout the trust there was sufficient medical cover to support people with their physical and mental health clinical needs. Staff across the trust knew the arrangements in their service if they needed urgent medical assistance. At the time of the inspection, junior doctor contracts especially relating to out of hours work were being reviewed. A few doctors expressed concerns about what the changes might mean for their working hours. However, junior doctors said that this would not impact adversely on patient safety and that they had good arrangements for discussing the changes with the trust. Also 100% of the doctors working for the trust had completed their revalidation process which was very positive.

- In terms of the impact of staffing challenges, the inspection teams found that whilst maintaining safe staffing levels was requiring high levels of management input on a daily basis, this was being achieved successfully. There were hot-spots such as Shoreditch ward at the John Howard Centre where there had been a very high turnover of staff, but plans were in place to address this situation. There were no areas where patient safety was being compromised. Managers were able to arrange additional staff based on the acuity of the patients. Every service was mindful of the need to try and promote consistency of care and this was done as well as possible. Staff in Luton and Bedfordshire spoke very positively about the improvements that were continuing to take place in terms of maintaining safe staffing.

- In May 2016, the overall trust compliance with mandatory training had reached 92.6%. In total there were 31 courses, a mix of face to face and on-line training. Managers at all levels had information about how many staff individually and as a team had completed the training. Staff were told when their mandatory training needed to be updated and they were able to book this on-line. There had been a few challenges with the mandatory training. Firstly all the prevention and management of violence and aggression training for staff working in the acute and forensic wards was below target. This was due to the departure of a trainer, but they had now been replaced and the training was booked. Secondly the life support and resuscitation training was at 71%, but further training was planned.

Assessing and managing risk to patients and staff:

- The inspection found that teams were identifying and managing risk well. For example the home treatment teams were reviewing the risk rating for each patient at a daily handover meeting and each patient was risk rated and the frequency of visits was arranged in line with this. The multi-disciplinary discussions supporting this were robust. On the London acute mental health wards there was a quality improvement project to reduce violence and aggression on the wards. The wards were carrying out a range of initiatives, for example using 'safety huddles', where the staff working on a shift would have a meeting to ascertain risk levels on the ward and consider how this could be managed. Wards also looked at incidents that had occurred on the ward and considered when these took place in terms of the day of the week and time of day and made changes in the ward routine to try and reduce the occurance of incidents.

- There were 36 falls recorded in the 12 months up to March 2016. These mostly happened in the community. On the wards for older people with mental health problems they had identified that the most significant risk to the patient group was the risk of falls. Across the service, staff used a multi-factorial falls prevention assessment tool which had been devised by clinical staff. Assessments were comprehensive and included a range of information, for example on footwear, medication and blood pressure. This led to measures being put into place to mitigate risk.

- In 12 months up to March 2016 there were 19 new pressure ulcers acquired by patients whilst in the care of the service or whilst being referred. Fourteen of these patients were receiving treatment from the district nurses. Quality improvement work had taken place which included better reporting, implemented Waterlow assessment and SSKIN bundle care planning tools. This had led to a 60% reduction in grade 2 ulcers reported in the last year. Two tissue viability nurses work in the service based at the East Ham Care centre and Vicarage Lane. Work was also done with carers and families to support them in caring for complex patients.

- In order to improve on the quality and consistency of the recorded risk assessments the trust had introduced an improved template for completing risk assessments in the electronic patient record system. This was meant to reduce the need for having paper records, but implementing this was still a work in progress. The inspection found that while risk was managed well, the quality of recorded risk assessments were variable. For example on the acute mental health wards in London the risk assessment records in the electronic patient record system were brief, but there was more detail in the risk management plans that were with the paper care plans. In the London home treatment teams one team was completing comprehensive risk assessments in the risk assessment section of the electronic patient record, whilst two other teams were still writing them in the patient progress notes. The impact of this was lower as there were reasonable levels of staff consistency across the services and staff knew the patients or had good systems of communication within the service.

- The trust had safeguarding processes in place, although there were some local variations and different alerting and recording arrangements. Policies and procedures were available for staff to access on the trust intranet. The operational lead for safeguarding was the director of nursing. The deputy director of nursing was the chair of the safeguarding committees which reported through the quality committee to the board. There were separate committees for adults and children and each presented an annual report to the board. These committees reviewed internal safeguarding audits, themes and trends from safeguarding alerts, work with other agencies, policy updates and safeguarding training. A central safeguarding team was available with leads who could deliver training and offer support to

staff where needed. There was an expectation that urgent alerts should be made in 24 hours and for other incidents there was 48 hours, although it is hard to monitor if this was happening. Staff had safeguarding training as part of their induction. Training compliance with safeguarding training at the time of the inspection was level 2 child safeguarding training 80%, level 3 child safeguarding training 75%, level 2 adult safeguarding training 74% and level 1 adult safeguarding training 89%. The reason for the lower figures was that the trust was having to provide additional courses in Luton and Bedfordshire as their compliance was lower than London. Staff working in the Newham children, young people and family community services had completed level 2 child safeguarding training at 89%. Each borough had easy read leaflets with local contact numbers. In Luton and Bedfordshire there were safeguarding champions across the service. The inspection found that staff had a good understanding of safeguarding. However, in London there were several cases where staff were struggling to identify the threshold for making a safeguarding referral. In Luton and Bedfordshire staff were more confident with this process. In the Newham community services for children, young people and families it was found that some staff needed more training on how to respond to potential incidents of domestic violence.

- The trust was working to ensure that restrictive practices including physical interventions were only used as the last resort and where appropriate. The trust had a reducing restrictive practices board. Some of the key actions that had already been taken included: updating key policies on seclusion, physical holding, long term segregation, observation and rapid tranquilisation; ensuring all staff had completed appropriate training on the positive management of violence and aggression; providing a handbook to give to staff who attended training; amending training to include a section on airway management during and after restraint and highlighting the risk of prone restraint. In addition a quarterly review meeting looked at trends; directorates had information on restraint on a monthly dashboard; an annual audit looked at restrictive practices; there were ward level review meetings looking at the data on restraint. There was also trustwide work taking place on developing a human rights framework for practices in psychiatric intensive care units.

Are services safe?

- The number of incidents of seclusion were high with 298 incidents of seclusion between September 2015 and Februry 2016, although most of these incidents were for patients using the psychiatric intensive care units across the adult mental health, forensic and children and young peoples services. Patients accessing these services had come from a wider geographical area due to their complex needs. In February 2016 there was a death in seclusion (Newham). Actions since then had included putting a sensor in the seclusion room to monitor patient breathing and this technology was being rolled out across all the seclusion rooms. The seclusion rooms were suitably equipped, although the seclusion room on Shoreditch ward at the John Howard centre needed a clock to be provided and the seclusion room on Gardiner ward needed the two way intercom to be improved as the volume was too low and visor to be installed to provide the patient with privacy when using the toilet.

- In the same six months there had been four cases of long term segregation, three on Westferry ward at the John Howard centre and one at Rosebank a female PICU. There were no cases of long term segregation at the time of the inspection.

- In the 6 months prior to the inspection there were 780 incidents of restraint – of which 26% were in the prone position of which 74% were associated with administering rapid tranquillisation. Some trusts are now only using prone restraint on a very small number of occasions, although again it is recognised that this trust provides services for patients who have a high level of acuity. Most of the restraint was used with patients in the psychiatric intensive care units. At the Coburn centre for adolescent mental health we found that prone restraints were documented fully but other incidents of restraint were not, which meant it was not possible to monitor if this had been done appropriately.

- The inspection found there were very few cases of blanket restrictions and some positive examples of reducing restrictions. For example on the London acute wards patients were allowed to keep their personal mobile phones and asked not to take photographs. This had been well received by patients and had resulted in a reduction in the incidents of violence and aggression. The only exception to this was at the John Howard centre which required all patients on escorted leave to also wear an electronic device, unless they had less than six months left until their discharge. During the inspection the trust recognised that this was too restrictive and did not reflect individual patient need. They introduced individual risk assessments to determine who should use the device but these needed further work as they did not relate clearly to patients' care plans or reflect their individual views.

- In the acute mental health wards there were variations between numbers of detained patients who were absent without leave (AWOL) in the 3 months prior to the inspection. The numbers of patients who had escaped from the wards were one person in Tower Hamlets, two in City and Hackney, 11 in Newham, 14 in Luton and six in Bedforshire. The number of patients who had gone AWOL during escorted leave were five in Tower Hamlets, six in City and Hackney, two in Newham, 14 in Luton and one in Bedfordshire. The board were monitoring this and taking steps where needed.

- The trust had a suicide prevention policy in place in Luton and Bedfordshire (developed with other agencies) but this was still being developed on London. In Luton and Bedfprdshire there had been a higher rate of suicides and so they were specifically looking at themes with the aim of developing a suicide prevention strategy. The trust had also developed a learning session on suicide prevention which was being delivered to staff.

- The trust had a lone working policy that had just been updated and included details such as how to risk assess, processes in teams such as completing up to date diaries and having a team secure word and also equipment such as mobile phones and alarms. During the inspection we looked at how these arrangements were working in practice, in clinics and especially where staff were going into patients homes. Across many of the mental health teams, the trust had recently issued personal alarms which also incorporate GPS so that staff could be tracked if needed. Staff felt this enhanced their safety. They also said they could always make visits in pairs where needed. In the Luton community mental health team we observed that alarms were available but some staff, despite being reminded did not take these into interview rooms when they were seeing a patient on their own.

- On the inpatient wards, staff had access to appropriate alarms so they could call for help were needed. Staff

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were identified to respond in an emergency. These arrangements were working well. The only negative impact of this was on Clerkenwell ward, a service for people with a learning disability of whom some were autistic at the John Howard Centre. Here the loud alarms and flashing lights was triggering the challenging behaviour of some of the patients and needed to be addressed.

- We found that patients were supported to have a crisis plan. In most cases this included details of local services they could contact in a crisis, such as the number of the crisis telephone line or the local A&E department. In some teams more in-depth work had been undertaken to support patients to decide what they felt would help them in the event of a crisis.

- The trust had arrangements in place for safe medicines management. The pharmacy service was fully clinically-focused, with pharmacy integration into the wider multidisciplinary team. Dispensary services were technician-led and were centralised in Mile End Hospital, with medication being delivered to each site via a dedicated courier system. All pharmacists and ward-based medicines management technicians (MMTs) had their own laptop, which they used to send clinically-screened orders electronically to the dispensary. There are small satellite dispensaries in each locality which could provide emergency items if needed. Staff could access emergency drug cupboards and fridges throughout the trust. A trust pharmacist was contactable out of hours.

- Each of the organisation's directorates had an allocated 'clinical lead pharmacist' who would oversee the pharmacists and technicians working in that directorate. Each clinical lead pharmacist reported to the 'lead pharmacist' for their locality. Pharmacy services in Luton and Bedfordshire were incorporated into the trust pharmacy service between October and November 2015. New pharmacy staff had been recruited and the trust policies and procedures are being rolled-out.

- Medicines were generally stored safely and securely across the trust. However, some clinical treatment rooms exceeded the maximum recommended ambient temperature of 25°c. Senior staff knew of this widespread problem. It had been included on the pharmacy risk register. Staff had installed mobile air

conditioning units in some areas, and capital funding had been approved for the installation of air conditioning in all clinical rooms. However not all areas had air conditioning. Pharmacy had implemented a system for reducing the expiry dates for medicines that had been stored at the incorrect temperature. This extended to fridge items that were being transported from Mile End pharmacy. The trust had identified that there was an issue with the transportation of fridge medicines. Although they were transported in cool boxes, the temperature readings were sometimes too high. As a result, the expiry dates of some medicines were reduced. The trust was looking into the possibility of transporting fridge medicines in refrigerated vans.

- All prescriptions that we reviewed were clearly written and included information about allergies, date of birth, and MHA status. Where appropriate, the documentation regarding legal authority to administer medicines to individual patients was readily available, apart from on Hoxton ward at Wolfson House where the forms were not attached to the medication administration record. On Columbia ward, photographs were included with the prescription charts to aid the identification of patients. In most cases, appropriate codes were used to note medicines refusals; however, we did find some wards where there were unexplained gaps on the prescription chart. On discussion with staff, they were not able to tell us why the doses had not been signed for. Missed doses were meant to be reported as an incident but this was not always happening.

- Management of covert medicines was good across the trust. Staff took the correct steps to enable staff to administer medicines covertly to patients that needed this. (When medicines are given covertly, it means that they are hidden in food or drink without the knowledge of the patient.) The consultant, the pharmacist and the next of kin were contacted before medicines were given covertly.

- Controlled drugs (CD) were stored securely and managed appropriately across the trust. All the CD cupboards that we saw complied with the Misuse of Drugs Regulations 1971. However, on one occasion we saw that a CD had not been signed out of the CD register when a patient transferred to another ward. The ward manager rectified this immediately during the inspection. On another ward at the John Howard centre,

one CD had not been recognised and managed as a CD. The CD accountable officer (chief pharmacist) sent regular reports of CD related incidents to the CD local intelligence network.

- Some clinical teams were visited by pharmacists daily, whilst other teams received less frequent visits. This was dependant on patient turnover and need. The extended primary care teams in London had very little pharmacy input. The chief pharmacist had identified that this team required more pharmacy support. We were told that the recruitment process for another pharmacist had begun.

- The trust had safe processes in place for managing patients on clozapine both within hospital settings and within community settings. In London, there was a crisis house where clozapine could be re-titrated, and patients were monitored for two hours post initial dose. A pharmacist visited the crisis house twice a day. The trust had a robust system for supporting patients to self-administer their medicines. Pharmacists were involved in monitoring and assessing patients on a regular basis. This enabled the multidisciplinary team to make informed decisions on whether to allow patients to be independent with their medicines.

- The intranet was a useful resource for medicines information. All staff had access to the online British National Formulary (BNF) and BNF for children via the intranet. Staff could see the formulary status of each medicine in the BNF. The trust had decided not to provide a formulary status for physical health medicines; therefore, staff could also access the relevant formulary for the associated CCG regarding physical health medicines. The formulary was linked to the MEDUSA system; staff could access information relating to intravenous drug administration. The intranet enabled staff to access drug safety updates as well as medicines policies. Antimicrobial formularies were available for each CCG.

Track record on safety:

- We analysed data about safety incidents from three sources; incidents reported by the trust to the national reporting and learning system (NRLS) and to the strategic executive information system (STEIS) and serious incidents reported by staff to the trust's own

incident reporting system (SIRI). These three sources are not directly comparable because they use different definitions of severity and type and not all incidents are reported to all sources.

- Providers are encouraged to report all patient safety incidents of any severity to the NRLS at least once a month. The trust reported a total of 3500 incidents to the NRLS between 1 April to the 30 September 2015. When benchmarked the trust was in the bottom 25% of reporters of incidents when compared with similar trusts. The trust explained that this was due to a technical issue following the merger with Luton and Bedfordshire which ended up taking 7 months to fully resolve. Since then the reporting was up to date and the level of reporting had improved but the trust was still on bottom 25% (nearer to the next quartile). The national staff survey placed the trust among the top ten trusts in the country for reporting and learning from incidents, with year on year improvement. During the inspection we found that staff were encouraged to report incidents and felt confident in using the reporting processes. The trust recognised that the reporting culture varied between directorates and was putting in directorate leads to promote reporting. This had already been implemented in Luton and Bedfordshire.

- From May 2015 to May 2016 there were 64 incidents reported on STEIS. These were all reported to the board including the actions that had taken place. From January – April 2016, 24 serious incidents were reviewed by the board. The board wanted assurance that each incident had been investigated properly and lessons learnt. The board also discussed any key themes. During this time there had been 11 suicides or attempted suicides for patients living in the community in Bedfordshire. This was higher than usual and the trust was monitoring this carefully. There had been one death in seclusion in Newham and new technology was being rolled out across the trust to monitor patients breathing in seclusion.

- The trust was also an outlier for how long it was taking to investigate incidents with 50% taking more than 136 days after the incident had taken place. The clinical commissioning groups said that the quality of investigation was really good, with high quality reports and evidence of good learning across the organisation.

Are services safe?

Reporting on incidents and learning from when things go wrong:

- The trust had a reporting, investigating and learning from serious incidents policy. The trust had central serious incident review team who supported the investigations and oversaw the process.

- Managers were expected to sign off incident reports within 48 hours. The trust had a senior team who met weekly to review, grade and decide how incidents would be managed and investigated. This included in a few cases using an external organisation to carry out the investigation.

- The trust stated that it had a number of ways to learn from incidents. Debriefing and reflective practice took place for staff involved in a serious incident. Teams and wards had access to incidents on a performance dashboard which displayed incidents from their own service and services across the trust. Incident report action plans were sent to teams. The directorates arranged local learning seminars and staff had to attend on a rotational basis, these seminars also included incidents from other directorates so there was cross directorate learning. We found that most teams were discussing incidents that had occurred in their own ward or team. The exception to this was in the community teams for district nurses, where some teams were not having regular meetings. In a few areas there was a lack of knowledge about incidents from other parts of the trust.

- The trust had a mortality review group which identified areas for learning. On a trust wide basis there were learning events twice a year. The last one was on suicide prevention and before that there was a learning event on the importance of listening to families and carers. The next learning event was planning to focus on safeguarding.

- The trust also undertook thematic reviews. The last one on suicides identified themes including poor follow up post discharge, the need to improve physical healthcare on inpatient wards and the need to improve risk assessments and crisis plans. In Luton and Bedfordshire the trust was also changing the staffing in the home treatment teams to increase access to psychological therapies as they had recognised this as a need for patients using these services who were at risk of suicide.

- The trust used several methods for sharing learning from medicines incidents across the organisation, including; clinical alerts issued via e-mail to all clinical staff by the medical director, medicines bulletin, issued every 2 months, sharing learning from medicines safety incidents; a medicines safety video podcast, issued every 2 weeks via e-mail to all staff- picking up on a theme in medication errors; online medicines safety training at different levels for specific groups of staff; face-to-face pharmacy training provided for individual teams or groups of staff; medicines awareness week run once a year for servicer users, carers and staff with a series of events raising awareness of medicines-related problems.

- The inspectors looked at four randomly selected root cause analysis reports from serious incidents and these were completed in a thorough manner with clear action plans and timescales. The trust had involved and supported families from the start of the investigation.

Duty of Candour:

- The trust had a duty of candour policy which is part of their broader policy on reporting, investigating and learning from serious incidents policy . There had been borough based seminars.

- All electronically recorded incidents have to record that the duty of candour had been applied. All serious incident reports clearly stated what contact there was with relatives and carers. This ensured the trust can monitor the application of the duty of candour.

- The clinical commissioning groups said the trust fully understood and followed duty of candour guidance.

- The inspection found that staff working in the adult and children's community services in Newham were less familiar with the term 'duty of candour' but understood and were applying the principles by being open and honest with patients and their families when an incident had occurred. The trust had completed a duty of candour internal audit which had also identified this as an area for improvement. The four incident investigation reports which were inspected all had applied the duty of candour.

Anticipation and planning of risk:

- The trust considered risk as part of its board assurance framework. In April 2016 the areas that were considered

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high risk were; the potential failure to transform the district nursing service to meet the meets of the local community, the risk of not meeting CQC standards of quality and safety, the risk of not providing a high quality service due to the quality of the premises and the risk of recruiting and retaining high quality staff and the risk of failing to fully implement NICE guidance.

- The director of corporate affairs was the trust's accountable emergency officer and also represented mental health trusts on the London health resilience partnership meeting, led by NHS England. The trust board received an annual report on emergency planning and business continuity. The purpose of this report was to provide an account of emergency planning, resilience and response and business continuity arrangements for the year. The board had approved the workplan for 2015/16. The trust participated in the NHSE annual assurance exercise. The trust received a score of full assurance (the best possible rating), being one of 9 trusts or clinical commissioning groups in London who achieved this score.

- During the inspection it was found that the services had a clear understanding of the action they would take to provide a service in the event of an emergency such as adverse weather or transport difficulties.

Are services effective?

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

Summary of findings

Our findings

Assessment of needs and planning of care:

- Staff in most of the areas we visited completed comprehensive assessments for the people they were supporting. The assessments varied depending on the needs of the individuals. For example in the forensic services, clinical staff would complete a pre-admission assessment before someone was admitted to the service. Staff used information about a patient's criminal offences, past and current risks and individual needs to decide whether they were appropriate for admission. Staff carried out comprehensive assessments in a timely way after a patient was admitted. We found that most assessments were holistic and had involved the patient and their carers. The only area where it was not clear if all the assessments had been completed were in the community health services for adults. The community teams in Newham which were mainly district nurses had patient records which were poorly organised and some assessments which should have been in place relating to falls, nutrition and pain management were not available in the paper or electronic patient records.

- We found that every patient had their physical health assessed as well as their mental health. The trust developed a single page physical health assessment proforma which included all the key cardio-metabolic parameters. The use of these was audited. Where appropriate physical health observations had been completed. There were a number of quality improvement projects taking place. For example across the community mental health teams in London pods were available where patients could check their weight

and blood pressure before their outpatient appointment. On Connolly ward an acute female mental health ward in City and Hackney they were extending the access to screening for womens' health.

- We also found that lifestyle assessments were taking place. This looked at the patients diet, physical exercise and smoking. Where patients smoked they were being offered support to stop or cut down. Most of the trust premises were smoke free.

- The quality of care plans were generally good including services which had not been involved with the patients for very long. For example in a number of services including the acute mental health wards, patients were completing a 'this is me' document with their key nurse which included information about their preferences, priorities and goals that were patient and recovery focussed. These were also being used on the wards for older people with mental health problems where they were completed to a good standard.

Best practice in care and treatment:

- The trust had a wide range of measures in place agreed with commissioners and other stakeholders such as NHS England with the aim of improving the outcomes of people who use their services. These included the measures agreed in the annual quality account. The commissioning for quality and innovation (CQUIN) framework had incentivised the trust to deliver improvement. A number of national and local targets were set. The targets for physical health were mostly met. In East London in 2015/16 the trust had met its targets for assessing, documenting and acting on cardio metabolic risk in inpatients with psychosis, and community patients in early intervention services; 90% of patients had either an updated CPA record or a comprehensive discharge summary shared with their GP; patients had an assessment of their lifestyle care needs; staff were trained to use the Lester tool; smoke free wards were introduced and staff who smoked had reduced. The only CQUIN target that was not met was for at least a third of the staff to have been trained on smoking cessation. In Luton and Bedfordshire they were

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also meeting the targets for assessing and acting on cardio metabolic risk and sharing information with the GP. The only CQUIN that was not met in Luton was on reducing mental health re-attendance at A&E.

- The trust carried out ongoing work to ensure it maintained the care it provided and associated procedures in line with the latest guidance. NICE guidance relevant to the trust was identified and reported monthly at the quality committee. The directorate management teams implemented a local plan to ensure further dissemination and discussion of the guidance. Individual teams were expected to discuss the guidance at team meetings and display the guidance. The directorates also identified where there was a gap between their practice and the guidance. Any significant gaps or variances were reported back to the quality committee so that a plan can be considered. For example at the time of the inspection the recognised that for CAMHS there was a gap in terms of the provision of care for young people with ADHD and autism which was highlighted with commissioners. The inspection found that staff in the trust were using best practice guidance to inform their procedures and delivery of care and treatment. For example the treatment delivered in community health services for adults reflected guidance for managing tissue viability and caring for people with diabetes. Also the treatment of young people with eating disorders at the Coburn centre followed the latest guidance.

- The trust was very aware of the need to support people receiving services for their mental health to have access to psychological therapies. There were lots of positive examples of this in the London services. For example in the home treatment teams there were psychologists in both the Hackney and Newham teams. They provided assessments and initial treatment in mindfulness, cognitive behavioural therapy and distress tolerance. Psychologists also supported nursing staff with therapeutic approaches that under pinned their interactions with patients such as cognitive analytical therapy, anxiety management and brief solution therapy. In Tower Hamlets, patients had access to psychological therapies by being referred to the crisis intervention counselling and psychology service. In the forensic services at Wolfson House there were a range of psychological therapies recommended by NICE to meet the individual needs of patients. Psychology staff offered

individual sessions and ran therapeutic groups, such as a group that talked about risk. This group was for up to 10 patients and ran over one year. Each patient in the group thought about risks associated with their criminal offence. A second group ran for four weeks and was for staff and patients to discuss risk models and assessments. In the memory clinics in London, patients diagnosed with dementia were offered cognitive stimulation therapy groups. In Luton and Bedfordshire the access to psychological therapies was more limited. The trust was re-configuring these services to improve access for patients.

- An area where the trust needed to improve was in relation to the use of positive behaviour support framework for people with a learning disability who have behaviours that challenge. At the time of the inspection, training was being arranged so that staff could ensure they used the correct approach and that positive behaviour support plans were in place. Staff were however working well with individual patients, using their other skills and experience. In August 2016, this information was updated and staff were in post to deliver training and some staff had already completed the training. The programme was for this training to be completed by the end of September 2016.

- The trust had prioritised the improvement of patients physical health. The medical director was the lead on physical health. There was a lead nurse for physical health in the trust and directorates had access to physical healthcare leads. The trust delivered a session during the induction on physical health for mental health staff and a two day physical health training course as part of staff development programmes. The use of national early warning scores was being carried out well across the trust and this meant that if a patients physical health deterioriated that this would be identified so that medical intervention could take place. There were clear arrangements in place across services for patients to access physical health input. In some services this was provided by GPs and in others by trust staff. In services such as forensic where patients were using the service for longer periods of time there we found good examples of working with specialist services such as clinicians who could support patients with diabetes. In the services for young people there was support to access sexual health services where needed. Also in forensic services there was a substance use

support service which offered educational and support groups that were open to all patients. There were also two peer support and peer led groups for patients approaching discharge or those recently discharged.

- Patients health was also being promoted through input from the pharmacy staff. For example they ensured that each patient's pharmacological treatment was safe and effective, for example through screening of prescription charts, ordering medication and providing advice to staff and patients. Pharmacy staff performed medicines reconciliation for all newly admitted patients. The targets for this were that that 95% of patients admitted to the London-based wards, and 75% of patients admitted to wards in Luton or Bedfordshire, should have medicines reconciliation completed within 72 hours of admission (or within one week for patients admitted to community health wards). These targets were being met by the pharmacy team. We saw examples of positive clinical input by pharmacists who gave advice to both staff and patients to improve medicines optimisation. Patients on high-risk medicines (for example, clozapine) had a yellow sticker to show this on the front of their prescription charts to prompt staff to carry out the appropriate physical health checks.

- The trust carried out a number of audits as part of their programme of ongoing assurance. These included audits of the implementation of procedures covering safeguarding children and adults, ligature risk assessments, whistle-blowing, staff appraisals, use of temporary staff, risk management. Ongoing audits included information governance, recruitment, duty of candour, management training and ongoing service integration. In addition there were regular clinical audits including; infection control, control drugs, record keeping and completion of CPA and risk assessment. During the inspection these audits were seen being used in wards and teams and action plans were in place and being implemented where needed. It was however noted by the trust that they had reduced the number of audits and had replaced this with their quality improvement work as a way of driving up standards of care and treatment.

- The trust had taken part and had action plans in place associated with the national audits, POM-UK, National

Audit of Intermediate Care and the National Audit of Schizophrenia. It could be seen that lessons from this had fed into ongoing work, especially around the use of medication reflected in the ongoing medication audits.

- Medicines management audits were conducted on a regular basis and results were shared with the directorates: These included: a controlled drug audit conducted quarterly in all clinical areas; safe and secure handling of medicines audit conducted at least twice a year in all clinical areas; medicines management audit performed at least every six months, looking at things such as the use of high dose antipsychotics and rapid tranquilisation, availability of medicine, and legality of treatment; missed dose ('blank box') audit conducted once a monthand the results published in league table format; medication-related patient complaints audited twice a year.

- In addition to these regular audits, more in-depth investigation into particular clinical areas were conducted as-and-when needed. For example, in the past year, there had been an in-depth study of high dose antipsychotic medication, and of the use of benzodiazepines drugs. In 2015, an in-depth study of medication administration errors was also conducted and became the largest such study ever performed in the mental health setting. The results were published in an international peer-reviewed journal, allowing learning to be shared across the world. The pharmacy team had embraced quality improvement (QI) methodology, and medicines safety was often the focus of QI projects. For example, in the mental healthcare of older people directorate, a QI project successfully reduced the number of missed doses on the wards, and was nominated for a national patient safety award.

- The trust was starting to measure outcomes for patients using their services, but similarly to other trusts this was a work in progress. All mental health services apart from CAMHS used the health of the nation outcome scales to measure the health and social functioning of people with a severe mental illness and over time the patient outcomes. The CAMHS used the 'experience of service questionnaires' which was given to all the families. The trust was about to run pilots within the community teams using DIALOG plus which is a patient reported outcome measure. This was being implemented as an integral part of the care programme approach care

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planning and documentation process. Since January 2016, 543 patients had used the patient reported outcome measure. The community health services in Newham were using a tool called EQ-5D which was a standardised instrument for use as a measure of health outcomes for all patients.

Skilled staff to deliver care

- Throughout the inspection, we met staff who had worked at the trust for many years and had been supported to complete qualifications and to receive training to move onto new roles and progress their career. This included healthcare assistants who had completed nurse training and a number of staff who had opportunities to complete post-graduate qualifications. Staff said how much they valued the opportunities they had been given and this was one of the reasons frequently given for why staff remained working within the trust.

- The trust provided a three day corporate induction. As well as providing information about the trust and its values, it also incorporated some essential mandatory training such as safeguarding and basic life support. Staff then received a local service specific induction. We heard that staff valued this training and that they were able to shadow experienced staff whilst learning the job.

- There was very positive feedback from staff about their opportunities to access continuing professional development. For example 140 unqualified staff in Newham had recently completed the care certificate. The trust had supported staff working for the home treatment teams to complete approved mental health professional training and to be a non-medical prescriber. Nursing staff were being trained to be able to deliver some psychological therapies.

- Staff had access to training to support them to meet the specific needs of the patients they were caring for. For example staff working in the inpatient and community services for older people with mental health needs had all completed training on dementia awareness. Staff working on the community inpatient wards in Newham had training on tissue viability, catheter care and end of life care.

- The trust had a range of ways in which it ensured staff had received the appropriate medicines management training. Some parts of the training were delivered via an online system. Junior doctors were not allowed to prescribe medicines until they had completed the training. They also had face-to-face teaching sessions on medicines two or three times a year. Nurses completed medicines competency checks.

- Staff all said they were having regular supervision. This was monitored by the trust and at the time of the inspection was in place for 91% of staff. Where staff needed separate management and clinical supervision there were also arrangements for this. Staff in most teams were able to talk about opportunities for reflective practice sessions.

- The figure for staff having a completed appraisal in March 2016 was 96%. In Luton it was an achieved CQUIN target for all the nurses to have 360 degree feedback as part of their appraisals. Staff said the quality of the appraisals was good and offered them a real opportunity to discuss their ongoing career.

- Staff talked about their attendance at regular team meetings and many teams said they had regular opportunities for team away days and these were opportunities to discuss their service and undertake some learning and development. This reflected how the trust valued and invested in staff development.

- Managers said they felt well supported when they needed to address performance issues in their team. The trust had completed a recent review of disciplinary processes and this had identified the need to improve the use of informal resolutions and this had now been incorporated into a revised performance framework.

Multi-disciplinary and inter-agency team working

- We saw many positive examples of internal multi-disciplinary work. Staff worked together in a respectful manner, making the most of each others skills and experience. We observed a number of hand-over meetings, ward rounds, daily planning meetings and patient review meetings. For example on the wards for older people with mental health problems we observed effective handovers, where staff used a comprehensive handover tool to ensure all the important information was passed on.

- There was very good working between teams within the trust. This helped to make bed management work smoothly. Staff from the home treatment teams and

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community mental health teams were observed attending ward rounds and bed management meetings to share information about the needs of the patient or ensure patients were supported with their discharge in a timely manner. In the CAMHS inpatient service, teachers said they worked very closely with the multi-disciplinary team. There were also some very positive advantages from the trust providing mental health and community services in Newham. For example the CAMHS teams worked closely with the community services for children, young people and families.

- There were many examples of how the trust worked positively with external agencies. On the Newham community health inpatient wards external agencies joined the discharge meetings. This included staff who worked in the acute trust and also staff from the local authority and the local hospice. In Luton and Bedfordshire members of the learning disability sensory impairment team participated in county wide eye care working groups and a hearing advisory group. The rehabilitation wards in Luton and Bedfordshire worked well with third sector organisations to support patients to attend a range of community based activities and also to arrange for patients to have support with their personal finances and arranging benefits. The CAMHS inpatient services maintained regular contact with the community teams supporting the young person. Where there these teams were a long distance away they could arrange from them to join CPA meetings by video link. In the London community mental health teams for older people, the team was co-located with staff from the Alzheimers Society which facilitated joint working. These teams also worked very closely with care homes.

- Clinical commissioning groups also said how much they valued working jointly with the trust. For example they were invited to join trust training events and other workshops.

- The arrangements for joint working with the local authorities varied across the trust. In Luton and Bedfordshire the trust directly employed social care staff. In City and Hackney a section 75 agreement was in place. In Newham the local authority staff had been withdrawn from the trust services. Local authority staff

were seconded to the trust in Tower Hamlets. However, we saw the trust working to maintain close working with local authorities and referring patients where needed for social care input.

- There was some very constructive joint work with GPs, although again the arrangements varied across the trust services. These developments were positively received by primary care clinicians. In London the services were arranged to provide regular contacts between primary care practices and a named consultant who was available for advice about possible new referrals and a nurse lead care management service for people previously in secondary care who could be managed in primary care. The mental health primary care nurses were employed and managed by the trust but the medical responsibility was transferred to the GP and the nurses recorded on the primary care clinical records system. About 4000 patients had been transferred to the scheme since 2012. Less than 10% had relapsed and needed to be re-referred. Patients were intended to be with the primary care service for 12-18 months and then receive GP only care.

- In Luton the trust had developed the primary care link workers from April this year who linked with GP clusters and bridge the interface between primary and secondary care. In Bedfordshire the primary area of joint/close working was that of the primary mental health link workers (PMHLW) who recorded on the GP record systems, but were employed and managed by the trust. Each PMHLW supported a number of practices but operated as a step up assessment/brief intervention service.

Information and Records Systems

- The trust was developing an IT strategy which was due to be in place shortly after the inspection. The board recognised this as an area for ongoing work.

- The trust was experiencing major challenges with the electronic patient record systems. In Luton and Bedfordshire the trust had inherited several electronic patient record systems, which did not join up. The decision had been made to roll out the system used in London to Luton and Bedfordshire. At the time of the inspection good progress was being made with this

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process. The new system was available at every trust location and trainers were provided to support staff in their place of work. Staff were mostly positive about the change.

- A risk was that across most services staff were using a mixture of electronic and paper records. Whilst staff were trained in information governance and knew the importance of maintaining secure confidential information, this was very hard to maintain when both systems were being used. There was also the possibility in some services that staff may not be able to easily locate the information they need.

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

- The trust's systems supported the appropriate implementation of the Mental Health Act 1983 (MHA) and its Code of Practice. The mental health law department managed the trust's responsibilities in relation to the MHA and related legislation and case-law. The executive lead was the director of nursing and quality. The department was managed by the associate director of mental health law with support from the clinical nurse specialist in mental health law (the designated lead for the MCA).

- There were 39 associate hospital managers who considered the power to discharge under section 23 of the MHA. This function was directly managed by the associate director and overseen by the trust board Mental Health Act sub-committee which was chaired by a non-executive director.

- The department had a programme to of audits during the year which covered the use of the MHA in community settings and the use of the MHA in in-patient settings.

- There were seven mental health law offices which administered the MHA and provided legal advice/ support to clinical teams. An additional two band 7 posts had been created to oversee the administration of the MHA in Eat London and Luton and Bedfordshire.

- MHA training was provided on a variety of subjects available to all staff through classroom sessions advertised on the intranet and bespoke sessions as requested by individual teams. The trust considered the training needs of three different groups: Mental Health

Law department staff, hospital managers and clinical staff. While MHA training was not mandatory it was considered essential for certain clinical staff. MHA courses available included and overview of the MHA, receipt and scrutiny of statutory forms and consent to treatment.

- The trust had reviewed all its policies and procedures to make them compatible with the Code of Practice. MHA activities were seen as integral to all other policies and procedures.

- During this inspection we completed nine Mental Health Act review visits pursuant to the CQC's duty under section 120 of the Act. We found evidence that detention paperwork was completed correctly, was up to date and was stored appropriately. However in the forensic service there was one instance noted of the use of concurrent sections as there were concerns that impending court hearings might not lead to hospital orders being made. This was not compatible with the principle of least restriction. On one acute ward there were some examples of the record of detention in hospital form (H3) not being signed.

- We found evidence that there was adherence to consent to treatment and capacity requirements overall. Copies of consent to treatment forms were mostly attached to medication charts where applicable. However on one ward some assessments of capacity for consent to treatment were very brief and on three wards there was no evidence of discussions with patients about the nature and effects of medication.

- There was evidence that most people had their rights under the Mental Health Act explained to them. However on two of the wards we visited it was not clear that all patients had been regularly reminded of their rights and on one of the wards we visited patients were not aware of the availability of the independent mental health advocacy service. When patients were on leave and being supported by the home treatment teams, not all patients were being reminded of their rights.

- A majority of the care plans we reviewed were comprehensive and individualised with evidence of patient involvement. On a Children and Adolescent Mental Health (CAMHs) ward we noted that one informal patient had been moved to the psychiatric intensive care unit (PICU) without a review of legal status. At each

Are services effective?

of the health based places of safety that were visited there were significant numbers of section 136 applications where it appeared that the patients had been taken into the health based place of safety from their own homes rather than a public place.

- On a CAMHs ward patients and staff in conjunction with the Royal College of Psychiatrists had developed a special patient friendly leaflet to explain what happens at Mental Health Tribunals.

Good practice in applying the Mental Capacity Act

- The mental health law department managed the trust's responsibilities in relation to the Mental Capacity Act 2005 (MCA) and related legislation and case-law.

- Administration of the MCA and the Deprivation of Liberty Safeguards was supported by a trust-wide MCA officer.

- The department had a programme of audits during the year which covered capacity to consent to informal admission and Deprivation of Liberty Safeguards.

- MCA training was available to all staff through classroom sessions advertised on the intranet and bespoke sessions as requested by individual teams. Whilst MCA training was not mandatory it was considered essential for certain clinical staff. MCA courses available included an overview of the Mental Capacity Act and Deprivation

of Liberty Safeguards. There were plans in place to make this training mandatory through attending the face to face sessions or accessing an e-learning product covering the MHA and MCA. The e-learning product had been selected and was being customised for the needs of the trust. The plans are for this to be available to use in October 2016.

- From August 2015 – February 2016 there had been 116 applications for an authorized Deprivation of Liberty Safeguard mostly on wards for older people with mental health problems.

- The inspection found that where staff were regularly using the MCA, for example in services for older people with dementia and in services for adults with a learning disability, staff had completed bespoke training and had a good understanding and were appropriately using the MCA. In other services, staff often lacked confidence about applying the act in practice, although they knew where to access support when needed.

- In services for young people under the age of 16 staff had a good understanding of Gillick competency and how to apply this in practice.

- Patients had access to advocates where needed and information on how to request an advocate was available across the services.

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

- Throughout the inspection we found that caring was either good or outstanding across all the core services we inspected. Patients and their carers were supported by staff who were caring, compassionate and kind. Staff showed considerable pride in their work and supporting people in the most appropriate manner to meet their needs. Many patients and carers shared with us their positive experiences of the care they had received.

- The care provided was holistic and staff made every effort to get to know and understand people and meet their needs. This was done in a non-judgemental way that respected people's individual choices. This included important details such as how people wanted to be addressed and ensuring they were contacted in a manner that suited them.

- Staff were very thoughtful in their manner and approach. We saw many examples of reception staff who were welcoming, helpful, efficient and professional. We observed ward rounds and CPA meetings where staff worked hard to ensure patients were fully part of the meeting and that their views were heard. We also saw care professionals taking the time to carefully explain about the patients treatment and answer questions. We saw that care was being delivered in a considerate manner. For example, on some acute wards patients were given a pack when they arrived containing essential toiletries. On Jade ward in Newham which is an acute ward, most of the patients came from other parts of London. Here staff organised trips for patients to the local area so they could orientate themselves for when they were able to take some leave from the ward.

- Staff were also very respectful. This included knocking on peoples bedroom doors before entering their rooms. They were also observed speaking about people respectfully during handovers and other meetings.

- Staff showed a very good understanding of peoples diverse needs. Examples of this included on the Coburn unit for young people, support was provided to young people who were transgender to have their individual needs met and where needed to be referred for additional support from specialist services. Across the services, the inspection took place during Ramadan and some patients had expressed a wish to fast. They had been supported to change the time of taking their medication, had appropriate food available at the correct time and prayer mats had been provided.

- Where there were areas for improvement they were raised at the time of the inspection and addressed immediately. For example, on Fountains Court a service for older people with mental health problems, in the North unit of the home some care was observed where the interaction with the patients could have been improved.

- The feedback from various surveys about the quality of care showed that the trust was similar or slightly below England average results. The results of the national community mental health survey in 2015, showed that patient satisfaction with services was better than average overall. In the family and friends test in March 2016 the number of respondents who said they were extremely likely to recommend the trust if they needed similar care or treatment was 81% which was below the England average of 87%. The trust had seen a significant improvement in this result in the previous 12 months. However the completion rates for this test were low. For the patient led assessment of care experience the score for privacy'dignity and well being was 90% which was similar to the England average result. In the community health services in Newham the trust used patient recorded experience measures and monitored trends over time. In March 2016 the percentage of patients giving positive responses was around 88% which matched the trust target, although this fluctuated on a month by month basis.

Are services caring?

Involvement of people in the care they receive

- Throughout the inspection we saw many excellent examples of patients and carers being involved in their care. The trust had a people participation team which had been operating for seven years. People participation leads were in each borough and had been recently introduced in Luton and Bedfordshire. The trust had a people participation strategy 'working together to improve quality'. Each are had a working together group and there was also trust wide working together group. Once a year there was a trust wide away day. There was a service user led website called Florid which provided information and supported the involvement work.

- Patient involvement in their care happened in a range of different ways throughout the trust. On an individual basis we saw that patients and their carers were fully involved in assessments and on-going decisions about their care and management of risk. Documentation such as 'this is me' helped to provide a more user friendly format for people to share information about themselves. Many patients had copies of their care plans. Patients and carers were invited to ward rounds and care planning meetings. Information about how to access advocacy services was clearly displayed and patients were supported to access these services where needed. In forensic services some patients had advance directives in place about how they would like to be supported when their behaviour was more challenging.

- Wards and teams were providing a range of useful information to help patients understand and feel welcomed to the services. Most wards and teams had very comprehensive information packs sharing essential information about the service. Wards had photos of the staff and on Ash and Willow wards in Luton and Bedfordshire ward staff were shown holding pictures of their promises to the patients, for example to listen and treat people with respect. The pharmacy teams also provided information to patients, discussed medication on a 1:1 basis and this input was recorded and had been growing.

- The trust was very committed to involving carers. The trust had carer leads and their names and contact details were on the trust website. Over the last 2 years the trust had developed a carers strategy. This included identifying carers in records, communication with carers, providing useful information for carers, working

- with young carers. For example in the services for older people with mental health problems there were carers groups and opportunities for people to learn about caring for people with dementia. On Thames ward the carers had been actively involved in decisions about the refurbishment of the ward. In the community mental health teams there was a target for the relatives or carers of patients on CPA to be contacted once a month by the care co-ordintor and this was monitored as a way of ensuring their was early intervention if someones mental health was deteriorating. In the community mental health services for people with a learning disability there was a monthly 'helping together' patient and carers group which provided social arrangements and educational sessions. Carers were also supported to have carers assessments so their need for support could be considered.

- Feedback was actively sought from patients. This was done in a variety of ways including electronic feedback using tablets where the results were collated and fed back to the ward teams. Some wards and teams had suggestion boxes. Also most wards had regular user groups where patients could discuss what was happening in the service and suggest areas for improvement. Wards and teams had 'you said, we did' notice boards that described improvements that had been made as a result of suggestions. For example on a forensic ward the patients had complained about the cleanliness of the ward and additional cleaning had been provided. Patients also took part in the PLACE assessments.

- There was extensive use of peer workers and volunteers providing activities and support. An example of this were the 'hope wall project' where patients displayed messages of hope to provide support to peers. Many service users said how the volunteering opportunities had built their confidence and helped them move onto paid employment.

- Patients and carers were supported to be actively involved in the running of the trust. Many people had completed training and were able to participate in staff recruitment processes. People were also involved in delivering staff learning and development. For example patients helped to deliver the induction training and also the training on physical interventions. Patients and carers were involved in the design of training for the

Are services caring?

recovery colleges. Patients were able to nominate staff for employee awards such as ward employee of the month. At the Coburn Centre young people had been involved in decisions about service redesign. Also in the day unit young people joined the staff at the end of the day for a session where they reflected on how the day had gone. During the inspection the trust held and inaugural award ceremony for patients to celebrate their achievements and work for the trust.

- There were also a number of service user led audits, for example looking at the quality of food and at how ward rounds were undertaken. This had led to positive improvements. For example at the City and Hackney mental health unit there was a food committee meeting involving patients which had led to changes in the catering contract. We also heard how wards rounds had changed to improve the involvement of patients and carers. For example on Ash and Willow ward patients completed a list of topics they wanted to discuss before their ward round.

- Patients were also involved in wider community work. For example patients at Cedar House a rehabilitation service and a group of young people from the CAMHS teams, had been involved in the trusts 'break the stigma' campaign in Bedfordshire. At the Bedford River Festival there were 'hope zones' which had user involvement. There was a joint project happening in London with the docklands light railway to provide support for patients using the service and provide more training for staff working on the railway. The inspection took place at the time of the European referendum and patients had been supported to exercise their right to vote including providing information and arranging transport to the polling station. In the community health services for children, young people and families the sickle cell and thalassemia service had set up a peer support group and this group had arranged a national conference for patients, families and professionals to discuss innovations in care, which was attended by 150-200 people. Also service users were participating as guest lecturers at University College Londons clinical and community psychology programme.

Are services responsive to people's needs?

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

Summary of findings

Our findings

Service planning

- The trust had a strategic plan 2014-19. This described how the trust will deliver the right care in the right settings in the context of financial sustainability. The trusts operational plan for 2015-16 explained how it worked with stakeholders to deliver services in line with the strategy.This reflected the local health economies and demographic changes in the areas covered by the trust. The trusts clinical strategy focused on the implementation of recovery orientated practice and interventions whilst providing integrated and holistic care to service users.

- Prior to the inspection we received feedback from a wide range of stakeholders. This included commissioners, professional bodies, NHS Improvement, local authorities, Healthwatch and other local organisations. They all said that the trust worked well with external stakeholders and were willing to actively contribute to plans to improve services, even if that was very challenging at times.

- At the time of the inspection the trust was organised based on geographical areas and specialist services. External stakeholders fed back that they valued that arrangement as it meant they could contact trust staff who knew and worked in their area. This could be challenging at times for staff working in the trust, who had to make an effort to work across geographical areas, especially when it came to opportunities to learn from incidents or share best practice.

Access and discharge

- Overall the trust was working to make the access and discharge arrangements work as well as possible and patients needing access to the acute care pathway were

receiving an outstandingly responsive service. There were differences between geographical areas in terms of how services were commissioned and this meant that the configuration of services varied.

- At the time of the inspection the average bed occupancy on the trust acute wards was 83%. There were variations between wards, with a couple going above 100% as an average between January and June 2016. These were Ruth Seifert ward in City and Hackney, London and Crystal ward in Luton and Bedfordshire. In Luton and Bedfordshire bed capacity had been increased with more intensive care beds.

- Maintaining these levels of bed occupancy required continuous work but made a significant contribution to the quality of care being provided. Beds were available for patients who needed admission and the focus of work was on supporting patients with their discharge. This work started as soon as they arrived on the ward.

- Regular bed management meetings involved senior staff and were well attended by relevant local representatives. This included the local authority housing teams, specialist teams for people who were homeless and teams for people who had no access to public funds.

- In the London services, patients were not placed outside East London and most people could be accommodated in their own borough. In Luton and Bedfordshire, since 40 additional acute and intensive care beds were opened it was very unusual for a patient to be placed outside their area. The only pressure was with female PICU beds where occasionally patients were placed in the independent sector. The trust provided some beds for patients from other trusts across London.

- Patients were followed up thoroughly when they were discharged with 96.5% of patients in quarter 4 of 2015-16 on the care programme approach followed up after their discharge within 7 days.

Are services responsive to people's needs?

- Between October – December 2015, five young people were admitted to adult acute wards while a CAMHS bed was found, but this was managed very appropriately with en-suite rooms and separate staff and in each case the length of stay was less than 24 hours.

- The home treatment teams acted as the gate-keepers for the acute beds to ensure that all other options had been exhausted before an admission was required. These teams were very responsive and would see urgent referrals within 4 hours (or in Bedfordshire within 2 hours in A&E). The London teams had a target of seeing 80% of new referrals within 24 hours, which they were meeting for 85% of the patients referred. Patients across the trust had access to a crisis line that operated throughout the night and where needed there was a duty emergency team. During the day there was a dedicated line for patients being supported by the home treatment team. This was answered by an experienced nurse who could arrange additional visits if needed.

- The trust in partnership with other organisations, provided a range of services to help provide support to people in the community. In City and Hackney the services included a crisis café; in Tower Hamlets there was a crisis house (10 beds) and an emergency service providing talking therapies; in Newham there was an acute day hospital (25 places 7 days a week); street triage had just started in Luton and Bedforshire and there was police triage in Tower Hamlets and a court diversion scheme in each borough.

- We inspected the three health based places of safety in London and the two in Luton and Bedfordshire. Again these services were very responsive. Patients were not excluded if they were intoxicated due to drugs or alcohol, unless they needed medical attention and an admission to A&E was more appropriate. Staff were available to provide support where needed.

- The acute inpatient wards also worked closely with the community mental health teams (CMHTs). Access arrangement for these teams varied between boroughs. Again urgent referrals could be seen in 24 hours, but most non-urgent referrals were seen within 28 days. Patients were allocated to a care co-ordinator. The percentage of patients on CPA who met with their care co-ordinator in the last 12 months was 95.1% in London and 87.4% in Luton and Bedfordshire. We did receive feedback prior to the inspection that CMHTs were discharging patients who did not engage and this could place people at risk. During the inspection we clarified that patients would only be discharged if the multi-disciplinary team agreed the risks could be managed without the intervention of the CMHT.

- All the community teams including home treatment teams, CMHTs for adults and older people all tried to be flexible with appointment times to meet people's needs. For example the Hackney South CMHT provided an assessment service to homeless people in the evenings at a local shelter. Patients told us that their appointments were usually on time and if the appointment was cancelled they were informed and the appointment re-arranged. Patients also said they were usually informed if the staff member was delayed. The only service where there were concerns about appointment times were the community health adult teams which provided district nursing. Here were heard that nurses sometimes missed their two hour appointment slot and did not let patients know when they were delayed.

- We looked at the number of patients who did not attend (DNA) their appointments. The highest number of people were patients with the CMHTs. These were mainly for first appointments. The Newham assessment and brief treatment team had a DNA rate of 31% and Tower Hamlets Bow and Poplar had a DNA rate of 32%. Teams used a range of measures to reduce DNA rates. This included sending letters, making phone-calls, offering flexible appointments and also home visits. Patients who DNA were discussed by the multi-disciplinary team to determine the level of risk. Work was ongoing to reduce the rates of patients who DNA.

- The trust was working to improve the responsiveness of the memory clinics. In London the three memory clinics had experienced an annual increase in referrals of 66% in 2015/16. Across the three clinics they were seeing 73% of patients in 6 weeks and completing a diagnosis for only 41% in 18 weeks. The trust were taking a number of steps. This included working with referrers to remind them of the service criteria to ensure only suitable patients were referred. It also involved rearranging the doctors clinic diary to identify an additional 25 feedback clinic appointments a month. Similarly in Luton and Bedfordshire measures were

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being put in to achieve the target timescales. In Bedfordshire 93 patients were waiting for their first appointment. This included care professionals prioritising seeing people who had already been referred, arranging for scans in a timely manner and ensuring patient records included all the necessary information before clinic appointments. When the trust was asked for an update in early August, progress was being made by the London services and Luton. But in Bedfordshire only one out of three clinics was meeting the anticipated trajectory for improvement.

- Access to the London CAMHS teams was through a single point of access where they were triaged. In Luton this arrangement had also recently been introduced and in Bedfordshire they were working towards this arrangement with a single point of access in place but some referrals still going directly to the teams. The CAMHS teams all had different targets for referral to initial appointment based on local commissioning arrangements. In London these were between 5-9 weeks for an initial assessment and in Luton and Bedfordshire targets had not yet been set but the trust was aiming to achieve similar waiting times to London. At the time of the inspection the waiting times for an initial appointment was 5 weeks in City and Hackney and Tower Hamlets, 9 weeks in Newham, 11 weeks in Luton and 7-11 weeks in Bedfordshire. Additional staff had been appointed in Luton and Bedfordshire to improve the waiting times. All the CAMHS teams had systems in place to identify young people who needed urgent input so their appointments could be prioritised. Initial appointment letters all said to contact the team again if there were any concerns or changes in the young persons mental health. After the initial assessment, the teams decided which was the most appropriate professional to provide ongoing input.

The facilities promote the recovery, comfort, dignity and confidentiality

- The trust provided services from a wide range of buildings. In Luton and Bedfordshire, there had been significant work over the previous year to improve inpatient facilities and this was a great achievement. A really significant change had been the improved environment for the acute mental health ward at the Weller Wing at Bedford Hospital. Here dormitory

accommodation had been transformed to provide individual bedrooms offering privacy. There was still more to do in a few inpatient areas and also some community team bases but there were plans in place.

- We saw many examples of where inpatient services had facilities which really tried to meet the needs of people using the services. For example many inpatient services included gym facilities and staff were trained to support patients to use the equipment. Many of the wards also had access to multi-sensory rooms. This included the psychiatric intensive care units (PICU) and the inpatient ward for young people. These facilities were very well received and were found to be very useful as a way of helping people to relax. In the Newham mental health unit the patients using the PICU had access to a sound proofed music room. On Coral ward an acute ward in Luton and Bedfordshire, patients were able to grow their own vegetables.

- There were many examples of where the environments had been made appropriate to meet the needs of people with dementia. This included, choosing appropriate colour schemes, matt flooring, signage and the use of wall art. Cedar Lodge used a traffic light system to reduce noise on the ward and create a calm, environment. We saw excellent use of pop up reminiscence rooms on Fountains Court and Townsend wards. Reminiscence themes included a shop where patient could make small purchases and a pub where patients could have a non-alcoholic beverage. The wards took particular care to respond to the needs of people who were not able to express themselves verbally, but responded to sights, sounds and smells. For example, on Poplars ward, Thames ward and Sally Sherman ward garden areas contained raised flower and plant beds where patients could participate in the activity. At the East Ham Centre, where some patients were receiving continuing care there was a hairdressing salon as people may not be well enough to have their hair done in the community.

- Services were very mindful of providing the appropriate facilities to support people with their recovery. For example in the forensic services patients could be employed, in the café. Patients were paid an hourly rate and the service supplied a reference for future employers. This was a positive scheme which gave patients experience and confidence in employment. At

Are services responsive to people's needs?

the Coburn centre for young people there was a school on site with a large classroom and smaller rooms for 1:1 teaching. Across most wards there were kitchen facilities so that patients could be supported to prepare their own food.

- In patient wards were mindful of the need to provide suitable facilities for relatives and friends visiting the services. For example on Ash and Willow acute mental health wards in Luton and Bedfordshire there was a separate room with a different entrance for family visiting which meant that children visiting their family members did not come onto the wards. This room had some toys and soft furniture which meant it was appropriate for children and young people.

- The community team and clinic facilities were generally good, although there were a few sites in Luton and Bedfordshire were further work was planned in order to ensure they were a satisfactory standard. These facilities provided waiting areas, access to appropriate information and private sound-proofed rooms for individual appointments. Some of the Newham community health services used health centres in partnership with GPs and other services. Some of these were also going through a significant reburbishment programme at the time of the inspection.

- Each ward had facilities for patients to make phone-calls. Most had a pay phone. The wards also had cordless phones which patients could use to make private phone calls in their rooms. However, patients were also allowed to use their own mobile phones on the wards including the acute mental helth wards where patients were reminded not to use the cameras on the phone.

- Inpatient areas all provided facilities for people to safely store their personal possessions, although these varied between services. For example the acute wards in London had lockable safes available. Forensic wards provided patients with their own bedroom keys. Some wards for older people could store valuable items in the staff office where needed.

- Most patients told us that the food was good. We saw from menus that a variety of food was available to meet people's health needs and also their religious or cultural requirements such as kosher, halal and African Caribbean food. Patients were able to give feedback on

the food and this had resulted in improvements. In a number of services, meals were provided for staff to eat with patients which was very positive. On Opal ward, an acute ward in Newham, staff had started a breakfast club at weekends which was very popular with both patients and staff. Patients had access to drinks and snacks throughout the day, although the arrangements for accessing this varied between services based on the needs of the patients. The only service where there were concerns about the food was the Coburn unit where staff did the cooking on site and the young people described the food as very uninspiring and of variable quality. However, there was a healthy menu with sufficient variety to meet people's needs including meals chosen by the young people, the chef met young people to discuss the menu and young people completed a weekly food satisfaction questionnaire.

- We saw that patients had opportunities to personalise their own bedrooms, including having pictures in the rooms and bringing items in from home. In some wards there had been collaborative work with local artists to introduce art into the wards.

- We found that there had been considerable work to ensure there were therapeutic activities available for patients using services. This had been supported by the recovery colleges in London and a newly opened one in May 2016 in Luton and Bedfordshire. In the inpatient wards, the extension of activities had frequently been linked to the quality improvement work to reduce incidents of violence and aggression.

- It was positive to note that many of the activities available involved accessing services in the community as well as just being on site. For example at the Coburn centre young people said that activities were available in the evening and weekends including trips out. They particularly mentioned some of the crafts available including jewellery making and tie dye. Within the forensic services, many of the activities were linked to employment. For example at the John Howard centre employment projects included the café project, working at the on site shop, design and print project, landscape gardening project, picture framing project and maintenance of the on site barber shop. Patients were referred from the ward and given a taster session of the work, and then spent time unpaid on placement within each project. Once the induction was done, patients

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Are services responsive to people's needs?

were given contracts of paid employment. There were also pathways to employment outside the John Howard Centre through links with local social enterprise groups who hired patients at the John Howard Centre. At Wolfson House examples of activites included creative writing, an allotment group, and relaxation group. Each ward had one hour a week for patients to access a computer room on the ground floor. Patients were able to access the internet during this time and there were no restrictions on sites, such as social media sites, although access was supervised by staff. On the acute wards therapy provision included art, music, drama, dance and movement therapies. Activities included gardening, computer skills, pottery and boating. Wards in City and Hackney mental health unit all had computers available for patients to use. On Coral ward an acute inpatient ward in Luton and Bedfordshire they were providing patients with a range of regular weekend activities in the community, for example bowling, football, and day trips. There were still a few wards where patients said they would like to have more activities, especially outings at the weekend.

Meeting the needs of all people who use the service

- The trust recognised and celebrated the diversity of the patients and staff and worked to meet the needs of people using the services.

- The trust had an equality, diversity and human rights (EDHR) steering group. This had undertaken a large piece to develop an EDHR strategy. This was developed in consultation with service users, carers, staff, governors and members, local communities and voluntary sector organisations. The strategy had an action plan and the steering group monitored the progress. The steering group also looked at new initiatives and how staff can make decisions from human rights perspective. An example of this was piece of work that was being started looking at human rights in PICU services.

- The trust produced an annual patient and staff equality and diversity report that was published on their website. There was an annual equality and diversity week and this included an event to encourage staff to to talk about equality and diversity issues across the organisation.

- Trust had 3 main networks. These are for people who are black, minority, ethnic (BME), disabled and lesbian,gay,bi-sexual and trans-gender (LGBT). These networks were also being developed in Luton and Beds. In March 2016 the trust hosted a BME conference in Luton and Beds and over 80 people attended from different communities.

- We heard of lots of exciting initiatives to meet the needs of people using the trusts services. This included a BME access project in Tower Hamlets and Hackney which included a life story project. There was also a 'tree of life' faith recovery project in Tower Hamlets which was developing culturally appropriate therapy for Bangladeshi men. The 'I am…..' project on Connolly ward (City and Hackney) celebrated people's cultural backgrounds and BME focus groups had been set up in some Luton inpatient services.

- There were also patient led evaluation, where service users had been trained evaluate the accessibility of buildings and these were taking place just after the inspection.

- The trust has a department of spiritual, religious and cultural care which was beginning to extend its work in Luton and Bedfordshire. They recognised the effect of each of these on people's mental well-being. They provided a range of training to equip staff and members of faith communities to holistically support people suffering from mental distress. These included an introductory course and also a one year university certificate jointly delivered with the psychology department of East London University. The team also provided one to one visits to wards and groups on wards, acts of worship from different faith traditions, connecting patients to faith leaders and communities, celebration of festivals, provision of religious texts and materials, individual spiritual needs assessments and liaison meeting with staff. We heard about the work that had been done with the mosques in East London and could see that patients who wished to celebrate Ramadan that was happening at the time of the inspection were being fully supported to do so. We also heard about other work with communities including the orthodox Jewish communities in Hackney. There had also been work with the Polish and Latvian

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Are services responsive to people's needs?

communities in Bedfordshire. Two teams were available in Luton and Bedfordshire to provide culturally specific support to people from a south Asian or African or Carribean background.

- Other practical ways in which the trust met the needs of people using their services included the provision of information about conditions, rights and services provided by the trust in a range of different community languages. The pharmacy department were piloting the use of a system that could translate dispensing labels into different languages. Information was also available in easy read formats and larger print.

- The trust also provided a telephone interpreting service and intepreters who could be booked to attend clinical meetings. There was also access to people who could use sign language for patients who are deaf.

- The trust also provided disabled access to most of its facilities.

Listening to and learning from concerns and complaints

- Information about how to complain was on the trust website, displayed on posters in inpatient areas and in community services. This signposted people to the ombudsman if needed. We were told patients using inpatient services were encouraged to raise concerns in weekly community meetings.

- In the 12 months from January 2015 , 412 complaints were received, 63 were upheld, 106 were partially upheld. Two were referred to the ombudsman, both of these investigations were ongoing.

- Themes in order of prominence included all aspects of clinical treatment, attitude of staff, communication/ information to patients, delay/cancellation of outpatient appointments, admission, discharge and transfer arrangements and patients property and expenses.

- Many concerns were dealt with informally by front-line staff and the Patient Advice and Liaison Service (PALS). There were two PALS team covering London services and one separate PALS team which covered Luton and Bedfordshire.

- The people participation team ran patient focus groups in which patients were informed on how to complain and were also encouraged to raise concerns within the focus groups.

- There was a quality improvement project in the Community Health Newham Directorate which aimed to reduce the number of formal complaints through an internal panel assessment of complaints received to determine the number that could be resolved informally in the first instance. Local managers would take responsibility for informal resolution.

- All formal complaints were centralised and dealt with by the assurance team. There was a weekly grading panel attended by senior staff which decide if a complaint can be dealt with informally, formally or should be investigated as an incident.

- Each formal complaint was handled formally by a senior manager (investigating officer) and received a written response by the Chief Executive.

- The trust aimed to acknowledge formal complaints within three days of receipt and responded to them within 25 working days. The trust's target to acknowledge formal complaints within three days was 90%. For the business year 2015-2016 the trust's compliance was above target at 95%.

- The trust provided a support package for staff that had a specific allegation made about them.

- The trust had a learning from complaints committee in which key themes were addressed, for example staff attitudes and medication. There were learning lesson seminars across the trust to address complaint themes, for example improving staff communication with patient's carers and family.

- We reviewed eight complaint files and responses provided to complainants by the trust. Investigation notes were included in the files and we could clearly see how conclusions had been reached by the investigators who were senior members of staff. We found evidence that face to face meetings with complainants had taken place so the process could be clearly set out in the most appropriate way. All formal complaints were closed and signed off by a letter from the Chief Executive to the complainant. All closing letters consistently sign posted complainants to the Ombudsman if they were

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dissatisfied with the trusts investigation and outcome. The closing letters outlined how the trust had addressed key issues and outlined the learning from the complaints.

- Only one of the complaints we reviewed was responded to after more than 25 days. This was because the investigating lead was on leave. There was no evidence

that the complainant had been sent a holding letter to forewarn the delay. The investigating lead apologised to the complainant for this delay in the delayed response letter.

- We found one of the complaints was not investigated due to being subject to criminal proceedings. This was clearly communicated with the complainant via a letter from the chief executive. They were encouraged to pursue the complaint with the trust once the criminal proceedings had closed.

Are services well-led?

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

Summary of findings

Our findings

Vision, values and strategy

- The vision of the trust was 'to make a positive difference to people's lives'. This was driven by their values which were: 'we care, we respect and we are inclusive'.

- The trust has a quality strategy which was their plan to provide the highest quality mental health and community care. In order to deliver this their stated aims were to; have quality underpinning every decision; listen to patients and carers; provide the safest care and learn lessons when things go wrong; support staff to deliver high standards; attract and retain the best staff and develop them further; work with commissioners in a positive relationship; foster a culture of quality improvement and maintain financial viability.

- The trusts quality priorities for the next three years were inclusion, equity and equality; care integration; listening and learning; access to services; reducing variation in the provision of evidence based care and use of technology.

- The inspection found that staff throughout the trust understood the vision and values of the trust. Some teams had done additional work looking at how it would develop these to reflect how they could be put into practice in their service.

- The trust was managing its budgets effectively and had a surplus. There was challenging ongoing work with commissioners, especially in Luton and Bedfordshire to ensure the trust had the resources to develop the services in line with their quality strategy.

Good governance

- The trust had very robust governance structures in place. This meant that from ward to board there was a good understanding of the challenges facing the trust.

Areas for improvement were recognised and work was done in a timely manner to make these changes. This meant that in almost every case throughout the inspection, where improvements were needed, well developed plans were aleady in place.

- There was a clear board assurance framework. This was organised to reflect the three key objectives for the trust: to improve service user satisfaction, improve staff satisfaction and maintain financial viability. Under each of these the main risks were identified and the improvement actions required. Progress was monitored.

- There were six committees that fed into the board; appointments and renumeration, audit committee, quality assurance committee, public participation committee, finance business and investment and Mental Health Act. There was also a quality committee chaired by the medical director that fed into the quality assurance committee.

- The trust was organised into nine directorates which were a mixture of borough and specialist services. Each directorate had one or two clinical directors and a service lead.

- At a directorate level scrutiny took place through a quarterly quality and performance review meeting led by members of the senior executive team. These meetings had a standard agenda which included quality assurance, quality improvement, strategic issues and performance. These were supported with very thorough information to support each area that was being considered. The directorates also had their internal quality assurance groups which were the main links back to wards and teams. These agendas included learning from serious incidents and complaints.

- The trust recognised the importance of having a strong programme of quality assurance. This included a system of internal inspection, clinical and patient led audits, using feedback from patients to drive improvement, embedding learning from serious incidents and complaints and assuring compliance against NICE clinical guidelines.

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- The main drive for delivering high quality services has been through the trusts quality improvement programme which was central to the work of the trust. The results of this work were seen in practice throughout the inspection. This sat alongside a number of other techniques to deliver improvements. These included the use of training and development, partnership working, values based recruitment, use of information management and technology, commissioning for quality and improvement, health promotion and accreditation.

- It was positive to see that each of the wards and teams had access to a range of management information, which was available in the trust intranet, displayed in an accessible format that identified trends and areas for improvement. This also fed into the directorate and trust wide management information and supported the board assurance framework. Wards and teams were able to keep their own risk register and these were brought together to form directorate and a trust wide risk register. The inspection team were very impressed by the quality and accessibility of this information and how staff were able to describe how this was used in practice. It was also possible to see how key information was being shared with wards and teams within directorates. This was a very effective governance process.

Fit and Proper Person Requirement

- The trust was meeting the fit and proper persons requirement (FPPR) to comply with regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This regulation ensures that directors of health service bodies are fit and proper persons to carry out their role.

- The trust had a fit and proper person policy and procedures in place.

- We looked at 8 personnel files which included four executive directors and four non-executive directors: the majority of whom had been in post prior to FPPR coming into force in November 2014.

- All the records included all the necessary information. This included a photo ID, completed DBS checks, a self declaration on occupationl health, certificates to prove professional qualifications and comptenecies, insolvency and bankruptcy checks, a full record of employment history and references.

Leadership and culture

- The trust had a very stable senior leadership team. At the time of the inspection the chief executive had announced his pending retirement but the deputy chief executive had been appointed as the new chief executive. This was well received by external stakeholders. It was also positive that the new chief executive was the only female BME NHS chief executive in the country.

- The chair was appointed in 2012. There were 7 other non-executive directors (NEDs). The board assurance framework had identified that two NEDs were ending their term of office in October 2016 and succession planning was underway. The chair and board were very impressive. It was very positive to see the diversity of the board and how they reflected the local communities. The non-executive directors had a wide range of professional skills and personal experience. This meant that the quality of questions, challenge and debate at board meetings was a very high quality. Board members very appropriately held executive staff to account to ensure the trust was meeting the needs of people using the services. There was no complacency and they set high standards and were always thinking about how the trust could improve. The board meetings were well organised and inclusive.

- External stakeholders told us they valued the openness and visibility of the trust leadership. The clinical commissioning groups said the trust 'are a high performing organisation, providing good quality clinical services, often in challenging circumstances. The trust aspire to continual quality improvement, setting high standards'.

- Trust just had just completed a well led review. This was very positive and just suggested two areas for improvement: to co-ordinate with other committees so records of meetings reach the board in a timely manner and to clarify what the board will consider – for example

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Are services well-led?

which commercial projects need to come to the board. It found the board had good balance and the information they received and exception reporting was good.

- The trust had an extremely healthy culture. It was in the top five trusts in the country in the latest staff survey. The very positive areas related to communication with senior management; quality of appraisals and training; satisfaction with flexible working. However there were areas for improvement including staff working extra hours, staff experiencing physical violence from patients and members of the public, staff experiencing discrimination at work and lack of career progression and staff experiencing bullying from patients, relatives and other staff. This was discussed by the board and action plans put into place. In March 2016 the sickness levels was 4%. The inspection found that staff were almost unanimously positive and said how much they enjoyed working for the trust. We heard staff talk about how they travelled long distances to work as they enjoyed their jobs and even staff who said they were sorry they were coming up to retirement. Staff talked about being valued and listened to. Many talked about how the trust was non-hierachical and how they knew senior leaders and felt able to raise issues. The few staff who were less positive were being affected by service changes.

- As part of this inspection we undertook a pilot inspection of the implementation of the Workforce Race Equality Standard (WRES). The WRES is a mandatory requirement for NHS organisations to identify and publish progress against nine indicators of workforce equality to review whether employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities, receive fair treatment in the workplace and to improve BME board representation.

- The trust held detailed information on the equality characteristics of its workforce. This was acknowledged in its most recent WRES report, which was shared with the board in October 2015, along with an accompanying action plan. Key findings from the WRES report showed that 25% of BME staff held senior management positions (band 8a and above for non medical staff) compared with the overall workforce which was 52% BME. The trust had introduceda BME staff mentorship

programme as part of its plan to address this area. The number of BME staff accessing non mandatory training and continuous professional development was 33.5%, which was higher than for white staff at 29.6%.

- Unconscious bias training was planned for managers involved in recruitment.Unconscious bias refers to a bias that people are unaware of, which happens outside of their control. It happens automatically and is influenced by people's background, cultural environment and personal experiences. The relative likelihood of white staff being appointed from shortlisting compared to BME staff was 1.3 times greater, which was significantly better than the national average. However, 27% of BME staff did not have confidence that the trust provided equal opportunity for career progression or promotion, compared to 7% of white staff. The survey results also showed that the likelihood of BME staff experiencing discrimination at work from their manager or other colleagues was the same as white staff. This had been the case for the last two years and was a considerable achievement. One of the measures the trust had taken to improve BME staff confidence that the trust was able to provide equal opportunity for progression was to ensure that secondment and acting up opportunities were more widely advertised.

- BME staff were 3.8 times more likely to enter disciplinary proceedings than white staff. The trust had conducted a comparative analysis of disciplinary proceedings to better understand the reasons for this. In addition the trust was putting in place new measures to resolve disputes before they reached the formal disciplinary stage.

- Overall, the most recent staff survey showed that the numbers of staff reporting bullying, harassment or abuse from patients was falling for all staff. BME staff, when compared to white staff, were 1.2 times less likely to experience bullying, harassment or abuse from patients. BME staff were 1.2 times less likely to experience bullying, harassment or abuse from staff than white staff. The trust had developed and implemented a pool of bullying and harassment support advisors to listen and support BME and white staff who experienced bullying and harassment.

- In London a BME support network was well established. This met regularly and had been involved in

consultation regarding the WRES action plan and EDHR workstreams. In Luton a BME network had been introduced, this was however in its early stages and had met only once at the time of our inspection.

- The inspection team met with BME staff from across the trust in two focus groups. The London focus group was well attended and overall staff spoke positively about the diversity of the staff group, feeling valued by the trust and the opportunities for staff development. They also commented that the BME forum was valued and listened to by the senior management team and that significant progress had been made in recent years in representing BME staff at a senior level within the trust. However, BME staff from one service spoke of different experiences. They did not feel valued by the trust, felt that opportunities for progression were limited for BME staff and that the leadership of the service at local levels did not reflect the workforce or the community. This staff group expressed feelings of being overlooked, demoralised and labelled when they raised concerns. In Luton the BME focus group was less well attended. Staff told us that the Luton and Bedfordshire BME network was in its early stages, having been founded in May 2016 and having met only once. There was less awareness of the WRES report and action plan amongst Luton and Bedfordshire staff attending the focus group. However, BME staff spoke positively about their experience, siting good opportunities for development and progression and the visibility of BME staff in senior leadership roles. Staff also commented that within their geographical area there was BME representation on recruitment panels and that recruitment was values based. Staff also commented that since the transition to the trust there had been increased equality and diversity awareness.

- The trust had as one of its key objectives to 'improve staff satisfaction'. The main way that staff were engaged in the work of the trust was through the quality improvement programme which had been implemented in 2014. The trust had invested heavily in training and developing staff to use this methodology. Staff were really proud of the quality improvement work in their teams.

- The trust also used a range of means to communicate with staff. This included making good use of the trust intranet which was very well developed, newsletters and other forms of social media to promote communication. Senior staff and board members also spent a lot of time visiting services and speaking to staff and service users.

- The trust understood the importance of recognising the hard work of staff across the trust. There were awards for staff within teams and across the trust. There was a strong culture of celebrating success and saying thank you.

- Trust had a 'speak out safety campaign' to encourage staff to raise concerns about staff safety. There are a number of ways that staff were able and encouraged to raise concerns at work. A freedom to speak up policy has been developed and was available to all staff on the intranet. If a whistleblowing concern or anonymous complaint was raised, it was discussed with the chief executive or deputy chief executive and a decision taken about the next steps. Support was provided to the person raising the complaint via the bullying and harassment advisors. Where there were 'clusters' of concerns additional action had been taken to encourage staff to discuss issues affecting them at work and as a 'listening' exercise for follow up action. The board had oversight of all whistleblowing and anonymous complaints and a report was provided at every part 2 board meeting. A recent audit of whistleblowing procedures had been undertaken.

Engaging with the public and with people who use services

- The trust had a council of governors. There were also 9600 public members and 5000 staff members. Communication with members took place through newsletters, webpage, workshops, events such as borough members meetings and an annual members meeting. There were annual planned consultation events and annual feedback surveys. The trust was working to ensure more participation from young people, to ensure Luton and Bedfordshire felt equally engaged and to improve communication further. At the time of the inspection the trust had completed quality improvement project to improve the work of the governors and engage more effectively with members. This had led to changes in how the meetings were conducted and the arrangements for engagement events.

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Are services well-led?

Quality improvement, innovation and sustainability

- The trust has a range of leadership development opportunities in place, with 'talent management and succession planning' policies in place. The trust had invested considerably in leadership development. A series of leadership development programmes has been procured and delivered in Luton and Bedfordshire to support the transformation of services. Bespoke leadership development at individual and team level was available. A new management training programme for middle managers was being developed. Also the trust was participating in a national pilot to develop a leadership strategy framework for the NHS, with the Kings Fund and NHS Improvement.

- Since 2011 there had been cohorts of inpatient nursing development programmes for bands 3 – 8a. All inpatient nurses from bands 6, 7 and 8a had been through a 20 day programme. In addition to that there ia an 'aspiring clinical practice lead' development programme for band 5 nurses who want to progress to band 6. The trust had over 100 staff who had been through this programme, and were in the process of accrediting the course at masters level through Middlesex University. All programmes had clinical and leadership modules and additionally the aspiring band 6 and above programmes all had a management module. A new band 6 community nurse development programme was starting in June 2016 and the first cohort had 30 staff across the boroughs. The trust were developing a new multi-disciplinary development programme starting with operational leads in community teams (September 2016). The trusts aim was for all staff to have been on at least one leadership development programme reflecting their belief that leaders are found at every level of the organisation. In Luton and Bedfordshire they were replicating the nurse development programme. This was also to enable all the staff in Luton and Bedfordshire to feel part of the trust and be aligned to the values.

- Throughout the inspection we heard from staff who were participating in the leadership development programme and heard about how this was supporting their career progression.

- Central to the trusts work was their focus on quality improvement. They were working with the Institute for Healthcare Improvement (IHI). They had a central QI team who co-ordinated QI work and supported directorates and teams. They had trained approximately 500 staff and 60 service users on QI methodology. There were 30 QI coaches. There were 150 active QI projects with 28 showing sustained improvements. QI won the education category at the BMJ awards in 2016.

- Other awards included being trust of the year at the patient safety awards 2015 and winning the staff engagement award in the health service journal awards in 2015.

- The trust has been awarded university status for international research conducted in partnership with Queen Mary's university.

- The trust participated heavily in the Royal College of Psychiatrists Centre for Quality Improvement. This included the accreditation for inpatient mental health services where 19 wards were accredited of which 16 were accredited as excellent and three were in the review stage. The forensic wards were a member of the quality network. The CAMHS in London was a member of the quality network. Other accreditations included the memory services national accreditation programme where three were excellent and one was in review. The Tower Hamlets home treatment teams had deferred its accreditation.

- The trust was participating in the Duke of Edinburgh scheme (Luton and Bedfordshire) the first in the country for a mental health trust.

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Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
Diagnostic and screening procedures	**Regulation 9 HSCA (RA) Regulations 2014**
Treatment of disease, disorder or injury	**Person centred care**
	The trust had not ensured the care and treatment was appropriate and met the needs of patients.
	Forensic services:
	On Clerkenwell ward at the John Howard Centre the loud alarms caused distress to some of the patients who had a learning disability and autism.
	Community mental health services for older people:
	The memory clinics especially in Bedfordshire were not all completing assessments and giving a diagnosis for patients with dementia in a timely manner.
	Mental health wards for people with a learning disability
	Patients with challenging behaviours did not have care plans in place that reflected a positive behaviour support approach.
	This was a breach of regulation 9(1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Forensic services The trust had not ensured that the risk assessments completed for patients who were taking leave consistently reflected their other care plans and risk assessments, or included the views of the patients. This was particularly in relation to the risk assessment that was used to decide if the use of an electronic device was appropriate. Risk assessments were not always stored in the same place in patient records and were not always readily accessible the staff who needed them. This was a breach of regulation 12 (1) and (2)(a)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Community health services for adults Systems and processes must be established and operated effectively to ensure compliance with the Health and Social Care Act 2014 The records in respect of each patient were not accurate and complete and so it was not possible to ensure they had been thoroughly assessed and had appropriate care and treatment plans in place that were being carried out in a timely manner. This was a breach of regulation 17(1)(2)(a)(b)(c)

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