Essex Partnership University NHS Foundation Trust

Evidence appendix

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Date of inspection visit:
29 July 2019 to 23 August 2019

Date of publication:
9 October 2019

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

Facts and data about this trust

The trust had 19 locations registered with the CQC (on 22 May 2019).

Registered location	Code	Local authority
The St Aubyn Centre	R1L22	Essex
Thurrock Hospital	R1L50	Thurrock
Mountnessing Court	R1L65	Essex
Rawreth Court	R1LJ2	Essex
Clifton Lodge	R1LJ3	Southend-on-Sea
Brockfield House	R1LK9	Essex
St Margaret's Community Hospital	R1LT1	Essex
Saffron Walden Community Hospital	R1LTH	Essex
Wood Lea Clinic	R1LX3	Bedford
Broomfield Hospital Mental Health Wards	R1LX7	Essex

Registered location	Code	Local authority
Chelmer & Stort Mental Health Wards	R1LX9	Essex
Colchester Hospital Mental Health Wards	R1LY2	Essex
Heath Close	R1LY3	Essex
Landermere Centre Mental Health Wards	R1LY4	Essex
Robin Pinto Unit	R1LY7	Luton
439 Ipswich Road	R1LY8	Essex
Basildon Mental Health Unit	R1LY9	Essex
Trust Head Office	R1LZ8	Essex
Rochford Hospital	R1LZ9	Essex

Bed numbers[1] (remove heading before publication)

The trust had 763 inpatient beds across 45 wards, 38 of which were children's mental health beds. The trust did not provide information regarding the number of clinics per week.

Total number of inpatient beds	763
Total number of inpatient wards	45
Total number of day case beds	0
Total number of children's beds (MH setting)	38
Total number of children's beds (CHS setting)	0
Total number of acute outpatient clinics per week	Not provided
Total number of community mental health clinics per week	Not provided
Total number of community physical health clinics per week	Not provided

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

[1] Universal PIR P1 Beds

Is this organisation well-led?

Leadership

The EPUT Board of Directors consisted of 8 Non-Executive Directors (NEDs) and 7 Executive Directors (EDs), with no current vacancies. Eighty six percent of executive director roles have been in post since 2017 when the merger of North Essex University NHS Foundation Trust and South Essex Partnership Foundation Trust took place. A recent review of the executive structure following a resignation saw the creation of a new post: Executive Director of People and Culture. The board created this role to align with their current strategies and to reflect the changing needs of the organisation.

The executive board had one (7%) black and minority ethnic (BME) members and two (13%) women. The non-executive board had one (7%) BME members and five (33%) women.

The trust board had the appropriate range of skills, knowledge and experience to perform its role. Board members modelled leadership behaviours and demonstrated the values of the organisation. The board was unitary, and NEDs provided the right level of challenge to the board.

The senior leadership team worked cohesively and efficiently together. Medical, operational and corporate leadership teams supported EDs. This included clinical directors, directors and associate directors. Medical, nursing and allied health professional roles had access to professional leadership structures.

Recruitment files demonstrated all appointments to the board had been completed in line with fit and proper person guidelines. More recent appointments demonstrated the involvement of governors and people who use services in the recruitment process.

The board engaged in continuous learning opportunities using board development sessions. Board development sessions took place bi-monthly and included participation in the NHSI Leadership for Improvement Board Development Programme. All members of the board received an appraisal in the last 12 months. This included individual 360 degree feedback facilitated by the NHSI leadership academy. The appraisal structure demonstrated that NEDs and governors contributed to the appraisal process.

The trust provided learning and development opportunities to staff, of all grades, through a leadership and development programme. The trust used this programme as a form of succession planning to develop and grow their own staff. In two years, 849 staff participated in the programme. Alongside the leadership development programme, 13 staff also enrolled in NHSI leadership academy courses. The trust talent management programme identified individuals with potential, the right behaviours and high levels of performance to be ‘stretched’ to achieve their full potential and to increase their skills and experience.

The board placed focus on visibility. The Chief Executive Officer (CEO) carried out 44 service visits in the last 12 months, including unannounced visits at night. Executive Directors (EDs) carried out 220 service visits and NEDs carried out 85. In addition, joint EDs, NEDs and governor service visits took place monthly. The board worked to improve their oversight and contact with specialist services such as substance misuse and end of life care, following the concerns raised at the last inspection. Feedback from services was mixed, some staff noted an improvement whilst some failed to recall when they had been visited by senior leaders.

Vision and strategy

The trusts vision and values are:

“Our organisational vision is: working to improve lives.

The vision is backed up by the values we operate under:

- Open
- Empowering
- Compassionate”

The trust developed the vision and values during preparation for the merger and continue to refer to them through values based recruitment, during inductions, training, supervision and appraisal. All staff knew the values of the organisation and demonstrated this in their day-to-day work. Staff gave examples where they felt their teams reflected the values of the organisation in their work with patients and carers. Managers and staff discussed vision and values during the appraisal process and at interviews to ensure the right people, with the same values, worked for the organisation. The trust embedded vision and values across the organisation; managers displayed values information in all the services we visited.

The trust had a robust and realistic strategy for delivering high quality care and achieving its priorities. The trust was in the process of developing a five year plan at the time of the inspection. Staff took part in engagement activities from January 2019 in order to contribute to the plan. Leaders planned to present the draft version to the board in September 2019. The trust had three strategic objectives:

- Continuous improvement of service user experience and outcomes
- Achievement of top 25% performance
- To be a valued system leader focussed on integrated solution

The trust quality strategy (2018-2020) describes the trust commitment to continuous quality improvement and the need to embed this in culture. The trust recorded its quality priorities as:

- Continued reduction in harm (particularly restraint, suicide/ unexpected deaths)
- Collective leadership
- Continuous improvement
- Increasing the use of technology.

Senior leaders monitored progress against quality priorities via annual reports which reflected key quality activities such as clinical audit and complaints.

The strategic framework of the trust outlined a further six strategies: Engagement, IM&T, Estates, Commercial, Medicines and Risk Management. Underneath the strategies, leaders monitored progress using 16 frameworks approved by the board.

Culture

Leaders prioritised culture following the merger in 2017 and continued to see this as a priority. This led to the creation of the post for an executive director of people and culture which will

continue to invest in and enhance the culture of the organisation. The trust employs lead roles to support cultural topics, including staff engagement, organisational development and equalities.

Senior leaders described the ‘command and control’ approach taken immediately post merger to ensure the trust met its immediate objectives bringing two organisations together. Leaders described a shift in approach and a focus on distributed leadership to increase the autonomy of local leaders and increase accountability for their services.

The trust undertook a variety of engagement events and allocated time for teams to hold away days to increase team working and to focus on service plans. Events included culture workshops and the head of psychological therapy delivered a programme to build staff resilience. One hundred and seventy-six staff participated in this programme.

The trust freedom to speak up guardian (elected by staff in 2017) worked to encourage staff to raise concerns. Twenty local guardians supported their work. There were 10 cases open to the guardian at the time of the inspection, with 30 concerns reported in total between 2018/19 financial year. The trust guardian met with local guardians and received support from executive and non executive speak up champions. Inclusion of modules relating to freedom to speak up in training and induction resulted in 944 staff receiving information about the role and its purpose. Alongside the freedom to speak up guardian, staff had access to a ‘I’m worried about’ area of the trust intranet where they could raise anonymous concerns. Between April 2017 and July 2019 staff raised 1328 questions or concerns which the senior leadership team posted responses to for all staff to see. Staff on wards and in services told us about this function and awareness of it was good.

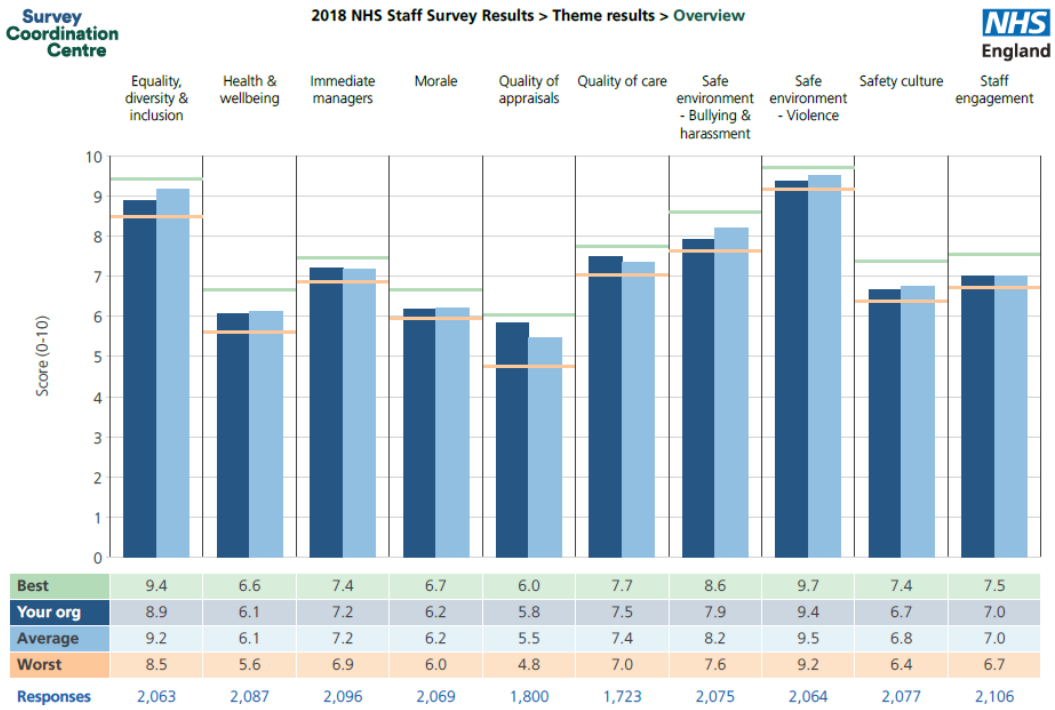
Senior leaders described work relating to embedding a ‘just culture’. A just culture ensures staff involved in incidents relating to patient safety are treated fairly. Just culture promotes a culture of openness to maximise the opportunities to learn from mistakes. Following the inclusion of this initiative into human resource processes there was a decline in employment related interventions. In July 2018 the number recorded was over 100 cases. In July 2019 the number recorded was under 30. The trust employed 12 staff mediators, who received specific training to resolve conflicts and complaints and reduce the number of formal grievances required.

Duty of Candour continued to be upheld appropriately. Complaint and investigation responses included apologies, where appropriate, and demonstrated compassion and transparency.

Whilst improvements had been made since the previous inspection in relation to equality and diversity, there remained work to do. Many examples of work described focused solely on the protected characteristics of race, despite equality and diversity networks being strengthened to include LGBTQ+, carers, disability and mental health and faith, alongside the BAME network. Senior leaders missed opportunities to engage with networks, not providing any executive attendance at the equality and diversity conference. Some senior leaders lacked confidence describing the function of the networks and the direction their work took. The trust identified 250 equality champions, increasing from 200 at the last inspection, whose role included the sharing of information, promote campaigns and offer advice and guidance. The trust established a reverse mentoring scheme for equality and diversity and reported that the first cohort of leaders and BAME staff took part in training in early 2019.

In December 2018, there were 7.9 occupied beds to each full-time equivalent member of the nursing staff, which was worse than the national average of 4.6.

The following illustration shows how this provider compares with other similar providers on ten key themes from the 2018 NHS Staff Survey. Possible scores range from zero to ten – a higher score indicates a better result.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.4	6.7	6.0	7.7	8.6	9.7	7.4	7.5
Your org	8.9	6.1	7.2	6.2	5.8	7.5	7.9	9.4	6.7	7.0
Average	9.2	6.1	7.2	6.2	5.5	7.4	8.2	9.5	6.8	7.0
Worst	8.5	5.6	6.9	6.0	4.8	7.0	7.6	9.2	6.4	6.7
Responses	2,063	2,087	2,096	2,069	1,800	1,723	2,075	2,064	2,077	2,106

The trust's 2018 scores for the following themes were significantly higher (better) when compared to the 2017 NHS Staff Survey:

- Quality of appraisals
- Staff engagement

The trust's 2018 scores for the following themes were significantly lower (worse) when compared to the 2017 NHS Staff Survey:

- Equality, diversion & inclusion
- Safe environment – Bullying & harassment

The trust intended to target specific areas of staff survey results including bullying and harassment and equalities. This work also included addressing scores relating to violence. Alongside achieving some positive results, the trust reported a higher engagement rate with the staff survey this year, compared to last.

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

1. The percentages of White and BME staff in each of the Agenda for Change (AfC) pay bands 1 to 9, and at Very Senior Manager (VSM) level (including executive board members), compared with the percentage of staff in the overall workforce: In 2018, there was under-representation of BME staff in nine out of 15 bands. There are less than 10% in bands 4, 8c, 8d, 9 and VSM. There has been a steady overall increase in the % of BME staff at EPUT by 2.5% (19.5% in 2017 – 22% in 2018).

2. In 2018, White candidates were 1.4% times more likely than BME candidates to get jobs for which they had been shortlisted. The trust performance against this measure has improved from 1.8% more likely in 2017.

3. In 2018, BME staff were 1.6% more likely to be disciplined[2] when compared with White staff. This has decreased from 2.5% more likely in 2017.

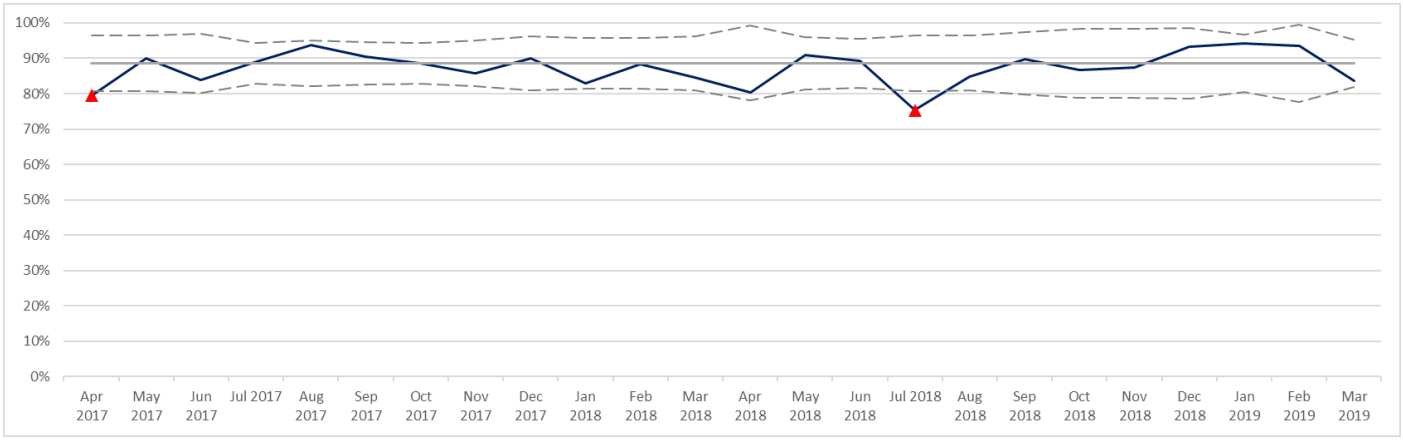
4. In 2018, White staff were 1.6% times more likely to take part in voluntary training than BME staff.

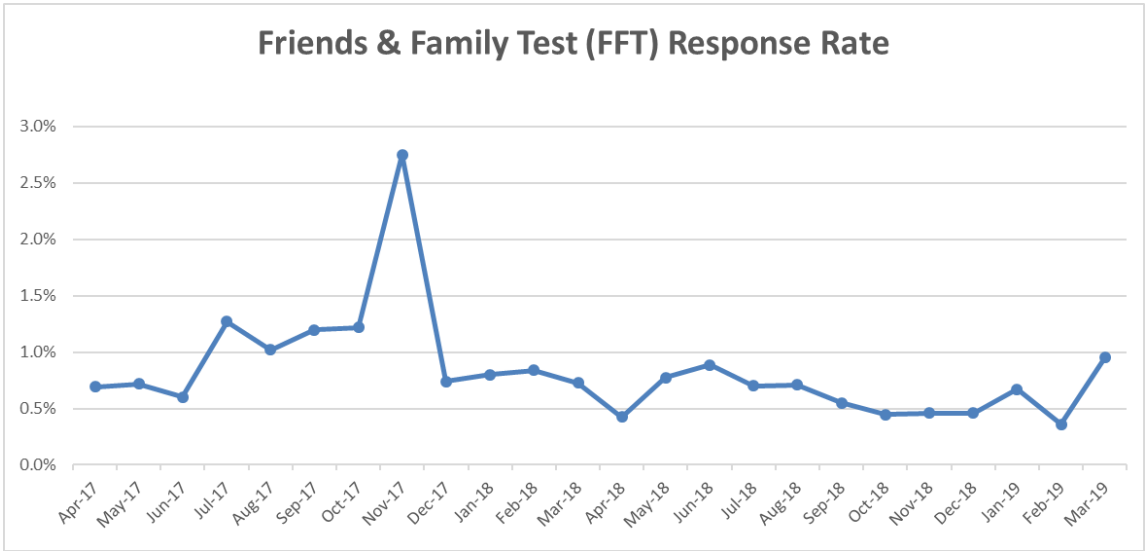
5. The percentage of BME staff on the board was 13% compared with 22% BME staff in the overall workforce. The percentage difference between the board voting membership and overall workforce was -9.3%.

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 75.3% and 94.3% between April 2017 and March 2019.

There were two points outside of the control limits. These unusual data points may be a sign of something out of the ordinary happening and merit further investigation to understand what happened in this time period and what can be learnt from this.



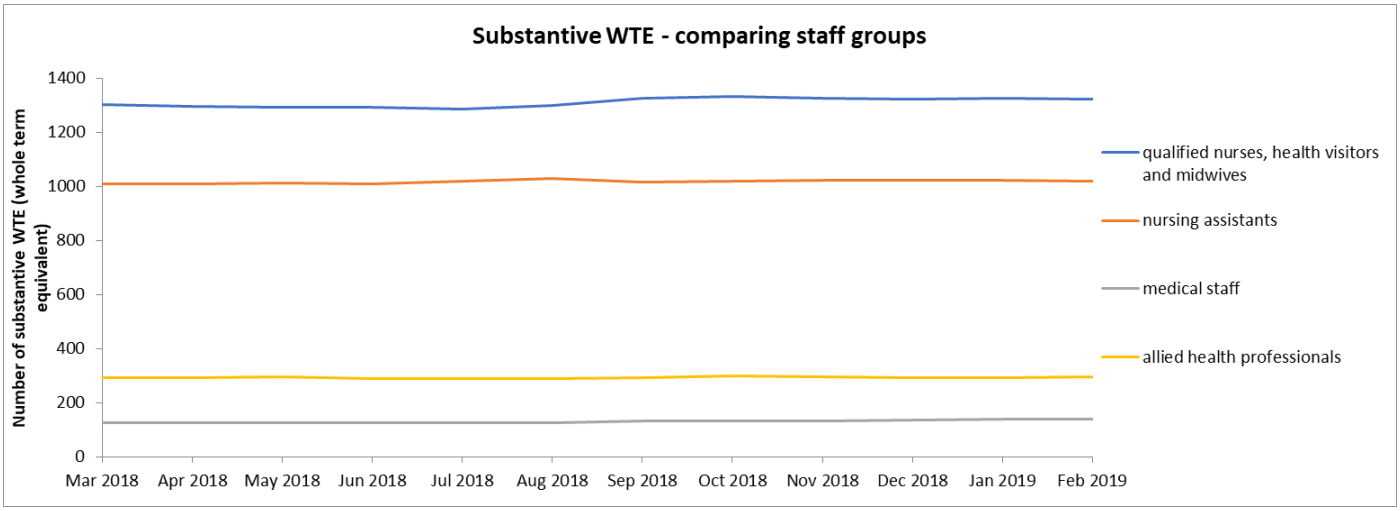


The Staff Friends and Family Test asks staff members whether they would recommend the trust as a place to receive care and also as a place to work.

There were no key messages related to the Staff Friend and Family test for this trust.

[2] WRES

The below chart shows the breakdown of staff in post WTE in this core service from 1 March 2018 to 28 February 2019.



Annual staffing metrics

	Core service annual staffing metrics (Vacancy, Turnover, Bank and Agency: 1 March 2018 – 28 February 2019) (Sickness: 1 April 2018 – 31 March 2019)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual "unfilled" hours (% of available hours)**
All staff	5265.1	12%	10%	4.6%			
Qualified nurses	1615.1	15%	8%	4.7%	375596 (13%)	176481 (6%)	22648 (1%)
Nursing assistants	999.2	13%	10%	6.1%	707717 (44%)	93647 (6%)	31562 (2%)
Medical staff	225.4	6%	4%	2.3%			
Allied Health Professionals	427.4	13%	15%	3.0%			

NOTE: Data regarding the number of medical locum hours filled by bank and agency staff was not clearly aligned to specific teams; therefore, this data was not usable for analysis.

All Staff

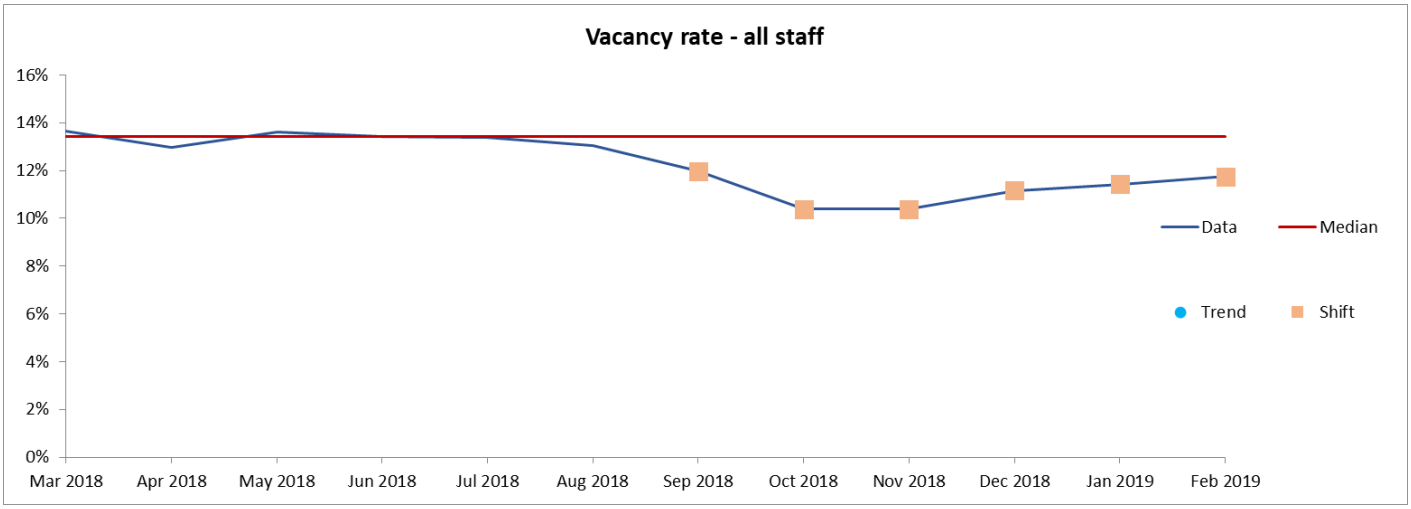


Figure 1

Monthly 'vacancy rates' over the last 12 months for all staff shows a shift from September 2018 to February 2019 (see figure 1). This could be an indicator of change.

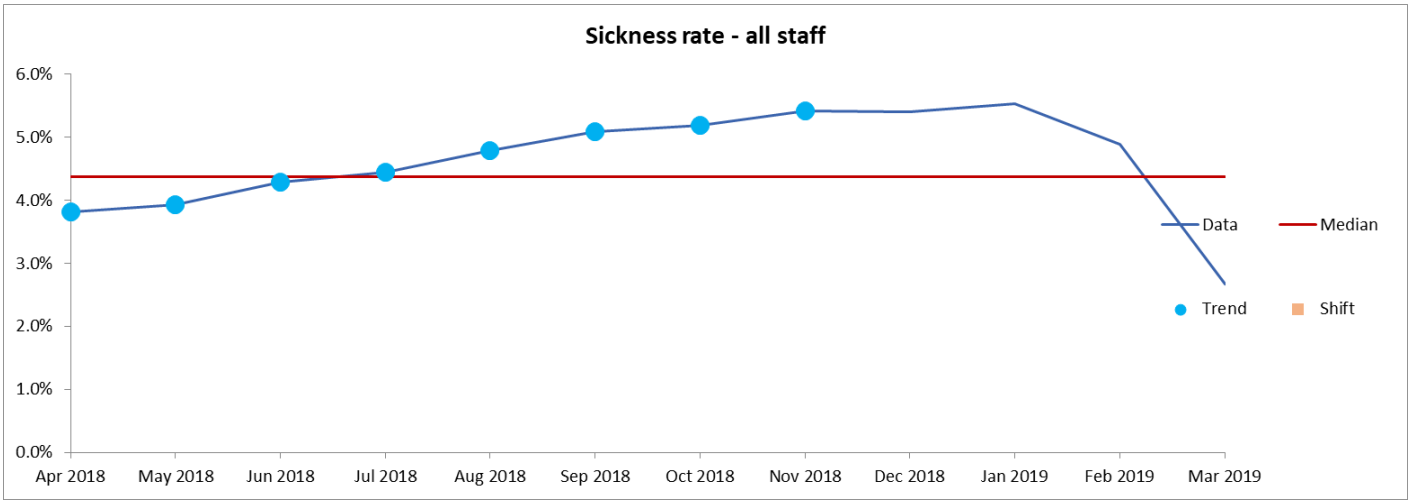


Figure 2

Monthly 'sickness rates' over the last 12 months for all staff shows an upward trend from April 2018 to November 2018 (see figure 2). This could be an indicator of deterioration.

Qualified Nurses

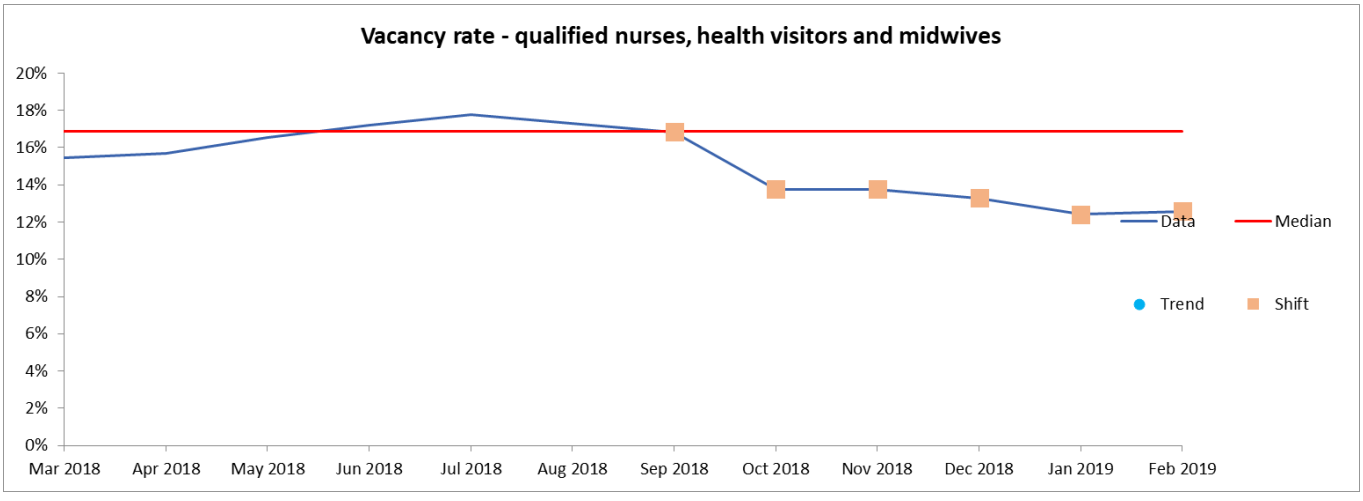


Figure 3

Monthly 'vacancy rates' over the last 12 months for qualified nurses, health visitors and midwives show a shift from September 2018 to February 2019 (see figure 3). This could be an indicator of change.

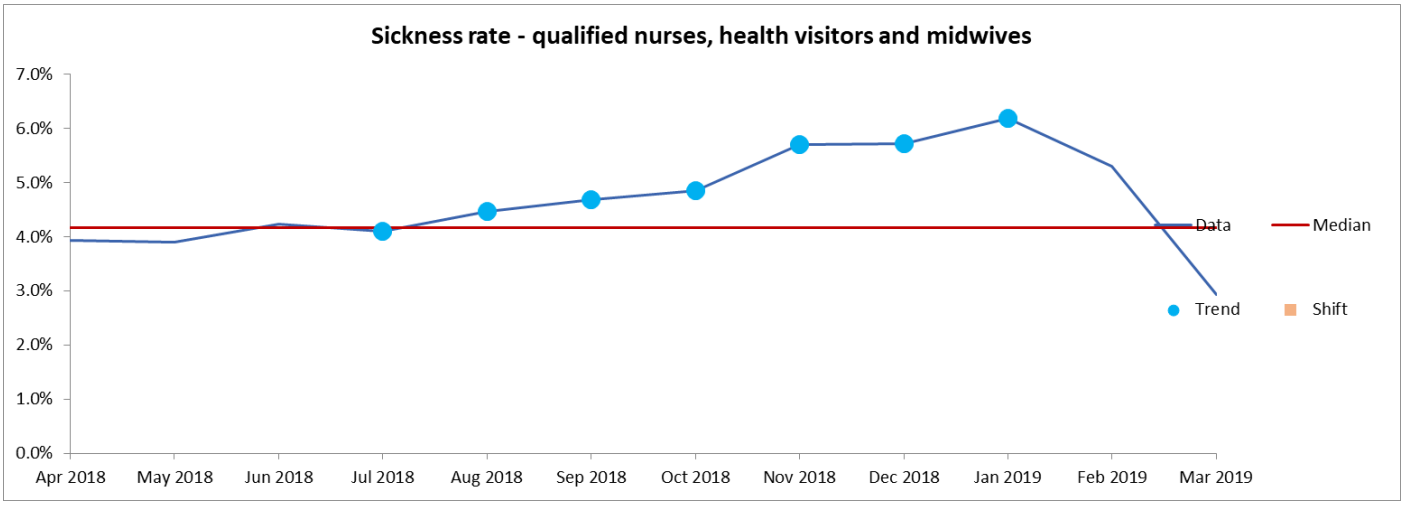


Figure 4

Monthly 'sickness rates' over the last 12 months for qualified nurses, health visitors and midwives show an upward trend from July 2018 to January 2019 (see figure 4). This could be an early indicator of deterioration. However, the average sickness rate for qualified nurses was in the lowest 25% when compared to other trusts nationally.

The average turnover rate for qualified nurses was also in the lowest 25% when compared to other trusts nationally.

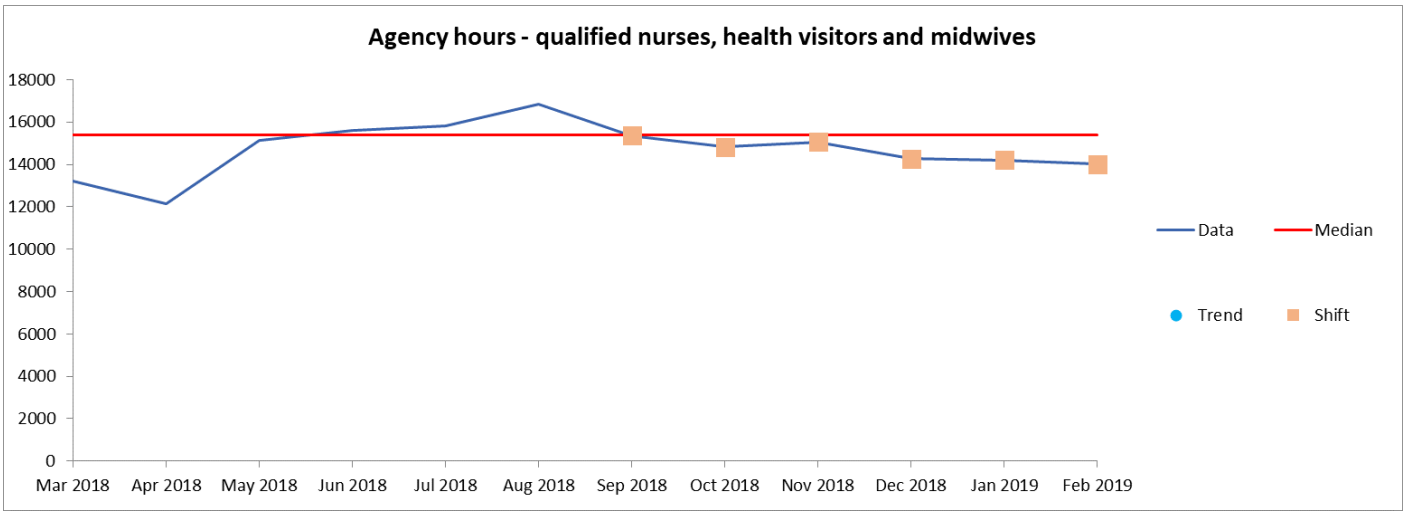


Figure 5

Monthly 'agency hours' over the last 12 months for qualified nurses, health visitors and midwives shows a shift from September 2018 to February 2019 (see figure 5). This could be an indicator of change.

Nursing Assistants

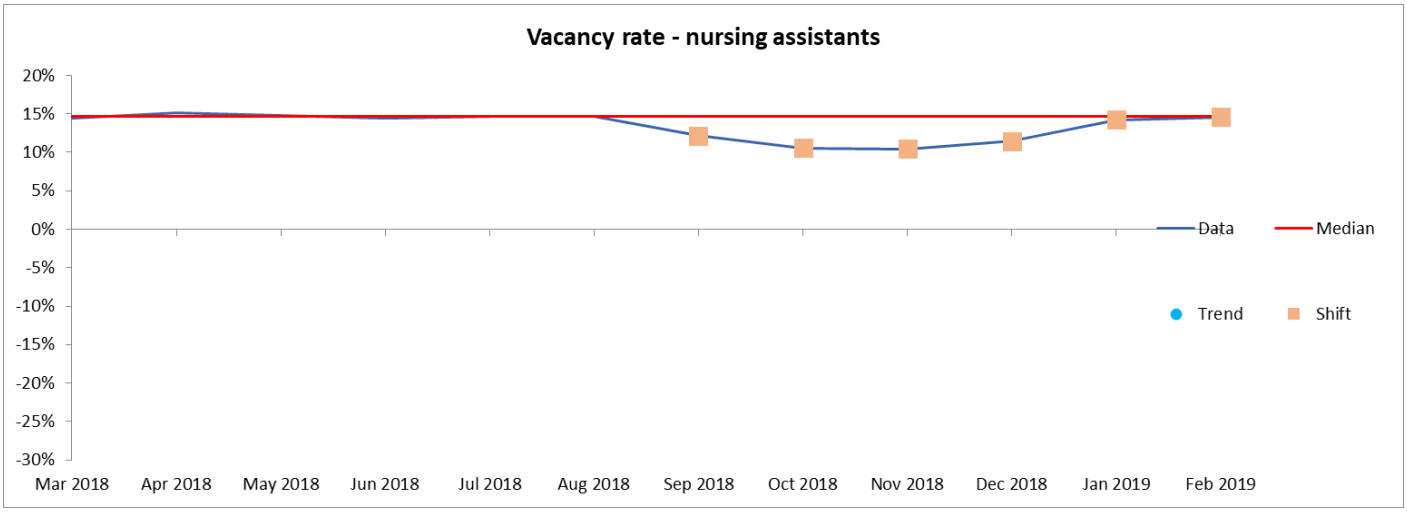


Figure 6

Monthly 'vacancy rates' over the last 12 months for nursing assistants shows a shift from September 2018 to February 2019 (see figure 6). This could be an indicator of change. However, the average vacancy rate for nursing assistants was in the highest 25% when compared to other trusts nationally.

Medical and Dental

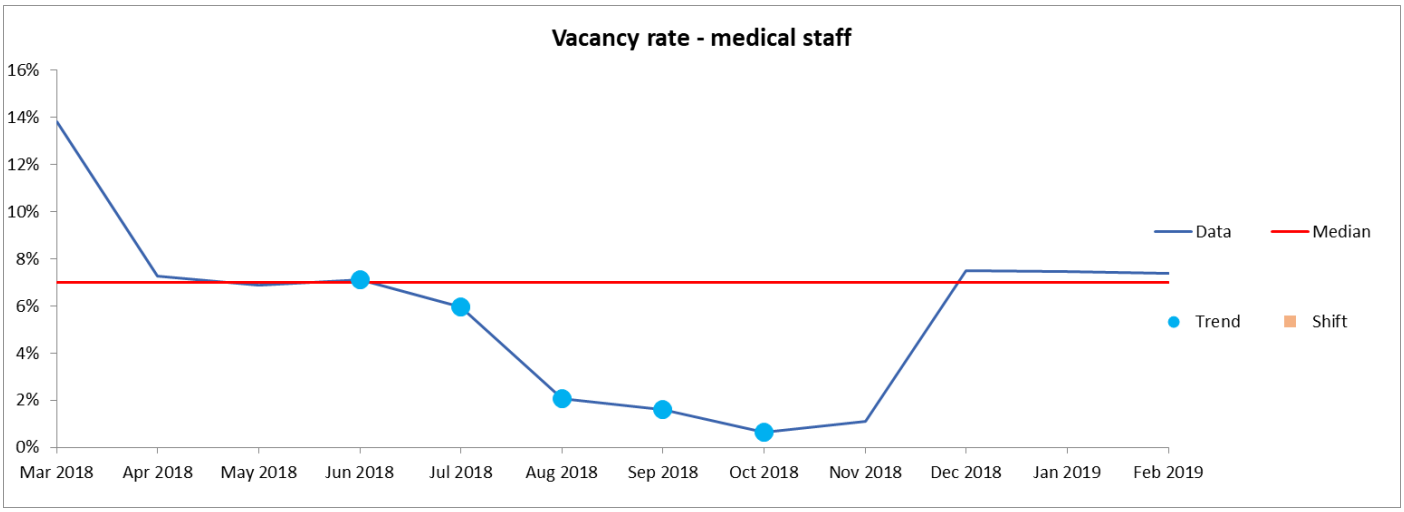


Figure 7

Monthly 'vacancy rates' over the last 12 months for medical staff shows a downward trend from June 2018 to October 2018 (see figure 7). This could be an early indicator of improvement. The average vacancy rate for medical and dental staff was in the lowest 25% when compared to other trusts nationally.

The average turnover rate for medical and dental staff was also in the lowest 25% when compared to other trusts nationally.

Allied Health Professionals

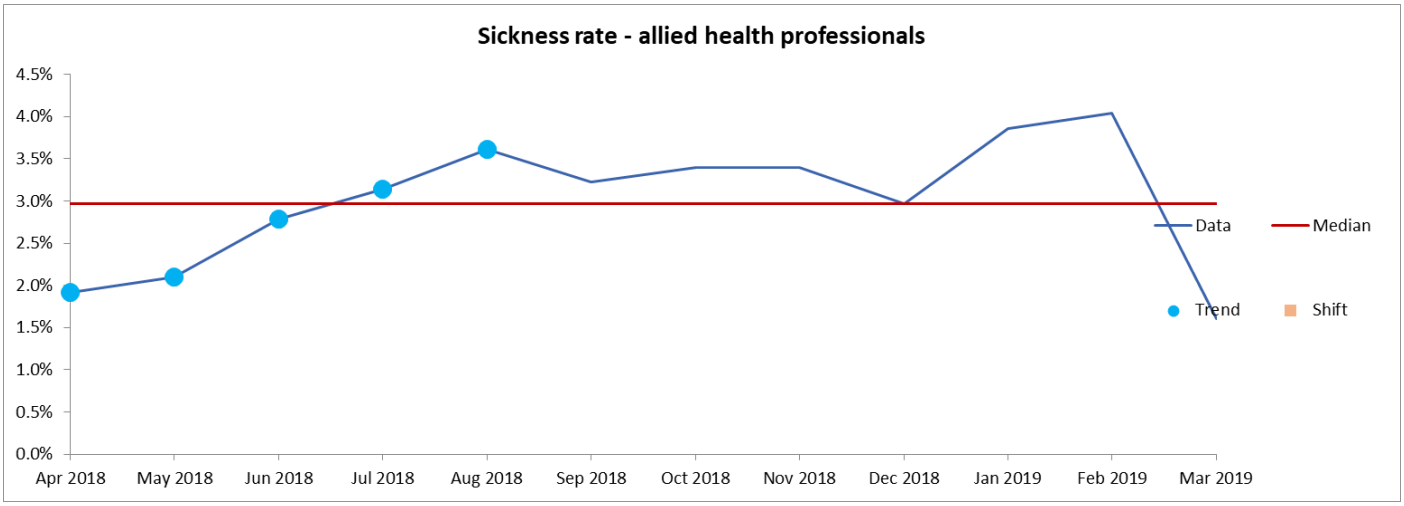


Figure 8

Monthly 'sickness rates' over the last 12 months for allied health professionals shows an upward trend from April 2018 to August 2018 (see figure 8). This could be an early indicator of deterioration.

The average turnover rate for allied health professionals was in the highest 25% when compared to other trusts nationally.

Between September 2017 and February 2018, 38.9% of healthcare workers involved with direct patient care were vaccinated against seasonal influenza, worse than the national average of 62.2%.

The trust identified staffing as an ongoing risk.

The trust reflected challenges around staffing on their board assurance framework (BAF) action plan. The board recorded nine actions required to recruit and retain staff and prevent vacancies remained less than the 10% national benchmark. Actions included: improving the attraction of the trust as an employer, improving the experience of BAME staff and reducing the turnover rate.

The trust monitored staffing levels through twice daily situational report meetings (SitREPS) where managers discussed staffing levels and unexpected absence.

The trust had a centralised system for booking agency staff and wards attempted to use regular staff to ensure continuity for patients.

The trust introduced initiatives and schemes to support retention of staff. This included a review of the flexible working policy and a retire and return scheme, encouraging people to return to the trust after retiring from their post. Last financial year (2018/19) 50 individuals chose to ‘retire and return’. The trust recognised their workforce age posed a risk as a high percentage were reaching retirement age. A retention plan was in draft format at the time of the inspection and was waiting for final authorisation. The trust introduced a new starter call back programme. This meant that new staff received a call from HR services after 3 months, then at nine and 12 months. The aim was to discuss any issues and anxieties that may impact a staff members decision to remain in their role. This was having a positive impact on the number of leavers in the 12 months the programme was available. Eighty percent of feedback received from new staff, three months into their role, was positive.

The trust established links with local universities to provide placements for those in nurse training and feedback received on the quality of placements provided was positive.

The compliance for mandatory and statutory training courses at 31 March 2019 was 90%. Of the training courses listed two failed to achieve the trust target and of those, none scored below 75%.

The trust set a target of 85% for completion of mandatory and statutory training modules including: Fire Safety 3 years, Fit for work, Induction, Information Governance, and Mental Health Act. The trust set a target of 90% for completion of mandatory and statutory training modules including: Safeguarding Adults (Levels 1, 2, & 3), Fire Safety 2 years, and Safeguarding Children (Level 3 & 4).

Training completion is reported as at end of reporting period.

The training compliance reported for this provider during this inspection was higher than the 87% reported in the previous year.

Key:

Below CQC 75%	**Met trust target** ✓	**Not met trust target** ✗	**Higher** ↑	**No change** →	**Lower** ↓

Training Module	**Number of eligible staff**	**Number of staff trained**	**YTD Compliance (%)**	**Trust Target Met**	**Compliance change when compared to previous year**
Safeguarding Adults (Level 1)	1459	1384	95%	✓	↑
Induction	5014	4787	95%	✓	↑
Safeguarding Adults (Level 2)	3398	3203	94%	✓	↑
Safeguarding Children (Level 4)	15	14	93%	✓	↓
Safeguarding Children (Level 3)	839	769	92%	✓	↑
Mental Health Act	684	621	91%	✓	↓
Information Governance	4904	4359	89%	✓	↑
Fit for work	4904	4358	89%	✓	↑
Fire Safety 3 years	7458	6504	87%	✓	↑
Safeguarding Adults (Level 3)	1773	1549	87%	✗	↓
Fire Safety 2 years	1166	992	85%	✗	↓
Total	**31614**	**28540**	**90%**	✓	↑

Staff continued to report difficulties with accessing accurate training data. Local team data did not always match that provided by the trust.

The trust's target rate for appraisal compliance is 90%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for non-medical staff was 55%. This year so far, the overall appraisal rate was 82% (as at 28 February 2019). Three of the 20 teams (15%) achieved the trust's appraisal target. The services with the lowest compliance were CHS – Sexual Health with 36%, CHS – End of life care with 60%, and MH – Eating disorder with 69%.

The rate of appraisal compliance for non-medical staff reported during this inspection is the same as the 82% reported at the last inspection.

NOTE: Comparisons to 'last inspection' data often do not refer to a whole year of data.

Core Service	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 28 February 2019)	% appraisals (previous year 1 April 2017 to 31 March 2018)
MH - Wards for people with learning disabilities or autism	17	16	94%	29%
Other	11	10	91%	50%
CHS - Children, Young People and Families	200	180	90%	52%
MH - Other Specialist Services	119	106	89%	47%
MH - Community mental health services for people with a learning disability or autism	60	53	88%	39%
MH - Community-based mental health services for older people	221	193	87%	46%
MH - substance misuse	47	40	85%	55%
MH - Long stay/rehabilitation mental health wards for working age adults	20	17	85%	55%
Provider Wide	973	795	82%	71%
MH - Child and adolescent mental health wards	67	55	82%	59%
CHS - Adults Community	673	548	81%	53%
MH - Community-based mental health services for adults of working age	524	425	81%	45%
MH - Wards for older people with mental health problems	193	155	80%	52%
MH - Secure wards/Forensic inpatient	186	148	80%	56%
MH - Mental health crisis services and health-based places of safety	103	81	79%	47%
MH - Acute wards for adults of working age and psychiatric intensive care units	244	189	77%	47%
CHS - Community Inpatients	183	139	76%	63%
MH - Eating disorder	16	11	69%	64%
CHS - End of Life Care	5	3	60%	67%
CHS - Sexual Health	22	8	36%	75%
Total	**3884**	**3172**	**82%**	**55%**

The trust did not provide data regarding appraisal compliance for permanent medical staff.

The trust's target of clinical supervision for non-medical staff is 90% of the sessions required. Between 1 March 2018 and 28 February 2019, the average rate across all 17 core services in this service was 97%.

The rate of clinical supervision reported during this inspection was higher than the 86% reported at the last inspection.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

Core service	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Other	112	112	100%
MH - Wards for people with learning disabilities or autism	205	205	100%
CHS - Adults Community	49	49	100%
MH - Community mental health services for people with a learning disability or autism	706	702	99%
MH - Secure wards/Forensic inpatient	1903	1891	99%
MH - Wards for older people with mental health problems	1829	1811	99%
MH - Community-based mental health services for older people	2190	2161	99%
MH - substance misuse	430	422	98%
MH - Child and adolescent mental health wards	648	630	97%
MH - Mental health crisis services and health-based places of safety	1182	1146	97%
MH - Acute wards for adults of working age and psychiatric intensive care units	2575	2494	97%
MH - Eating Disorders	173	166	96%
MH - Community-based mental health services for adults of working age	5195	4949	95%
MH - Long stay/rehabilitation mental health wards for working age adults	152	144	95%
MH - Other Specialist Services	1300	1223	94%
Provider wide	617	579	94%
Trustwide	536	469	88%
Trust Total	**19802**	**19153**	**97%**

The trust did not provide data regarding clinical supervision compliance for permanent medical staff.

The trust provided supervision and appraisal templates that incorporated the values of the organisation. The trust expected all staff to receive formal supervision every eight weeks. For administrative and corporate staff, it was expected every three months. Managers recorded supervision using a tracker. Directors accessed the tracker to monitor performance against the trust target of 90%. Overall supervision compliance was above target at 92%. Appraisal compliance featured as a 'hotspot' for the directors' key performance monitoring scorecard, falling below target at 86%.

Governance

The trust had a clear and robust governance structure to oversee performance, quality and risk. Eight governance committees reported directly to the board, with several sub-committees reporting below. Governance spanned the entire organisation, with local managers discussing issues at service level in team meetings. We saw a variety of minutes and papers from meetings during the inspection which demonstrated staff reviewed risk, quality and performance.

The trust established six key committees to oversee the performance of the organisation. These were: Audit, Quality, Strategy & Planning, Finance & Performance, Remuneration and Nomination and Charitable Funds. Non executive directors chaired the committees and reported assurance to the board by way of reports of discussions risk and actions. Sub committees reported to the six standing committees and covered a range of functions. Executive directors chaired sub committees, or this was completed by senior leaders. Sub committees' responsibilities included acting on any risks identified by the standing committees. The finance and performance Committee was responsible for overseeing the governance arrangements in place in the trust.

The governance structures of the organisation were in place from the point of merger and the trust reviewed their efficacy on an annual basis, the last review being in quarter three of 2018.

Local managers knew the reporting structure for sharing information and escalating concerns and could describe the ward to board governance structure.

The trust responded to the issues raised in the last CQC inspection relating to the monitoring and oversight of substance misuse services and end of life care. The trust employed two substantive consultants for substance misuse services, a consultant and a clinical lead for end of life care to improve the leadership arrangements. The trust introduced the same governance systems and processes in those teams that were in place in other areas of the organisation.

The trust undertook an internal well led assessment in March 2019, to assess compliance with CQC and NHSI well led key lines of enquiry. The board of directors completed all NHSI self certification requirements in May 2019.

There was a Mental Health Act (MHA) and safeguarding committee that were responsible for oversight of the monitoring of the Mental Health Act. The MHA and Safeguarding committee provided a report to the board of directors. The senior MHA manager developed trust policies relating to the MHA. They were sent to the relevant governance committee for sign-off. The trust had 35 Associate Hospital Managers who met three times each year to receive update training and discuss Act implementation within the trust.

In May 2019, the trust was categorised as 'provider offered targeted support' by the NHS Improvement Single Oversight Framework. This means there are concerns in relation to one or more of the themes. NHSI identified targeted support that the provider could access to address these concerns, but which they were not obliged to take up.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

	In Days	**Current Performance**
What is your internal target for responding to* complaints?	3 days	100%

	In Days	Current Performance
What is your target for completing a complaint?	Agreed timescale with complainant	88.1%
If you have a slightly longer target for complex complaints, please indicate what that is here	N/A	N/A

* Responding to defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken

	Total	Date range
Number of complaints resolved without formal process*** in the last 12 months	72	1 April 2018 to 31 March 2019
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	2	1 April 2018 to 31 March 2019

**Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example, PALS resolved or via mediation/meetings/other actions

This trust received 1252 compliments during the last 12 months from 1 April 2018 to 31 March 2019. This was higher than the 661 reported at the last inspection. CHS – Adults community had the highest number of compliments with 21%, followed by MH – Acute wards for adults of working age and psychiatric intensive carer units with 19% and MH – Wards for older people with mental health problems with 12%.

The trust had a robust approach to investigating and responding to complaints. Leaders set specific timeframes for acknowledgements and final responses to be sent. The trust had a dedicated team working to address and investigate complaints. The trust expected an initial acknowledgement to be sent within three days, an investigator to be assigned within five working days and investigation to take place within 30 days for mental health services and 25 days for community health services. The trust allocated ten days to assure the quality of investigations and responses. If managers did not meet internal deadlines it was expected they would contact the complainant and agree an extension, providing a rationale and explanation for the delay.

Of the ten recent complaints reviewed all followed the above process and responses contained apologies when something had gone wrong. Investigators identified lessons and made recommendations based on the outcome of complaints and created action plans for the relevant service.

The learning oversight committee collated and shared lessons from complaints with the wider organisation. We identified some problems with the sharing and embedding of lessons which are described later in the report.

Essex Partnership University NHS Foundation Trust has submitted details of one external review commenced or published in the last 12 months (1 April 2018 to 31 March 2019). This included: police investigation into the former NEPT deaths between 2000-2016.

The outcome was that no further action would be taken against the trust as a body or any executive member within the trust during the period above. The investigation was passed to the Health & Safety Executive and their investigation is continuing.

In response to a request for the details of the outcomes of the review, the trust stated that it failed to fulfil its responsibility to the complainant as a carer. He was not offered a carer's assessment. When he was it was inadequate. The trust has agreed with Essex County Council (ECC) an improvement plan based on lessons learnt, which is discussed at the monthly Finance Performance and Quality meetings as a standing agenda item. EPUT has reviewed its Carers Framework/strategy. Training has been reviewed to ensure it emphasises our duties and responsibilities within the Care Act, including carers assessments. 2) The complainants alleged that the trust made unsubstantiated allegations; that parents minimised daughter's health needs, undermined the treatment plan, allegation of domestic abuse, trust failed to deal with allegation made by daughter against a carer. The trust to review its child protection procedures and whether safeguarding referrals are to be approved by the treating Consultant. The Trust will submit reports to the Local Authority for child protection conferences where it has made a safeguarding referral. Devise a letter explaining the limits of confidentiality for those taking part in family therapy sessions and circumstances where information may be disclosed. Revise procedures to ensure allegations about carers are referred directly to LADO. Produce a leaflet for young people on how their complaints will be dealt with. Consider issuing advise to staff about pregnancy tests and when consent from parents may be required. Whether further training from Safeguarding advisors to ensure that reports for conferences reflect the information available. 3) The PHSO found a failing in respect of trust's letter which incorrectly stated that the patient had been discharged from hospital rather than discharged from section. The trust described what it had done to ensure that lessons had been learnt from the failing. New letter template had been designed.

Following prevention of future death reports that have been issued by the coroner, the trust are now taking forward the following actions:

- Trust policies to be brought before the relevant committee and governance group for review and sign off prior to implementation and for any lessons learned to be cascaded to operational groups.
- For young people and their families on poplar ward to be consulted on their bedroom environments
- The protocol for patient’s use of mobile phones on ward was reviewed by the ward team and service clinical governance and quality group
- The PFD report and RCA report relating to the investigation were shared with the lead provider for the veteran’s service and NHS England.
- For joint working between EPUT and the veteran’s partner organisations to be strengthened.
- Staff now have access to the Health Information Exchange to screen all new referrals and for any referrals known to EPUT, immediate contact with the lead professional will be made.
- Staff were reminded that they should ask patients for their consent to share information and involve their families/cares at the start of the patients’ treatment episode. If patients give their consent, then a timescale for contact with family/carer should be agreed between the clinician and the patient and this should be recorded on Mobius.
- Staff were reminded that at the start of a treatment episode staff should ask patients if they have a carer and record the carer’s details on Mobius.

The trust commissioned a 'Developmental review of governance against the well led framework' and received the final report in July 2019. The review was undertaken by an independent provider of audit and assurance services. The report made a total of 11 recommendations.

Management of risk, issues and performance

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts to make improvements. This included 'Five Key Lesson' briefings communicated to staff electronically and via poster format. However, we queried the effectiveness of this system following review of six serious incidents as there were similar themes identified in incidents such as communication with external organisations, record keeping and the administration of emergency treatment. Staff described 'the same issues coming up' which questions how embedded learning and the changing of practise is in the organisation.

A dedicated serious incident team managed the investigation process following a serious incident being reported. At the time of the inspection there were challenges in the team due to ongoing staff absence. The trust addressed this with the introduction of short term support from a deputy director post. The trust also recruited a service manager to the team to increase the oversight of serious incident action plans. At the time of inspection there were 23 serious incidents open to the team. Staff reported approximately eight serious incidents a month that required action by the serious incident team. There were 12 serious incident action plans outstanding, meaning that the recommendations and actions had not been signed off as completed within the services they related to. One action plan dated to December 2018 which was not identified in a timely way by the team.

From March 2019 to August 2019 staff recorded 183 incidents involving prone restraint. Eighty five percent (156) of those incidents occurred to administer IM medication. We were not assured that the trust worked to reduce prone restraint at pace. Many leaders discussed the use of prone being attributed to the administration of intramuscular injection. Staff continued to use prone restraint to administer intra-muscular (IM) medication to patients, despite being policy supporting staff to inject in other sites. Leaders described staff culture as a challenge in this area due to many years of this practise. The trust described quality issues with the raw data relating to restraint and stated it did not describe the level of restraint or if the patient resisted. The trust had a quality priority to review data and recording methods, however this issue contributed to our concerns regarding data quality, which is reflected later in this report.

The risk management and assurance framework set out arrangements to monitor and manage risk. The trust reviewed this framework in July 2019. The board assurance framework identified 16 potential risks to the trust's strategic objectives as of July 2019. The most significant risks related to: potential health and safety executive prosecution, fire safety, bed capacity, skills and capacity, cost improvement programmes, environmental ligature risks, capacity to support the transformation programme and embracing innovation. To address potential risk, the trust developed action plans which they assigned to standing committees to manage and monitor. The board reviewed action plans on a quarterly basis. The board considered the board assurance framework at each board meeting.

The trust had a corporate risk register and a directorate risk register. The corporate risk register identified 22 risks and the board reviewed this every three months. Directorate risk registers captured service specific risks.

The finance and performance committee took responsibility for monitoring national and local indicators along with contractual targets. The committee submitted reports relating to 'hot spots' and under performance through the board of directors scorecard.

The trust identified risk relating to capacity of inpatient mental health services. This was particularly reflected in the core service report for acute mental health wards, where wards reported bed capacity of over 100%. The trust reviewed patient flow and capacity during twice daily SitREP calls and allocated an Operational Pressures Escalation Level (OPEL) status to determine whether to act to escalate internally and to wider mental health system partners. The trust had access to an internal dashboard that reflected real time live data relating to occupancy. The trust achieved significant progress in reducing out of area placements, ensuring more local people received treatment in their home area. At the time of the well led inspection four people received care and treatment outside of Essex.

In recent months the trust identified an issue with staff members sleeping whilst on shift, which they recognised as a risk to patient safety. Alongside their programme of unannounced night visits (issues being during night shift teams). In the four months prior to inspection incidents of this nature were in double figures. The trust took a learning approach to this issue and HR business partners worked with frontline staff to understand the issues contributing to incidents. The trust identified most incidents related to agency staff and worked with preferred agencies for assurance that staff were fit to work. A standardised procedure was in place to address staff that slept on duty. The trust had plans to introduce full health rostering by the end of the financial year which prevented individuals being able to work continuous shifts. The trust had plans to implement technology to support with this issue.

The trust had a programme of internal audits to review and monitor aspects of their services, linked to the risks identified on the board assurance framework. Throughout the 2018/19 financial year the trust undertook nine internal audits relating to data quality, general data protection regulation, seclusion and segregation, serious incidents, policy implementation, violence and aggression, cyber security, fire safety and financial systems. Cyber security and fire safety resulted in an outcome of 'limited assurance' for the effectiveness of controls in place. The trust planned to undertake ten audits across 2019/20. In local teams 42 clinical audits took place in the last financial year, with 38 planned for 2019/20. The trust participated in 14 national clinical audits.

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	Historical data		**Projections**	
Financial Metrics	Previous financial year (2 years ago)	Last financial year (1 April 2017 to 31 March 2018)	This financial year (1 April 2018 to 31 March 2019)	Next financial year (1 April 2019 to 31 March 2020)
Actual income	Not available	£352,257.00	£311,873.00	£304,745.00
Actual surplus (deficit)	Not available	£199,980.00	£2,731.00	-£2,379.00
Actual costs/expenditure - full	Not available	£152,492.00	£309,158.00	£307,474.00
Planned budget or (deficit)	Not available	-£6,635.00	-£2,720.00	-£2,379.00

The trust monitored financial performance through the finance and performance committee who met monthly. The board received assurance via the report provided by the committee.

For 2019/20 the trust control total, excluding the provider sustainability fund, is £867000 deficit. This required improvement on the previous year's plan of £5,114. The trust submitted a plan to overachieve the control total and deliver a deficit of £367000, which includes an efficiency requirement £11,661. At month 4 the Trust was on plan cumulatively and expecting to remain on plan for the remainder of the year. The capital programme for 2019/20 year was revised in July 2019 in response to a national over-commitment of capital. The current plan was £9,398 and included IT investments of £2,919 and patient safety and environment improvements of £5,889.

The trust has submitted details of six serious case reviews commenced or published in the last 12 months.

Reference Number	Recommendations	Actions Taken	Outstanding Actions
STW formally GSB	The targeting of Sexual Abuse and raising professional awareness of early identification will be reviewed	Training will include the learning from a Serious Case Review involving sexual abuse as a framework for a case study	None
STW formally GSB	The voice of the children within the family is to be effectively represented within Children Community Services care plans and records	The lived experience of children and family members into their assessments and care planning for families.	LSCB reviewing available assessment tools for use across partnership
STW formally GSB	Core Groups and the complexity and challenges involved in the work within them is reviewed within	Training to incorporate a case study where the complexity and challenge within core groups is included	None
ER	Health visiting should identify barriers to working effectively with fathers when safeguarding children	Barriers are less availability and accessibility, Revised appointment letters attended training and devised fathers pack	None
ER	Health visiting services review the tools to assist identifying discrepant information	National Assessment Framework tool in place	None
ER	Barriers to providing quality supervision for health visitors should be understood and addressed	Standard Operation Procedure defines expectations and tool in place for supervisors	None

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. 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. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents.

Between 1 March 2018 to 28 February 2019 the trust reported 115 serious incidents. The most common type of incident was 'Apparent/actual/suspected self-inflicted harm meeting SI criteria' with 85. Fifty-two of the incidents occurred in 'MH – Community-based mental health services for adults of working age.'

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with 115 reported. There were two incidents that were reported on SIRI but not on STEIS (one in CHS – Community Inpatients and one in MH – Community-based mental health services for working age adults). There were also two incidents that were reported on STEIS but not on SIRI (one in MH – Acute wards for adults of working age and psychiatric intensive care units and one in MH – Mental health crisis services and health-based places of safety). The trust clarified that one of these incidents did not meet serious incident reporting requirement and was therefore investigated as a critical incident.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. The trust reported three never events during this reporting period, all were within MH – Acute wards for adults of working age and psychiatric intensive care units.

The number of serious incidents reported during this inspection was lower than the 125 reported at the last inspection.

Type of incident reported	**CHS – Adults Community**	**CHS – Community Inpatients**	**MH – Acute wards for adults of working age and psychiatric intensive care units**	**MH – Child and adolescent mental health wards**	**MH – Community-based mental health services for adults of working age**	**MH – Community-based mental health services for older people**	**MH – Mental health crisis service and health-based places of safety**	**MH – Other Specialist Services**	**MH – Secure wards/Forensic inpatient**	**MH – Substance misuse**	**MH – Wards for older people with mental health problems**	**Total**
Apparent/actual/suspected self-inflicted harm meeting SI criteria			9		51	4	11	7	1	1	1	**85**
Slips/trips/falls meeting SI criteria		5	3								5	**13**
Unauthorised absence meeting SI criteria				2					8			**10**
Adverse media coverage or public concern about the organisation or the wider NHS						1	1					**2**
Pressure ulcer meeting SI criteria	1										1	**2**
Other											1	**1**
Surgical/invasive procedure incident meeting SI criteria	1											**1**
Apparent/actual/suspected homicide meeting SI criteria					1							**1**
Total	**2**	**5**	**12**	**2**	**52**	**5**	**12**	**7**	**9**	**1**	**8**	**115**

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. The average time taken for the trust to report incidents to NRLS was 44 days compared to 23 for all trusts (April 2018 to September 2018).

The highest reporting categories of incidents reported to the NRLS for this trust for the period 1 March 2018 to 28 February 2019 were Self-harming behaviour, Treatment and procedure, and Disruptive aggressive behaviour. These three categories accounted for 7358 of the 15146 incidents reported. Self-harming behaviour accounted for 43 of the 90 deaths reported.

Ninety-five percent of the total incidents reported were classed as no harm (73%) or low harm (22%).

Incident type	**No harm**	**Low harm**	**Moderate**	**Severe**	**Death**	**Total**
Self-harming behaviour	1758	841	37	7	43	**2686**
Treatment, procedure	2508	117	7			**2632**
Disruptive, aggressive behaviour (includes patient-to-patient)	1746	281	11	1	1	**2040**
Patient accident	1262	529	35	8	1	**1835**
Implementation of care and ongoing monitoring / review	152	1007	507	1	1	**1668**
Access, admission, transfer, discharge (including missing patient)	1329	154	33	1	4	**1521**
Medication	723	136	5			**864**
Other	340	163	23	1	38	**565**
Consent, communication, confidentiality	415	23	3			**441**
Infrastructure (including staffing, facilities, environment)	280	36	2		2	**320**
Documentation (including electronic & paper records, identification and drug charts)	280	14				**294**
Patient abuse (by staff / third party)	81	44	2	1		**128**
Medical device / equipment	51	6				**57**
Infection Control Incident	32	14	2			**48**
Clinical assessment (including diagnosis, scans, tests, assessments)	37	9	1			**47**
Total	**10994**	**3374**	**668**	**20**	**90**	**15146**

Organisations that report more incidents usually have a better and more effective safety culture than trusts that report fewer incidents. A trust performing well would report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death).

Essex Partnership University NHS Foundation Trust reported more incidents from 1 March 2018 to 28 February 2019 compared with the previous 12 months. There were a higher number of incidents resulting in death, severe harm, moderate harm, low harm and no harm.

Level of harm	**1 March 2017 – 28 February 2018 (previous year)**	**1 March 2018 – 28 February 2019 (most recent)**
No harm	7032	10994
Low	2519	3374
Moderate	444	668
Severe	10	20
Death	75	90
Total incidents	**10080**	**15146**

Between October 2017 and September 2018, one person for every 1,000 aged 0-74 in contact with community mental health services died due to self-harm or undetermined injury, which was much worse than the national average of zero.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing future deaths.

In the last two years, there have been eight 'prevention of future death' reports sent to Essex Partnership University NHS Foundation Trust. Details of which can be found below.

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

Date of report: 16 June 2017

A person killed themselves whilst the balance of mind was disturbed.

The Coroner's concerns were:

The state failed to protect the person's life evidenced by the following. Risk of suicide was not properly and adequately assessed and reviewed by transfer of verbal and written information, risk assessment, and quality of observation.

Adequate and appropriate precautions were not taken to manage risk of suicide. For example, the search policy at the time of the incident, quality of observation, current policies at the time and previous recommendations of risk and environmental factors were not implemented adequately.

The trust's search policy was scrutinised in the course of the inquest and, even an updated version was found to be unclear.

The following learning / recommendations were given:

The court heard very helpful expert evidence from Dr Isaac, a consultant psychiatrist at the Maudsley Hospital during which he referred to his own trust's policy. He explained that the approach should be that the presumption is that all items are removed during a search unless it can be shown positively that they might not cause harm to the patient – a radically different philosophy from that underpinning the Linden Centre policy. A fresh, careful look needs to be taken at the current EPUT search policy.

Date of report: 19 September 2017 (ENQ1-4499206746)

A person was hit by a train.

A formal response to a Regulation 28 report was provided from the trust, however we are unable to locate the original Regulation 28 report.

In the formal response to the Regulation 28: Report to prevent future deaths, the trust stated that they had been in contact with the patient's parents to discuss how they feel having an individual who is ultimately responsible for the complete care of the patient from initial treatment, admission, and follow-up, may contribute to care.

MH – Child and adolescent mental health wards

Date of report: 9 August 2018

A person hung themselves from a light fitting in their bathroom using shoe laces.

The Coroner's concerns were:

The evidence revealed that some time previously the patients shoe laces had been returned to them. The court accepts that this sort of decision is a clinical decision but wants to be assured that there are rigorous trust policies surrounding such decisions.

Comments were recorded regarding the environment in which the patient lived in.

The following learning / recommendations were given:

Action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

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

Date of report: 20 April 2017

A person committed suicide by jumping in front of a tube train.

The coroner's concerns were:

It was apparent from the evidence that there were five principal failures by the trust in relation to the treatment and care provided to the Deceased. These were:

1. The Deceased was first assessed by the Trust's Early Intervention and Assertive Psychosis Team who recognised that they were in need of psychiatric treatment and care by another team but, despite referring on to other psychiatric teams within the trust, made no effective transfer of care before discharging back to the General Practitioner and closing the case. A significant number of clinical and managerial staff were involved in this process and none of them prevented the deceased's premature discharge.

2. Prior to the Deceased's discharge no sufficient assessment was made of risk of suicide. Despite at least two clinical staff being involved, there was insufficient evidence gathering, including from the deceased's family, and a wholly inadequate assessment was made despite the use of the Trust's electronic assessment tool (which was not properly completed). Further, no plan was put in place to manage the deceased's recognised risk of suicide.

3. Prior to the Deceased's discharge no care plan was put in place and no single person had responsibility for ensuring their care was properly assessed, co-ordinated and delivered prior to discharge.

4. The Deceased was discharged back to the care of the General Practitioner with a recommendation for the prescription of psychiatric medication without having been seen or assessed by the psychiatrist who made the recommendation and with no means of monitoring its subsequent effectiveness.

5. Despite the matters set out in (1) to (4), the General Practitioner's request, made on 15 March 2016, for an urgent assessment was not granted and the Trust's Access and Assessment Team provided an appointment for a date five weeks later on 20 April 2016.

I was told by witnesses from the trust (and in submissions made on behalf of the trust) that the trust had adequate relevant policies and procedures in place at the time and that the failings set out above occurred because all the staff involved failed to follow those policies and procedures. It was said that there has been no subsequent amendment of the policies and procedures but, in summary, that staff have been reminded of them and what ought to happen (by email) and there is now an increased level of monitoring of compliance.

Whilst the staff directly involved, who gave oral evidence at the inquest, told me that they now understand that the above failings ought not to have happened and would not occur now, I remain concerned that one or more of the above failings could recur in the future. Although the Trust has taken steps to inform current staff of what went wrong in the Deceased's case, it has not taken steps to ensure that the above failings could not occur again (whether by amendment or clarification of its policies and/or procedures or sufficient training of staff or otherwise).

Most particularly, the evidence provided to me did not satisfy me that the trust's policies and procedures, and the training given upon them, now ensure that every patient who is referred to the trust will be assessed and treated in a timely manner, even if transfer between teams is necessary. Nor did it satisfy me that every patient's risk of suicide is now properly assessed and managed so as to ensure the risk is minimised.

In all the circumstances I consider that there is an ongoing risk that any one or more of the above failings could recur. If that risk is permitted to continue, it could have an adverse impact on the assessment, treatment and care of current and future patients and upon the protection of their lives.

The following learning / recommendations were given:

In my opinion action should be taken to prevent future deaths by addressing the concerns set out above and I believe you have the power to take such action.

MH – Other specialist services

Date of report: 6 August 2018

A person committed suicide by hanging with a rope.

The coroner's concerns were:

1. There is no joined up working between Veterans seeking access to NHS England and NHS Essex Partnership University Trust since the change to the Veterans Service in April 2017.

2. Where there is a lack of engagement by Veterans with CMHT, the procedures currently in place do not adequately ensure service users are identified and supported by NHS England and Community Mental Health NHS Essex Partnership University Trust.

3. There is inconsistent or non-existent record keeping through the REMEDY computer system operating within NHS England and NHS Essex Partnership Trust, by clinicians to ensure risk is managed and service users' needs met.

The following learning / recommendations were given:

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

Prisons

Date of report: 15 February 2018

A person died after collapsing in their prison cell. The deceased was using drugs including prescription medication and morphine patches.

The coroner's concerns were:

Healthcare staff seemed unclear as to how to fill in an Intelligence Report.

The following learning / recommendations were given:

There needs to be better communication between Healthcare staff and disciplinary staff as to the purpose of an Intelligence Report. Some criteria need to be developed and a system in place. An appropriate audit system needs to be in place.

The processes and systems for reducing access to illegal substances need to be improved and tightened up

The processes for referrals by both prisoners and staff to psychosocial services needs to be tightened up and improved.

The standard and accuracy of record keeping by both disciplinary and Healthcare staff needs to be improved.

Date of report: 20 December 2017

A person died as a result of hanging in a prison cell.

The coroner's concerns were:

There is no form/template to deal with the situation of a prisoner who needs to be referred to the mental health service. Reliance upon the transfer of this vital information to Healthcare by means of a telephone conversation could be unreliable.

The following learning / recommendations were given:

A robust, simple documentary system is required for the communication of such important information, namely that a prisoner needs to be referred to mental health services for an assessment to be carried out by mental health services. This would be distinct from the TAG system which caters for a brief assessment to be relayed across.

Other

Date of report: 14 August 2017

A person died after jumping from a carpark.

The coroner's concerns were:

1. Call handling and record-keeping at The Lakes
2. Call handling and record-keeping at the police custody suite
3. The sufficiency of guidance and training to police call handlers as to whether an individual is, objectively, at an immediate risk
4. The sufficiency and guidance to mental health assessors as to the circumstances n which the input of family members should be sought
5. The sufficiency of information sharing and coordination between the police, hospital trust and probation service.
6. Training/guidance for mental health clinicians in relation to persons who are subject to a warrant. The evidence pointed to a lack of understanding as to the effect of a warrant upon the clinician's ability to assess and treat.

The trust had a mortality review process in place. The board reviewed mortality reports on a quarterly basis. During the financial year 2018/19 leaders reviewed 236 deaths of patients under the care of the trust, under the mortality process. The process identified 116 required a grade one review, 18 required grade two and 69 required grade four. Leaders had not reviewed 43. Grade one review required review by the deceased patient review group. The group reviewed serious incidents to ensure the appropriate action was taken and lessons identified and shared. The group also initiated case note reviews of incidents that do not meet serious incident criteria as a further measure to identify learning. Grade two review was a structured review and grade four required root cause analysis investigation under the serious incident policy.

The trust undertook thematic reviews in their organisation and presented findings to the mortality review steering committee, including identification of learning and how to take it forward.

In May 2019 the national learning and reporting system ranked the trust as the third highest in respect of rates of incident reporting in the cluster group. The trust identified this to a positive reporting culture in their organisation. In the financial year of 2018/19 staff reported 23, 147 incidents. Staff report incidents at service level using an electronic system. All incidents receive triage by the risk team to ensure correct categorisation and grading. Any incident graded as moderate or above, received review by the moderate harm group. All incidents required sign off by managers and included identification of learning. All incidents meeting the threshold for serious incidents received internal investigation. In 2018/19 staff reported 106 serious incidents, 68 of which the trust classified as unexpected deaths. From April 2018 – June 2019 staff reported 20 serious incidents of which the trust classified ten as unexpected deaths. The trust produced timely investigation reports. Of 14 reports since April 2019 none beached the 60 day target, with two having an extension agreed by the local clinical commissioning groups.

The trust had a policy for major incidents and a continuity plan in place for emergencies. For example, to deal with adverse weather, a flu outbreak, or disruption to business continuity.

Where cost improvements were taking place, there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. Leaders challenged business development proposals if the impact on the trust was less than

positive. Where cost improvements were taking place, the focus was on not compromising patient care.

Information Management

The trust used six electronic patient records across the organisation. In order to support staff the trust provided a health information exchange (HIE) to provide clinical information regarding patient care. This supported staff to assess and review patients who may transfer to different services across the organisation. Staff in services reported difficulty accessing the HIE and reported issues with the quality of information available. We identified this at this inspection and at the previous focused inspection in April 2019.

Following the April 2019 inspection, the trust increased access to the HIE by 1200 staff and launched a programme increasing awareness and offering training. Mental health staff could request access to both electronic patient record systems.

The trust had a plan in place to review electronic patients record systems outlined in a five year plan (starting from merger). The trust planned to review the systems in year 3 (2020/21) to consider options for streamlining.

The remained challenges for the trust relating to data quality. Staff described inconsistency in training data accuracy and data produced for performance reports. Senior leaders described data as incorrect and requiring exception reporting to accurately reflect performance.

The team who had oversight of information risk and rights had processes in place to identify and respond to risk in this area. There was information governance training in place to help staff. We saw a consistent flow of information escalated to board and shared with all staff via the intranet. Systems were in place including confidentiality of patient records. The trust learned from data security breaches and followed a robust process for investigating such incidents. Staff reported 291 information and/or security breaches in 2018/19. None met criteria for reporting to the information commissioner's office. The trust is on target to achieve the gold standard cyber essential plus accreditation by January 2021. This followed the strengthening of cyber security arrangements following a cyber attack in 2017.

The information governance committee oversaw all items relating to information management.

When a patient is detained under the Mental Health Act (MHA) in hospital, the provider is required to submit a record to the Mental Health Services Data Set each month until the detention ends. Between December 2017 and November 2018, the trust only provided end dates for 52.8% of Mental Health Act episodes for detentions, which had ended. This gives an incomplete picture about the provider's use of the MHA and indicates there may be problems with recording or sharing data externally.

Engagement

The trust identified key priorities for engagement in its engagement strategy. Key areas of focus included:

- Patient experience
- Membership
- Communications

- Workforce
- Organisational development carers

The trust prioritised engagement with service users, carers and families, engagement with the workforce, engagement with stakeholders and creating a culture of openness.

The trust worked in a complex system. It worked in partnership with three sustainability and transformation partnerships (STPs) and three local authorities. The trust had increased their visibility and engagement with wider partners since the last inspection. This included active participation in all STPs. The chief executive was the first chief executive lead for the new care models project board.

External stakeholders provided positive feedback in the lead up to this inspection.

The trust had a variety of ways to collect feedback from stakeholders. Leaders combined the friends and family test into a satisfaction survey named 'How did we do?'. This asked service users and families to rate the trust out of ten in different areas. Across 10,271 responses combined people rated the trust 9.6 for feeling they treated them with dignity and respect and that staff treated them kindly and with care. The lowest score with 7.4 related to food quality and received 643 response. Leaders reported outcomes of 'How did we do?' to services on a monthly basis.

The trust continued to hold 'your voice' meetings in public locations. Governors chaired the meetings and provided an opportunity for the public to provide feedback on services. Meetings took place twice a year in five different localities.

Forensic mental health services took the lead on co-production. This meant they involved patients in many elements of the service including recruitment, training and working to improve services.

The trust had access to 250 volunteers involved in taking forward lived experience work. Patient involvement teams were in year two of a two year strategy, with plans to develop a new three year strategy for 2020-2023. The strategy would focus on increasing co-production across all areas of the organisation.

The trust provided a 'listening to you' hub on the intranet. This allowed staff to communicate any issues and to share good practise with colleagues.

The results of the national community mental health patient survey 2018 were improved on those in previous years, but still identify room for improvement. In 27 out of 28 domains covered by the survey the Trust was rated as "about the same" as other providers.

Learning, continuous improvement and innovation

Seven trust services received external accreditation for their work. This included Accreditation for Inpatient Mental Health Services (AIMS), Quality Network for Inpatient CAMHS (QNIC), The Electroconvulsive Therapy Accreditation Service and Memory Services National Accreditation Programme (MSNAP).

The trust committed to research and innovation. A head of research and innovation was in post and approximately 30 staff worked in the research department, within the medical structure. The trust was involved in 22 National Institute of Health Research (NIHR) non-commercial studies, 12 NIHR commercial studies and 9 non NIHR non-commercial studies, as of June 2019.

Quality improvement (QI) featured as a standard agenda item in meetings and staff discussed this in multidisciplinary meetings.

The trust introduced a quality academy in 2017 that met regularly to look at ways to develop and share best practice. The quality academy had oversight of all projects and audits to pull together themes, lessons and ideas. Six hundred and seventy staff received quality improvement training through the training academy. Four senior leaders participated in the NHSI QSIR (Quality Service Improvement and Redesign) College programme which supported quality and efficiency improvement capability within organisations or across systems, to enable the building of a sustainable local skills base.

The trust supported staff to take on a role of quality champion. Bronze champions received training and committed to completing one QI project in their area of work. Silver champions additionally cascaded the QI approach and gold also provide coaching and mentoring for those aspiring to become a champion. Thirty staff received gold level QI champion.

The trust quality hub was being rolled out to all divisions to consider service specific issues and QI priorities. There was a trust wide QI forum in place. within secure mental health services, these are now being rolled out to all divisions. At board meetings staff presented quality improvement projects to senior leaders.

Community health services

Community health services for end of life care

Facts and data about this service

Information about the sites and teams, which offer community health services for end of life care at this trust, is shown below:

NOTE: There were issues with the core service allocation of services across CHS – End of life care and CHS – Adults community. In the sites list integrated care teams were classified as both types of core service. The trust explained that the end of life service is integrated into the CHS integrated community team provision. As much of the integrated team's work is unlikely to relate to CHS – End of life care, it was decided that this appendix will focus solely on the palliative care teams highlighted in yellow below.

Location / site name	Team/ward/satellite name	Services provided	Address (if applicable)
Trust Head Office	Palliative Care Team	A community service for people with long term conditions where there is limited expectation of improvement in the condition and may lead to an end of life diagnosis. Register Team within the service identifies people coming towards	Rochford Hospital, Union Lane, Rochford, Essex

Location / site name	Team/ward/satellite name	Services provided	Address (if applicable)
		the end of their life to ensure specialist care and support is in place.	
Trust Head Office	Integrated Team (Epping)	Service containing OT, district nursing, community matrons, support workers etc. for patients in their own homes and clinics focusing on recovery and increasing independence	Epping Forest Unit St. Margaret's Community Hospital The Plain Epping Essex
Trust Head Office	Integrated Team (Harlow)	Service containing OT, district nursing, community matrons, support workers etc. for patients in their own homes and clinics focusing on recovery and increasing independence. Service links with local hospices, support and liaison for end of life	Latton Bush Centre Southern Way, Harlow, Essex
Trust Head Office	Integrated Team (North Uttlesford)	Service containing OT, district nursing, community matrons, support workers etc. for patients in their own homes and clinics focusing on recovery and increasing independence	Saffron Walden Community Hospital, Radwinter Road, Saffron Walden, Essex
Trust Head Office	Integrated Team (Leigh)	Service containing OT, district nursing, community matrons, support workers etc. for patients in their own homes and clinics focusing on recovery and increasing independence	Leigh Primary Care Centre, 918 London Road, Leigh on Sea, Essex
Trust Head Office	Integrated Team (Central Southend)	Service containing OT, district nursing, community matrons, support workers etc. for patients in their own homes and clinics focusing on recovery and increasing independence	Rochford Hospital, Union Lane, Rochford, Essex
Trust Head Office	Integrated Team (Night Service)	Service containing OT, district nursing, community matrons, support workers etc. for patients in their own homes and clinics focusing on recovery and increasing independence	Rochford Hospital, Union Lane, Rochford, Essex
Trust Head Office	Integrated Team (Hockley)	Service containing OT, district nursing, community matrons, support workers etc. for patients in their own homes and clinics focusing on recovery and increasing independence	Hockley Clinic 53 Spa Road Hockley Essex Hockley
Trust Head Office	Palliative Care Team	A community service for people with long term conditions where there is limited expectation of improvement in the condition and may lead to an end of life diagnosis	Rochford Hospital, Union Lane, Rochford, Essex
Trust Head Office	Integrated Team (South Uttlesford)	Service containing OT, district nursing, community matrons, support workers etc. for patients in their own homes and clinics	Stansted Community Clinic, Crafton Green,

Location / site name	Team/ward/satellite name	Services provided	Address (if applicable)
		focusing on recovery and increasing independence	Stansted, Essex
Trust Head Office	Integrated Team (Canvey & Thundersley)	Service containing OT, district nursing, community matrons, support workers etc. for patients in their own homes and clinics focusing on recovery and increasing independence	Thundersley Clinic 8 Kenneth Road Thundersley Benfleet Essex

Is the service safe?

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

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The trust set a target of 85% for completion of mandatory and statutory training modules including: Fire Safety 3 years, Fit for work, Induction, and Information Governance. The trust set a target of 90% for Safeguarding Adults (Levels 2 & 3) training.

A breakdown of compliance for mandatory training courses from 31 March 2018 to 31 March 2019 at trust level for qualified nursing staff in the palliative care team is shown below:

Training module name	31 March 2018 to 31 March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Fire Safety 3 years	10	10	100%	85%	Yes
Information Governance	5	5	100%	85%	Yes
Safeguarding Adults (Level 2)	5	5	100%	90%	Yes
Induction	5	5	100%	85%	Yes
Fit for work	5	4	80%	85%	No
Safeguarding Adults (Level 3)	5	0	0%	90%	No

In palliative care the target was met for four of the six mandatory training modules for which qualified nursing staff were eligible.

Training data for medical staff in community services for end of life care was not provided.

The information above, supplied by the trust in advance of our inspection, was inaccurate. We asked the trust to provide accurate data relating to mandatory training completion rates. The compliance for end of life care champions in east Essex was:

Training module name	Compliance in July 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Fire Safety 3 years	7	7	100%	85%	Yes
Information Governance	7	7	100%	85%	Yes
Safeguarding Adults (Level 2)	7	7	100%	90%	Yes
Basic life support	7	7	100%	90%	Yes
Induction	7	7	100%	85%	Yes
Fit for work	7	7	100%	85%	Yes
Safeguarding Adults (Level 3)	3	4	75%	90%	No

The compliance for the specialist palliative care team in south east Essex was:

Training module name	Compliance in July 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Fire Safety 3 years	12	12	100%	85%	Yes
Information Governance	12	12	100%	85%	Yes
Safeguarding Adults (Level 2)	12	12	100%	90%	Yes
Basic life support	12	12	100%	90%	Yes
Induction	11	12	92%	85%	Yes
Fit for work	11	12	92%	85%	Yes
Safeguarding Adults (Level 3)	4	5	80%	90%	No

All staff received standardised mandatory training on initial employment, which was then supplemented with a periodic refresher training. Staff undertook additional modules where relevant to their specific roles. For example, the single point of access (SPA) team received de-escalation training specific to supporting distressed people by phone. All staff received generic fire safety training that was = supplemented with training specific to their usual place of work. Syringe driver training was mandatory for all community nurses and matrons, who were required to demonstrate competency before they could practice.

It was not mandatory for staff in integrated and community care teams to complete end of life care training if they were not undertaking end of life care champion duties. However, the clinical lead had implemented a training programme open to all staff, regardless of their usual team. This included an end of life care induction and training on the end of life care framework, syringe drivers, frailty, anticipatory medicine and dignity at the end of life. The clinical lead advertised this widely and encouraged all community nurses and healthcare assistants to attend.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from 31 March 2018 to 31 March 2019 at trust level for qualified nursing staff in the palliative care team is shown below:

Training module name	31 March 2018 to 31 March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults (Level 2)	5	5	100%	90%	Yes
Safeguarding Adults (Level 3)	5	0	0%	90%	No

In community services for end of life care the 90% target was met for one of the two safeguarding training modules for which qualified nursing staff were eligible.
Safeguarding training data for medical staff in community services for end of life care was not provided.

We obtained accurate information from senior staff on training targets and completion rates during our inspection. All staff who had patient contact completed adult and child safeguarding to level 2. Clinical staff at band 6 or above were required to complete training to level 3. Amongst the end of life care champions in east Essex, all staff were up to date with safeguarding training with the exception of one individual who was awaiting a date for a level 3 refresher course. Senior staff were arranging this at the time of our inspection.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The palliative care team made zero safeguarding referrals between 1 April 2018 and 31 March 2019.

The information provided to us by the trust in advance of our inspection, indicated above, was incorrect. After our inspection the trust provided updated information that showed staff made 10 safeguarding referrals between August 2018 and July 2019. We reviewed each referral and found it was appropriate and in the best interests of the patient. Staff made referrals in instances where they were concerned about a patient's welfare, suspicious of neglect or concerned about the impact of their needs on their loved ones. In each case staff based their decision on concern and compassion and followed up with reporting authorities when they did not receive a timely response. Reports indicated staff were proactive in responding to potential risk. For example, a member of the integrated team had contacted the local authority safeguarding team when they were concerned about the care a patient on an end of life care pathway was receiving in a care home. The member of staff acted quickly, escalated their concerns appropriately and secured

significantly improved care for the patient.

Each locality had a safeguarding lead and several staff were safeguarding champions. Leads and champions attended the end of life care steering group and quality meetings.

The safeguarding team responded to feedback from staff and increased their visibility and engagement with clinical services. They provided drop-in sessions to help staff develop skills and knowledge and worked with staff writing policies and standard operating procedures.

Multidisciplinary staff worked together to manage complex safeguarding needs. For example, staff worked with patients' relatives that had a mental health issue, if the patient's condition deteriorated due to their relative's ill-health.

Cleanliness, infection control and hygiene

The service controlled infection risk well. They used control measures to prevent the spread of infection before and after the patient died**.**
During our observations staff adhered consistently to infection prevention and control standards. For example, they used personal protective equipment (PPE) such as disposable gloves before patient contact and used antibacterial hand gel at appropriate intervals.

Staff managed sharps in line with the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 and waste in line with Department of Health and Social Care national guidance on the management of healthcare waste. They used adapted processes to manage both systems in the community when moving between patients in different locations.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.

Each integrated care team (ICT) managed their own equipment and supplies stock, including syringe drivers and occupational therapy equipment. Teams had established relationships with hospices and NHS emergency departments to store equipment for more rapid access for patients in urgent need. Equipment tracking processes were in place, which ensured staff could locate equipment at any given time. A dedicated team collected trust equipment after a patient's death in a timely manner.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff used a monitoring template to review patient needs in the last days of life. This included 12 key observations designed to identify if the patient needed further intervention to keep them safe and as comfortable as possible. For example, staff recorded issues such as nausea and vomiting, agitation and breathlessness and implemented additional care to control the symptoms.

Staff used the national early warning scores (NEWS) to assess patients for deterioration. They liaised with other professionals to deliver urgent care, such as the respiratory team. Where

patients had an advanced decision to refuse treatment (ADRT) in their care plan, staff discussed the deterioration with them to ensure care continued to meet their wishes and beliefs. Where patients could not communicate and had an advanced decision to refuse treatment in place, staff discussed deterioration with those close to them and worked to make them comfortable.

Integrated care and multidisciplinary teams responded quickly to patients at risk. Community nurses attended patients in their usual place of care and liaised with consultants and GPs to review patients when needed. In the south east Essex area, clinical nurse specialists worked on a 24-hour rota and attended to patients out of hours with urgent needs or who were deteriorating. Advance care plans helped patients and relatives to know what to expect at the end of life and the on-call team provided support in case people felt worried or anxious.

The south east Essex team had developed a frailty register in partnership with primary care services to streamline care for patients at high-risk of injury. This was part of a broad strategic improvement plan and reflected the drive of staff to improve patient safety and care.

Integrated care teams had developed escalation processes with the regional NHS ambulance trust. This enabled paramedics to escalate a patent's care to community matrons if they found evidence of weight loss or other concerns.

All staff responsible for delivering care had access to escalation pathways to assist in caring for patients with urgent needs. This included direct access to duty GPs and hospices.

Several teams in integrated care offered a rapid response service to patients in their home or place of care. This included the occupational therapy team and the respiratory team. This was part of rapid escalation processes that ensured patients at the greatest risk received priority care.

Where patients were at increasing risk, staff discussed options with them and clearly stated the urgency of their needs. For example, one patient with deteriorating health was reluctant to try medicines that would help to control their anxiety. The member of staff explained the nature of the medicines, how they worked and what safeguards they would put in place to avoid dependency. This noticeably reassured the patient, who agreed to try this approach to symptom management.

Staff used a risk-based dependency monitoring system to identify each patient's level of need. This helped staff to decide whether patients needed a home visit or if a phone call would be a safe method of checking up on them. The palliative care team had delivered training sessions to GPs on the correct use of the dependency tool.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

From March 2018 to February 2019, the comparison of staff groups in post WTE in the palliative care core service is shown in the chart below.

	Core service annual staffing metrics (Vacancy, Turnover, Bank and Agency: 1 March 2018 – 28 February 2019) (Sickness: 1 April 2018 – 31 March 2019)

Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual "unfilled" hours (% of available hours)
All staff	11.2	17%	19%	3.4%			
Qualified nurses	5.5	15%	18%	6.0%	N/A	N/A	N/A
Nursing assistants	5.7	19%	19%	1.0%	N/A	N/A	N/A

The trust set a target of 12% for vacancy rate. From March 2018 to February 2019, the trust reported an overall vacancy rate of 17% in palliative care. This did not meet the trust's target. In palliative care, vacancy rates for nursing staff were 15% and for nursing assistants were 19%

During the reporting period from March 2018 to February 2019, palliative care reported that there were zero cases where staff have been either suspended or placed under supervision.

Nurse staffing differed between west Essex and south east Essex. In west Essex, community nurses and matrons delivered care and staff with extended end of life care training acted as champions in these roles. Nurses worked to individual training and development plans and choose their own job title based on their level of training and experience with end of life care. For example, in one locality there was a 'life-limiting nurse'. This individual had more advanced end of life care training and worked to support community colleagues to develop. Another locality in west Essex had an end of life care coordinator. In south east Essex, clinical nurse specialists and matrons formed the specialist palliative care team. The range of nurses worked well based on local needs and nurses coordinated care across each area.

A clinical lead for end of life care worked across both areas and led nursing teams clinically and operationally.

Consultants and GPs provided medical cover across the trust. The clinicians were not employees of the trust but provided services to their patients in line with local agreements and other providers managed all aspects of their work, including training, registration and employment.

A GP from the south east Essex area provided four sessions a week to the trust in a strategic role to improve clinical input and to represent frailty and urgent care for the trust's patients. Other clinicians involved in delivering care included a consultant clinical lead for frailty and community services, a hospice medical director and a clinical psychologist.

Four urgent advanced assessment nurses provided the community assessment and referral service (CARS) team. This service operated seven days a week, from 8am to 9pm and was based in the emergency department of another trust's acute hospital.

A manager, six clinicians and five healthcare administrators led the single point of access team (SPA).

Staffing levels were consistent across most teams. There was a vacancy for one clinician in the single point of access team. The trust told us that the community assessment and referral service team had no vacancies. A commissioning decision meant resource had recently been deployed to the community integrated team, reducing the capacity of the CARS team.

Quality of records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Staff used a standardised, electronic care record system to document patient reviews and care plans. This system was accessible by all specialties in the integrated community team and wider trust. The system enabled staff to access test and imaging results as well as care plans, case notes and risk assessments. Staff duplicated records onto systems shared with other providers responsible for delivering care. They completed this in line with established safety and governance standards.

The specialist palliative care team and community nurses had mobile electronic access to care records in patient's homes. This meant they could access test results and reviews whilst they were with the patient.

The trust monitored the quality of care records through a commissioning for quality and innovation (CQUIN) process. Staff reviewed performance through monthly meetings and all members of the team contributed, including allied health professionals.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff used medication templates to record prescribing according to trust standards. This included for anticipatory medication. Anticipatory prescribing refers to medicines prescribed in advance so that patients can take them at the onset of expected symptoms. Staff consistently recorded patient's allergies and sensitivities. However, a January 2019 audit indicated an urgent need for improvements in documentation. The audit found staff had documented anticipatory medicine plans in 73% of cases and medicines were in place in only 80% of cases. Where patients had an implantable cardioverter device in place, staff had not documented the patient's wishes regarding deactivation in any of the 7% of patients who had a device. An implantable cardioverter device automatically shocks a heart when it stops, as a strategy to revive a patient until emergency help arrives. It is common practice to deactivate such devices at the end of life as the effects on the patient and those around them can be distressing.

Prescribing staff used established guidance when coordinating anticipatory medicine, including assessing symptoms that typically develop in the last days of life. This meant the team maintained an up to date understanding of the patient's medicines needs and stopped inappropriate interventions in a timely manner.

The pharmacy team maintained a palliative care formulary, which staff used alongside other guidance such as the trust's injectable medicines guidance. A formulary is an official list of approved medicines for specific use.

The pharmacy team and end of life care clinical lead had established a standard operating procedure for the safe use of syringe drivers. This provided community and hospice staff with clearer guidelines on when to use the equipment and when to withdraw it.

The service had improved medicines management to offer a safer service. This reflected the findings of an audit that highlighted gaps in stock taking and safety risks. Senior staff commented on the fragmented medicines policies in some areas and staff were actively working with the pharmacy team and nurse prescribers to improve them.

Staff maintained the contact details for out of hours pharmacies that held stocks of anticipatory medicines. This meant they had rapid access to essential medicines at any time.

The community health services pharmacist was working with GPs and the clinical commissioning group to improve practices following medicines management incidents that compromised patient safety. The pharmacist found inconsistencies in prescribing practices and errors in documentation that the nursing team had missed. The team had implemented new safety requirements to reduce risk. The non-medical prescriber forum had prioritised this issue in recent meetings and identified causes with staff along with strategies to resolve it. These included closer working with GPs and clinical commissioning groups.

The trust did not undertake audit activity in relation to medicine management or prescribing. In west Essex, CCG's led this audit activity. In south east Essex, there were challenges in collecting reliable data for audits due to multiple different systems in place. The pharmacy team were working with clinical commissioning groups to address this.

Safety performance

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and the public.

A 'skin matters' panel convened monthly and reviewed all pressure ulcers documented by staff, regardless of which service they were attributed to. The team used this information to identify gaps or omissions in care and put in place more consistent standards. The skin matters process was part of a wider system designed to ensure patients maintained skin integrity. To achieve this, staff provided pressure-relieving equipment and managed fluids using standard charts and the waterlow system. Occupational therapists and physiotherapists played a key role in managing skin integrity and worked closely with nursing colleagues.

Staff had implemented substantial improvements to skin integrity and pressure management followed a serious incident that involved a service-acquired grade 3 pressure sore. Senior staff had introduced more detailed training for nurses on the use of the waterlow score and ensured staff were proactive in sourcing pressure-relieving equipment early.

Incident reporting, learning and improvement

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers implemented and monitored actions from the patient safety alerts.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From 1 March 2018 to 28 February 2019, the trust reported no instances for palliative care.

In accordance with the Serious Incident Framework 2015, the trust reported zero serious incidents (SIs) in community services for palliative care, which met the reporting criteria set by NHS England from 1 March 2018 to 28 February 2019.

The number of the most severe incidents recorded by the trust incident reporting system is comparable with that reported to Strategic Executive Information System (STEIS). This gives us more confidence in the validity of the data.

In February 2019 the trust reported one serious incident, which related to a grade 3 pressure ulcer a patient acquired whilst in the care of the service. Staff carried out a root cause analysis, which found the patient's care team had not followed standard practice to manage skin integrity and had not completed adequate documentation. Although the root cause analysis identified areas for improvement, the investigator noted very brief recommendations. It was not evident how this would result in significantly improved practice. The investigator noted the duty of candour had been triggered but it was not evident the team had implemented this in a timely manner. For example, the incident had occurred in February 2019 and the investigator noted a duty of candour letter was not due to be sent out until April 2019. The root cause analysis did not establish reasons for this significant delay.

The senior team maintained a dedicated, secured incidents folder online that all staff in the service had access to. This meant staff could access learning outcomes at any time to help them maintain safe standards of care. Senior staff discussed the outcomes of incidents in team meetings and during supervisions and appraisals.

Systems were in place to ensure staff identified learning from incidents and implemented this into their work and that of the wider integrated teams. For example, following the deaths of two patients living with dementia in community inpatient wards, staff undertook training for the Gold Standards Framework. Following a medicines incident, community nurses spent time shadowing the palliative care team to build their skills and knowledge of medicines management. Staff maintained a lessons learned log and shared this openly. All the staff we spoke with said they were happy to report incidents and felt senior staff facilitated a no-blame culture.

Incident reporting systems were robust and meant staff had standardised access regardless of where they worked. For example, the community assessment and referral service team worked for this trust but provided care in the emergency department of another trust. In the event of an incident, the team reported the incident on both trust systems to ensure the senior teams in each trust could investigate it.

The end of life care clinical lead reviewed all incidents, regardless of where they occurred, at monthly sub-committee meetings. This meant they maintained oversight of patterns and trends of incidents.

We reviewed the incidents reported for the end of life care champions, the specialist palliative care team and the community assessment and referral service between August 2018 and July 2019. We also reviewed the incidents submitted by any member of staff that related to patients on an end of life care or palliative care pathway to ensure we understood incidents across all teams that delivered care. Staff across these groups reported 730 incidents. Of these, staff classified 72% as resulting in no harm or low harm and 28% as resulting in moderate harm. All incidents classified as moderate harm related to pressure ulcers that developed in the care of the service or that were found by staff when the patient entered their care. The outcomes of each incident indicated staff worked with the wider multidisciplinary team to relieve symptoms and to implement preventive

measures. For example, staff had liaised with tissue viability specialists, secured pressure-relieving equipment, updated care plans and implemented more frequent turning protocols in response to individual needs. Nurses also documented medical photographs with the patient's consent to help care planning and incident investigation. Staff took action for each incident that resulted in low harm or no harm to help identify learning or to demonstrate how they had worked to improve the situation for the patient. For example, the community assessment and referral service had reported an incident when a patient was discharged to a hospice without medicines charts in place. This was coordinated with the emergency department to enable the patient to reach their preferred place of care as quickly as possible and the team liaised with the hospice to ensure they initiated medicines as soon as possible.

Staff used a critical incident analysis meeting to review the care of patients following an incident or where staff had identified barriers to care or inconsistencies. This was a multidisciplinary process designed to reduce future risk and incidents. For example, the team had scheduled a critical incident analysis meeting to review the care pathway of patient who had experienced a delay in receiving medicine. The process involved a review of the care delivered and provided staff with the opportunity to reflect on their work.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Staff delivered care that adhered to best practice guidance issued by relevant organisations, including the Leadership Alliance for the Care of the Dying People. The National Institute for Health and Care Excellence and the Department of Health and Social Care. Staff used specific standards for advanced care planning and documentation, including National Institute for Health and Care Excellence quality statement 13 for end of life care adults and clinical guidance 140 for the use of opioids in palliative care. Staff used the Leadership Alliance for the Care of the Dying People priorities for care of the dying person to guide care planning and Department of Health and Social Care strategies to guide service delivery.

The service had participated in the first round of the national audit of care at the end of life (NACEL) between April 2017 and March 2018. The trust performed well overall and scored better than the national average in all nine measures. The audit indicated a need for improved governance and patient information, both of which the trust had addressed.

The service had developed an end of life care framework and issued this to all staff. This established more robust standards and scope of service and reflected a broad improvement in the structure and basis of the service. The framework was based on national Ambitions for Palliative and End of Life Care.

The service had adapted care following the withdrawal of the Liverpool Care Pathway for the Dying Patient in 2014 by implementing the five priorities of care of the One Chance to get it Right (2014) document. This aligned care and service standards with national guidance and comparable services.

Care plans included essential elements of end of life care as established by national standards, including for nutrition and hydration, symptom management and spiritual and cultural needs. An audit in January 2019 found variable documentation of symptom management. For example, staff documented effective management of the six most common symptoms at the end of life in 59% of cases. This reflected a range between 47% for nausea and vomiting and constipation to 70% for mouth care. There were significant gaps in data due to the different systems staff used to record key information, which meant the results were not fully accurate. The senior team included this in a quality improvement plan and training development.

Staff used the national five-step 'SSKIN' care bundle in care plans in addition to high impact care bundles, such as for catheter care. SSKIN is an acronym that stands for each step of the assessment process.

As part of the trust's implementation plan for end of life care, the clinical lead had audited a sample of 30 medical records of deceased patients. The clinical lead used acute inpatient standards to assess the quality of care delivered and produced an action plan to direct improvements.

Staff used a treatment escalation plan to help guide them in managing the care of patients whose condition was worsening. The plan used a validated assessment tool to ensure staff adhered to best practice.

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves.

Staff included patients' nutrition and hydration needs in care plans, including advance care plans. They discussed this information with the patient where this was possible as well as with their primary carer. Staff used the national malnutrition universal scoring tool (MUST) to monitor patients for malnutrition.

A team of dedicated dieticians worked across integrated community services and provided on-demand support for patients. Dieticians had access to patient care plans and contributed to these as needed.

The speech and language therapy team were developing a pathway to help integrated care teams care for patients who could no longer swallow. The pathway, combined with speech and language therapy delivered training, which helped nurses identify when to begin at-risk feeding in a patient's best interest and when to stop using interventions such as percutaneous endoscopic gastronomy (PEG) feeding.

During our observations of care, staff demonstrated consistent oversight of patients' nutrition and hydration needs. Where they noted patients had lost weight they assessed causes and put in place interventions if it was a result of issues such as low mood or depression. An audit in January 2019 reflected this, which found consistent standard of food and drink management for patients at the end of life.

Staff explored alternative feeding options where patients' anatomy or medical condition meant usual routes of support were not possible. For example, the speech and language therapy team supported nurses in at-risk feeding for a patient who was unable to receive percutaneous endoscopic gastronomy.

Nutrition and hydration were key elements of the last days of life care plan and staff consistently documented care in this area.

A locality team had worked with a dietician to redevelop the in-house hydration training and redesign the hydration information leaflet for patients and their carers.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed pain at regular intervals as part of on-going care planning and used the trust pain assessment template to monitor treatment and symptom control.

The trust did not have a specialist pain team. Nurses assessed pain and referred patients to specialist services where they could not control pain. Several clinicians worked in partnership with the integrated care teams and support staff to manage pain effectively.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The trust have participated in three clinical audit in relation to this core service as part of their Clinical Audit Programme.

Audit name	Area covered	Key Successes	Key actions
End of Life audit CHS Teams	Integrated Team (Epping), Integrated Team (Harlow), Integrate Team (Uttlesford), Integrated Team (Leigh), Integrated Team (Central Southend), Integrated Team (Canvey & Thundersley), Integrated Team (Hockley), Palliative Care Team	Not provided	Data collection completed, analysis in progress and report being written

Each patient had a ‘my plan’ document, which staff completed collaboratively with them. Patients kept this in their place of care and carried it with them if they needed to attend GP appointments or hospital. We reviewed a sample of six plans and found them to be robust and comprehensive. Staff had documented discussions about each patient’s future wishes, preferred place of care and preferred place of death. Staff also documented the patients’ wishes about organ donation. Staff worked collaboratively to complete care plans and the examples we reviewed reflected the nature of the multidisciplinary working that contributed to care.

Staff worked together to ensure patients experienced the care outcomes they wanted. For example, when one team went off duty they ensured another team understood the patient’s current situation and needs. Integrated care teams were responsible for discharging patients from hospital to their preferred place of care. This involved securing appropriate equipment for delivery to the patient’s home in advance of their departure from hospital and ensuring a care package was

in place with community partners aware of it. They worked closely with a hospice at home team, who provided home care for patients overnight when trust staffing levels were reduced.

Where patients had extensive clinical needs, staff worked together in pairs based on their skill mix and experience to ensure care was appropriate and effective. Staff had established links with specialist nurses across Essex to support patients with highly complex needs, such as Parkinson's disease and Huntingdon's disease. For example, one patient was cared for with multiple medical devices in addition to a syringe driver. This was a significant clinical need and integrated care team nurses and allied health professionals worked with specialists in other services to manage the patient's care.

Between October 2018 and July 2019, the specialist palliative care team had documented a preferred place of care in 81% of cases and preferred place of death in 72% of care plans. In this period, 84% of patients achieved their preferred place of death. This data related only to south east Essex and was part of the pilot phase of a new end of life care dashboard to monitor patient outcomes. This represented a significant improvement in the monitoring of patient outcomes and senior staff were developing the tool for use across the whole of the trust. The same audit found staff had documented patients' spiritual and religious needs in only 24% of cases.

Staff monitored the number of patients who had achieved their preferred place of death through multidisciplinary meetings. At the time of our inspection, the south east Essex area had achieved this in 80% of cases in the previous month.

The trust had carried out an audit to establish a baseline of outcomes for patients, measured against the standards of the national strategy and the trust end of life care framework. The audit found variable practice, with compliance in the 26 measures ranging from 14% to 100% and an overall average of 82%. The audit team had implemented a range of action plans following the audit to address areas of underperformance. This included a review of the last days of life care plan and significantly increased training opportunities.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The trust provided the following information about their clinical supervision process:

Clinical supervision is required for all staff and the frequency and methods of recording are set out in the Appraisal and Supervision Policy. Clinical supervision should cover performance and practice and will be measured by reference to:

- customer feedback e.g. compliments, complaints, friends and family test outcomes
- the trust's Competency Framework
- trust Values and Service Standards
- professional standards (where applicable)
- maintenance of professional registration (where applicable)

- core clinical competencies

- achievement of objectives and targets

- compliance with mandatory training requirements. Clinical staff must have supervision at least once within an eight-week period and those within the probation/preceptorship period must be seen more regularly. The supervision is recorded on the documentation as set out in the policy and a signed copy is kept by both the supervisor and the supervisee. The supervision record is kept electronically and can be viewed for all members of staff via the trust intranet. The supervision compliance is reported monthly as part of the Performance Report.

From April 2018 to February 2019, 60% of required staff in palliative care received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Community end of life care total

Staff group	April 2018 to February 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Nursing and Midwifery Registered	2	3	67%	90%	No
Additional Clinical Services	1	2	50%	90%	No
Total	**3**	**5**	**60%**	**90%**	**No**

During our inspection we found the data provided by the trust in advance of our inspection was inaccurate. After our inspection the trust provided accurate data, which showed appraisal rates as follows:

- End of life care champions (west Essex): 100%
- Specialist palliative care team (south east Essex): 92%

Most staff spoke positively about the appraisals process and said it encouraged them to reflect on their work and identify opportunities for development. For example, one nurse had identified training in respiratory medicine as something that would improve the care they delivered. As a result, they scheduled time shadowing respiratory nurses to help build their skills, knowledge and confidence.

The senior team had developed end of life care competencies and had started to deliver these to community staff across the trust. End of life care champions, with the support of the multidisciplinary team, undertook extended training. For example, champions spent time working alongside colleagues in hospices and in the clinical nurse specialist team to build their skills and competencies.

Palliative care and integrated community nurses had a range of specialist experience and skills in their teams. This included cardiology and emergency medicine experience.

Single point of access teams were the first point of contact for patients and their relatives in most cases across the trust's patch. The end of life care clinical lead had introduced a training programme for single point of access staff to help them provide a more tailored service to patients and those close to them. The programme included understanding of symptoms and emotions at the end of life and training to help staff communicate with people experiencing acute distress and anxiety.

Allied health professionals undertook end of life care training based on their areas of responsibility.

All staff received a standardised induction, supplemented with a specialised induction based on their specific role and location of work.

The service had extended training to partners across the county to improve the skills, competence and confidence of health teams they regularly worked with. This included care homes, hospices, paramedics and NHS 111 staff.

The trust had clear development and progression pathways for staff. For example, band 3 healthcare assistants had the opportunity to develop into band 4 nurse associates or senior healthcare assistants and undertook a national vocational qualification to do so.

Heart failure nurses had delivered training to community teams to help nurse prescribers coordinate care for effectively and safely.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Multidisciplinary working was evident in care planning standards. For example, a multidisciplinary team coordinated each patient's care plan and re-evaluated it every three days for patients at the end of life. Multidisciplinary teams typically consisted of nurses, a consultant or other doctor, and AHPs such as physiotherapists, occupational therapists, speech and language therapists and dieticians. Teams met weekly to review patients who were actively dying.

The trust had embedded the principles of multidisciplinary working in the end of life care framework. This focused on an integrated approach to care that involved internal specialists, external services and patients and those close to them.

Patients and relatives commented positively on the multidisciplinary approach of their keyworker nurse. For example, people said they appreciated that nurses coordinated communication with other agencies and providers and chased up appointments and other actions from them.

The single point of access teams provided direct referral to each locality team and provided access to specialists not part of the trust but who provided care to patients. For example, they facilitated access to psychologists, mental health nurses and adult social care professionals.

Staff used integrated electronic patient information systems to coordinate care between services. On contact from a patient or healthcare professional, the single point of access team could identify if the patient was known to other services in the area in additional to the trust integrated care team. This ensured the most appropriate person visited the patient. Staff in each locality had access to the records system used by GPs, which helped to coordinate each patient's holistic care needs between services.

The community assessment and referral service (CARS) team was based in the emergency department in a hospital operated by another trust. They coordinated care across multiple services

to help reduce the need for hospital admissions, including for patients on a palliative pathway or approaching the end of life. The team worked with care homes, hospices, the ambulance service and acute hospital colleagues to ensure patients had the most appropriate care plan in place. They could arrange for out of hours care home and hospice admissions and worked directly with the ambulance service to secure transport in a timely manner to reduce the length of time patients remained in the emergency department. Senior nurses made up the team and worked closely with emergency department nurses and consultants to ensure patients were medically stable before staff discharged patients to their preferred place of care.

Monthly multidisciplinary meetings took place in both of the trust's areas, west Essex and south east Essex. These were hosted by other providers and included significant input from this trust's teams as well as clinical nurse specialists who worked for a hospice. We attended two multidisciplinary meetings, one in west Essex and one in south east Essex, as part of our inspection. A range of appropriate professionals attended each meeting, including consultants, medical directors, nurses, pharmacists, GPs, allied health professionals and social care staff. In each case the teams used the meetings to review patients with long-term or complex needs and to plan care collaboratively. There was a demonstrable ethos of coordinating care in patients' best interest and staff worked well together to overcome problems and challenges. For example, in some areas where patients experienced difficulty in obtaining urgent medicines from GPs. The multidisciplinary worked together to understand the cause of such issues and to establish plans to address them.

The integrated care team and community assessment and referral service teams had established close working relationships with hospice at home teams to facilitate rapid discharge from hospital to a preferred place of care.

We spoke with hospice staff, including a medical director. Whilst these individuals did not work for this trust, they provided care to patients and were therefore included in our inspection in the context of the patient experience. Medical staff contributed to weekly case reviews for patients with long-term and complex needs and worked with the wider integrated care team to ensure advance care plans met individual needs of patients.

Staff spoke positively of multidisciplinary working relationships and said they felt logical and patient-centred.

Integrated care team nurses attended gold standard framework (GSF) meetings with GP practices along with adult social care and mental health colleagues.

We accompanied a trust psychologist when they were delivering care to a patient at home. They used a multidisciplinary approach with a social worker colleague to coordinate care for the patient's complex medical and psychological needs.

Health promotion

Staff gave patients practical support to help them live well until they died.

Staff had participated in the national Dying Matters week to promote good quality, individualised care in the community. As part of this week they had visited hospices, GP practices and hospitals to delivery informative sessions to other healthcare professionals. Sessions aimed to raise awareness of good standards of care, national best practice and to engage staff who might need more confidence and knowledge in delivering care to patients at the end of life. A wide range of

staff attended the events including social care professionals and AHPs, which helped to increase health promotion knowledge across the region.

Staff supported the relatives of patients to maintain their health and wellbeing. We observed staff offer to bring food for a relative who was struggling to cope as their family member approached the end of life and did not want to leave home. They also gave advice on better sleeping general health balance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

As Mental Capacity Act Training is incorporated into Safeguarding Level 1 training, the data is unsuitable for analysis. The trust did not provide DoLS training data.

From 1 April 2018 to 31 March 2019 the trust reported that 309 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority. None of which were pertinent to community health services for end of life care.

CQC received 274 direct notifications from the trust as a whole between 1 April 2018 to 31 March 20193. However, the trust reported that 158 direct notifications were sent to CQC. Under HSCA legislation, all DoLS applications should also be sent to the CQC in the form of a direct notification so it is relevant that these numbers are different.

Staff demonstrably considered the mental health needs of patients at all stages of care. They supported patients and their relatives in accessing information on establishing a Lasting Power of Attorney and making an advance decision to refuse treatment. During advance care planning, staff assessed patients using recognised tools to ensure they had the capacity to consent to care and to understand the proposed care plan.

Staff consulted with independent mental capacity advocates (IMCAs) where this was in a patient's best interests and included them in advance care planning.

Staff had training to deliver care to patients with mental health needs and those living with dementia or learning disabilities. They carried out best interest assessments and involved consultants and psychologists as needed. We found consistent standards of practice in the completion of do not attempt resuscitation authorisations and staff maintained oversight of these when completed by different clinicians. The team audited the use of the do not attempt resuscitation tool in a 2019 audit and found staff had completed the tool for 81% of patients identified as being at the end of life and 93% of patients had an authorisation in place when they died. The same audit found staff had discussed resuscitation with 55% of patients. Where this had not been possible, staff had documented reasons for this.

Community matrons had worked with GPs to improve the consistency and standards of do not attempt resuscitation documentation. The team was in the process of launching an audit to establish the standards of decision-making amongst local GPs.

We observed staff use appropriate processes to obtain consent when visiting patients at home. During one of our observations staff asked for the patient's consent before delivering care and asked for their consent to speak to them alone without a relative present.

[3] CRM

Where patients lacked capacity to make decisions, staff included them in discussions about their health as far as possible.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff considered the individual needs of patients in the last days and hours of life. They included nutrition and hydration needs, spiritual, cultural, social, symptom control and psychological needs. Nurses considered all of these aspects in care plans, including advance care plans, and spoke with patients, relatives and carers about them.

Dignity, respect and compassion were key elements of the trust's end of life care framework and placed symptom management and minimal suffering as key areas of focus.

Staff delivered care with kindness, dignity and compassion. Patients commented on the responsiveness of staff and said it felt like nothing was too much trouble for them. One carer said they had been pleased staff could source equipment and medicine at very short notice, which had greatly improved the comfort of the patient. Patients, relatives and carers repeatedly said staff made a difficult job look effortless, which helped lower their stress and anxiety.

The service was developing diversity champion roles, which would promote more specialist support for patients.

End of life care and palliative care had not previously been included in the NHS Friends and Family Test (FFT) in the trust. The clinical lead had worked with the trust to address this and new Friends and Family Test surveys now included both services. At the time of our inspection the first Friends and Family Test results for the service were pending.

Staff had a clear ethos of supporting patients to achieve a dignified death and supporting their relatives and loved ones during times of crisis. The End of life care team worked with community partners to implement consistent standards of care for patients at the end of life that focussed on comfort. For example, integrated care teams worked with paramedics to reduce the need for standard assessments such as blood pressure, which were unnecessary for patients approaching the end of life.

We reviewed 15 comments cards from the relatives of deceased patients. In all cases people made positive comments. Themes included the kindness, dignity and warmth of staff. People commented on the calmness and reassurance of staff and felt their empathy was genuine and heartfelt.

We observed exceptional standards of compassion from staff when speaking with relatives of patients who were anxious, tearful and upset. Staff listened carefully and patiently and discussed the different options they had to get help at home. Staff understood patients and their relatives could experience a loss of dignity if symptoms worsened towards the end of life and worked to ensure the care they delivered maintained dignity. For example, where relatives struggled to help someone with toileting and personal care, staff arranged for home care and pads to help maintain a standard of dignity.

In April 2019 the specialist palliative care team carried out a user survey of 175 relatives or next of kin of patients who had died whilst receiving specialist care from the trust and achieved a 23% response rate. The results highlighted areas of good practice, including 98% agreement amongst

relatives that staff had listened to their fears and worries and 95% overall satisfaction. The team acted on feedback for improvement, including a more consistent out of hours service and standardised printed information. All improvements had been fully implemented at the time of our inspection and staff had contributed to significant action taken following the survey.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff had good understanding of the emotional distress people could feel when a loved one was approaching the end of life.

Staff prepared a printed information leaflet to accompany bereavement support. This was a sensitive and easy to understand. Staff recognised the emotional time relatives, carers and friends would experience after the death of a loved one and the leaflet reflected this with the provision of contact details for 28 specialist organisations that worked with people who were bereaved. This range reflected the diversity of the trust's patient population and included details of organisations for the parents of young people as well as for families of a specific faith, no faith or who identified as interfaith.

Chaplains were available 24-hours, seven days a week across the trust's patch and all staff knew how to contact them. Nurses provided chaplaincy contact details to patients and their relatives for use at any time.

The keyworker for each patient carried out a bereavement visit to their relatives or carer after they died. This provided continuity of care for those close to them and ensured people understood who they could contact for on-going help and support.

Staff facilitated access to specialist counsellors for patients and their relatives in their preferred place of care. This included at home and in hospices and staff could refer patients to psychologists if they needed more clinical support.

The integrated care team referred relatives and carers to bereavement cafes. These services offered scheduled drop-in sessions for the recently bereaved and help to provide continuity of care once a patient had died and relatives had left the care of the trust.

Community nurses had undertaken advanced communication skills training to help them lead and facilitate difficult and challenging conversations. This included talking to patients and relatives who were experiencing an acute crisis or who were experiencing high levels of anxiety. We spoke with matrons about this who demonstrated knowledge and confidence in supporting people to have emotional, difficult conversations. The end of life care team had delivered training to paramedics to help them provide support and care to patients who were dying and their relatives.

During our observations of care staff delivered kind, understanding emotional support to patients with highly complex needs. This included patients who reported suicidal thoughts and those with a history of domestic abuse. In all cases staff were patient and demonstrated a high level of skill in supporting patients. Staff clearly knew patients well and used this understanding to support them. For example, staff helped remind patients of the positives in their lives and built on these to support their resilience. This had a demonstrably positive affect on patients, whose demeanour became notably more positive and cheerful.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

The team had produced a series of printed leaflets for patients, their relatives and carers to provide information on palliative and end of life care services. This reflected an improvement from our last inspection in May 2018, after which we told the trust they must improve information provided to people. Staff based information on a range of national best practice, including from a partner hospice. The information was clearly written, avoided jargon and was based on specific stages of the patient journey. Leaflets included details of who to contact in the event of an emergency as well as what to do when a loved one died.

The community resuscitation team had prepared a printed leaflet to help support discussions with patients and relatives about advanced decision making. This included guidance on making decisions and thinking about preferences towards the end of life, such as cardiopulmonary resuscitation (CPR). The information included an overview of the Lasting Power of Attorney and the advance decision to refuse treatment (ADRT). Staff included signposting to relevant information resources, including those available through the NHS and from specialist non-profit organisations. All clinical staff carried copies of the leaflets with them and we saw patients, relatives and carers had them in documentation files kept with them.

During our observations, staff involved patients and those close to them in all elements of delivering care and discussing care plans. For example, staff introduced themselves and explained what they were there to do. They gave people time to ask questions and answered these patiently and honestly. Where staff observed a deterioration in a patient's condition, they discussed the implications with them and presented them with their options in a clear and compassionate manner. They explained the causes of symptoms in a way people could understand and discussed management options.

Staff ensured patients and those close to them had their contact details and the details of alternative staff when they were not working. They discussed emergency plans so that people knew the action to take in the event of a change in symptoms or an emergency. Patients and carers we spoke with showed us the information folders staff had given them, which included contact details for services such as day centres and hospices.

Staff worked with patients and relatives to understand their religious needs and implemented advance care plans that respected specific requirements, such as those required by patients of Jewish and Muslim faiths. Equally, where patients had no faith and no spiritual beliefs, staff ensured they met their needs in line with their end of life care wishes.

Staff had a holistic approach to supporting patients with complex needs. For example, one patient with chronic unmanaged pain did not want to be prescribed more medicine and felt that talking was a more effective strategy for them. To ensure the patient received the appropriate level of support, staff scheduled an appointment with a talking therapies counsellor and helped them to attend complementary therapy sessions, including acupuncture.

Staff were sensitive to the concerns of patients who had reservations about accessing talking therapies and psychological support.

Staff were skilled and experienced in balancing the needs of patients and their relatives when these were at odds. For example, patients often stated a preferred place of death that their

relatives disagreed with. Staff helped people to discuss their concerns rationally and in a timely manner and worked with them to establish a plan they both agreed with.

Staff developed a clear understanding of family dynamics and relationships and used this to develop care plans that were tailored to individual need.

In March 2019 the specialist palliative care team wrote to the next of kin of all patients who had died between May 2018 and July 2018 and asked them to complete a survey. Staff designed this to provide them with an understanding of how people had perceived the care their loved ones had received. The team achieved a response rate of 23%, which demonstrated the following:

- 95% of respondents felt the specialist palliative care team had listened to and understood the needs of the patient.
- 98% of respondents felt the specialist palliative care team had given them to share their worries about the patient.
- 80% of respondents felt they had the opportunity to talk about the impact of being a carer on their health and mental wellbeing.
- 93% of respondents felt the specialist palliative care team had given them support as a carer.
- 43% of respondents felt that more information would have been useful.

The team had acted on these results. Staff provided substantial support to carers and took time to understand their holistic needs, including for mental wellbeing.

The trust had undertaken an audit in 2018 to establish a baseline of patient care as part of a programme to identify areas for improvement. The audit found consistent standards in measures that assessed the involvement of patients and their loved ones in care. For example, the audit found staff had documented communication with patients and demonstrably involved them in care in 100% of cases. Staff had included an offer of support when planning care with patient's relatives in 97% of cases and had demonstrated how they treated the patient as an individual in 97% of cases.

Is the service responsive?

Planning and delivering services which meet people's needs

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Staff coordinated care and planned caseloads to promote continuity and try to ensure that patients remained under the care of the same nurse and consultant as far as possible. Each patient was assigned a keyworker from the nursing team who acted as a main point of contact and care coordinator.

The service had a broad programme of work to improve end of life care across the county to ensure patients received high quality, consistent care regardless of their place of residence. To achieve this, staff had rolled out a number of training programmes for colleagues in other providers they regularly worked with. This had recently included training in hospitals, hospices and

care homes to train staff to recognise when someone was dying and to help them become more comfortable in managing care at the end of life.

The end of life care clinical lead and specialist palliative care team in south east Essex had delivered specialist training to colleagues in other organisations to improve services available for patients and their families locally. This included training in the use of syringe drivers and administration of anticipatory medicine to paramedics. This had significantly reduced the need for paramedics to transport patients to emergency departments and meant they could provide specialised care in urgent situations in the patient's place of care. Training was practical and included role play scenarios based on previous cases. The clinical lead had filmed the training and used the videos to deliver advanced communication training. This programme of work was on-going and was designed to improve service delivery to patients and their families, avoid hospital admission and ensure patients at the end of life received the most appropriate standard of care.

The service was working with an ambulance provider to trial a rapid paramedic intervention service. This helped to increase service provision for patients on an end of life care pathway by providing a rapid out of hours response when patients' symptoms worsened or became unexpected. This helped reduce the pressure on community nurses and avoided unnecessary hospital attendances. We spoke with a paramedic who said the training had helped increase confidence and helped the team work to avoid hospital admission by working more closely with the integrated care team, hospices and adult social care services.

The service had facilitated a range of training opportunities to paramedics as a strategy to improve care for patients who experienced urgent medical needs or crisis situations. We spoke with a paramedic who said the training had improved their confidence and enabled the team to reduce unnecessary hospital attendances because they were able to provide care more readily at a patient's home. Training had included student paramedics and ambulance technicians, which meant more healthcare professionals in the area were able to provide care.

A dedicated team of clinical nurse specialists led the community assessment and referral service (CARS) team. This team was based in the emergency department in an acute hospital operated by another trust. The team responded to referrals from hospital staff to assess patients with complex needs and begin community care pathways that this trust would deliver. The team had access to community beds, end of life care champions and the specialist palliative care team. The team liaised with care homes in the patient's area to identify appropriate places of care and checked GP records systems to better understand the patient's medical history. This was a highly specialised team that provided well-coordinated cared to patients with complex needs, including those relating to frailty.

As part of the service's work to reduce hospital admissions, an occupational therapist was based in the emergency department of another hospital. They worked with nurses to carry out assessments and put in place equipment and care plans to help the patient have a faster departure to their preferred place of care.

Community matron teams included a number of non-medical prescribers. This meant they could prescribe medicines for specific purposes with oversight from the pharmacy team and end of life care clinical lead.

Each locality had an out of hours pharmacy contact. The team sent on-call details to senior nurses in each area in advance to reduce delays in the event they needed to be contacted.

The SWIFT team had developed a new relationship with the local ambulance service that meant a SWIFT member of staff joined the ambulance operations team daily from Monday to Friday. The SWIFT staff helped identify if a member of their team or a paramedic was best placed to attend the patient. To date this had stopped 18 unnecessary hospital admissions.

Palliative care nurses had undertaken verification of expected death training as part of a new commissioning agreement. This significantly reduced delays for relatives and reduced the emotional impact often experienced from a paramedic call out.

Clinical nurse specialists and administrators made up a dedicated palliative care register team. This team was responsible for uploading patients' wishes and care decisions to a centralised register. This was accessible to all staff who saw patients and meant they had immediate access to the patient's information at any time.

The palliative care register team provided an in reach service to a local hospital and assessed patients as part of multidisciplinary teams in the renal service, respiratory medicine and cardiology. The team identified patients who may be approaching the end of life and worked with hospital colleagues to establish a palliative care pathway.

A dedicated team of nurses provided the SWIFT service. This team was in place to facilitate a safe, fast discharge from hospital for patients who had been taken to the emergency department. Staff worked with GPs and the ambulance service to reduce attendances and to alert them when a patient known to palliative services was taken to taken.

In January 2019 the clinical lead and integrated team managers audited patient care records to assess the standard of care given relating to specific end of life needs. This included patients living with dementia and diagnoses of long term conditions and/or cancer. In 93% of cases, staff had documented the patient's preferred place of care and their preferred place of death. The audit found staff documented the support they provided to those involved in the patient's care in 93% of cases. People important to the patient were present at the time of death in 93% of cases. The audit established staff had recognised and acknowledged the likelihood of death in the short term in 97% of cases and had individualised care in 100% of cases.

The trust supported staff to attend an end of life care summit that took place four times a year. A range of professionals attended the summit to discuss the latest care standards and research to benchmark their own practices. We reviewed the details of the most recent two summits and found a clear focus on assessing, benchmarking and improving the services offered to patients in the region. Numerous specialty teams, including from the trust, represented their respective areas of work and used the opportunity to expand the range of services offered. This included identifying the range of challenges in end of life and palliative care services and building on joint working opportunities to address these. The summits provided staff with opportunities for learning and development and enabled different organisations to share learning from incidents to improve safety and care.

Meeting the needs of people in vulnerable circumstances

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Printed information was available in large print, audio CD, Braille and a range of languages other than English.

A detailed, easy to understand bereavement support leaflet was available for the relatives, carers and friends of people who had died. This included the action next of kin needed to take after a death, including registering the death. The leaflet listed each location this could be accomplished at in the trust's service area as well as the contact details for local coroners and how to obtain a death certificate. The information included contact details for advocacy organisations and for the British Association of Counselling and Psychotherapy. Staff recognised the complex social needs of people and included details of how to explore options for financial, legal and funeral help.

Nurses discussed the National Council for Palliative Care with the relatives and carers of patients at the end of life as a tool to obtain ongoing support.

Staff used the international 'message in a bottle' scheme through a partnership with a non-profit organisation. This scheme provided free bottles and blank forms to complete and store for immediate access by emergency healthcare staff such as paramedics. When signed and dated, the forms provided healthcare staff with information on the patient's wishes and consent. The organisation provided a sticker for patients to display in a specific place in their home so emergency staff would know to look for the existence of the bottle and its location.

Staff were trained to support patients living with a learning disability during palliative care and in the last stages of life. They used communication tools to help patients understand what was happening and ensured their relatives had additional, on-demand specialist support. Staff worked closely with carers to ensure the patient's holistic needs were met and they were supported to be comfortable

Care teams worked closely with local hospices. The hospices were not part of the trust and we did not inspect them, but we considered the services they provided to help understand how this trust's community teams coordinated care. Specialist nurses had delivered training to hospice teams to help them better care for vulnerable patients, including managing anticipatory medicines.

Staff consistently went above and beyond their roles and exceeded expectations by delivering care that was individualised. For example, one patient was distressed when they had required an unavoidable hospital admission at the end of life. They had made a personal request to community nurses about not dying in the emergency department and to be able to have their favourite drink before they died. The community team worked with the emergency department and arranged for the patient to be made comfortable in a hospital bed, in a secluded area outside of the department, with the drink of their choice. In another example, a patient had asked the integrated care team to be serenaded with the music of their lifelong favourite singer. Staff had sourced a singer experienced in these songs and arranged for them to sing to the patient at the end of their life. Staff recognised themes amongst requests from patients in the last days of life. For example, many patients wanted to be able to south east Essex photographs of their loved ones from their bed, which staff arranged. This demonstrated the attention to detail and exceptional multidisciplinary working embedded in the team.

Community teams used a 'yellow folder' system to ensure all staff who delivered care understood each patient's wishes. The yellow folder was standardised across localities and meant anyone attending the patient, such as hospice consultants, community matrons or paramedics, knew to look for the same item. The yellow folder contained details of the patient's wishes for palliative or end of life care and helped avoid actions such as hospital attendances. Staff included advance care plans in the yellow folders, which provided fast access to on-going care and symptom management for staff attending the patient's place of care.

Resources were available to provide care for patients living with dementia. For example, community nurses had undertaken advanced communication training to help them care for patients on palliative care pathways and at the end of life. This helped to meet complex needs and provide their loved ones with structured tools to help them cope and to provide care at home.

Staff referred patients to a range of services to improve their wellbeing and emotional outlook in addition to their care plan. For example, they facilitated access to talking therapies, befriending services and day hospices.

Staff worked to provide the type of care people needed to be safe and comfortable and to match this with specific individual requests. For example, one patient had begun to experience seizures at home, which had resulted in recent attendances to a hospital emergency department. The patient wished to avoid hospitals at all costs and to address this, staff arranged for training for the patient's care time in managing seizures. This meant staff could manage the patient's condition safely at home and adhere to their wishes about on-going place of care.

Staff maintained a bereavement list and tracked this on a weekly basis. This ensured a member of the team always saw relatives who were bereaved.

An end of life care champion had designed a new care package that included specialised toothpaste and lip moisturiser to help make patients more comfortable at the end of life. The member of staff was working with the senior team to obtain funding to implement this.

An end of life care champion was part of a multidisciplinary working group to improve the 'This is Me' care document. The group met quarterly with people who had lived experience of supporting loved ones at the end of life along with adult social care staff and care volunteers. The champion planned for the document to more closely align with the national end of life care priorities and used the feedback from the group to trial changes.

The community assessment and referral service team had access to a range of resources to support patients living with dementia. This included soothing music to play in the background and items to reduce anxiety such as twiddle mits. This team had a close working relationship with the dementia team and learning disability team who worked in the hospital for the host trust.

Access to the right care at the right time

People could access the service when they needed it and received the right care in a timely way.

The largest ethnic minority group within the trust catchment area is Black/African/Caribbean/Black British: African with 1.7% of the population.

Ethnic minority group	Percentage of catchment population (if known)
Black/African/Caribbean/Black British: African	1.7%
Asian/Asian British Pakistani	1.6%
White Irish	1.1%

The trust did not provide referrals data for community services for end of life care.

A single point of access (SPA) team provided 24-hour cover across the trust's patch. In west Essex, calls were diverted to a central trust team and in south east Essex the team maintained continuous cover. End of life care champions in west Essex were available from 7am to 11pm and in south east Essex the specialist palliative care team were available 24-hours, seven days a

week. The single point of access team had direct access to out of hours services, including hospices and hospital acute medical teams. This meant the service provided seamless, fully integrated care provision with its community partners.

Between May 2019 and August 2019, the single point of access team answered calls in an average of one minute and one second and did not abandon any calls.

Patients were referred to palliative and end of life care services using local systems depending on where they lived. In south east Essex, patients were referred to the specialist palliative care team. In west Essex, patients were referred to the integrated community team who then allocated an appropriate nurse. Referrals came from a range of services, including acute hospital emergency departments, GPs and community nurses.

The service accepted referrals from a wide range of sources. This included from acute trusts, GPs and community allied health professionals and patients and relatives could self-refer. Staff responded to referrals for all aspects of end of life care and palliative care, including malnutrition and skin care. The trust had established service times depending on the locality, level of urgency and whether the request was out of hours. Response times ranged from two hours for urgent cases to 24 hours for more routine requests.

The specialist palliative care and SWIFT teams were part of a broad, substantive project to avoid hospital admission. In south east Essex. Between April 2018 and January 2019, the teams helped to avoid 997 potential emergency department admissions. Of these patients, 21% were seen in hospital within seven days of the initial avoidance. This reflected a 79% success rate amongst patients' staff initially supported outside of the hospital environment and resulted from well-coordinated, responsive care between different provider teams.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff**.** The service included patients in the investigation of their complaint.

From 1 April 2018 to 31 March 2019 the trust received one complaint about community services for end of life care (0.4% of total complaints received by the trust). The trust took 95 days to investigate and close this complaint, the trust's target for completing a complaint is an agreed timescale with the complainant.

A breakdown of complaints by subject is shown below:

Type of complaint	Number of complaints	Percentage of total
Systems and Procedures	1	100%
Total	**1**	**100%**

From 1 April 2018 to 31 March 2019 the trust received 60 compliments for community services for end of life care, which accounted for 5% of all compliments received by the trust as a whole.

Team	Number of compliments
Palliative Care	59
The Community Macmillan Specialist Palliative Care team	1
Total	**60**

Contact details for the patient advice and liaison service were included on all printed information resources for patients, their relatives and carers.

The end of life care clinical lead met with the patient advice and liaison service manager every month to review trends in feedback for end of life care and palliative care.

Complaints were rare and when they did occur senior staff responded immediately. Between August 2018 and July 2019 end of life and palliative services received two formal complaints. A recent complaint had occurred when a patient had been discharged from hospital, deteriorated rapidly at home and community intervention had been delayed. The end of life care clinical lead arranged a home visit by a matron within hours of receiving the complaint and had established an investigation with the service responsible for the patient's discharge. This rapid action resulted in the team establishing an immediate care plan for the patient and a hospice admission within 24 hours. Ultimately this led to a comfortable death in the patient's preferred place. The complaint led to changes in process, both within this trust and with their partners. This included more robust communication requirements within the single point of access team and from clinical nurse specialists.

A locality team received a complaint from the relative of a patient who felt left out of important information between services. The team investigated and found the patient had capacity and had made their own decisions about care and communication.

Between November 2018 and July 2019, the trust patient advice and liaison service received five complains regarding end of life or palliative care. All complaints related to communication and the team addressed these immediately. Four issues with communication related to difficulty in reaching palliative care nurses by phone. In response the team improved the information issued regarding how to contact clinical staff out of hours.

Between July 2018 and July 2019, the service received 58 written compliments from the carers and relatives of patients. We reviewed all of these and found people commented on the responsiveness of the team to their needs, including for emotional support and liaison with other services. People praised the team for their kindness and understanding and the comments were reflective of the care we observed during our inspection.

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

An end of life care clinical lead worked across the trust's patch in west Essex and south east Essex. They provided a consistent leadership presence for end of life care and palliative services. Each area had a director and assistant director. In south east Essex, a service manager supported the service and in west Essex an integrated service managed fulfilled this role. Each locality within the broad county areas had a matron and team leaders led two single point of access teams, one in each of west Essex and south east Essex. The clinical lead had recently expanded their role, which had been initially restricted to west Essex. Community staff spoke positively of this change

and said it had significantly increased the visibility and advocacy of their work in the trust and local health services.

Senior staff were present in a variety of roles, including a head of community services and respiratory care and an equipment services lead.

The trust executive nurse and a non-executive director represented end of life care and palliative care services at board level.

Integrated services managers worked at each locality and led integrated care teams.

Staff spoke positively of senior staff and said there was good visibility from their line managers. The specialist palliative care team had a vacancy for senior nurse in a leadership role and senior staff identified this as an urgent area of need to address a gap in leadership.

There was no clear leadership in place to support the community assessment and referral service (CARS) team. The team line manager had been on secondment for several months and had not been replaced. Although the team operated in a hospital operated by another trust and had daily support, there was no equivalent arrangement from this trust. Senior staff did not visit the team or engage with them and there was an overall lack of understanding of the team's role and challenges.

Dedicated leads for integration and for transformation were in post and worked across integrated care teams to support staff during change and development.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had developed an end of life care framework that was based on the trust's overarching quality strategy and the national Ambitions for Palliative and End of Life Care and the Strategy for End of Life Care 2008. The service had aligned the national five priorities of care and the eight foundations in the national ambitions with the framework and staff had established community partnerships to help achieve these. The trust had established six ambitions based on its population needs and service delivery and aimed to achieve the national standards through delivery of these ambitions. Staff discussed how the framework and ambitions applied to their role and were confident in prioritising coordinated care and maximising comfort and wellbeing.

There had been significant change in end of life care services following our inspection in May 2018. This included more robust, structured development plans, vision and strategy. The senior team had worked with staff to develop the service's own strategy and care objectives and new members of the senior team brought significant experience in navigating commissioning priorities and decisions. The new strategy incorporated a risk-averse approach for nurses working alone in the community and had led to new safety protections for them. Stronger integration between multiple services and a focus on keeping up with new trends and standards across the sector.

An assistant director had developed, with the wider team, a comprehensive, defined specification for palliative care that included key performance indicators and corporate objectives for the first time. The objectives were wide-ranging and specific to end of life care and were aimed at improving quality, performance and governance through multiple projects.

There was a notable lack of vision, strategy and sustainability for the community assessment and referral service team. The team felt isolated and we were unable to establish what the trust's plans were for this team and service. At the time of our inspection, half of the team were unavailable for work. This meant two individuals were providing a seven day service between them.

The head of service was in the process of delivering a redesign of the community respiratory service, which provided care for palliative and end of life care patients. The palliative care team was due to undergo a similar process once the first programme had been completed.

Integrated teams were developing a single comprehensive community offer for palliative care and end of life care. Senior staff were in the process of establishing a service specification, key performance indicators and a triage plan. The human resources team were undertaking a full workforce review to identify the additional skills staff might need. Senior staff described this as a key priority for the future of the service and the integration and transformation work to date had engaged staff in future development work. The trust planned to introduce this from September 2019.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The trust broadly advertised the Freedom to Speak Up Guardian although not all staff were clear on this individual's role or purpose. None of the staff we asked knew who this individual was and did not know how to immediately make contact with them. Most staff understood the principles of whistleblowing although there were broad differences in whether individual staff would feel confident to report a concern.

Staff had undertaken human rights training in partnership with hospice and hospital colleagues. The training included human rights specifically in relation to people at the end of their lives and helped staff to support patients and carers.

There was a demonstrable focus amongst integrated care teams to use challenges as an opportunity to learn. Although we saw evidence of this in all community services, it was not evident this ethos was replicated by the trust for the community assessment and referral service team. For example, the nurse establishment of the community assessment and referral service team had been reduced by 50% in the previous three years without explanation. In addition, some staff felt the trust was reluctant to accept responsibility for improving working practices.

There was a clear drive within the trust to ensure staff worked in an environment that was supportive, valued them as individuals and was free from discrimination. An equality and diversity inclusion committee and an equality champion worked across locality teams to establish fair and equitable working practices. A BME (Black and minority ethnic) staff group had uploaded an interactive page to the intranet that included questions they were often asked about their ethnicity and how it made them feel. The trust recognised and supported LGBTQ+ (lesbian, gay, bisexual, transgender, queer) staff and provided rainbow pendants, which staff could wear to demonstrate they could express themselves in a non-judgemental environment. Staff attended an awareness-raising session before they were issued with a pendant, which helped them to understand its meaning and purpose.

Staff spoke positively about the values of the trust and their teams. They said honesty and transparency were of key importance when discussing care plans and next steps with patients and their relatives. Staff said empowering patients and relatives at challenging times in their lives was an important aspect of their work, which we observed in practice.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

An end of life care sub-committee reported to the quality committee and the trust board. Local service leads were responsible for strategic operational goals and local service leads were responsible for service delivery and the end of life care framework in each locality. We reviewed the minutes of the most recent five sub-committee meetings. Appropriate specialists had attended, with input from clinicians, senior trust staff, the patient experience team, the pharmacy team and a range of others involved in service delivery. The sub-committee was demonstrably focused on maintaining and improving services for patients and on the development of more robust clinical governance and quality management systems. The sub-committee had maintained oversight and provided multidisciplinary expertise in the development and implementation of the end of life care framework.

Most staff spoke positively of changes to governance processes and frameworks following our last inspection in May 2018. For example, community staff said managers had listened to their concerns and acted on these. The trust had implemented new governance processes for end of life care. For example, an end of life care steering group convened monthly with a standardised agenda that enabled staff to raise issues locally and then centrally with the trust.

Staff had established robust governance processes with community and primary care partners, which demonstrated a clear alignment of care and service priorities.

The trust executive nurse had a governance-based role and chaired monthly end of life care steering group meetings.

Services were provided across nine clinical commissioning groups (CCGs), three sustainability and transformation partnerships (STPs) and three local authorities, which generated significant challenges in continuity of care as staff navigated multiple different systems, pathways and commissioning priorities. The senior team proactively engaged with primary care networks, including nine new networks in south east Essex. The team recognised the importance and benefits of aligning palliative care with wider primary care objectives.

A joint medicines management working group had developed a new palliative care formulary in west Essex. This area had not previously had such a resource and it would significantly improve the structure and framework within which staff could administer medicines. The working group had developed this with multidisciplinary input, including from hospice teams, and had issued a copy to all prescribing clinicians in the area.

This trust had been formed from the merger of two separate trusts and its primary funding was for mental health services. At our previous inspection in May 2018, staff felt the trust did not view end of life care services as a priority. At this inspection staff said there had been a significant improvement and they felt the service was a key priority of the trust. Senior had developed a new strategy, framework and objectives as evidence for this.

The medicines management group and a non medical prescriber forum maintained oversight of safe practice in the trust. Both groups met monthly and reviewed feedback from staff and incidents.

Staff maintained action logs to track improvements and changes to the service following discussions in team meetings.

Governance processes were effective and resulted in service improvements and development. For example, the specialist palliative care team and palliative care register team used a joint meeting to implement oxygen therapy training sessions for staff and to review a draft service specification. The teams had identified a need for more robust crisis response for certain patients and invited the SWIFT team to their next meeting to plan this work.

The SWIFT team held monthly meetings. We reviewed the minutes and action logs of the most recent four meetings and found a clear drive to improve patient-centred care and continually identify opportunities for integrated working. For example, the team had worked with GPs to improve the process for ordering blood work and had implemented an updated national early warning score system, called NEWS2, to help identify deteriorating patients more accurately. Staff had used team meetings to improve processes, including handover documentation, and to access culture and behaviours training.

The community assessment and referral service (CARS) met bi-monthly. We reviewed the minutes and action logs from the most recent six meetings. The structure of the meetings ensured staff adhered to governance standards from this trust and from the trust that operated the hospital they worked from. This ensured the team remained up to date with safety processes and policies. End of life care was a standing agenda item for each meeting and the minutes demonstrated how the team worked with the hospital and community teams to facilitate rapid, specialist care.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust used quality and safety meetings as the primary means of reviewing performance, standards of care and risk. The end of life care clinical lead attended each meeting to represent the service.

End of life care and palliative care teams did not have dedicated risk registers. Instead senior staff entered risks to an operational risk register and said the trust would not always accept these. It was not evident the trust had oversight of service specific risks, performance or issues at a senior level above directors. Senior leaders in the trust were not aware of gaps in evidence-based practice in some aspects of care, such as pain control. In addition, we received conflicting information from senior service staff and the senior trust team that was indicative of differences in understanding of the service. This related to the role end of life care champions had in caring for patients with on-going substance misuse challenges.

A named member of staff was accountable for each risk and had implemented an action plan and mitigation strategies.

Staff raised concerns regarding a service review and stated that this had been ongoing for over 12 months. The trust provided information that indicated they were working with system partners to remodel the service, but did not provide timescales for this to be completed.

It was common practice for staff to work alone in the community when caring for patients and travelling. The trust had a lone working policy to help promote the safety and wellbeing of staff. The trust provided personal alarms on request. The senior team had recently trialled new lone worker devices that could summon help in an emergency remotely. Staff who had participated in the trial said it had worked well although they said there were no plans to implement this as a requirement.

Risk and quality systems were in place to support and guide staff who worked remotely or on the premises of other providers. For example, the community assessment and referral service team worked in an emergency department in another NHS trust. The team had honorary contracts with the other trust to ensure they could access essential information and operational systems in the course of their work. They had on-site processes for escalation to senior clinicians or hospital managers. They reported to both trusts in relation to incidents and complaints, which meant both governance and leadership teams maintained appropriate oversight.

Staff spoke positively of access to corporate services such as human resources and the IT team. Each corporate service had a named point of contact in each locality and staff said they were easy to access.

Each locality team had a business continuity plan specific to their area. Plans were specific to local operating procedures and the trust's central teams maintained oversight. This meant in the event a local office became uninhabitable or a local service was suspended, the central trust team could intervene to reduce disruption.

The senior team had developed a quality dashboard to improve understanding of performance and use this to better drive service improvements. The dashboard established distinct measurements for End of life care and aimed to address disparities in care caused by delivering a service across multiple clinical commissioning groups. The dashboard had improved learning and communication between west Essex and south east Essex teams and meant where managers identified learning in one locality, staff could more readily share it with colleagues across the trust.

The dashboard was based on the population health model, which focused on holistic health. This approach meant the service did not discharge a patient once they entered a palliative care or end of life care pathway and staff monitored their needs for the entirety of the remainder of their lives.

A manager was always available on call for staff to escalate situations. The service had developed a working relationship with the NHS 111 team, whose staff understood the nature and scope of the service.

An assistant director had implemented a quality improvement plan for palliative care and end of life care to fully integrate services across the trust. This aimed to improve the integration of key performance indicators and patient outcomes across services.

Senior multidisciplinary staff from across the trust attended monthly mortality review sub-committee meetings. This sub-committee reviewed mortality in the trust and provided oversight of policies and thematic reviews that affected staff and patients. We reviewed the minutes of the most recent six meetings and saw members maintained active review and understanding of themes and trends in the organisation. The sub-committee reviewed patient deaths within a

defined scope and worked to improve the influence and outcomes of the deceased patient review group.

Trust staff attended a monthly respiratory steering group, which a clinical commissioning group led. This enabled staff to stay up to date with community developments and ensure patients always had access to specialist care as part of their end of life or palliative pathway. We reviewed the minutes of the most recent three meetings and saw they were effective in coordinating care and resources across community and integrated care teams.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Staff submitted data or notifications to external organisations as required.

Staff managed information consistently, including when using multiple different systems between providers. For example, staff routinely used GP patient records systems and hospital-based systems to document and track patient care, in addition to the trust's own systems. Staff demonstrated how they kept patient data secure between each system and use was in line with data confidentiality guidance. GPs in the same locality often used different systems and community teams managed this seamlessly, reducing risk and delays through their experience of interacting with the various processes.

Information sharing agreements were in place with each external provider staff worked with. This meant staff in any provider could access a patient's care records to provide coordinated care and ensure they adhered to the patient's advance care plan. Staff obtained consent to share information and would only do so when each provider had appropriate data protection safeguards in place, including compliance with the General Data Protection Regulations 2016/679 (GDPR).

Staff were contributing to a joint project with an NHS acute trust to ensure a plan to share electronic systems between community and acute services would be compliant with the General Data Protection Regulations.

The clinical lead and integrated team managers found a need for improvements in the use of the electronic information system shared between community staff and GPs. The different systems resulted in duplication of work and omissions and inconsistent documentation of patient needs. For example, staff sometimes documented care in one system and not the other system. This restricted the number of colleagues who could access it and increased the risk of missed information. The senior team recognised this as a priority area for improvement and were working with GPs, hospitals and the community teams to improve standardisation.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

There was consistent engagement with community teams in the trust from the senior locality teams. The end of life care clinical lead had carried out a survey with community staff, including non-clinical staff, and asked them to self-identify gaps in training for delivering care to patients at the end of life. They had used the feedback to develop an end of life care competency training package that was bespoke and catered to staff needs.

Staff spoke openly and honestly about the key challenges in their area of work. Common challenges included the extra work created by using multiple records and patient care systems between localities and a lack of 24-hour specialist end of life care provision in west Essex.

The trust had implemented an equality agenda with input from staff that the senior team had ratified before the inspection.

Staff said senior managers and the executive team visited localities frequently and held leadership forums to improve engagement.

Staff provided care to patients often on a long-term basis and formed appropriate bonds during this time. The relatives of patients who had died often invited staff to their funerals and the trust supported staff in this.

Although most staff said they felt valued by the trust and the senior team, others said they lacked confidence that they had an important role to play.

The clinical lead and associate director for practice development had joined the NHS Improvement end of life care practitioner forum as a strategy to increase engagement with other trusts and learn from their work.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

NHS Trusts are able to participate in several accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust did not report any accreditations specific to this service.

The End of life care team had identified a gap in care for young people with mental health needs in addition to their palliative or end of life needs. Staff were proactive in seeking solutions to such needs and had prepared a business case to be presented to the clinical commissioning group to increase specialist psychology provision.

Senior staff said they were focused on staying a step ahead of developments in national end of life care policy and standards. A quality improvement programme (QIPP) formed part of this approach and senior staff had presented a proof of concept to the clinical commissioning group as part of substantial service development and improvement plans. This was part of an overarching plan that would increase corporate scrutiny and provide enhanced supervision and development for staff. For example, the senior team had developed a rotation programme for staff nurses that would enable integrated care teams to develop into specialist roles.

The patient advice and liaison service (PALS) manager and an end of life care champion planned to visit another NHS trust to spend time with their end of life care team that was more established and had a track record of quality performance. This was due to happen shortly after our inspection and was reflective of the team’s approach to learning and sharing best practice.

Community non-profit organisations had recognised the trust for the work they had completed in developing apprentices into permanent, qualified roles. The trust had increased intake from

university students by 18% in the previous year and increased the internal ‘grow your own’ development strategy. We spoke with three members of staff who had joined the trust in junior roles. Managers had supported staff members to gain qualifications and progress to more senior roles. Each individual was positive about the support they had received from the trust. The trust had increased its offer to student nurses, which had resulted in greater recruitment of newly-qualified nurses. The senior team facilitated a new support group and provided protected time for nurses to meet with each other and reflect on their experiences. These achievements reflected the trust’s drive to recruit and develop local talent and to encourage loyalty amongst existing staff.

Although the trust had increased involvement with students overall, this did not apply to the community assessment and referral service team, in which the trust had suspended student placements. Staff said student placements had been highly beneficial and the trust had not explained its decision.

Staff developed positive relationships with other service providers and openly shared their work at appropriate stages. For example, hospices had approach staff and asked to use the new end of life care training competencies. Staff agreed to this and saw it as an opportunity for winder improvements in care.

We spoke with staff who had progressed to more senior roles during their employment with the trust. Staff spoke positively about the support they had received, which had included support for staff to develop into qualified positions. We spoke with staff who had undertaken such development, who said they found it fulfilling.

During the 2018 winter pressures period, the Uttlesford locality team changed their usual ways of working to ensure staff saw patients despite disruption caused by extreme weather. Staff swapped shifts and usual places of work to reduce travel time and planned patient care responsively, making short-notice changes to avoid missing visits. The trust recognised the efforts of the team with a quality award. Staff spoke positively of this and said it made them feel recognised and valued.

The service had introduced a pilot scheme that meant occupational therapists spent time shadowing paramedics. The pilot intended to increase cross-team working and further contribute to hospital admission avoidance.

The senior team demonstrated a clear commitment and drive to delivering service and care improvements. Audits in January 2019 and April 2019 had benchmarked the service and identified baseline standards of care using national standards. The team had launched an action plan to address seven key areas for improvement, including around reporting systems and the measurement of quality. At the time of our inspection, the team had completed four actions and planned to complete the remaining three actions by the end of 2019.

As part of ongoing training and development opportunities offered to colleagues in and out of the trust, the clinical lead implemented a survey to help staff self-identify gaps in training and what they would like to take part in. The clinical lead planned to analyse the results in early 2020 and use them to develop future training opportunities. They included all staff who provided care for patients on a palliative or end of life care pathway, including mental health teams, prison services and inpatient staff. The survey included questions about the new end of life care framework and the clinical lead planned to use the responses to adapt communication about the new governance tools.

Senior trust staff and a clinical commissioning group had implemented a network work plan in south east Essex to drive substantial improvements in palliative and end of life care delivery and governance. Senior staff were using a development plan to combine the services offered by palliative care and end of life care into a single community service. This would improve access for patients and standardise care across a wide area. Both plans were based on national priorities and designed to complement work already completed in the trust.

Mental health services

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

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Basildon Mental Health Unit	Assessment Unit	20	Mixed
Basildon Mental Health Unit	Grangewater Ward	28	Mixed
Basildon Mental Health Unit	Hadleigh PICU	15	Mixed
Basildon Mental Health Unit	Kelvedon Ward	18	Mixed
Rochford Hospital	Cedar Ward	24	Mixed
Colchester Mental Health Wards	Ardleigh Ward	18	Female
Chelmer & Stort Mental Health Wards	Chelmer Ward	16	Female
Broomfield Hospital Mental Health Wards	The Christopher Unit	10	Mixed
Trust Head Office	ECT Suite (Mid)	0	Mixed
Broomfield Hospital Mental Health Wards	Finchingfield Ward	17	Male
Broomfield Hospital Mental Health Wards	Galleywood Ward	18	Female
Colchester Mental Health Wards	Gosfield Ward	18	Male
Colchester Mental Health Wards	Peter Bruff Unit	17	Mixed
Chelmer & Stort Mental Health Wards	Stort Ward	16	Male
Basildon Mental Health Unit	Thorpe Ward	21	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

Safety of the ward layout

Staff mostly took action to observe patients on the wards. For example, Chelmer ward had some blind spots and staff completed staff hourly checks. Gosfield ward had a blind spot opposite the nursing station but was in a regularly monitored area. Peter Bruff ward garden had a blind spot and bushes were overgrown which could present a risk staff would not see all areas. On one occasion we visited there were no staff in the garden monitoring the area. Staff were aware of the risk and were looking to extend close circuit television coverage.

Over the period from 1 January 2018 to 31 March 2019 there were no same sex accommodation breaches within this service.

The number of same sex accommodation breaches reported in this inspection was lower than the one reported at the time of the last inspection.

NOTE: Comparisons to 'last inspection' data often do not refer to a whole year of data.

Trust data for south showed no mixed sex breaches

The trust continued to provide mixed sex accommodation as eight of 14 wards were mixed. Wards had specific areas for men and women's bedrooms. Although on Grangewater ward not all female designated area signage was put back up after redecoration. However, patient privacy and dignity was affected on Peter Bruff ward. Female patients still had to walk through the male bedroom corridor area to access their bedroom area or the communal areas.

There were ligature risks on 14 wards within this service. All wards had a ligature risk assessment in the last 12 months. There were no ligature risk assessments on ECT suites. However, staff informed us that patients are escorted to the suite and fully observed at all times.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Galleywood	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Risks included in hotspots and heat maps. Tasks raised as appropriate.
Chelmer	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Risks included in hotspots and heat maps. Tasks raised as appropriate.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Ardleigh	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Actions signed off by the Ligature Risk Reduction Group. Risks included in hotspots and heat maps. Tasks raised as appropriate.
Finchingfield	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Actions signed off by the Ligature Risk Reduction Group. Risks included in hotspots and heatmaps. Tasks raised as appropriate.
Stort	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Risks included in hotspots and heat maps. Tasks raised as appropriate.
Gosfield	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Actions signed off by the Ligature Risk Reduction Group. Risks included in hotspots and heat maps. Tasks raised as appropriate.
Peter Bruff	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Actions signed off by the Ligature Risk Reduction Group. Risks included in hotspots and heat maps. Tasks raised as appropriate.
Christopher Unit	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Risks included in hotspots and heat maps. Tasks raised as appropriate. Actions to be agreed by the Ligature Risk Reduction Group.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Grangewaters	This is a vulnerable group of patients who have the potential to self-harm. Due to the age and fabric of the building it is difficult to design out all potential ligature risks and as the obvious risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Actions signed off by the Ligature Risk Reduction Group. Risks included in hotspots and heat maps. Tasks raised as appropriate.
Thorpe	This is a vulnerable group of patients who have the potential to self-harm. Due to the age and fabric of the building it is difficult to design out all potential ligature risks and as the obvious risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Actions signed off by the Ligature Risk Reduction Group. Risks included in hotspots and heat maps. Tasks raised as appropriate.
Hadleigh Unit	This is a vulnerable group of patients who have the potential to self-harm. Due to the age and fabric of the building it is difficult to design out all potential ligature risks and as the obvious risks are removed recent surveys and feedback has identified an increase in finding alternative methods.	Yes	Risks included in hotspots and heat maps. Tasks raised as appropriate. Actions to be agreed by the Ligature Risk Reduction Group.
Kelvedon	This is a vulnerable group of patients who have the potential to self-harm. Due to the age and fabric of the building it is difficult to design out all potential ligature risks and as the obvious risks are removed recent surveys and feedback has identified an increase in finding alternative methods.	Yes	Risks included in hotspots and heat maps. Tasks raised as appropriate.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Mental Health Assessment Unit	This is a vulnerable group of patients who have the potential to self-harm. Due to the age and fabric of the building it is difficult to design out all potential ligature risks and as the obvious risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Risks included in hotspots and heat maps. Tasks raised as appropriate. Actions to be agreed by the Ligature Risk Reduction Group.
Cedar	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Actions signed off by the Ligature Risk Reduction Group. Risks included in hotspots and heat maps. Tasks raised as appropriate.

Maintenance, cleanliness and infection control

The sites which deliver MH – Acute wards for adults of working age and psychiatric intensive care units within Essex Partnership University NHS Foundation Trust were compared to other sites of the same type and the scores they received for 'cleanliness' and 'condition, appearance, and maintenance' were found to be about the same as the England average.

The trust had not ensured that all ward areas were clean, well maintained and fit for purpose. We had identified this as a concern at our April 2019 inspection for Thorpe and Grangewater wards.

The trust's systems to ensure wards were clean was not fully effective. Whilst the trust had ensured wards had regular cleaning staff visiting, it was not sufficient as three of 14 wards were not clean including Gosfield, Kelvedon and Cedar wards. For example, we found urine on floors on two wards and there was a strong smell of urine in some bathrooms. This posed an infection risk and. We found mould in a bathroom ceiling on Ardleigh ward. Seven of 33 patients (21%) across wards complained about unclean or blocked toilets. However, we noted the trust had introduced a 'peer/mystery shopper' service to check further on the décor and cleanliness of services. A trust infection control action plan for Peter Bruff ward dated December 2018 did not identify who was accountable or timescales for actions to be completed.

Wards had changed over to eco-friendly cardboard sanitary bins which also promoted cervical screening. However, Chelmer ward staff was disposing of them via household waste. Whereas other ward staff said they disposed of them via clinical waste.

The trust had not ensured all maintenance issues were assessed, reported and resolved promptly. For example, Chelmer's fire doors in bedroom corridor did not close properly. Staff had reported the matter to the maintenance team who made a temporary repair.

Seclusion room (if present)

Seclusion rooms seen for Ardleigh, Gosfield, Peter Bruff wards and the Hadleigh Unit, allowed clear observation and two-way communication. They had a toilet and a clock. We were unable to check the room on the Christopher unit as it was occupied.

Other wards Cedar, Galleywood, Finchingfield, Chelmer, Stort, Grangewater, Thorpe, Kelvedon and the Assessment Unit did not have a seclusion room. Staff said they would transfer patients to a PICU if seclusion was required

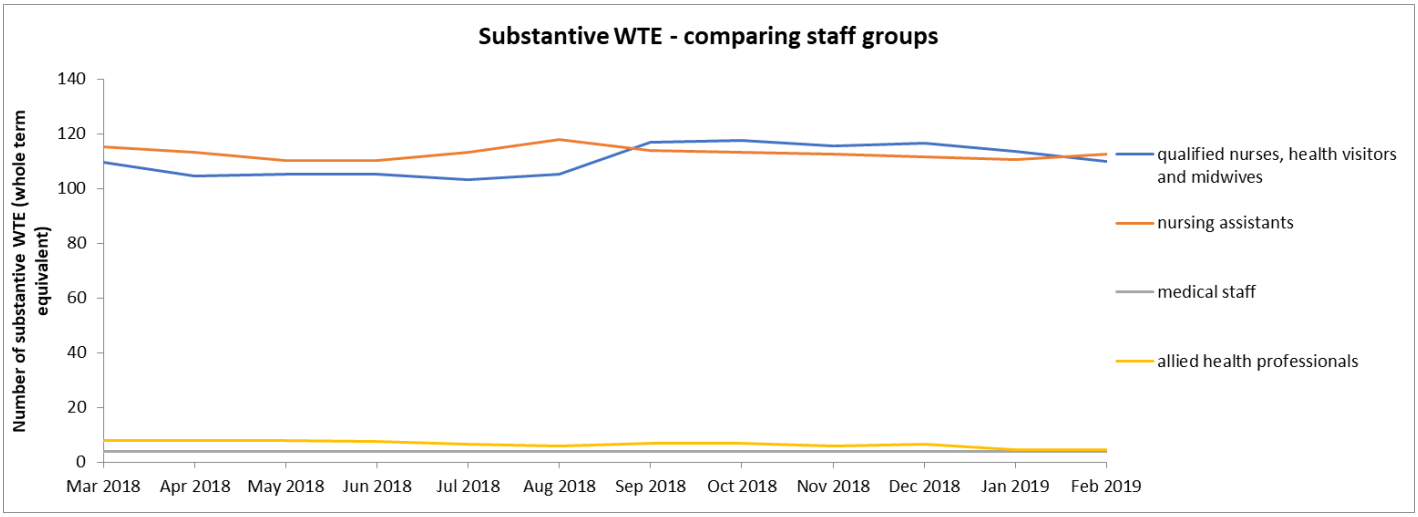
Clinic room and equipment

Most clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. However, Finchingfield was awaiting a replacement examination couch. Chelmer and Stort did not have aprons and the last oxygen cylinder check on Chelmer was '23 October 2015'. Chelmer staff had not restocked items in a first aid box. Cedar's clinic fridge was unlocked.

Staff checked, maintained, and cleaned equipment. However, Gosfield and the Assessment Unit staff had not fully completed daily checks for emergency equipment. Chelmer's clinic whilst neat and tidy did not have an apparent cleaning audit. Cedar ward staff had not fully completed some cleaning and fridge temperature check records.

Safe staffing[4]

The below chart shows the breakdown of staff in post WTE in this core service from 1 March 2018 to 28 February 2019.



The below table covers staff fill rates for qualified nurses and care staff during January 2019 and February 2019.

Key:

> 125%	< 90%

	Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)

[4] Staffing run chart; Staff fill rates; Vacancy benchmark; Sickness benchmark; Turnover benchmark

	January 2019				February 2019			
Ardleigh	101%	186%	200%	148%	95%	196%	193%	145%
Assessment Unit - Basildon	93%	99%	98%	100%	93%	99%	93%	100%
Chelmer	111%	131%	140%	103%	113%	195%	143%	268%
Christopher PICU	90%	113%	102%	115%	77%	137%	96%	130%
Finchingfield	112%	116%	139%	94%	119%	115%	136%	79%
Galleywood	103%	121%	100%	123%	102%	107%	100%	96%
Gosfield	97%	145%	100%	203%	95%	152%	100%	204%
Grangewater	100%	106%	95%	119%	100%	103%	100%	107%
Hadleigh Unit	89%	171%	87%	315%	100%	196%	93%	355%
Kelvedon	69%	135%	106%	101%	83%	148%	104%	100%
Peter Bruff	89%	94%	97%	100%	89%	93%	98%	101%
Stort	106%	160%	200%	100%	101%	110%	200%	50%
Thorpe	95%	126%	95%	142%	95%	139%	98%	157%

Kelvedon and Peter Bruff wards had below 90% of the planned registered nurses on day shifts in January 2019 and February 2019. Across the service there appears to be a tendency for care staff fill rates to be over 125% of the planned rates. The reason for this is not clear.

The service had increased staff vacancy rates and increased rates of bank and agency nursing staff usage in the last year. Managers told us they had nurse and nursing assistant vacancies across most wards. Trust data from April to July 2019 showed 98% of nursing staff shifts were filled. However, 645 were not filled (2%). Of these, 331 were nurse shifts (3%) and 314 were nursing assistant shifts (2%). April 2019 had the highest amount with 194 unfilled shifts (3%). Peter Bruff, Kelvedon and Gosfield wards had the highest unfilled nurse shifts with 6%. Cedar and Finchingfield ward had the highest unfilled nursing assistant shifts with 6%. However, they had the highest cover of nurse shifts. Ardleigh ward had the highest cover of nursing assistant shifts.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The trust was reviewing ‘Safer Staffing’ data to confirm it was safely staffed or make recommendations. They were initiating a review of staffing and skill mix requirements to be undertaken every six months. Managers said they tried to limit their use of bank and agency staff and requested staff familiar with the service. They were reliant on the trust central team to screen bank and agency staff to ensure they had the correct skills and experience to work on their ward. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

There were no reports where the service did not have enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

Annual staffing metrics

	Core service annual staffing metrics

	(Vacancy, Turnover, Bank and Agency: 1 March 2018 – 28 February 2019) (Sickness: 1 April 2018 – 31 March 2019)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual "unfilled" hours (% of available hours)**
All staff	427.7	17%	8%	7.3%			
Qualified nurses	160.5	21%	5%	5.8%	80257 (25%)	50884 (16%)	6872 (2%)
Nursing assistants	161.0	22%	10%	8.7%	228460 (87%)	25274 (10%)	8420 (3%)
Medical staff	36.0	-8%	0%	N/A	N/A	N/A	N/A
Allied Health Professionals	5.0	-10%	10%	3.8%			

NOTE: Data regarding the number of medical locum hours filled by bank and agency staff was not clearly aligned to specific teams; therefore, this data was not usable for analysis.

The following information and charts highlight specific staffing areas where there is noteworthy evidence that may prompt further investigation on site.

All Staff

The average sickness rate for all staff was in the highest 25% when compared to other similar core services nationally.

Most managers did not have up to date information about their overall sickness data but knew which staff were off on long term sickness leave. Managers supported staff who needed time off for ill health. Trust data sent after the inspection for June 2019 for five north wards showed Chelmer had the highest sickness rate with 9% for June 2019 affected by staff on long term sickness.

Qualified Nurses

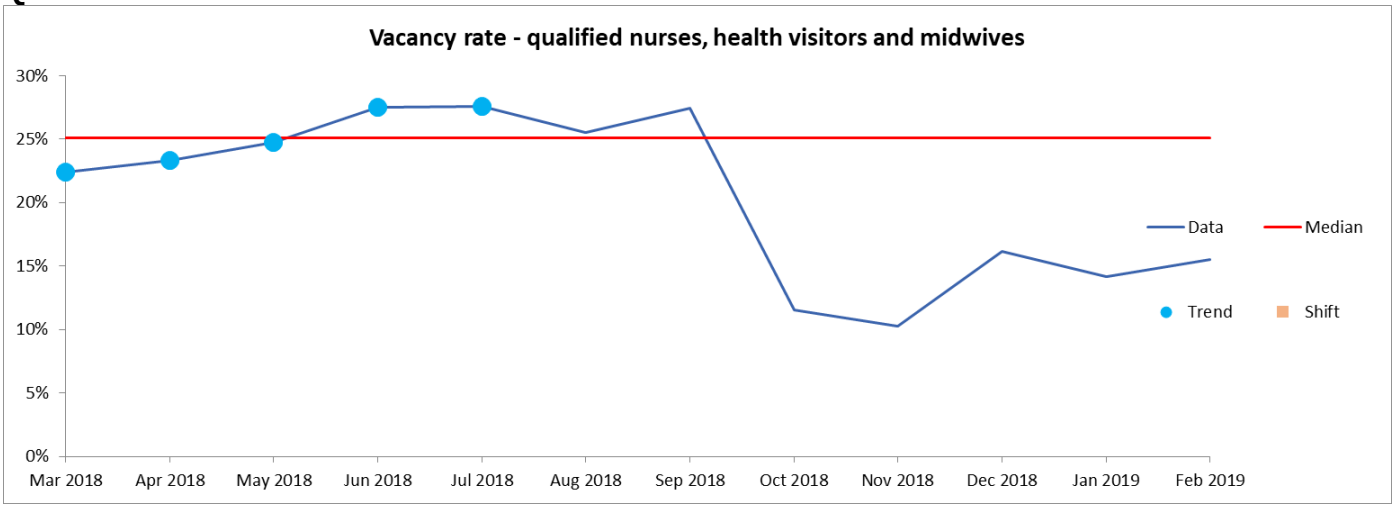


Figure 1

Monthly 'vacancy rates' over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from March 2018 to July 2018 (see figure 1). This could be an early indicator of deterioration.

Additionally, the average sickness rate for qualified nurses was in the highest 25% when compared to other similar core services nationally. However, the annual turnover rate for qualified nurses was in the lowest 25% when compared to other similar core services nationally.

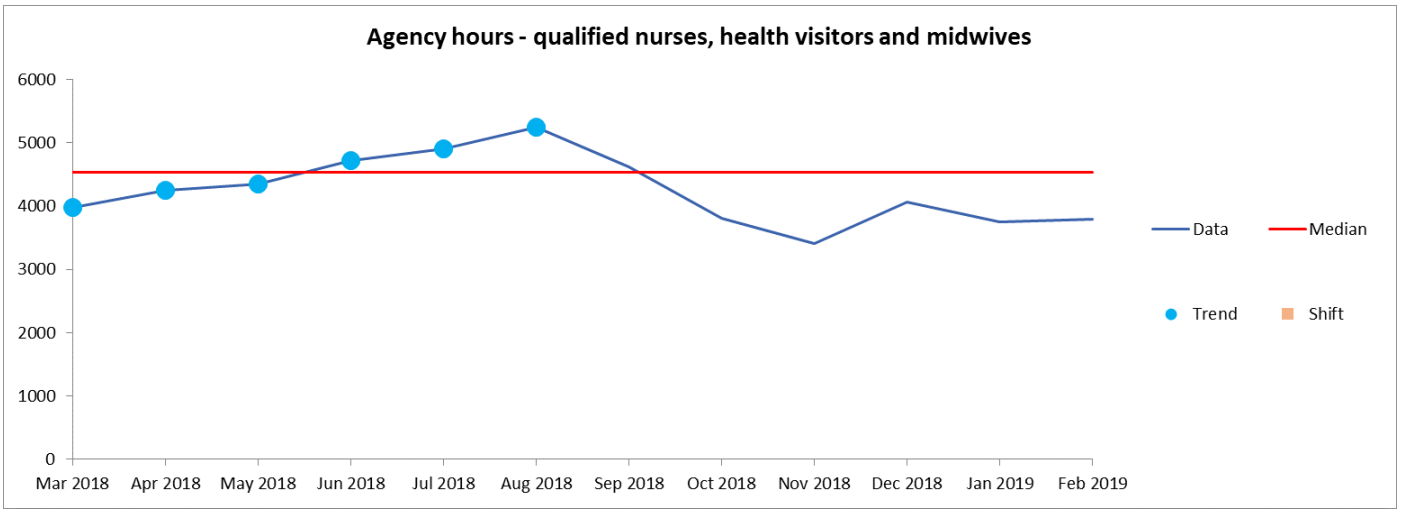


Figure 2

Monthly 'agency hours' over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from March 2018 to August 2018 (see figure 2). This could be an early indicator of deterioration.

Nursing Assistants

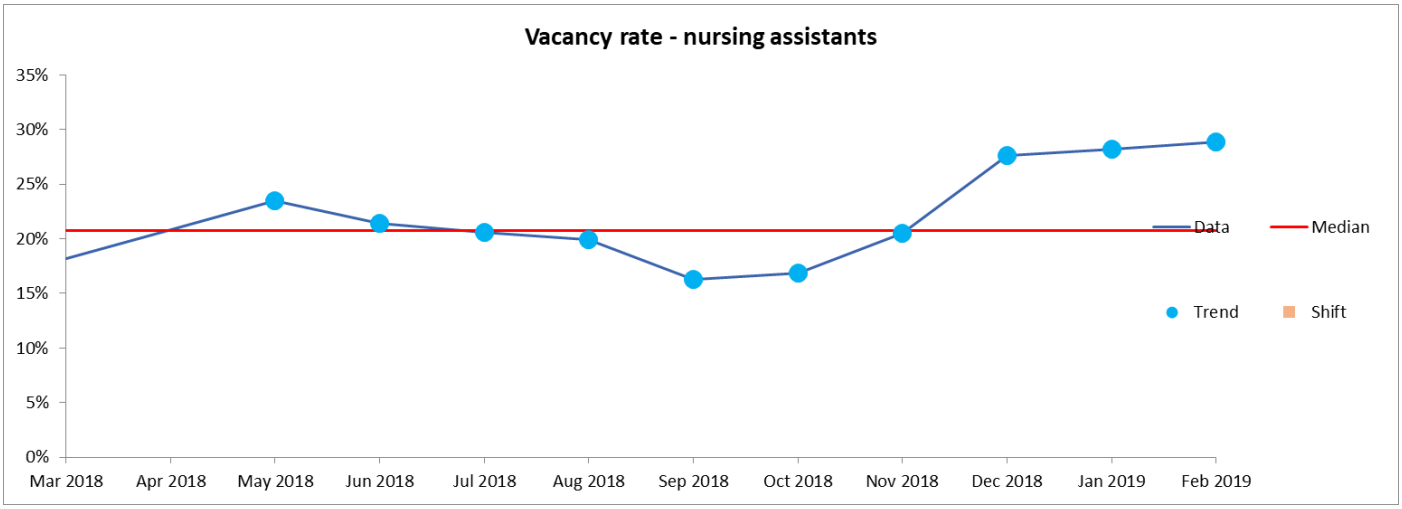


Figure 3

Monthly 'vacancy rates' over the last 12 months for nursing assistants shows an upward trend from September 2018 to February 2019 (see figure 3). This could be an early indicator of deterioration. This merits investigation to find out if this trend has continued and to learn about the cause, impact and possible actions undertaken by the provider to reverse the deterioration. In addition, it shows a

downward trend from May 2018 to September 2018 (see figure 3). This could be an early indicator of improvement.

The average vacancy rate for nursing assistants was also in the highest 25% when compared to other similar core services nationally.

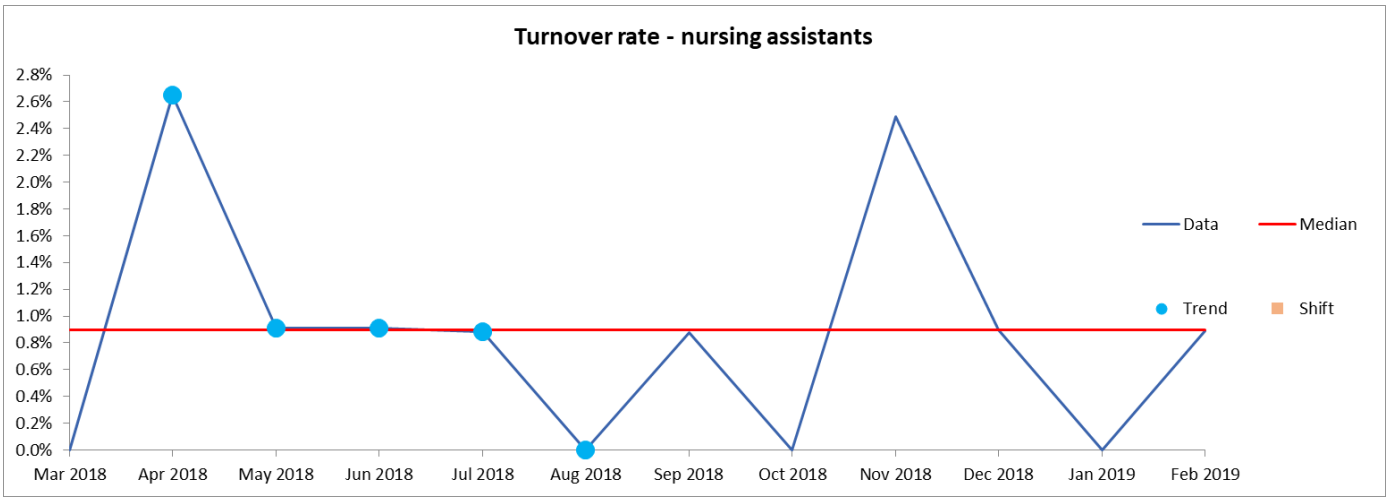


Figure 4

Monthly 'turnover rates' over the last 12 months for nursing assistants shows a downward trend from April 2018 to August 2018 (see figure 4). This could be an early indicator of improvement.

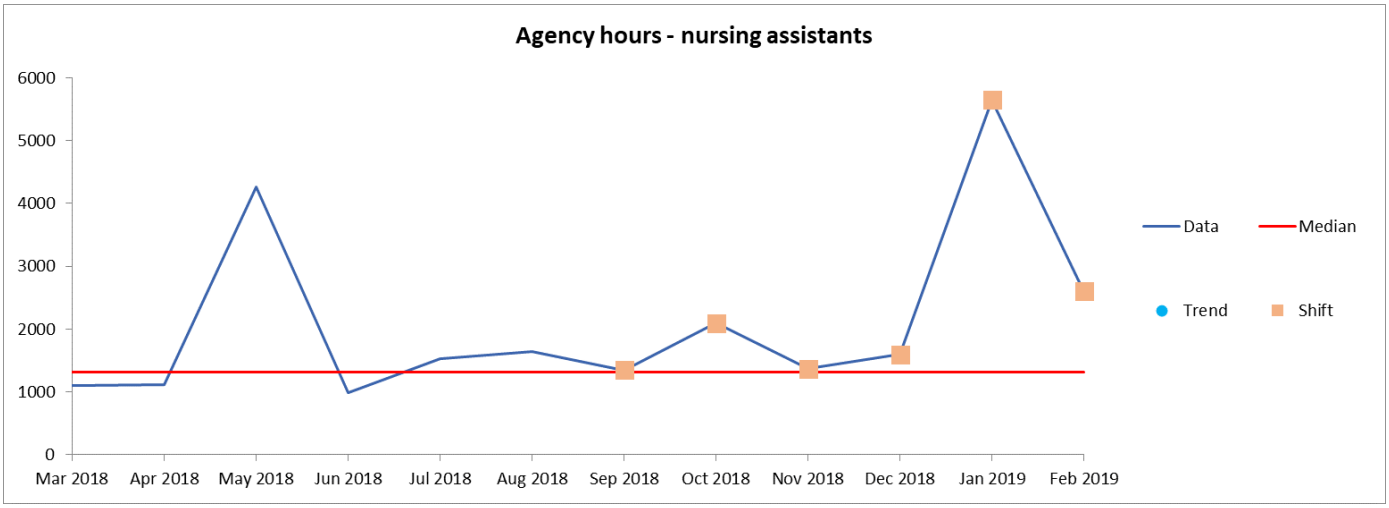


Figure 5

Monthly 'agency hours' over the last 12 months for nursing assistants shows a shift from September 2018 to February 2019 (see figure 5). This could be an indicator of change. This merits investigation to find out the causes and impacts of the possible change.

The service had reducing staff turnover rates since our last inspection.

Allied Health Professionals

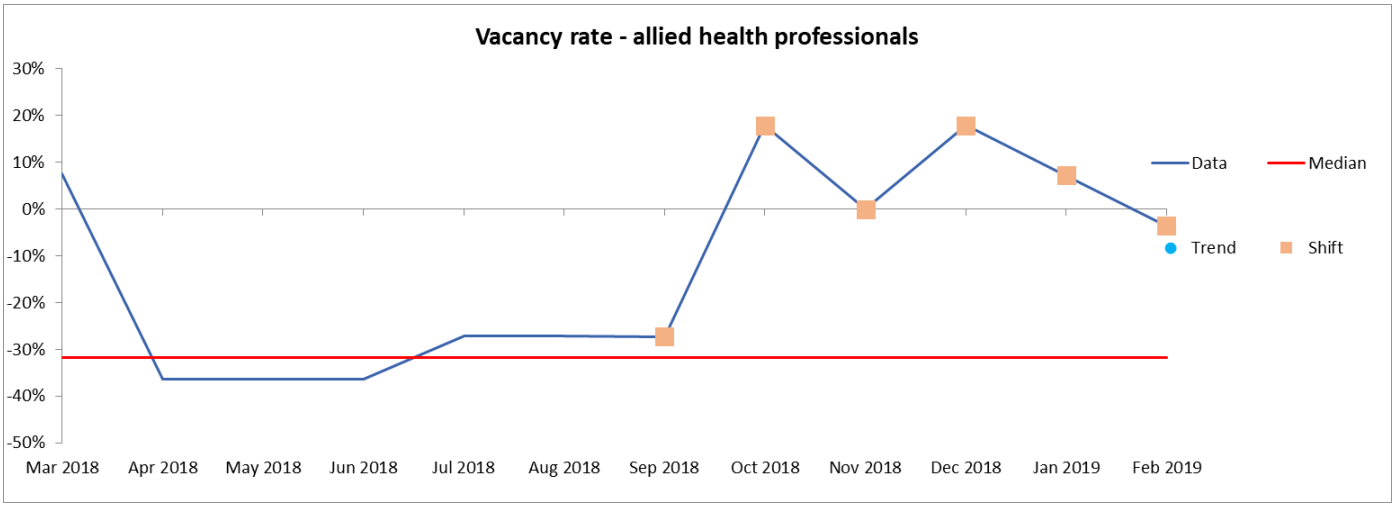


Figure 6

Monthly 'vacancy rates' over the last 12 months for allied health professionals shows a shift from September 2018 to February 2019 (see figure 6). This could be an indicator of change. This merits investigation to find out the causes and impacts of the possible change.

Despite this shift, the average vacancy rate for allied health professionals was in the lowest 25% when compared to other similar core services nationally.

Medical

The average vacancy and turnover rates for medical and dental staff were in the lowest 25% when compared to other similar core services nationally.

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Managers could call locums when they needed additional medical cover.

Mandatory training

The compliance for mandatory and statutory training courses at 31 March 2019 was 92%. Of the training courses listed three failed to achieve the trust target and of those, none scored below 75%.

The trust set a target of 85% for completion of mandatory and statutory training modules including: Fire Safety 3 years, Fit for work, Induction, Information Governance, and Mental Health Act. The trust set a target of 90% for completion of mandatory and statutory training modules including: Safeguarding Adults (Levels 1, 2, & 3), Fire Safety 2 years, and Safeguarding children (Level 3).

Training completion is reported as at end of reporting period.

The training compliance reported for this core service during this inspection was higher than the 88% reported in the previous year.

Key:

Below CQC 75%	**Met trust target** ✓	**Not met trust target** ✘	**Higher** ↑	**No change** →	**Lower** ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults (Level 1)	4	4	100%	✓	N/A
Safeguarding Adults (Level 2)	249	243	98%	✓	↑
Induction	262	252	96%	✓	↑
Fire Safety 3 years	38	36	95%	✓	N/A
Mental Health Act	135	121	90%	✓	↓
Fit for work	253	228	90%	✓	↑
Fire Safety 2 years	229	203	89%	✗	↓
Information Governance	253	222	88%	✓	↑
Safeguarding Adults (Level 3)	124	109	88%	✗	↓
Safeguarding Children (Level 3)	8	7	88%	✗	N/A
Total	**1555**	**1425**	**92%**	✓	↑

Staff had completed and kept up to date with their mandatory training. However, the trust had recently updated their training requirements for staff and managers could not easily show us their latest data on site when we visited. Trust data sent 16 August 2019 showed this core service overall had 95% compliance with essential training identified by the trust. Staff compliance with basic life support training was 94% and fire safety 92%. The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed comprehensive risk assessments for most patients when they were admitted and reviewed this regularly, including after any incident. However, staff had not updated six of 49 records (12% across Cedar, Ardleigh and Grangewater wards although Grangewater staff had updated the patients care plan to reflect risks). Trust information for June 2019 showed no wards had met the trust target of 95% for completed patients' risk assessment within four hours. Finchingfield ward was the highest with 93% compliance and Grangewater had lowest compliance with 25%.

Staff used a trust risk assessment tool. Basildon Mental Health Unit psychology staff additionally used 'My care my safety' plans for patients identified at risk of self-harm. The trust had identified a need to improve 'transport risk assessments' form for all patient transfers and completed audits to check on this.

Management of patient risk

Improvements were required relating to staff's risk management on wards to keep patients safe.

Staff did not always fully complete observation records of patients as we found gaps in 21 records across three wards Gosfield, Cedar and Grangewater. We found three occasions across Cedar and Gosfield wards where staff carried out enhanced observations of patients for more than two hours which is not in line with trust policy.

Patients' personal items were not always safe and secure on wards. Whilst wards had items for patients to have a secure locker this was not in their bedroom. The trust had not ensured that all patients could lock their bedrooms (or dormitories) and keep items secure from others for example Cedar, Thorpe, Grangewater, assessment unit and Kelvedon. Whereas other wards including Chelmer, Stort, Ardleigh, Gosfield and Peter Bruff gave patients a card to access their rooms (subject to risk assessment). This meant that some bedrooms were unlocked which posed a risk of patients' accessing bedrooms other than their own. Whilst managers tried to ensure a regular presence of staff checking corridors and rooms it would not fully reduce the risk of this. We saw examples where patients had complained about a variety of issues such as alleging people had gone into their room without their permission or property had been stolen. The trust had displayed disclaimers stating patients should not keep valuables on the ward and they could make arrangements for patients to keep some items secure.

There was risk that patients identified at high risk of self harm could access items to self-harm with. Staff were aware that patients could be innovative with developing new ways to self-harm and use items to ligate with (mostly not to a fixed point) and shared information across wards where risks were identified. However, staff were not consistently following the trust's search policy and restricted items lists as we saw a top with ties in a dormitory on Grangewater ward despite a restriction on items such as shoelaces, belts, scarves and tracksuit ties. Staff across wards reported limitations with the trust's search policy and process (use of a magnetic wand and pat down) stating patients' secreted items such as lighters and razors. At times they did not have two staff of the same sex to search patients, for example, on Thorpe ward. Staff had reported incidents where patients had been smoking on the ward and a fire was on Finchingfield ward April 2019.

We saw examples of staff having overly restrictive rules for patients because of the risks posed to a small amount of patients as opposed to looking at other ways to manage risks. These included staff restricting patients access to hot drinks for example on Ardleigh and Peter Bruff wards. Several wards such as Galleywood did not allow patients to access the garden to uses vapes or 'e cigarettes' to encourage attendance at therapeutic activities on the ward or after 18:30 hours. Grangewater had a curfew for informal patients to return to the ward by 20:00 hours. Most wards had locked doors to prevent patients going into the garden without staff for example, because of potential ligature or absconsion risks. Staff had restricted Finchingfield patients access to activity rooms at times when they had less staff on duty to observe the communal areas of the ward.

We saw examples where staff helped patients with a history of self harm to develop alternative safer ways to manage for example using ice. Staff gave examples of risk assessing patients access to their own bedroom to reduce the risk of them self-harming alone not in staff eyesight. We saw examples where staff had increased or reduce the level of staff observations required according the patient's presentation and level of risk they posed to themselves or others.

We saw examples on wards where staff used nationally recognised tools to assist in their risk assessment and management of patients. These included, the SBAR communication tool (situation, background, assessment, recommendation) when completing records about the patient that day. This is a structured form of communication that enables information to be transferred between staff. Additionally, staff used the 'Safewards' model to help with risk management of patients. This included staff holding daily 'mutual help' community meetings with patients. Additionally, staff used safety huddles, short multidisciplinary briefings, held at a predictable time and place, and focused on the patients most at risk. Peter Bruff staff gave examples of where professional meetings for complex cases management took place, where trust inpatient and

community staff met with other key agencies such as emergency services, housing departments and adult social care to develop a multi-agency plan to manage patients' risks when having leave/being discharged into the community.

Use of restrictive interventions

This service had 813 incidences of restraint (299 different service users) and 94 incidences of seclusion between 1 January 2018 and 31 December 2018.
The below table focuses on the last 12 months' worth of data: 1 January 2018 to 31 December 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Ardleigh Ward	21	65	26	12 (18%)	17 (26%)
Chelmer Ward	0	16	12	3 (19%)	6 (38%)
Christopher Unit (PICU)	13	153	33	49 (32%)	76 (50%)
Finchingfield Ward	3	34	20	12 (35%)	16 (47%)
Galleywood Ward	0	147	35	9 (6%)	47 (32%)
Gosfield Ward	15	50	23	11 (22%)	18 (36%)
Peter Bruff Ward	16	45	23	7 (16%)	9 (20%)
Stort Ward	1	15	15	0 (0%)	7 (47%)
Cedar Ward	0	97	40	24 (25%)	43 (44%)
Grangewaters Ward	0	95	36	48 (51%)	62 (65%)
Hadleigh Unit (PICU)	25	96	36	34 (35%)	59 (61%)
Core service total	**94**	**813**	**299**	**209 (26%)**	**360 (44%)**

There were 209 incidences of prone restraint, which accounted for 26% of the restraint incidents. Over the 12 months, incidences of restraint ranged from 52 to 91 per month. The number of incidences (813) had increased from the previous 12-month period (677).

There were 360 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from 22 to 47 per month over (1 January 2018 to 31 December 2018). The number of incidences (360) had increased from the previous 12-month period (277).

There have been zero instances of mechanical restraint over the reporting period. The number of incidences (0) was the same as the number of incidences from the previous 12-month period (0).

The number of restraint incidences reported during this inspection were not comparable to the last inspection.

Trust information received showed more restrictive interventions for wards than the previous year. The trust has a restrictive interventions reduction programme, which met best practice standards. Staff told us they made every attempt to avoid using restraint by using de-escalation techniques

and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff understood the Mental Capacity Act definition of restraint and worked within it.

The trust was monitoring the use of prone (face done) restraint. We received mixed feedback from staff across wards as to if this was used only in exceptional circumstances or not. Most staff said it was not a taught technique anymore nor was it promoted. However, some staff said it was used at times to administer emergency injection medication to patients 'as per trust policy', inferring it was planned and not exceptional.

From a sample of incidents, we only found one occasion on Cedar ward where staff had not fully completed a record where staff had restrained a patient which the manager was investigating. Two patients on Chelmer and Ardleigh wards said they had been injured during restraint. These incidents were investigated.

There have been 94 instances of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from four to 13. The number of incidences (94) had increased from the previous 12-month period (44).

The number of seclusion incidences reported during this inspection was not comparable to the last inspection.

The trust needed to make improvements to ensure staff followed best practice guidelines and completed thorough records when they placed a patient in seclusion. For example, we could not find any records for the seclusion of two Peter Bruff ward patients, and therefore were not assured that staff were regularly reviewing if seclusion was used for the least restrictive purpose and time and that staff were monitoring their mental and physical health. We found gaps in 12 of 17 records sampled across wards. These included two records each on the Christopher unit and Finchingfield, three of six records for Peter Bruff, three of five records on Hadleigh Unit. Issues included a lack of recording that staff were monitoring patients every 15 minutes; nurse reviews every two hours; medical reviews every four hours until the first (internal) multi-disciplinary team and staff developing seclusion care plans. Records we checked for Gosfield and Stort were complete.

There have been nine instances of long-term segregation over the 12-month reporting period. The number of incidences (nine) had increased from the previous 12-month period (four).
The number of segregation incidences reported during this inspection was not comparable to the last inspection.

We checked staff records for a patient in long term segregation on the Christopher unit and found staff followed best practice, including guidance in the Mental Capacity Act Code of Practice.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted

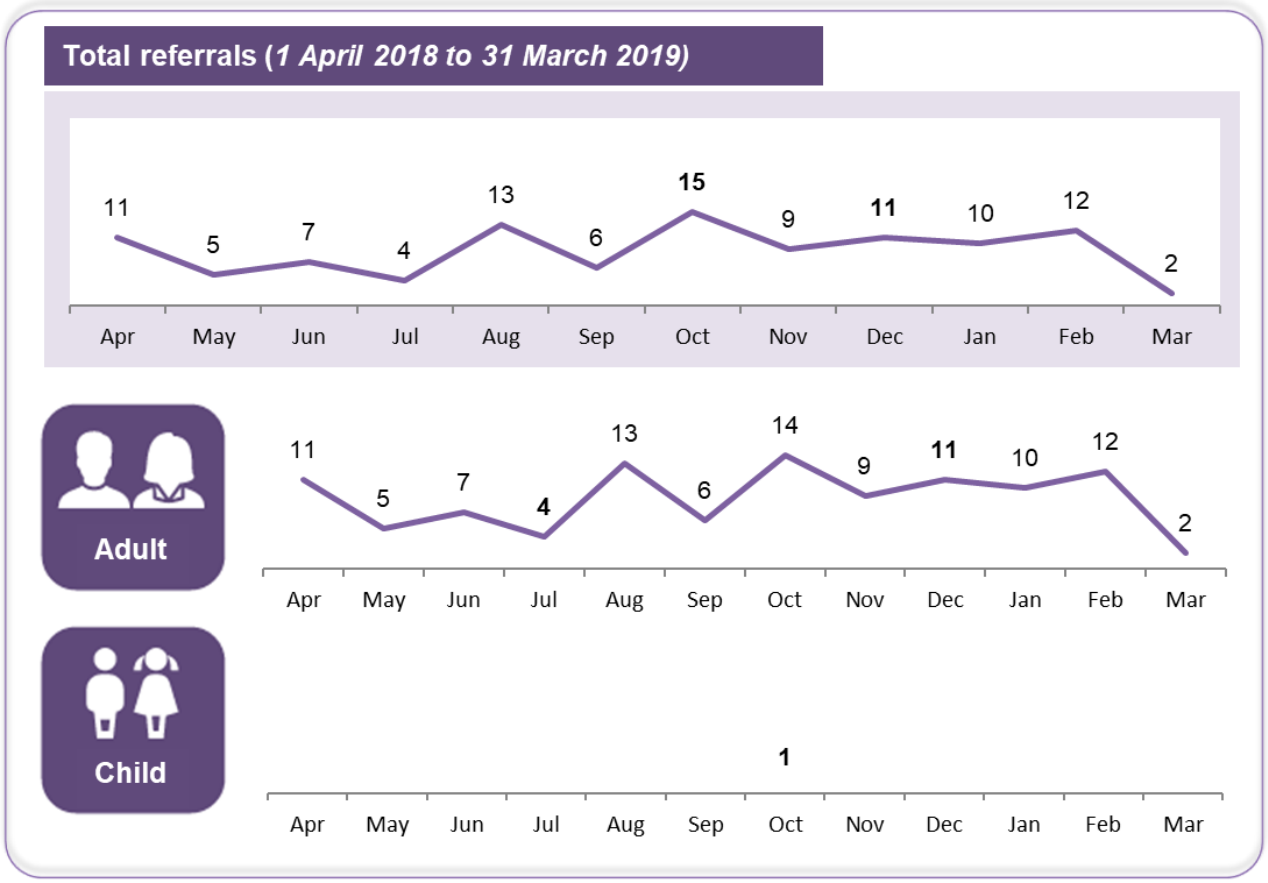
to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 105 safeguarding referrals between 1 April 2018 and 31 March 2019, of which 104 concerned adults and one concerned children. The number of safeguarding referrals reported during this inspection was not comparable to the last inspection.

Number of referrals		
Adults	**Children**	**Total referrals**
104	1	105

The number of adult safeguarding referrals in month ranged from two to 14 (as shown below).

The number of child safeguarding referrals ranged from one to zero (as shown below).



Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. As of 16 August 2019, this core service had achieved 98% compliance with safeguarding level three and four training. The trust had recently introduced level three safeguarding children training for staff and had achieved 85% compliance.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The trust had promoted greater sexual safety awareness on wards to staff and patients through displaying posters and leaflets and encouraged patients to raise any concerns they had for investigation, so staff could take action to reduce the risks. Grangewater ward staff had also added this as standard agenda item for ward community meetings. Staff followed clear procedures to keep children visiting the ward safe. The Trust does not have a

specific ward-based risk assessment for sexual safety, but there are individual patient risk assessments and an operational policy for staff to follow which is in the process of being revised.

Staff knew how to make a safeguarding referral and who to inform if they had concerns for example if a patient was vulnerable to exploitation. Staff had not clearly documented their actions in relation to possible safeguarding issues in two Ardleigh patients' records.

The trust has submitted details of zero serious case reviews commenced or published in the last 12 months (1 April 2018 to 31 March 2019) that relate to this service.

Staff access to essential information

Patient notes were comprehensive, and staff could access them easily. Records were stored securely. Staff told us the trust aimed to become 'paper light' and use more electronic records.

The trust had acted since our inspection in April 2019 to improve staff's access to the health information exchange portal to share essential patient information between north and south wards and locations who used differing electronic patient record systems. This meant that when patients transferred to a new team, there were no delays in staff accessing their records. However, four of 69 staff (6%) said there were still some challenges with systems such as slow systems, finding records and delays in paper documents being scanned and uploaded to the electronic record.

Medicines management

The trust's actions since our last inspection in 2018 were not fully effective as actions were still required to improve medicines management.

Improvements were still needed to ensure safe medicines management. Ardleigh ward did not have easy access to emergency drugs as was stored on Gosfield and staff were unfamiliar with where it was kept. We found on 29 patients records across Gosfield, Cedar, Thorpe, Grangewater wards and the Assessment Unit occasions where staff had not given patients medication due to a lack of supply. Staff said the trust's pharmacy service had relocated to Chelmsford which had led to delays in staff getting medication.

We found seven examples across The Christopher Unit, Finchingfield, Galleywood, Chelmer and Stort wards where staff had not recorded if they had given medication to patients.

Chelmer ward had some unprescribed controlled drugs in cabinet which we raised for staff attention and disposal, as this had not been addressed previously by staff. We found seven occasions where staff had not recorded the patient allergy on the prescription card on the Christopher unit, Finchingfield, Galleywood and Stort wards which posed a risk staff would not know what medications they could not give. Patients' photographs were missing on all medication cards on Kelvedon, Thorpe, Grangewater and Assessment unit wards.

We found gaps in staff monitoring checks of fridge and room temperatures where medicines were kept on the Assessment Unit and Gosfield ward. Chelmer and Stort wards did not have a British National Formulary book in their clinic but did have access online. However, the trust had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure patient's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance.

Track record on safety

Between 1 March 2018 and 28 February 2019 there were 12 serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'apparent/actual/suspected self-inflicted harm meeting SI criteria' with nine. There were no unexpected deaths in this core service.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS with 13 reported. There was one additional incident reported to STEIS which was not reported to SIRI, this was an incident of 'apparent/actual/suspected self-inflicted harm meeting SI criteria.' The trust responded that this incident did not meet SI reporting requirement and was investigated as a critical, not serious incident.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported three never events during this reporting period.

The number of serious incidents reported during this inspection was higher than the nine reported at the last inspection. At the last inspection and this inspection, the highest number of incidents were on Basildon Mental Health Assessment Unit and Gosfield Ward.

	Number of incidents reported		
Type of incident reported (SIRI)	**Apparent/actual/suspected self-inflicted harm meeting SI criteria**	**Slips/trips/falls meeting SI criteria**	**Total**
Mental Health Assessment Unit Basildon	3	1	**4**
Gosfield Ward	2		**2**
Cedar Ward	1		**1**
Ardleigh Ward	1		**1**
Chelmer Ward		1	**1**
Peter Bruff Ward	1		**1**
Stort Ward		1	**1**
Thorpe Ward	1		**1**
Total	**9**	**3**	**12**

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing future deaths.

In the last two years (since April 2017), there have been eight 'prevention of future death' reports sent to Essex Partnership University NHS Foundation Trust. Two of these related to this service, details of which can be found below.

Date of report: 16 June 2017

A person killed themselves whilst the balance of mind was disturbed.

The Coroner's concerns were:

The state failed to protect the person's life evidenced by the following. Risk of suicide was not properly and adequately assessed and reviewed by transfer of verbal and written information, risk assessment, and quality of observation.

Adequate and appropriate precautions were not taken to manage risk of suicide. For example, the search policy at the time of the incident, quality of observation, current policies at the time and previous recommendations of risk and environmental factors were not implemented adequately.

The trust's search policy was scrutinised in the course of the inquest and, even an updated version was found to be unclear.

The following learning / recommendations were given:

The court heard very helpful expert evidence from a staff member at the Maudsley Hospital during which he referred to his own trust's policy. He explained that the approach should be that the presumption is that all items are removed during a search unless it can be shown positively that they might not cause harm to the patient – a radically different philosophy from that underpinning the Linden Centre policy. A fresh, careful look needs to be taken at the current EPUT search policy.

Date of report: 19 September 2017 (ENQ1-4499206746)

A person was hit by a train.

A formal response to a Regulation 28 report was provided from the trust, however we are unable to locate the original Regulation 28 report. We recommend that the inspection team request further details regarding this from the trust.

In the formal response to the Regulation 28: Report to prevent future deaths, the trust stated that they had been in contact with the patient's parents to discuss how they feel having an individual who is ultimately responsible for the complete care of the patient from initial treatment, admission, and follow-up, may contribute to care.

The trust needed to make improvements to how they shared and embedded learning from incidents across all the wards. There were inconsistencies of the trust checking to ensure learning from incidents and actions were applied across wards. For example, Thorpe and Cedar ward had identified risks with ceiling tiles which they had replaced following an incident and had requested removal from other areas. Yet we saw these on other wards including Grangewater. Finchingfield and Galleywood wards had fencing to reduce the risk of patients' getting onto the roof. Yet Cedar ward did not despite an incident in the last year, also Ardleigh and Gosfield did not. The trust had identified the risk for Ardleigh and Gosfield on their risk register but not Cedar. Ardleigh and Galleywood had fixed garden furniture whereas Cedar ward did not despite a recent incident. This posed a risk that a similar incident might occur. The trust had not ensured that a safeguarding investigation outcomes, learning and actions were shared with staff at Colchester hospital mental health wards. Whilst concerns were raised in 2018 the investigation report had not been completed by January 2019 as expected but was still awaiting senior management approval before sharing with staff. This meant there was a risk that staff would not know what actions to take to increase patient safety and prevent a reoccurrence. Two managers said they did not get feedback on themes and trends for their ward to be able to compare their performance with other wards.

Most staff knew what incidents to report and how to report them. Staff reported most incidents that they should report. Staff reported serious incidents clearly and in line with trust policy. The service had reported three never events on wards relating to incidents when collapsible rails had not

collapsed. Managers shared learning with their staff about never events. However, we found an example where staff had not reported an incident of placing a patient in seclusion until three months after the event.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers said they debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff gave examples where they received feedback from investigation of incidents, both internal and external to the service. Staff had some opportunities to meet to discuss the feedback and look at improvements to patient care. There was some evidence that changes had been made as a result of feedback. For example, following serious incidents on Stort and Peter Bruff wards, staff had made changes to improve their risk assessments of patients' going on leave to ensure the nurse in charge was accountable for approving their leave off the ward. Although we understood Cedar ward did not have this same process.

Is the service effective?

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient at the time of admission or soon after. The trust used a 'trusted assessor' approach which meant that staff accepted the initial assessment from the previous team if they were admitted or transferred between wards. The psychiatric unit staff if not urgent visited the patient to assess them for suitability for their service. If urgent these took place over the telephone with staff.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff regularly reviewed and updated care plans when patient's needs changed.

Most patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward for example Galleywood held weekly health check clinics. The trust monitored patients who had been on wards for over a year. Trust data for June 2019 showed four wards Ardleigh, Chelmer and Gosfield and the Hadleigh Unit had achieved 100% above 95% trust threshold. Four wards had not met the trust threshold as Cedar and Finchingfield had 50% compliance, Grangewater and Thorpe had 0%. Other wards did not have patients on their ward for over a year. Five of 49 patients records (10%) held minimal information (Cedar and Kelvedon). For example, two Cedar patients had refused a check, but it was unclear if staff had asked them again.

Best practice in treatment and care

This service participated in 17 clinical audits as part of their clinical audit programme 2018 – 2019.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Record Keeping / Care Planning MH Adult	Ardleigh, Cedar, Chelmer, Christopher Unit, Finchingfield, Galleywood, Gosfield, Grangewaters, Hadleigh, Kelvedon, Mental Health Assessment Unit Basildon, Peter Bruff, Stort, Thorpe	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	ongoing	Audit results shared in Quality and Safety Committees. Results appear on the performance dashboards in each unit.
Mental Health Clinical Handover	Ardleigh, Chelmer, Christopher Unit, Finchingfield, Galleywood, Gosfield, Grangewaters, Hadleigh, Kelvedon, Mental	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	18/02/2019	Findings shared with services, for them to develop appropriate action plans based on results

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
	Health Assessment Unit Basildon, Peter Bruff, Stort, Thorpe				
National audit of inpatient falls	Ardleigh, Chelmer, Christopher Unit, Finchingfield, Galleywood, Gosfield, Grangewaters, Hadleigh, Kelvedon, Mental Health Assessment Unit Basildon, Peter Bruff, Stort, Thorpe	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	In progress	Data collection based on incidents of hip fractures, as yet none reported. Collection time frame to end December 2019
Physical Health and MEWS in Adult Acute	Ardleigh, Cedar, Chelmer, Christopher Unit, Finchingfield, Galleywood, Gosfield, Grangewaters, Hadleigh, Kelvedon, Mental Health Assessment Unit Basildon, Peter Bruff, Stort, Thorpe	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	12/02/2019	The audit results were presented to the Physical Health Action and Implementation Group. Report was also shared with the service quality and safety committee to review.
Resuscitation Audit	Ardleigh, Cedar, Chelmer, Christopher Unit, Finchingfield, Galleywood, Gosfield, Grangewaters, Hadleigh, Kelvedon, Mental Health Assessment Unit Basildon, Peter Bruff, Stort, Thorpe	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	In progress	Report reviewed at Resuscitation Group and awaiting Executive sign off before being disseminated to services.
National Audit of Anxiety and Depression	Ardleigh, Gosfield, Basildon Mental Health Assessment Unit, Cedar,	MH - Acute wards for adults of working age and	Clinical	In progress	Data collection completed in April 2018. Report expected in

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
	Grangewaters, Thorpe	psychiatric intensive care units			between January and June 2019
National Audit of Psychological Therapies Spotlight	Ardleigh, Cedar, Chelmer, Christopher Unit, Finchingfield, Galleywood, Gosfield, Grangewaters, Hadleigh, Kelvedon, Mental Health Assessment Unit Basildon, Peter Bruff, Stort, Thorpe	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	In progress	Data submission completed. Report due to be published Summer 2019
Behaviour Support Plans	Christopher Unit, Hadleigh Unit	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	In progress	Quarter 2 report available baseline data for secure services, re - audit in Quarter 4 analysis to be completed.
Re audit of Seclusion and Baseline Long Term Segregation	Hadleigh, Stort	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	In progress	Data collection completed, analysis in progress and report being written
Discharge against medical advice	Inpatient services in Basildon Mental Health Unit: Grangewaters, Thorpe and Basildon Mental Health Assessment Unit	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	01/03/2018	Present findings in teaching sessions to raise awareness. To also present in new and junior doctors induction. Consider introducing a checklist of actions to complete when patients wish to self discharge.
Physical health assessment on admission /transfer to MH older adult wards	Christopher Unit, Finchingfield, Galleywood	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	In progress	Data collection in progress
Audit of completion of medication charts in the North East	Ardleigh, Gosfield, Peter Bruff	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	01/04/2018	Present findings at Tuesday Doctors meeting, in the East Area of EPUT, in the next 6 months. Doctors should

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
area of the trust					be informed that the medication cards are in great compliance with the standards, but weight, height and BMI are important as well and must be always documented. Re-audit in the following one year to see if standards are the same or have changed.'
Use of cardio metabolic form on mobius	Cedar, Hadleigh Unit and Grangewaters	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	In progress	data collection in progress
Physical health monitoring in an acute adult inpatient service	Cedar	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	In progress	Data collection in progress
Pattern of referrals to general hospital and the quality of information exchanged between professionals	Finchingfield and Galleywood	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	01/06/2018	A standardised referral form (as above) can be considered, presentation of findings from audit to Physical Health Steering Group and academic teaching meeting to create awareness amongst local doctors. Liaise with the local A&E clinical lead with findings and discuss options of overcoming the delay of communicating the information
VTE Risk Assessment	Stort and Chelmer Wards	MH - Acute wards for adults of working age and psychiatric intensive care units	Clinical	In progress	Data collection in progress
Audit of Peter Bruff Unit pathway	Peter Bruff Unit	MH - Acute wards for adults of working age and	Clinical	In progress	data collection in progress

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
		psychiatric intensive care units			

Staff provided a range of care and treatment suitable for most patients in the service. Staff delivered care in line with best practice and national guidance (from relevant bodies such as The National Institute for Health and Care Excellence). For example, occupational therapists at Basildon Mental Health Unit used the model of creative ability, sensory integrated therapy, relaxation and massage with patients. Several wards offered pet therapy. Cedar ward offered mindfulness. Psychology teams had developed groups, for example at Basildon Mental Health Unit, such as 'breaking the silence' preventing suicide, drug and alcohol, self-harm reduction and 'how did I get to here' understanding mental health. Staff ran groups across evenings and weekends. Wards also offered 'chill out boxes' to help patients with stress reduction and relaxation and promoting better sleep. Several wards held 'survival groups' helping patients understand their mental health and past experiences.

Staff made sure patients had access to physical health care, including specialists as required. Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements.

Skilled staff to deliver care

The service had (access to) a full range of specialists to meet the needs of the patients on the ward.

The trust had recruitment systems to ensure permanent staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Managers gave each new member of staff a full induction to the service before they started work. This included staff completion of a 'standard verification of competency framework and medical device' which included information about the Modified Early Warning Score and SBAR. Managers supported staff through regular, constructive appraisals of their work. Additionally, wards such as Chelmer had a staff reflective practice group.

Managers made sure staff received some training for their role. Staff told us they worked with patients with a personality disorder and had an opportunity to attend some training (half day) but it was not mandatory. We requested further information from the trust about how many staff had completed this training, but this was not provided.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers recognised poor performance, could identify the reasons and dealt with these.

The trust's target rate for appraisal compliance is 90%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for non-medical staff within this service was 47%. This year so far, the overall appraisal rate was 76% (as at 28 February 2019). The teams with the lowest appraisal rate at 28 February 2019 were Clinical Support The Lakes with an appraisal rate of 33% and Ardleigh Ward with an appraisal rate of 18%.

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 67% rate reported at the last inspection.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 28 February 2019)	% appraisals (previous year 1 April 2017 to 31 March 2018)
Nurse Management Harlow	3	3	100%	33%
Administration Harlow	9	9	100%	63%
Linden Centre Administration	8	8	100%	13%
Ect Suite Essex	1	1	100%	0%
Stort Ward	13	12	92%	58%
Chelmer Ward	11	10	91%	73%
Finchingfield Ward	17	15	88%	46%
MH Assessment Unit	15	13	87%	75%
Cedar Ward	15	13	87%	29%
The Christopher Unit	11	9	82%	17%
Hadleigh Unit (Picu)	11	9	82%	44%
Grangewaters Ward	11	9	82%	27%
Galleywood Ward	10	8	80%	67%
NORTH - Adults Inpatient Management	5	4	80%	80%
The Lakes General	10	8	80%	10%
Gosfield Ward	17	12	71%	47%
Peter Bruff Ward	17	12	71%	36%
Linden Centre Site Co-Ordinator	3	2	67%	33%
Thorpe Ward	7	3	43%	100%
Clinical Support The Lakes	12	4	33%	67%
Ardleigh Ward	11	2	18%	60%
Core service total	**217**	**166**	**76%**	**47%**
Trust wide	**3884**	**3172**	**82%**	**55%**

Managers made sure that most permanent non-medical staff working on the wards who had appraisals met or exceeded the trust target by the end of the year. However, trust data for south wards as of June 2019 showed seven of 14 wards were below trust target of 95% compliance. The lowest was Peter Bruff with 65%. All other wards were 75% or above compliance.

The trust did not provide data regarding appraisal compliance for permanent medical staff.

The trust's target of clinical supervision for non-medical staff is 90% of the sessions required. Between 1 March 2018 and 28 February 2019, the average rate across all 28 teams in this service was 97%.

The rate of clinical supervision reported during this inspection was higher than the 85% rate reported at the last inspection.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Grangewaters Ward	141	141	100%
Kelvedon Ward	34	34	100%
Hadleigh Unit (Picu)	137	137	100%
Thorpe Ward	110	110	100%
Psychology in Acute Spec.Teams	12	12	100%
Finchingfield Ward	184	184	100%
Cedar Ward	167	165	99%
Ardleigh Ward	148	147	99%
Gosfield Ward	187	185	99%
Peter Bruff Ward	184	182	99%
The Christopher Unit	136	135	99%
Assessment Unit	157	154	98%
Inpatient MH Management Team	101	99	98%
Galleywood Ward	122	120	98%
In Patient Psychology	59	58	98%
Linden Centre Site Co-Ordinator	36	35	97%
Mh Discharge Team	23	22	96%
Stort Ward	103	99	96%
Ot Inpatient Services	168	162	96%
NORTH - Adults Inpatient Management	24	23	96%
Chelmer Ward	108	102	94%
Clinical Support The Lakes	149	122	82%
Psychology Ward Activity	11	7	64%
Core service total	**2501**	**2435**	**97%**

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Trust Total	**19802**	**19153**	**97%**

Managers supported most non-medical staff through regular, constructive clinical supervision of their work. However, Peter Bruff ward had the lowest staff supervision rates with 58% compliance, for June 2019.

The trust did not provide data regarding clinical supervision compliance for permanent medical staff.

Managers supported medical staff through regular, constructive clinical supervision of their work.

Multi-disciplinary and interagency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations.

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

As of 31 March 2019, 90% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and community staff, depending upon their role.

The training compliance reported during this inspection was higher than the 74% reported at the last inspection.

Trust information sent following the inspection 16 August 2019 showed 94% staff compliance with Mental Health Act training.

The Christopher and Hadleigh psychiatric intensive care units had patients all detained under the Mental Health Act. In contrast the Assessment Unit and Peter Bruff wards had mostly informal patients and other treatment wards had a mixture of both detained and informal patients.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up to date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. The

trust had developed leaflets and processes for explaining informal patients' rights such as their right to leave the hospital.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We found that most forms for detailing patients consent to treatment or not (known as T2 or T3 forms) were not held with the patient medication chart but staff could access them electronically. However, north ward staff had not clearly documented patients' consent to treatment in records. The trust had action plan to address this following feedback from a past CQC inspection that still highlighted this as an unresolved issue.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients we spoke with, knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

As Mental Capacity Act Training is incorporated into Safeguarding Level 1 training, the data is unsuitable for analysis.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles as trusts had displayed information across wards. However, three nursing assistants could not recall receiving any training.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

The trust told us that six Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 April 2018 to 31 March 2019.

The greatest number of DoLS applications were made in September 2018 with two.

CQC received 274 direct notifications from the trust as a whole between 1 April 2018 to 31 March 2019[5]. However, the trust reported that 158 direct notifications were sent to CQC. Under HSCA legislation, all DoLS applications should also be sent to the CQC in the form of a direct notification so it is important that these numbers are different.

The number of DoLS applications made during this inspection was higher than the four reported at the last inspection.

	Number of 'Standard' DoLS applications made by month												
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Standard applications made	0	1	0	0	1	2	0	1	0	1	0	0	**6**
Standard applications approved	0	0	0	0	0	0	0	0	0	0	0	0	**0**

	Number of 'Urgent' DoLS applications made by month												
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Standard applications made	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Standard applications approved	0	0	0	0	0	0	0	0	0	0	0	0	**0**

[5] CRM

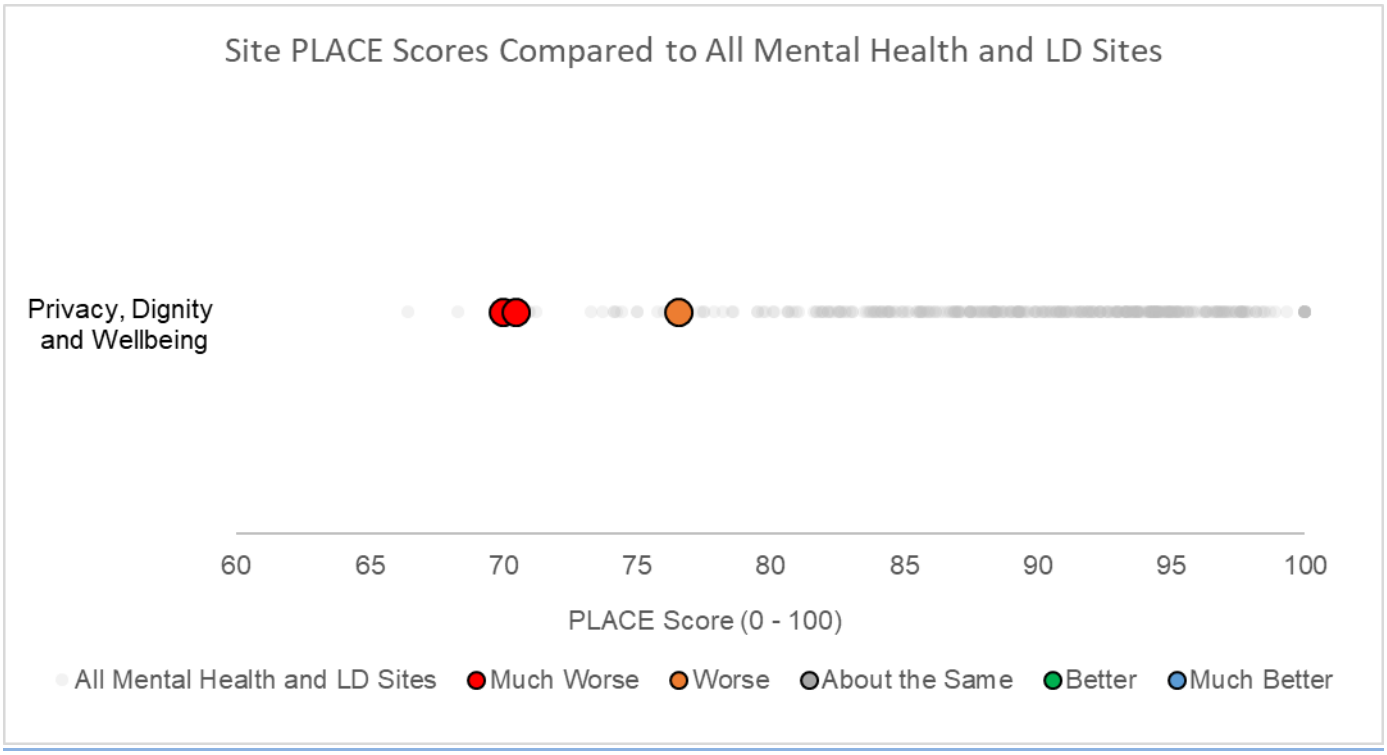
Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

PLACE assessments aim to provide a clear message from patients on how the care environment may be improved. They are undertaken by teams of local people alongside healthcare staff and assess privacy and dignity, food, cleanliness, building maintenance and the suitability of the environment for people with disabilities and dementia.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), Broomfield Hospital scored worse than the average for Mental Health and LD for privacy, dignity and wellbeing, Colchester scored much worse, and Christopher Unit scored much worse. The scores for the other sites were found to be about the same as the England average when compared to sites of a similar type.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Broomfield Hospital	MH – Acute wards for adults of working age and psychiatric intensive care units MH – Secure wards/Forensic inpatient MH – Other specialist services MH – Wards for older people with mental health problems MH – Mental health crisis services and health-based places of safety	76.5%
Colchester – The Lakes	MH – Acute wards for adults of working age and psychiatric intensive care units MH – Wards for older people with mental health problems MH – Mental health crisis services and health-based places of safety	70.0%
Christopher Unit (Linden)	MH – Acute wards for adults of working age and psychiatric intensive care units	70.5%
Trust overall		**89.2%**
England average (mental health and learning disabilities)		**91.0%**



Most staff were discreet, respectful, and responsive when caring for patients. They gave patients help, emotional support and advice when they needed it. They supported patients to understand and manage their own care treatment or condition. Most staff understood and respected the individual needs of patients. However, 15 of 34 patients (44%) and one carer we spoke with said some staff could be more caring towards them. For example, patients often referred to asking staff for help and at times getting variable support. Some patients told us staff could be rude and gave examples of this, such as night staff or agency not knowing them (and vice versa). We noted that these patients did give us examples where staff had treated them well and behaved kindly.

Staff directed patients to other services and supported them to access those services if they needed help. However, Chelmer and Stort wards did not have easily visible information about how patients could access the advocacy service. The Christopher unit did not have advocacy posters displayed because of a patient incident but staff were getting another product to hold them up.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff followed policy to keep patient information confidential. Trust 'friends and family test' patient feedback for July 2019, showed Peter Bruff ward had the highest amount of positive feedback with 16 responses and 100% of patients recommending the service. Other wards had 100% recommendation from patients including Chelmer, Galleywood, Gosfield, Kelvedon and Thorpe wards. Stort, Grangewater and the Assessment Unit had below 70% recommendation. Other wards had not received any feedback for that month.

Involvement in care

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff involved patients and gave them access to their care planning and risk assessments. For example, staff encouraged patients to use documents 'my care my recovery' and 'my care my leave' documents to help inform care and treatment. The trust monitored wards compliance with this. However, we found four of five patients care plans on Cedar ward were not holistic and recovery focused and held limited details of patient involvement. Staff told us staffing pressures had affected this.

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

Patients could give feedback on the service and their treatment and staff supported them to do this. However, whilst we saw examples of patients developing crisis plans we did not see specific examples where patients made advanced decisions, and this had informed their care plans.

Involvement of families and carers

We saw some examples where staff supported, informed and involved families or carers. The psychology team led carers' groups at Ardleigh. Basildon Mental Health Unit matrons were holding afternoon tea with carers in August 2019 for them to give feedback on the service.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for eight wards in this service between 1 March 2018 to 28 February 2019. Information for the remaining six wards was not provided.

Eight of the wards within this service reported average bed occupancies ranging above the minimum benchmark of 85% over this period.

Ward name	Average bed occupancy range (1 March 2018 – 28 February 2019) (current inspection)
Ardleigh	100%-108%
Chelmer, Derwent	99%-120%
Finchingfield	94%-107%
Galleywood	100%-109%
Gosfield	98%-111%
Peter Bruff	68%-109%
Stort	84%-108%
The Christopher Unit	73%-101%

The trust had not ensured that bed occupancy was 85% or below. Three of 14 wards were over occupied when we visited (Kelvedon, Grangewater and Ardleigh). Trust data received at the onsite inspection for June 2019 showed nine wards were above this: Cedar ward had the highest with 139%, Chelmer had 122%,Thorpe had 119%; Ardleigh had 112%, Kelvedon and the Christopher Unit had 110%, the Hadleigh Unit and Galleywood had 108%, Gosfield 106% Finchingfield had 102%, Peter Bruff 101% ,Grangewater 100% and Stort 95%. Only the Assessment Unit was below with 70%. However, four wards: Galleywood, Thorpe, the Hadleigh Unit and Pete Bruff had bed vacancies when we visited (although Peter Bruff were in the process of planning for a patient's admission).

Ardleigh, Cedar, Chelmer, Galleywood, Gosfield and Stort ward staff explained that occasionally the trust offered a patient a bed temporarily in a section 136 suite if they needed an inpatient admission and there was no bed available. This placed a further pressure on staffing and the rooms are only designed for short term use and do not promote recovery. However, trust information showed there was one incident between May and July 2019 of an "inappropriate admission" whereby a patient had been nursed in the Section 136 suite due to a lack of bed availability and out of area placement. Staff gave other examples of how they managed bed occupancy such as extending patients community leave (Galleywood), looking at alternative wards to admit patients' to if a bed was not available on their ward (Gosfield). We saw staff had reported one incident relating to lack of bed availability on Ardleigh and there were four complaints made about bed availability (in the last two months) from patients or carers from Ardleigh, Peter Bruff and Grangewater wards. Ten of 69 staff (14%) also raised concerns about patients frequently being readmitted and bed pressures. Staff gave examples of where some patients were regularly 'revolving' in and out of the wards and community. These included patients with a diagnosis of emotionally unstable personality disorder; patients who had been under child and adolescent mental health wards and struggled with the transition to adult services; patients with dual mental health and drug and alcohol issues or patients' with 'socio economic' problems. Staff said there could be seasonal impacts such as an increase during winter.

The trust had increased their adult assessment and treatment beds since our last inspection by 13 beds with a total of 225 beds. There were 25 psychiatric intensive care unit beds. The trust had created Kelvedon an extra adult acute ward. This helped them gradually reduce beds and occupancy on other wards as part of the 'regeneration' process to upgrade wards and eliminate dormitories at Basildon Mental Health Unit. The Assessment Unit had reduced from 20 to 18 beds. Grangewater had reduced from 28 to 24 beds with plans to reduce further to 20. To avoid patients transferring out of area, the trust would try to keep them within Essex and some patients from the north of Essex transferred to wards in the south and vice versa.

The trust noted an increase on demand for inpatient admissions. They had identified bed occupancy on their risk register and had a lead for 'flow and capacity'. The trust had identified systems for staff to assess patients to judge if they required inpatient admission and also for reviewing their inpatient stay. Patients would usually be admitted to the Peter Bruff or Assessment Unit wards for short stay assessment. These ward teams held daily reviews with the home treatment team to consider if patients still required an inpatient stay. Since opening approximately a year ago Peter Bruff staff said they had admitted over 900 patients with approximately 70% discharged back into the community. Staff usually transferred patients requiring treatment or those detained under the Mental health Act 1983/2007 to a treatment ward. The trust completed daily safer staffing and bed management situation reports completed and communicated in line with the NHS operational pressures escalation level (OPEL) structure. Wards had 'swing beds' so they could adjust their bed vacancies to manage an increase in male or female patients.

The trust provided information for average length of stay for the period 1 March 2018 to 28 February 2019.

Ward name	**Average length of stay range (1 March 2018 – 28 February 2019) (current inspection)**
Ardleigh	84-163 days

Ward name	Average length of stay range (1 March 2018 – 28 February 2019) (current inspection)
Chelmer, Derwent	54-183 days
Finchingfield	91-141 days
Galleywood	54-103 days
Gosfield	47-127 days
Peter Bruff	4-116 days
Stort	49-84 days
The Christopher Unit	37-140 days

The trust systems for reviewing the length of stay for patients with the aim of ensuring they did not stay longer than they needed to, were not fully effective.

Chelmer ward had the highest average length of stay (54-183 days). Latest onsite trust data for June 2019 showed Ardleigh ward had the highest occupancy that month with an average of 207 days and Finchingfield ward next with an average of 180 days. This is well above the average of 33 days across trust (2016). Trust data given for all six treatment wards were notably above this. The exceptions were the Assessment Unit with the lowest length of stay (six days) and Peter Bruff ward (seven days). These wards were set up to be shorter stay.

This service reported 63 out area placements between 1 January 2018 to 28 February 2019. As of 28 February 2019, this service had zero ongoing out of area placements. There were zero placements that lasted less than one day, and the placement that lasted the longest amounted to 81 days.

All 63 out of area placements were due to capacity issues.

The number of out of area placements reported during this inspection was lower than the 261 reported at the time of the last inspection.

Number of out of area placements	Number due to specialist needs	Number due to capacity	Range of lengths (completed placements)	Number of ongoing placements
63	0	63	1-81 days	0

Trust data sent following the on-site inspection from August 2018 to July 2019 showed there had been 47 patients placed in out-of-area placements with 33 of these placed over 50 km away which poses a risk of them having difficulty keep in in touch with family, friends and their local community. The longest length of stay was for one patient with 320 days and the lowest was for four patients with one day each. Ten patients were from the Basildon and Brentwood and Mid Essex areas.

This service reported 265 readmissions within 28 days between 1 March 2018 and 28 February 2019. Of the 265 readmissions, 102 (38%) were readmissions to the same ward as discharge. The average number of days between discharge and readmission was 11 days. There were nine instances whereby patients were readmitted on the same day as being discharged but there were 17 where patients were readmitted the day after being discharged.

At the time of the last inspection, for the period 1 April 2017 to 31 January 2018, there were a total of 160 readmissions within 28 days. Of these, 76 were readmissions to the same ward (48%) and the average days between discharge and readmission was 12 days.

Therefore, the number of readmissions within 28 days has increased between the two periods and the average time between discharge and readmission has decreased slightly.

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
Grangewater	14	2	14%	2-25 days	13 days
Thorpe	28	6	21%	0-21 days	7 days
Cedar	16	4	25%	0-23 days	10 days
Galleywood	30	6	20%	0-26 days	8 days
Gosfield	24	5	21%	0-27 days	9 days
Peter Bruff	98	64	65%	0-28 days	12 days
Stort	9	3	33%	0-18 days	8 days
Chelmer	14	8	57%	1-26 days	11 days
Ardleigh	16	2	13%	3-27 days	14 days
The Christopher Unit	5	0	0%	3-23 days	15 days
Finchingfield	11	2	18%	4-24 days	13 days

Trust information for 1 April 2019 to 31 May 2019 showed there were 21 occasions where patients were readmitted within seven days of being discharged from hospital. Peter Bruff had the highest with five and Cedar had four patients. This posed a risk that inpatient or community care and treatment was not always effective. Kelvedon, Stort, Gosfield and the Hadleigh Unit had none.

Trust information from the onsite inspection for May to July 2019 showed there have been no incidents reported of a patient not having a bed to return to following leave.

Patients were not always moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff told us they did not move or discharge patients at night or very early in the morning. However, we found two occasions when patients were moved between 23:00 and 07:00 hours.

The psychiatric intensive care unit mostly had a bed available if a patient needed more intensive care and this was usually not far away from the patient's family and friends.

Discharge and transfers of care

Between 1 March 2018 to 28 February 2019 there were 3380 discharges within this service. This amounts to 61% of the total discharges from the trust overall (5546).

The total number of delayed discharges across the 12-month period was 58 and ranged from one to eight.

The proportion of delayed discharges reported during this inspection was not comparable to the time of the last inspection.

The trust had 61 of 1057 (6%) delayed discharges from April to July 2019. The highest was Finchingfield with 17 and Ardleigh wards with 13 patients. Trust data for June 2019 showed 41 delayed discharges, the highest was Grangewater ward with nine. This led to delays in being able to admit patients who needed assessment or treatment. There were not always clinical reasons for delaying discharge from the service. Problems with discharging patients were usually due to a lack of suitable or specialist accommodation for patients to move to and delays with gaining external agency funding.

Staff told us where possible they tried not to discharge patients who were homeless without giving some support to find accommodation. If accommodation was not available staff gave the patient a letter to present to the local housing department stating, they needed accommodation. However, staff were not always assured that patients did this. We found a recent example in July 2019 where a patient was discharged from Grangewater ward but was then readmitted to Peter Bruff ward as did not have accommodation to go to. Staff told us that Southend and Colchester homeless population had increased.

The Hadleigh Unit had five patients over 100 days above the expectation of eight weeks. These patients were not deemed as delayed transfer of care as needed an alternative inpatient placement.

We found two patients in this service had been in hospital over 500 days. We considered this was not conducive for their recovery and posed a risk they could become institutionalised.

Staff planned patients' discharge and worked with care managers and coordinators to make sure this happened.

The trust had systems for informal patients to be assessed by the Home Treatment team within 72 hours of admission and plans to facilitate discharge implemented. Home Treatment teams would support leave plans from wards, thereby promoting earliest safe discharge. Additionally, they had a small dedicated discharge coordination team' whom staff contacted to help support patients' with their discharge. However, staff reported that community teams had pressures, and this affected their ability to deliver long term preventative treatment to support patients to remain in the community. Staff supported patients when they were referred or transferred between services. The service followed national standards for transfer

Managers monitored the number of delayed discharges for example at daily meetings, and monthly inpatient quality meetings. They had some systems to try and improve patients' discharge into the community or transfer to a specialist placement. The trust had a weekly inpatient and community meeting to escalate actual and potential delays in transfer of care. This had representation and participation from each community and inpatient team, discharge coordinators and social work consultants, to agree joined up actions to address and resolve. The trust also had a 'complex high-risk cases – the high intensity users' group' established to review the plan of intervention for frequent and high intensity patients and ensure comprehensive and joined up care plans are in place, particularly around transfer of care from hospital.

Facilities that promote comfort, dignity and privacy

The sites which deliver MH – Acute wards for adults of working age and psychiatric intensive care units within Essex Partnership University NHS Foundation Trust were compared to other sites of the same type and the scores they received for 'ward food' were found to be about the same as the England average.

The trust needed to make improvements to wards to ensure they were more recovery focused and welcoming for patients. Cedar, the Christopher unit and Galleywood wards décor was tired and bland in need of updating. Staff had reported it again twice and were still waiting for a full repair. Thorpe had shower out of action. Cedar ward had faulty underfloor heating which meant it was permanently on during summer for two months before repair. Corridors had dull lighting with several lightbulbs not working. Peter Bruff were waiting for a replacement window and blind for their seclusion room since March 2019. Thorpe and Cedar wards were waiting for new bedroom door keypads. Finchingfield had damaged flooring from a fire in April 2019, floor seals and a door strip in an activities kitchen waiting for replacement. The assessment unit had some floor seals needing replacement and flaking paint in a bathroom.

The trusts contingency plans for extreme weather were not fully effective as patients and staff across three wards Cedar, Galleywood and Grangewater had raised concerns about excessively hot rooms or lack of ventilation. During our visit some ward areas were over 25 degrees Celsius and staff had reported some areas of above 30 degrees the previous week. Patient bedrooms and dormitories were humid and smelt of body odour, for example Grangewater. Patients across 13 wards did not freely have access to the garden. However, the trust had some solutions to control the temperature such as providing air conditioning for communal lounges which patients and staff appreciated and ensuring patients had regular access to cold drinks to prevent dehydration.

Not all patients had their own bedroom, as three wards at the Basildon Mental Health Unit Thorpe Kelvedon and Grangewater wards still had dormitories. The trust had plans in place to eliminate them by 2021. Chelmer and Stort wards were the only wards where patients all had en-suite shower rooms.

Patients had a secure place to store personal possessions but not in their bedrooms. Most wards were clinical. However, Stort ward staff displayed posters to make the communal area warm and patients could have plants in their room subject to a risk assessment. Ardleigh ward had displayed recovery trees and inspirational quotes to help to encourage patients' recovery and hope.

Staff used a full range of rooms and equipment to support treatment and care. The service had quiet areas and a room where patients could meet with visitors in private, except on the Christopher Unit. The Christopher Unit did not have enough chairs for patients. Two Assessment Unit patients said the furniture needed improving.

Most patients could make telephone calls in private and could use their own mobile phones and laptops subject to risk assessment. However, patients on Grangewater and the Christopher Unit said telephones was broken, but there were other alternatives. Chelmer and Stort wards, Galleywood and Basildon Mental Health Unit had limited WIFI availability and signal. Galleywood and the Christopher Unit had broken televisions. Cedar ward had an electronic game table waiting for replacement parts for six weeks.

Not all wards had an outside space that patients could access easily, for example at Basildon Mental Health Unit. Chelmer and Stort patients had limited access to a downstairs garden area and managers had made a business case to improve the area and make more accessible to patients. Cedar's garden was small and bleak.

Not all wards supported patients to easily make their own hot drinks and snacks as on Ardleigh and Peter Bruff wards patients were dependent on staff to give them access. The service offered a variety of food which met most patients' needs. However, nine of 33 patients (27%) said the food or drinks access could be improved such as more variety including having more salads during hot weather.

Staff offered a range of leisure activities for patients including massage on Ardleigh ward. Basildon Mental Health Unit recently held in July 2019 a 'positive mental health music' event led by patients and staff and due to its success were planning other events. However, four Galleywood patients said there needed to be more activities at weekends especially when patients did not have community leave.

Patients' engagement with the wider community

Staff helped patients to stay in contact with friends, families and carers as relevant. Staff encouraged patients to develop and maintain relationships both in the service and the wider community. For example, the trust had links with an external agency whose staff visited wards and offered short-term outreach support to patients experiencing a range of problems that are impacting their health, financial and housing wellbeing.

Most wards were not able to show how they supported patients to have access to opportunities for education and work. Although Chelmer wards had supported a patient with charity volunteer work and the Assessment Unit had invited peer workers from the recovery college to promote recovery for patients.

Meeting the needs of all people who use the service

The sites which deliver MH – Acute wards for adults of working age and psychiatric intensive care units within Essex Partnership University NHS Foundation Trust were compared to other sites of the same type and the scores they received for 'disability' and dementia friendliness' were found to be about the same as the England average.

Some improvements were needed on wards to promote further equality, diversity and inclusivity. The trust collated data about patients in relation to protected characteristics under the Equality Act. However, only six of 49 patients (12%) of care records showed evidence of staff referencing this in their care plan. The trust was developing the role of ward equalities champions to give support to staff and patients and promote equality and diversity.

Only one of 49 patients care plans referenced if they had any faith or spiritual or cultural needs and what help they needed for their recovery. Cedar ward staff said they had difficulties with arranging religious support for patients if they did not have established contact with a group already. However, staff told us they supported patients' cultural, spiritual or religious needs by arranging for faith leaders to visit them or where appropriate have community leave to attend services. Wards/ locations had areas patients could use privately for prayer or contemplation. Hadleigh Unit staff showed they had supported patients for religious fasting by being flexible and changing the times they gave patients their medication. Ward staff said they could arrange for patients to have halal, vegetarian, vegan and kosher meals.

Staff across most wards had difficulty telling us how they supported LGBT+ patients. They told us transgender patients would often be given extra care bedrooms as opposed to a bedroom in the ward area or gender of their choice and were unsure if this was the trust's policy. However, the trust had developed a 'frequently asked questions' information leaflet to help staff know how to

better support lesbian, gay, bisexual and transgender patients. We saw Galleywood staff wearing rainbow lanyards which visually identified themselves to LGBT+ patients and staff as someone they could approach if they needed any support.

The trust could support and make adjustments for disabled people and those with communication needs or other specific needs. Trust leaflets had some detail on the back to indicate they could be available in other languages or in accessible forms (relevant for the Accessible Information Standard) if patients had difficulties reading English. Staff said they could get help from interpreters or signers when needed. Wards had identified areas more suitable for patients with mobility difficulties or using a wheelchair. However, staff were not aware of a patient needing to use their telephone to translate their care plan which we brought to their attention. The Christopher unit did not have an accessible bath but had showers. Peter Bruff ward used their accessible bathroom as a storage area.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Most wards had a range of information posters and leaflets for patients about care and treatment. Staff offered patients an information pack on admission to help them know about the ward which usually included a 'welcome to inpatient services' leaflet. However, Galleywood ward did not, due to patients destroying them. Chelmer ward staff gave verbal rather than written information on paper as were moving towards being 'paper light'.

The trust was still developing their 'personality disorders and complex needs' service pathway which included greater community support for patients to avoid inpatient admission. The trust was recruiting specialist staff to support this such as psychotherapists, clinical or counselling psychologists focusing on treatment of patients in community teams, in a specialist multi-disciplinary team and in-home treatment and transitioning teams. These staff would also develop other staff training. The plan was that where a patient with a diagnosis of personality disorder required inpatient admission, staff would be clear about the purpose, the agreed length of stay (with an aim of discharge within two weeks of admission), and any risks that are likely to be increased by the individual being in hospital. The trust had identified on their risk register a directorate objective to rollout the pathway.

Listening to and learning from concerns and complaints

This service received 79 complaints between 1 April 2018 to 31 March 2019. Four of these were upheld, 42 were partially upheld and 16 were not upheld. None were referred to the Ombudsman.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Mental Health Assessment Unit Basildon	**21**		15	2		3	1	
Peter Bruff Ward	**10**	3	3	1		3		

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Thorpe Ward	**8**		4	3		1		
Galleywood Ward	**7**		4	2		1		
Ardleigh Ward	**6**		2	3			1	
Grangewaters Ward	**6**		3	1		1	1	
Christopher Unit (PICU)	**5**		3	1		1		
Hadleigh Unit (PICU)	**5**		1	2		2		
Gosfield Ward	**4**	1	3					
Stort Ward	**3**		1			2		
Cedar Ward	**2**		2					
Finchingfield Ward	**2**		1	1				

Patients knew how to complain or raise concerns. Wards had various ways patients could give their feedback on their care and treatment or the service. This included suggestion boxes and mutual help daily community meetings. Some wards had displayed the actions they had taken in response to this on 'you said we did' boards. However, from a sample of community meeting minutes checked we found the minutes varied in quality and detail. Not all showed how staff had involved patients in the meeting and if staff had responded to actions from the previous meeting.

Staff understood the policy on complaints and knew how to handle them. The service received a low number of complaints reflecting that patients were satisfied with their care. Managers investigated complaints and identified themes. Patients received feedback from managers after the investigation into their complaint. Ardleigh staff additionally kept a local resolution complaints log book and documented their response to patients.

Staff received feedback from managers after investigations. For example, managers had given feedback to staff regarding a recent Parliamentary Health Service Ombudsmen report relevant for this core service. This included the actions the trust was taking in response.

This service received 235 compliments during the last 12 months from 1 April 2018 to 31 March 2019 which accounted for 19% of all compliments received by the trust as a whole.

The trust received compliments that reflected patients were satisfied with their care. Wards had received 'thank you cards' from patients and their carers, but staff said they were not always

recording these as compliments. The trust shared compliments for this core service each month with wards.

Is the service well led?

Leadership

The trust had not ensured that staff, leaders and governance processes addressed all risks identified at our 2018 and April 2019 inspections. At this inspection, we identified further risks for this core service relating to ward environments, staffing and bed management.

Staff told us their local managers and leaders were visible in the service and supported staff to develop their leadership skills and take on more senior roles. However, we received mixed feedback from staff about the accessibility of executive board team members.

Vision and strategy

Wards displayed the trust vision and values for staff, patients and others. Grangewater had specifically referred to the trust vision ‘working to improve lives’ in the patient welcome pack.

Culture

The majority of staff felt respected, supported and valued. They could raise concerns without fear. The trust had a ‘reverse mentoring’ scheme where nursing assistant equalities champions gave support to the executive team. However, staff gave examples of where improvements could be made relating to promoting equality and diversity in senior management positions, providing opportunities for career development and improving staff parking. Three of 67 staff (4%) told us they had experiences of being bullied at work by managers.

Governance

Leaders ensured there were some structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Wards had staff champions who led on various areas such as equalities and safeguarding. The trust had newsletters giving staff governance updates on issues relevant for their ward such as ‘Quality matters’ and ‘five key learning points’. However, we checked a sample of ward team meeting minutes which often held the same generic statements cut and pasted. This promoted consistency, but it was not always clear how staff were empowered to contribute and raise any matters they wanted to.

Management of risk, issues and performance

The trust did not always ensure risks were managed and actions taken from learning from incidents were consistently applied across wards. Chelmer, Cedar, Galleywood, Gosfield, Kelvedon and the Christopher Unit environments needed improvements. The trust had systems for monitoring staffing and bed occupancy on a daily basis, but patients and staff were still reporting challenges with risks. Ligature assessments still did not capture all ligature risks and management. Trust audits of staff seclusion and observation records of patients were not fully effective as we found gaps in completion. The trust’s restrictive interventions reduction programme was not fully effective as staff had used more restraint and seclusion with patients in 2018 than the previous year.

Leaders had some systems to manage performance and identify, understand and monitor, risks. Kelvedon and Cedar wards had identified maintenance, ligature risk management and the smoking policy on the risk registers. We noted on the inpatient adult and emergency care reference to maintenance, ligature risk management but not the smoking policy.

The trust had not fully ensured enough suitably skilled staff for the wards. We had identified this as a risk at the focused inspection in April 2019. The service had increased staff vacancy rates and increased rates of bank and agency nursing staff usage in the last year. Managers told us they had nurse and nursing assistant vacancies across most wards. Trust data sent after the inspection for June 2019 for five north wards showed Chelmer had the highest amount of vacancies with 32%. Some wards had staff on long term sickness or parental leave.

Staff had reported 11 staffing issues incidents between May and July 2019. The highest was the Christopher Unit, Finchingfield, Stort and Cedar Wards who had reported two incidents each. Nineteen out of 69 staff (28%) and 15 out of 34 patients and carers (44%) identified staffing risks across wards including, not having enough permanent staff due to vacancies; not enough staff to cover tasks especially if a higher number of patients needed enhanced observation, poor quality agency staff who did not know the ward or patients' needs to deliver effective care and treatment, patient activities and section 17 community leave being cancelled due to not enough staff to support. The trust's screening process was not fully effective as managers told us occasionally they were sent staff who they had concerns were not competent to work on their ward and during our visit we came across a recent example of this on a ward. Managers said if they had concerns about this they had a system for notifying the central team about this and could block them from working elsewhere in the trust. They told us they did not get information sent to them about the individual agency staff identified to work on their ward. However, the trust told us this information was easily available for managers.

Staff and patients gave examples where staff (permanent and agency) were reported to be asleep on duty including when on enhanced observation of individual patients. Staff had reported these incidents for investigation. However, no patients or staff told us that harm had occurred for patients. Managers gave examples of checks they carried out to reduce the risk of this such as checking with staff if they felt tired or unwell, ensuring they had breaks and matrons carried out spot checks at night. The trust had also introduced 'fit for work' mandatory training for staff to help reduce this risk. Gosfield ward had recruited 5% more staff than their establishment. The trust had approved for Cedar ward to overrecruit to nursing assistants as they had difficulties recruiting nurses. They were in the process of recruiting five nurses. Kelvedon had four nurse and four nursing assistant posts vacant because the ward was temporarily established to help alleviate winter bed pressures. The trust had systems in place to monitor gender mix on the wards, to ensure that patient needs are met by staff of the preferred gender. However, staff were unable to provide this information on the ward as this was monitored at a higher level.

The trust's governance and oversight of ligature risk assessment and management still needed improving. Whilst the trust had given this area a high priority, the systems for reviewing and updating ward assessments, were still not fully effective to identify all ligature points, for example on Gosfield ward and the assessment unit where we had identified issues at our 2018 inspection. Additionally, the trust had replaced wardrobes on the assessment unit after our April 2019 inspection, but they had not replaced them on Cedar ward. We still found garden area ligature risks were not always identified. However, the trust had an environment risk reduction works

programme in place and staff gave us examples of where they were waiting refurbishment relating ligature points.

The trust had not reviewed the effectiveness of a no smoking policy across the trust. Staff across wards reported challenges with the implementation. For example, relating to risk assessment and stopping informal patients from having leave to smoke outside the hospital and incidents where patients became violent or aggressive or had tried or managed to self-harm if given unescorted leave. Staff did not usually escort patients to smoke. Staff said that sometimes agencies or teams bringing patients for admission had not explained the no smoking policy to the patient which had frustrated patients on admission. Data for May to July 2019 showed 24 'smoking category' and 24 'Smoking (Aggravating Factor)' incidents including six verbal and two physical assaults. Finchingfield ward had the highest number of incidents with six and the Assessment Unit overall had five. However, the trust offered smoking cessation support to patients and had changed their policy to allow use of 'e cigarettes' and vapes in gardens.

Information management

The trust collected information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure. Wards had staff performance stations which gave some information about their performance. However, the trust had affected accurate ward staff training data by recently introducing new training courses. For example, several wards showed overall compliance of '0%' and managers expressed their frustration at this. Galleywood had a task and finish group which reviewed staff sickness, support, staffing and skill mix. However, most ward managers did not have easy access to data about their staffing sickness and turnover. Most ward managers struggled to show us key performance data.

Wards referenced having the 'perfect ward app' made for smartphones and technology tablets for staff to gain and give easier information about their ward. However, several wards had limited WIFI access to use this effectively.

Engagement

The trust had some systems to engage with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services. For example the patient engagement team used social media to get people to share their experiences '*#FeedbackFriday'*. Additionally, we saw events planned for Colchester in August 2019. Patients and carers could also give feedback on service via 'how did we do' and 'friends' and family surveys.

Staff had opportunities to join equalities networks for support and give feedback on the trust such as for LGBT+, and black and minority ethnic networks. Staff were aware the trust had systems to analyse their performance regarding the Workforce Race Equality Standard. However, ward staff were not able to give much detail of how they or the trust involved patients and carers in the development and improvement of this core service. Some staff gave feedback the trust could have had better engagement with staff in the recent review of administration staffing.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain

standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Core service	Service accredited	Comments
AIMS - AT (Assessment and triage wards)	MH – Acute wards for adults of working age and psychiatric intensive care units	Basildon Assessment Unit	November 2016
AIMS - WA (Working Age Units)	MH – Acute wards for adults of working age and psychiatric intensive care units	Grangewaters Ward	July 2017

Staff were keen to improve. Leaders encouraged innovation and participation in research. For example, doctors on Galleywood and Peter Bruff wards were involved or had been in research including working with patients with a personality disorder polypharmacy and reduction. The Christopher and Hadleigh units were involved in a quality improvement project looking at use of rapid tranquilisation, seclusion and restraint use. Staff had a toolkit to help them with de-escalation with patients and provide an alternative to self-harm. Thorpe ward were starting a new quality improvement project with the aim of reducing use of agency staff and making less popular shifts more attractive.

Ward staff had developed their own quality stars, where they identified goals and actions for improvement, in line with the CQC five domains of safe, effective, caring, responsive and well led. Ward's gave 'star of the month' awards for staff's good practice.

The Hadleigh unit had developed links with former staff working in Hungary who were setting up a psychiatric intensive care unit. The trust had supported staff to visit them in September 2019 to cross exchange learning and development.

The trust has been selected to participate in the Royal college of psychiatry 'Mental Health Safety Improvement Collaborative' in respect of Sexual Safety. Both assessment units will be participating in the programme that commences in October 2019 and runs through until November 2020.

MH – Long stay/rehabilitation mental health wards for working age adults

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
439 Ipswich Road	439 Ipswich Road	11	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

The ward was clean, well equipped, well furnished and well maintained.

Staff completed a risk assessment of the ward environment annually.

The ward layout did not allow staff to observe all parts of the ward. The provider had mitigated some blind spots using convex mirrors. However, during the inspection we identified blind spots in the main house, in the conservatory, upstairs and in the garden which staff had not identified. Staff had overlooked ligature anchor points in a room which they could use as a patient lounge. Whilst staff could improve their awareness of these issues, patients were low risk patients capable of having access to the community where they would have access to many similar risks.

Safety of the ward layout

The ward complied with guidance on eliminating mixed sex accommodation. Over the period from 1 January 2018 to 31 March 2019 there were no same sex accommodation breaches within this service. Patients had their own bedrooms, some with en-suite facilities, some with shared bathrooms. Staff accommodated female patients in en-suite bedrooms. Patients could lock their doors.

The number of same sex accommodation breaches reported in this inspection was the same as the last inspection with zero.

NOTE: Comparisons to 'last inspection' data often do not refer to a whole year of data.

There were ligature risks on one ward within this service. All wards had a ligature risk assessment in the last 12 months.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Ipswich Road	Rehab unit, low risk client group	No	Risks included in hotspots and heat maps. Tasks raised as appropriate.

Staff assessed the environment for potential ligature risks annually. A ligature anchor point is anything which a person could use to attach a cord, rope or other material for hanging or strangulation. However, during the inspection we found potential ligature anchor points in the environment which staff had overlooked as in an area with supervised patient access. However, the ward could also use this room as a female lounge and therefore needed to hold it to the same standards as other patient areas. Staff assessed patients' individual risk and did not routinely admit patients who were at risk of ligature, patients needed to be safe to access the community which would contain many similar risks to those presented by the ward environment.

Staff had access to personal alarms to call for help in case of an emergency.

Maintenance, cleanliness and infection control

During the inspection we found the environment was clean and well maintained. Patients and carers told us they always found the environment clean. The estates team, who maintained the environment, were responsive. At the time of the inspection we saw that estates team members

were attending to some damage which had occurred the day before. The ward maintained a cleaning rota and patients cleaned areas themselves. Staff did not keep cleaning audits.

Staff controlled the heating in the bedrooms directly by controls connected to the radiators. The trust had agreed to purchase a central thermostat system which they had not installed at the time of the inspection.

439 Ipswich Road was not assessed as part of PLACE so cannot be compared to similar sites.

Staff observed infection control principles. The ward had handwashing facilities and hand foam available.

Clinic room and equipment

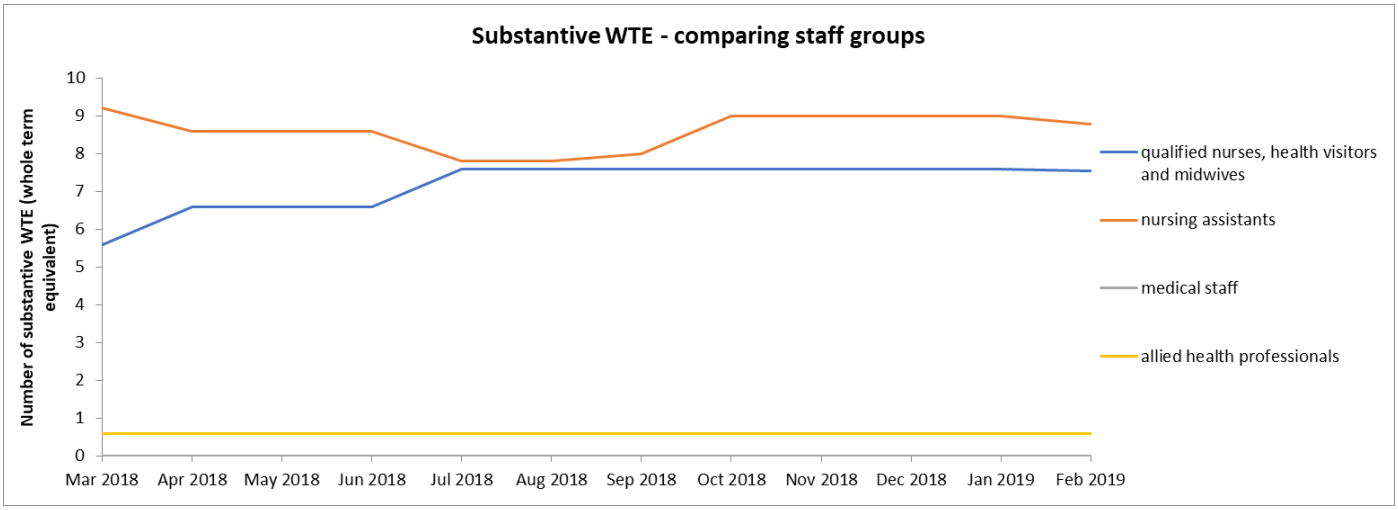
Staff had access to most equipment they needed to monitor patients' physical health needs, except an examination couch. Staff had to use patient bedrooms to conduct a physical examination or procedure as they did not have a dedicated room. This did not meet infection control requirements. The ward had accessible resuscitation equipment and emergency drugs that staff checked regularly.

We checked cleaning records and found that staff cleaned and maintained physical health monitoring and resuscitation equipment regularly.

Safe staffing[6]

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

The below chart shows the breakdown of staff in post WTE in this core service from 1 March 2018 to 28 February 2019.



Managers had calculated the number of staff, based on the needs of the patients and the crisis line which the service ran. They reviewed this daily or when patients needed additional support. There was always one qualified nurse on the ward and managers had increased the minimum number of nurses to two on ward review days to ensure enough cover. The ward manager reported staff fill rates each week to senior managers.

[6] Staffing run chart; Staff fill rates; Vacancy benchmark; Sickness benchmark; Turnover benchmark

Staffing levels were sufficient that patients could have one to one time with their allocated nurse and staff could manage patient safety incidents. In most cases patients did not require an escort to take leave from the ward, but staff were able to support patients if they needed an escort.

The below table covers staff fill rates for qualified nurses and care staff during January 2019 and February 2019.

Key:

> 125%	< 90%

	Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	January 2019				February 2019			
439 Ipswich Road	105%	99%	103%	103%	102%	99%	104%	96%

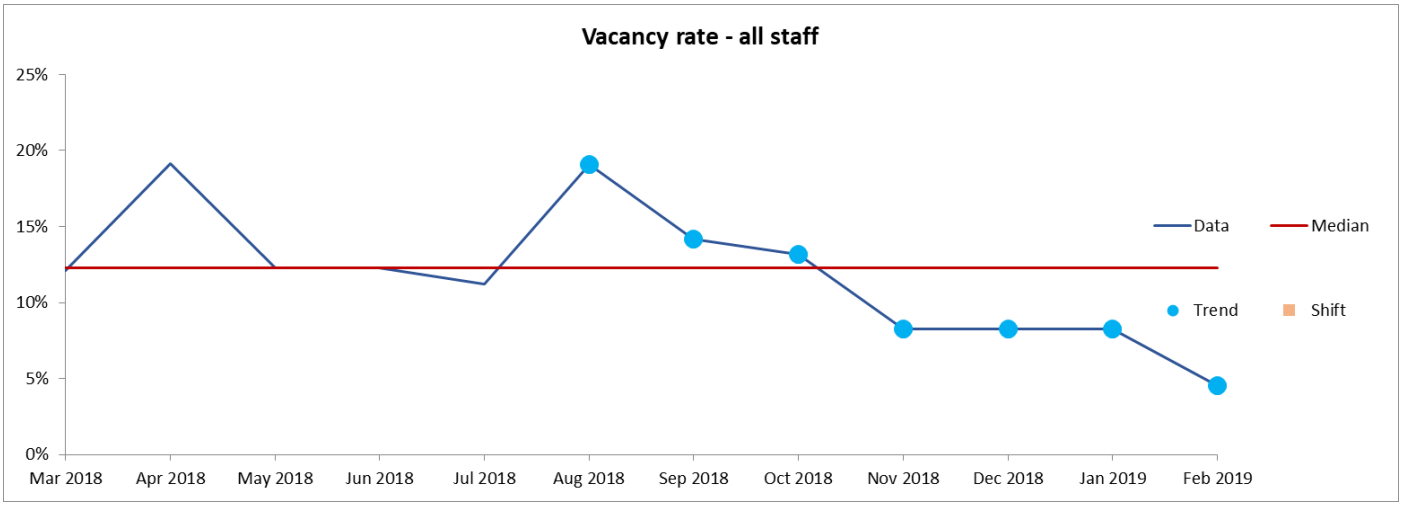
The fill rates data did not flag any specific concerns at 439 Ipswich Road.

Annual staffing metrics

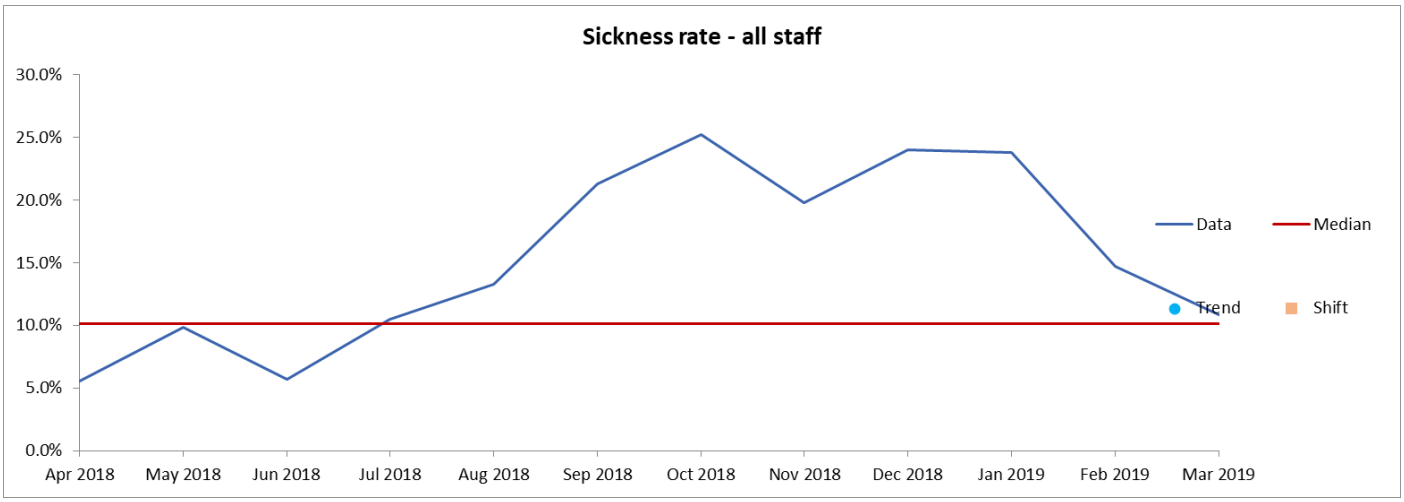
	Core service annual staffing metrics (Vacancy, Turnover, Bank and Agency: 1 March 2018 – 28 February 2019) (Sickness: 1 April 2018 – 31 March 2019)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual "unfilled" hours (% of available hours)**
All staff	20.3	12%	4%	15.5%			
Qualified nurses	5.8	-19%	0%	5.6%	4302 (38%)	0 (0%)	141 (1%)
Nursing assistants	9.6	12%	0%	26.7%	5862 (31%)	87 (<1%)	212 (1%)
Allied Health Professionals	1.5	60%	0%	0.3%			

NOTE: Data regarding the number of medical locum hours filled by bank and agency staff was not clearly aligned to specific teams; therefore, this data was not usable for analysis.

All Staff



Monthly 'vacancy rates' over the last 12 months for all staff shows a downward trend from August 2018 to February 2019. This could be an early indicator of improvement.



Monthly 'sickness rates' over the last 12 months for all staff are not stable and may be subject to ongoing change. The average sickness rate for all staff was also in the highest 25% when compared to other similar core services nationally.

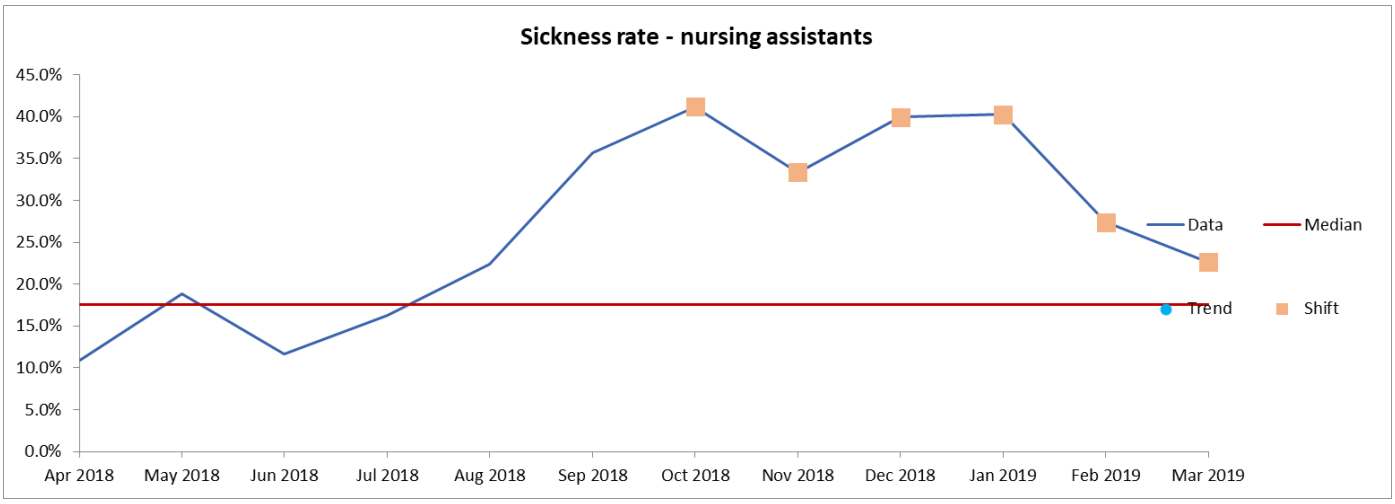
The annual turnover rate for all staff was in the lowest 25% when compared to other similar core services nationally.

Qualified Nurses

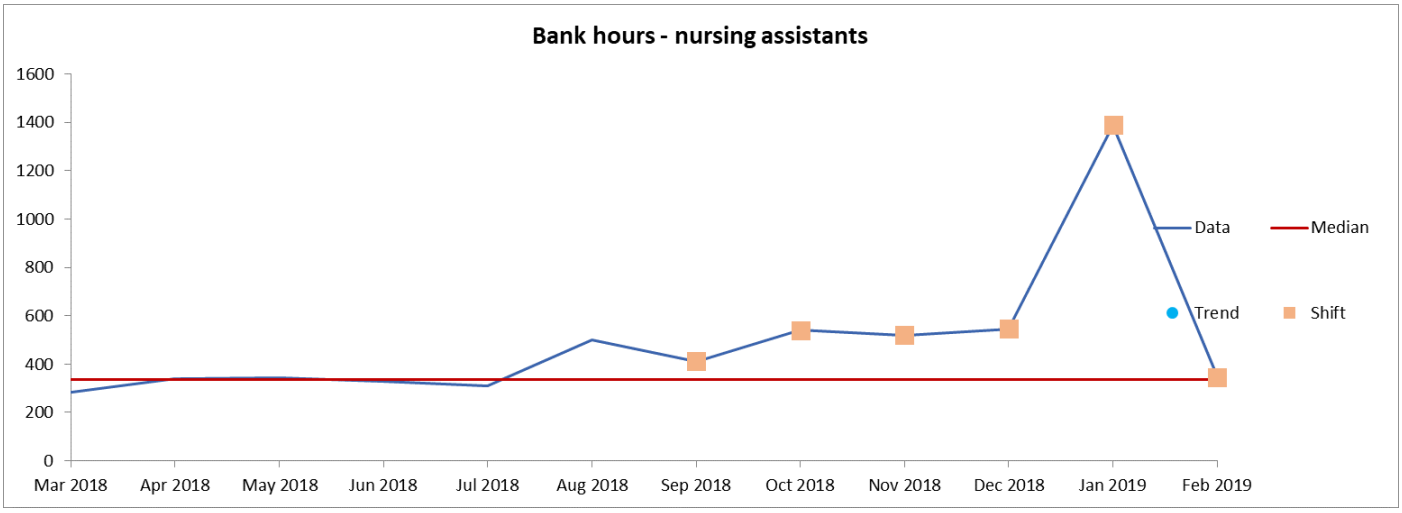
The average vacancy and turnover rates for qualified nurses were in the lowest 25% when compared to other similar core services nationally. Monthly staffing figures for the past 12 months were also analysed, and no indications of improvement, deterioration or change were identified.

At the time of the inspection the service had an establishment of seven whole time equivalent nurses with no vacancies. No nursing staff had left the service recently.

Nursing Assistants



Monthly 'sickness rates' over the last 12 months for nursing assistants shows a shift from October 2018 to March 2019. This could be an indicator of change. Two staff were on long term sick leave at the time of the inspection. The average sickness rate for nursing assistants was also in the highest 25% when compared to other similar core services nationally.



Managers booked bank staff only when necessary. They ensured bank staff were familiar with the ward and the patients. Managers provided temporary staff with an induction, shadowing time with other staff on the ward, and time to familiarise themselves with patients' notes. Managers offered bank staff supervision.

Monthly 'bank hours' over the last 12 months for nursing assistants shows a shift from September 2018 to February 2019. This could be an indicator of change. Managers had arranged a staff away day in January which had resulted in a temporary increase in bank staff use during that month.

The service did not routinely use agency staff.

The annual turnover rate for nursing assistants was in the lowest 25% when compared to other similar core services nationally.

Medical and Dental

Staffing figures within this core service were compared to other similar services and annual vacancy, sickness and turnover rates were found to be about the same as the national average. Monthly staffing figures for the past 12 months were also analysed, and no indications of improvement, deterioration or change were identified.

The ward had an allocated consultant who was available five days per week. Junior doctors and an on-call doctor service provided cover outside of this time and could respond during an emergency.

Allied Health Professionals

The average vacancy rate for allied health professionals was in the highest 25% when compared to other similar core services nationally. However, the average sickness rate and the turnover rate for allied health professionals were in the lowest 25% when compared to other similar core services nationally. Monthly staffing figures for the past 12 months were also analysed, and no indications of improvement, deterioration or change were identified.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The compliance for mandatory and statutory training courses at 31 March 2019 was 92%. Of the training courses listed one failed to achieve the trust target but it did score above 75%. At the time of the inspection staff had recently attended a group training day of this course and compliance was 100%.

The trust set a target of 85% for completion of mandatory and statutory training modules including: Fire Safety 3 years, Fit for work, Induction, Information Governance, and Mental Health Act. The trust set a target of 90% for completion of mandatory and statutory training modules including: Safeguarding Adults (Levels 1, 2, & 3), Fire Safety 2 years, and Safeguarding children (Level 3).

Managers discussed staff training compliance during supervision meetings and supported them to book sessions. Training completion is reported as at end of reporting period.

The training compliance reported for this core service during this inspection was not comparable to the previous year.

Key:

Below CQC 75%	**Met trust target** ✓	**Not met trust target** ✘

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Fire Safety 3 years	6	6	100%	✓
Safeguarding Adults (Level 1)	2	2	100%	✓
Safeguarding Adults (Level 3)	10	10	100%	✓
Safeguarding Adults (Level 2)	20	20	100%	✓
Safeguarding Children (Level 3)	1	1	100%	✓
Induction	22	22	100%	✓
Mental Health Act	10	9	90%	✓
Information Governance	22	19	86%	✓
Fit for work	22	19	86%	✓
Fire Safety 2 years	19	15	79%	✘

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Total	**134**	**123**	**92%**	✓

Assessing and managing risk to patients and staff

Staff achieved the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they did not use restraint or seclusion. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

The ward aimed to admit patients with low risks.

Staff completed a thorough risk assessment of patients on admission using a recognised risk assessment tool. During the inspection we reviewed six patient records and found that all had an up to date risk assessment.

Management of patient risk

Staff updated patients' risk assessments every two weeks and met to discuss any changes. Staff responded to deteriorations in patients' mental health by increasing observation levels and seeking admission to another service. Staff screened patients who were at risk of substance misuse routinely. Staff searched patient's rooms only if they suspected that they were in possession of contraband items.

Staff enforced blanket restrictions, they displayed a list of foods they would and would not reimburse patients for when shopping, foods provided for were healthy. Staff did not reimburse patients who purchased high sugar or fat items. Staff did not allow patients to eat at different times of the day to the ward meal times.

Staff adhered to best practice in implementing a smoke-free environment, they had made changes to local policy to ensure the safety of patients if they did smoke and offered a smoking cessation service.

Staff told informal patients verbally that they could leave at will but did not record this. There was not a sign on the door to tell informal patients they could leave when they wanted to.

Use of restrictive interventions

Restrictive data was submitted by the trust between 1 January 2018 to 31 December 2018. However, there were no restrictive incidents reported for this core service.

Staff participated in the provider's restrictive intervention reduction policy. Ninety-four percent of staff had attended training on the prevention and management of violence and aggression. Staff used de-escalation methods and knew patients well enough to avoid the need to use physical interventions.

Staff did not use rapid tranquilisation or seclusion to manage patient behaviour.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. All staff had attended training on how to recognise and report abuse and knew how to apply it. Managers gave staff opportunities to discuss safeguarding concerns during meetings and clinical supervision. Staff could give examples of times when they had acted to protect patients from abuse including those with protected characteristics under the Equality Act 2010.

Staff worked in partnership with external agencies such as social services and the police to protect patients from harm. Patients' care co-ordinators from the local authority attended ward reviews when they could, and the ward could arrange for police to attend meetings if needed.

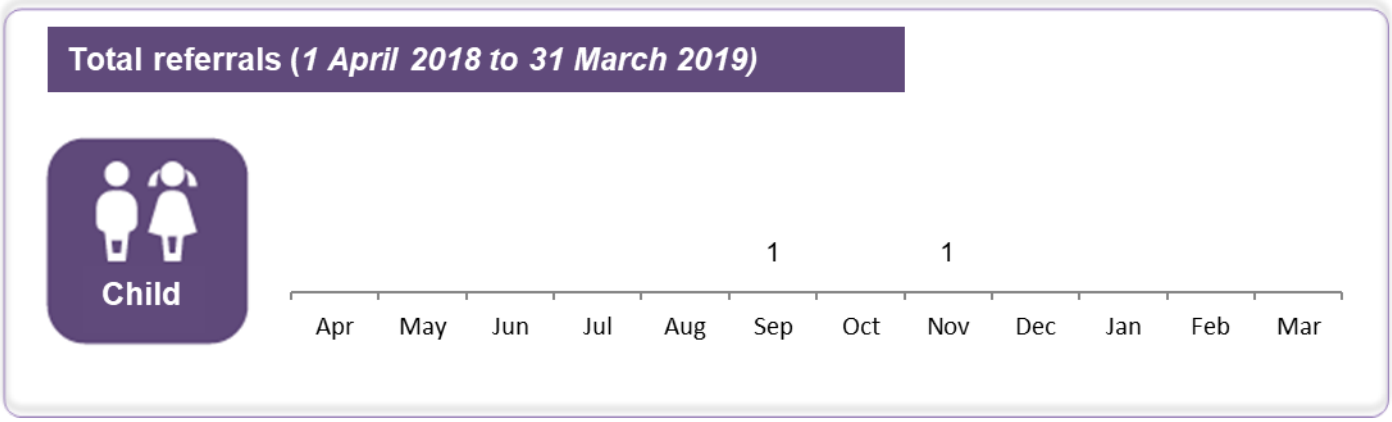
A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made two safeguarding referrals between 1 April 2018 and 31 March 2019, of which zero concerned adults and two concerned children. The number of safeguarding referrals reported during this inspection was not comparable to the last inspection.

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
MH – Long stay/rehabilitation mental health wards for working age adults	0	2	2

The number of child safeguarding referrals per month ranged from zero to one (as shown below)



Staff did not allow children to visit the ward, instead they helped facilitate visits within the community.

The trust has submitted details of zero serious case reviews commenced or published in the last 12 months (1 April 2018 to 31 March 2019) that relate to this service.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Staff had access to the information they needed to deliver care through an electronic notes system. In addition, ward staff kept paper files to provide easy access to essential information, they stored this information securely.

All staff had access to the internal electronic system and most had access to the Health Information Exchange system. The Health information Exchange allowed staff to access basic notes for patients who had transferred from another part of the trust and may have records on a different system.

Doctors and pharmacy team members were able to access information from patient's GP records.

Staff did not report any difficulty recording information on the electronic system.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff did not regularly review the effects of medications on each patient's mental and physical health.

During the inspection we reviewed five medicine prescription charts and the monitoring records associated with them. Prescribers had written all legally and within national guidelines they recorded appropriate safety information.

Staff ensured that patients who were on high risk medicines, such as antipsychotics had their physical health monitored on a regular basis.

Staff encouraged patients to manage their own medicines through a three-stage self-administration process. Staff assessed patients' ability at each stage before giving them more independence.

Staff did not always record monitoring of side effects. One of the six medicine charts which we reviewed had an associated side effect assessment however, this was from the year prior to the inspection.

Track record on safety

Between 1 March 2018 and 28 February 2019 there were zero serious incidents reported by this service. There were also no unexpected deaths in this service.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with zero reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

The number of serious incidents reported during this inspection was the same as the zero reported at the last inspection. The manager attended monthly meetings to facilitate sharing of information about incidents.

Reporting incidents and learning from when things go wrong

The service responded to patient safety incidents well; however, some staff we spoke with lacked insight on lessons learned following an incident.

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff we spoke with knew how to report incidents through the electronic recording system and what they should be reporting. We reviewed 14 incidents and found that staff had reported a range of incidents including violence and aggression, medicines concerns and substance misuse.

Staff we spoke with, understood their responsibilities regarding duty of candour. Carers told us about times when staff had been open and transparent about incidents and had apologised and offered support when appropriate.

Managers investigated incidents in good time and fed back to staff during supervisions and by email. Staff met to discuss incidents and lessons learned at monthly meetings. They kept minutes of these meetings and shared the information by email and on paper with team members not in attendance. Managers maintained a ‘lessons learned’ folder with information about incidents which had occurred across the trust including ligatures, equipment problems and medicines.

Records we reviewed showed that staff had made changes to practice following incidents. Two patients had had their medicines changed to improve adherence and staff had increased observation levels for another patient.

However, staff did not always identify learning from incidents and some learning was not fully embedded. Some staff did not attend meetings, others, we spoke with were unable to recall any lessons learned from incidents and some staff were unaware of recent safety alerts from the trust. Of the 10 completed incidents we reviewed, staff had not recorded lessons learned for four of them.

There had been no recent serious incidents. Trust policy gave staff an opportunity to de brief after serious incidents. Managers gave staff opportunities to discuss incidents during supervision.

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing future deaths.

In the last two years (since April 2017), there have been eight ‘prevention of future death’ reports sent to Essex Partnership University NHS Foundation Trust. None of these related to this service.

Is the service effective?

Assessment of needs and planning of care

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

During the inspection we reviewed six patient risk assessments. Staff had completed a thorough risk assessment of each patient on admission and updated this regularly. Staff gave patients a physical examination on admission and reviewed their needs throughout their stay.

During the inspection we reviewed six patient care plans. We found all care plans were personalised, holistic and recovery orientated. Plans set recovery goals based on life and social skills which the assessment process had identified. Staff had updated all but one care plan in the last two weeks.

Best practice in treatment and care

Staff offered some treatments and care for patients based on national guidance and best practice, but not others. Treatments provided, included support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives. However, the ward team was unable to offer psychological interventions. We found that the ward did not have a psychologist who attended regularly and therefore did not offer psychological interventions recommended by the National Institute of Health and Care excellence. The service supported patients to access external courses to manage their anxiety and depression, but this did not fully meet the needs of their patient group.

Staff provided treatment based on the Model of Human Occupation, an occupational therapist led approach which aims to identify problems a person is having and build a set of skills and habits which will help them in their life after recovery. Staff supported patients to live as independently as possible and encouraged them to: cook their own meals, manage their own healthcare and medicines and do their own laundry.

Doctors followed National Institute for Health and Care Excellence guidelines on prescribing and monitoring medicines.

Patients could access an annual health check through their local GP and staff monitored patients whose medication or other physical health needs may need closer monitoring. Patients had access to a range of physical health specialists including dentists, opticians and hospital specialists. Records showed that staff encouraged patients to manage their own appointments and helped patients to access them.

Staff supported patients to plan their meals and shop for themselves. This included advice and support to make healthy choices in their diet. Staff supported patients to live a healthier lifestyle based on the 'Closing the Gap' improvements identified by the Department of Health. They did this by offering walking groups, healthy eating education and smoking cessation sessions with a dietician, physiotherapist and occupational therapist working together to deliver.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit and quality improvement initiatives.

Staff monitored the success of patient treatment using the Model of Human Occupation Screening Tool, The Recovery Star, and Health of the Nation Outcome Scale.

Staff used technology to support patients effectively. Staff helped patients to use laptops to access recovery resources and supported them to complete online assessments for benefits, apply for work opportunities and manage their budgets.

This service participated in seven clinical audits as part of their clinical audit programme 2018 – 2019.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Record Keeping / Care Planning MH Adult	439 Ipswich Road, Ardleigh, Cedar, Chelmer, Christopher Unit, Finchingfield, Galleywood, Gosfield, Grangewaters, Hadleigh, Kelvedon, Mental Health Assessment Unit Basildon, Peter Bruff, Stort, Thorpe	MH – Long stay/rehabilitation mental health wards for working age adults	Clinical	ongoing	Audit results shared in Quality and Safety Committees. Results appear on the performance dashboards in each unit.
Mental Health Clinical Handover	439 Ipswich Road, Ardleigh, Chelmer, Christopher Unit, Finchingfield, Galleywood, Gosfield, Grangewaters, Hadleigh, Kelvedon, Mental Health Assessment Unit Basildon, Peter Bruff, Stort, Thorpe	MH – Long stay/rehabilitation mental health wards for working age adults	Clinical	18/02/2019	Findings shared with services, for them to develop appropriate action plans based on results
National audit of inpatient falls	439 Ipswich Road, Ardleigh, Chelmer, Christopher Unit, Finchingfield, Galleywood, Gosfield, Grangewaters, Hadleigh, Kelvedon, Mental Health Assessment Unit Basildon, Peter Bruff, Stort, Thorpe	MH – Long stay/rehabilitation mental health wards for working age adults	Clinical	In progress	Data collection based on incidents of hip fractures, as yet none reported. Collection time frame to end December 2019
Physical Health and MEWS in Adult Acute	439 Ipswich Road, Ardleigh, Cedar, Chelmer, Christopher Unit, Finchingfield, Galleywood, Gosfield, Grangewaters, Hadleigh, Kelvedon, Mental Health Assessment Unit	MH – Long stay/rehabilitation mental health wards for working age adults	Clinical	12/02/2019	The audit results were presented to the Physical Health Action and Implementation Group. Report was also shared with the service quality and

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
	Basildon, Peter Bruff, Stort, Thorpe				safety committee to review.
Resuscitation Audit	439 Ipswich Road, Ardleigh, Cedar, Chelmer, Christopher Unit, Finchingfield, Galleywood, Gosfield, Grangewaters, Hadleigh, Kelvedon, Mental Health Assessment Unit Basildon, Peter Bruff, Stort, Thorpe	MH – Long stay/rehabilitation mental health wards for working age adults	Clinical	In progress	Report reviewed at Resuscitation Group and awaiting Executive sign off before being disseminated to services.
POMHuk Topic 6d - Assessment of the side effects of depot antipsychotics	439 Ipswich Road	MH – Long stay/rehabilitation mental health wards for working age adults	Clinical	In progress	Data submitted, await report expected June 2019
National Audit of Psychological Therapies Spotlight	439 Ipswich Road, Ardleigh, Cedar, Chelmer, Christopher Unit, Finchingfield, Galleywood, Gosfield, Grangewaters, Hadleigh, Kelvedon, Mental Health Assessment Unit Basildon, Peter Bruff, Stort, Thorpe	MH – Long stay/rehabilitation mental health wards for working age adults	Clinical	In progress	Data submission completed. Report due to be published Summer 2019

Skilled staff to deliver care

The ward team included or had access to a range of specialists required to meet the needs of patients on the ward however, the ward lacked a psychologist. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The team included a range of specialists including Occupational Therapists, Doctors, nurses and healthcare assistants. A dietician and a physiotherapist provided input to the service. The ward lacked psychology input, therefore patients did not benefit from any psychological interventions.

Staff on the ward had enough experience to meet the needs of the patient group. Managers ensured that new staff had an induction which met the standards of the care certificate. Managers gave bank and agency staff a structured local induction and all new staff undertook shadowing opportunities to get to know the patients.

Managers provided staff with an annual appraisal which focussed on goals and development. The trust's target rate for appraisal compliance is 90%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for non-medical staff within this service was 55%. This year so far, the overall appraisal rates was 85% (as at 28 February 2019).

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 77% reported at the last inspection.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 28 February 2019)	% appraisals (previous year 1 April 2017 to 31 March 2018)
439 Ipswich Road	20	17	85%	55%
Core service total	**20**	**17**	**85%**	**55%**
Trust wide	**3884**	**3172**	**82%**	**55%**

The trust did not provide data regarding appraisal compliance for permanent medical staff.

Managers ensured staff had regular clinical supervision (meetings to discuss case management, to reflect on and learn from practice and for personal support and professional development). The trust's target of clinical supervision for non-medical staff is 90% of the sessions required. Between 1 March 2018 and 28 February 2019, the average rate for the one team in this service was 95%.

The rate of clinical supervision reported during this inspection was lower than the 98% reported at the last inspection.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

We reviewed two months of supervision records for three staff and found that managers completed them regularly and they had a clear structure, identified actions needed and showed evidence of staff development. Whilst managers offered bank and agency staff supervision, students told us that they usually had to request supervision if they wanted it.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
439 Ipswich Road	152	144	95%
Core service total	**152**	**144**	**95%**
Trust Total	**19802**	**19153**	**97%**

Clinical supervision for medical staff[7] (Internal use only - Remove before publication)

[7] Clinical Supervision

The trust did not provide data regarding clinical supervision compliance for permanent medical staff.

Managers identified the learning needs of staff and gave them opportunities to develop their skills and knowledge. The ward manager offered staff training opportunities through team meetings and away days and had arranged for healthcare assistants to complete emergency skills training if they wanted to.

The trust did not offer staff access to necessary specialist training to nursing staff. Doctors told us they could access this externally if they wanted to.

Managers had not had to deal with any staff performance concerns recently. We saw evidence in supervision notes that they tracked and supported staff with high sickness levels.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with staff in services providing care following a patient's discharge and engaged with them early in the patient's admission to plan discharge. However, the ward lacked a psychologist.

Staff held multidisciplinary meetings on a weekly basis. We reviewed minutes for these meetings and found that they had a clear structure. Doctors, nurses and a discharge co-ordinator attended multidisciplinary team meetings. Ward staff held twice daily meetings between shifts to handover any changes in patients' risks or treatments. However, we found that the occupational therapist was not always able to attend meetings and was sometimes unable to give input. A pharmacist attended the ward on a weekly basis.

Staff we spoke with told us that there were good working relationships between members of the multidisciplinary team and with outside organisations such as social services and the police, however care co-ordinators from the local authority did not often attend ward reviews until the patient was likely to discharge the patient.

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

Staff did not adhere to all their responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers made sure that staff could explain patients' rights to them, but staff did not record when they spoke to informal patients about their rights.

As of 31 March 2019, 90% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and community staff, depending upon their role.

The training compliance reported during this inspection was higher than the 28% reported at the last inspection.

Staff had access to administrative and legal support for advice on the Mental Health Act. Staff could access policies and procedures for the mental health act on the staff intranet and the ward kept a paper copy with a copy of the Mental Health Act code of practice.

Patients had access to an independent mental health advocacy service and staff displayed the contact details on a patient notice board. Staff knew how to arrange a visit from the advocate.

Staff explained to patients their rights under the Mental Health Act in a way they could understand. Of the six patient records we reviewed during the inspection, one was detained under the Mental

Health Act, we saw staff read their rights and recorded this on the electronic system. Staff gave patients a leaflet to tell them about their rights when they admitted them.

Staff ensured that patients had access to take Section 17 leave when arranged by their doctor. Most patients did not need staff to escort them, so staff never cancelled leave if they were short staffed.

Staff requested an opinion from a Second Opinion Appointed doctor when required. Staff stored copies of patients' detention papers and associated records on the electronic system where all staff who needed to, could access them. Some records were on paper and staff stored these in the relevant patient folder. We checked five prescription charts and found that staff had stored relevant Mental Health Act paperwork alongside the chart when needed.

Staff did not always record when they told informal patients about their rights. We checked five records of informal patients and none showed that staff had told patients about their rights on a regular basis. There was no sign on the ward to tell informal patients they could leave.

Staff arranged access to section 117 aftercare through a community care co-ordinator and trust community teams.

Mental Health Act administrators completed regular audits on Mental Health Act paperwork and sent the actions to the ward manager. We checked the most recent audit and saw that managers had resolved the one issue raised. Managers ensured they sent any issues found during these audits to doctors.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. However, staff did not know how the trust monitored compliance to the Mental Capacity Act or how to get advice.

As Mental Capacity Act Training is incorporated into Safeguarding Level 1 training, the data is unsuitable for analysis. All staff had completed Safeguarding Level 1 training at the time of the inspection.

Staff had a good understanding of the five principles of the Mental Capacity Act and displayed details of this on the ward notice boards.

Staff had access to a policy on the Mental Capacity Act through the staff intranet.

Staff did not know how to access advice about the Mental Capacity Act.

Staff assessed and recorded patients' capacity, we saw evidence of this in patient notes. Staff understood how to support patients to make decisions and could give examples of when they had. Examples included times when staff had recognised a patient's right to make an unwise decision and had written a care plan around the situation.

For patients who lacked capacity to make a specific decision, staff would make decisions in their best interests whilst considering the person's wishes, feelings, culture and history.

The trust told us that zero Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 April 2018 to 31 March 2019.

CQC received 274 direct notifications from the trust as a whole between 1 April 2018 to 31 March 20198. However, the trust reported that 158 direct notifications were sent to CQC. Under HSCA legislation, all DoLS applications should also be sent to the CQC in the form of a direct notification so it is important that these numbers are different.

The number of DoLS applications made during this inspection was the same as the zero reported at the last inspection.

Staff did not have access to audits on the application of the Mental Capacity Act and were unaware of how the service monitored adherence.

[8] CRM

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We observed three interactions between staff and patients and spoke to three patients. We found that staff were kind and treated patients with respect. Staff encouraged patients to be caring to each other and protected them from abusive behaviour or attitudes using treatment contracts. Patients told us that staff made them feel safe and that the ward environment was homely.

Staff supported patients to make decisions about their own care and empowered them to take responsibility for their own treatment. Patients cooked their own meals, did their own shopping, cleaning and laundry. Staff directed patients to external services such as education courses and supported them with housing and benefits applications. Staff ensured that they met patients' needs and gave them a choice of treatments and therapies.

Staff protected patients' confidentiality and privacy, they stored patient records securely electronically or locked away and staff knocked before entering a patient's bedroom. Patients could lock their bedroom doors and kept their own keys. Staff sought patients' consent before sharing information with others. We saw examples where staff had respected a patient's wish not to have their family involved in their care.

439 Ipswich Road was not assessed as part of PLACE so cannot be compared to similar sites.

Involvement in care

Involvement of patients

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Staff gave patients a welcome pack on admission which covered information about how the ward worked and who each of the staff were. They kept this information in patients' bedrooms and in communal areas of the ward.

Staff gave patients a copy of the trust workbook 'my care my recovery' when they admitted them. All six patient records that we reviewed showed that staff had involved all patients in their care plan. Staff gave patients leaflets about their care and treatment and gave them options about what activities they would like to do each day. Staff supported patients to take responsibility for their food through self-cooked meals and their medicines through self-administration.

Patients could attend a weekly community meeting where they could feed back about the service and request activities. The ward also sought feedback from patients through the ward suggestions box and at ward reviews.

Staff supported patients to make advance decisions when appropriate.

Staff ensured that patients had access to advocacy, the advocate visited the ward regularly and staff gave all patients their contact details with their welcome pack on admission.

Involvement of families and carers

Staff informed and involved families and carers appropriately. We spoke with three carers, all were positive about the care that staff gave their family member. One carer was directly involved in their relative's treatment and attended ward reviews. Staff gave them opportunities to feed back to the service.

The ward did not provide carers with details on how to access a carers assessment.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancy for one ward in this service between 1 March 2018 to 28 February 2019.

The one ward within this service reported an average bed occupancy ranging above the minimum benchmark of 85% over this period.

Ward name	Average bed occupancy range (1 March 2018 – 28 February 2019) (current inspection)
439 Ipswich Road	71%-88%

Average Length of Stay data[9] (Remove before publication)

The trust provided information for average length of stay for the period 1 March 2018 to 28 February 2019.

Ward name	Average length of stay range (1 March 2018 – 28 February 2019) (current inspection)
439 Ipswich Road	579-810 days

This service reported zero out of area placements between 1 January 2018 to 28 February 2019.

The number of out of area placements reported during this inspection was the same as the zero reported at the time of the last inspection.

Staff did not fill patients' beds when they went on leave, so patients always had a bed to come back to when they returned.

Patients moved between wards only when clinically necessary, for example when their mental health deteriorated, and they required more support from staff. In this case, staff would support them with increased observations until they could find a suitable placement for them. Staff could access a bed in a Psychiatric Intensive Care Unit if needed however this was rare.

This service reported zero readmissions within 28 days between 1 March 2018 to 28 February 2019.

At the time of the last inspection, for the period 1 April 2017 to 31 January 2018, there was a total of one readmission within 28 days. This readmission was to a different ward and there were six days between discharge and readmission.

Therefore, the number of readmissions within 28 days has decreased between the two periods.

Discharge and transfers of care

[9] Length of Stay

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. Whilst patients did sometimes have excessive lengths of stay, lack of suitable community placements was usually the cause.

Staff planned for discharge by working with the service discharge co-ordinator and the patient's care co-ordinator. We found all six patient records we reviewed contained a discharge plan, and in all cases the multidisciplinary team was reviewing this regularly. Staff facilitated patients attending a potential new placement to support their transition.

Between 1 March 2018 to 28 February 2019 there were 11 discharges within this service. This amounts to 0.2% of the total discharges from the trust overall (5548).

Delayed discharges across the 12-month period ranged from one to two per month, with a total of six delayed discharges.

The number of delayed discharges reported during this inspection was higher than the two delays reported at the time of the last inspection.

These delayed discharges were often due to patients risks and history, making it difficult to find them a suitable placement. We saw that multidisciplinary staff worked with patients to resolve these barriers and continued to follow up potential placements.

Staff referred patients to the local acute hospital if they needed support with their physical health. Staff could attend with a patient if required.

Staff wrote notes and discharge summaries in a way which met national transfer of care standards.

Facilities that promote comfort, dignity and privacy

All patients had their own bedrooms, some with en-suite bathrooms and some with shared bathrooms. Patients could personalise their bedrooms, but we did not see any who had. Patients could lock their bedroom doors with their own key and had somewhere to secure their personal belongings. Patients had access to their bedrooms throughout the day.

Patients had access to rooms which met a range of needs including a patient lounge, a quiet area, disabled access rooms and laundry facilities. However, staff did not have access to a dedicated clinic room where they could examine patients and had to use their bedrooms. This practice does not meet infection control guidelines.

Patients could make a phone call in private when they wanted to using mobile phones and cordless phones.

Patients had access to a garden which they could enter freely. There was seating and patients were growing their own plants and vegetables.

Staff supported patients to self-cater and they could make hot drinks and snacks at any time. Patients had their own cupboard, fridge and freezer space in the kitchen. They did their own shopping in the community and staff reimbursed them for the cost of healthy foods.

439 Ipswich Road was not assessed as part of PLACE so cannot be compared to similar sites.

Patients' engagement with the wider community

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

Staff displayed education and work opportunities on noticeboards and two patients were studying functional skills at a local college. One patient was working.

Staff supported patients to maintain relationships with those who mattered to them. Patients in touch with families could visit them and stay overnight. The staff team promoted a good dynamic between patients and offered opportunities to raise issues through community meetings and mediation. Staff encouraged patients to go out to the local community, use public transport, access group therapies, and do their own shopping.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristics such as race, disability or religion. Staff helped patients with communication, advocacy and cultural and spiritual support.

439 Ipswich Road was not assessed as part of PLACE so cannot be compared to similar sites.

Staff made adjustments for disabled patients. All communal areas were on the ground floor, there was one bedroom on the ground floor in both the main house and the coach house. The entrances had accessible ramps. For patients who used sign language, staff could access a signer.

Staff kept a leaflet stand and a noticeboard in the main hallway, this displayed leaflets and posters about treatments, patient rights, local groups and the complaints procedure. Staff could have leaflets translated if needed or could order accessible formats such as large print or easy read. Staff could access an interpreter if needed.

As the ward was a self-catering environment, patients could purchase a choice of food which met their dietary requirements.

Staff supported patients to access spiritual support. Two patients had regularly attended a nearby church, and staff were able to signpost those of other religions.

Listening to and learning from concerns and complaints

The service had not received any concerns or complaints. Staff understood how to handle complaints and managers could investigate them. Managers understood the need to share complaints with the staff team.

This service received zero complaints between 1 April 2018 to 31 March 2019.

This service received zero compliments during the last 12 months from 1 April 2018 to 31 March 2019.

Patients knew how to complain about the service. Staff provided information about the complaint’s procedure in the form of the welcome pack and leaflets.

Staff understood the process for both formal and informal complaints and were aware of the need to protect complainants from discrimination and harassment.

Whilst the ward had not received any formal complaints there was a section in the structure of staff and community meetings which allowed for discussion of any concerns.

Is the service well led?

Leadership

Managers at local level had the right skills and abilities to run a service providing high-quality sustainable care. They understood the service they managed, and it followed a recognised model for rehabilitation care. Managers were arranging for members of the senior leadership team to attend training events, to make them more accessible to the team.

All patients and staff we spoke with, knew who the local managers were and could approach them with any concerns. The ward manager was studying a management development programme at the time of the inspection.

Vision and strategy

All staff we spoke with understood the trust's vision and strategy. Managers had discussed how staff roles related to the trust vision in supervision and team meetings. Senior leadership had provided a poster detailing the trust vision and values which staff had displayed on the ward.

Staff and patients had contributed to the vision and strategy of the service. The ward displayed a local set of goals and values, which staff and patients had written collaboratively.

Staff explained that they worked towards a philosophy of their patients gaining the skills they needed to live their life independently. Whilst the ward staff had the equipment they needed, some highlighted that a tight activities budget meant they could not run all of the activities they would like to.

Culture

All staff we spoke with felt respected, supported and valued. Managers discussed team morale at meetings and had recently held an away day to improve this. Managers had developed an action plan following this away day.

Most staff we spoke with felt that Essex Partnership University Foundation Trust was a good place to work and were proud to work for the trust. None felt negatively.

Staff felt able to raise concerns about the service without fear of retribution. Some staff had raised concerns at the recent away day.

Whilst most staff we spoke with knew how to use the trust whistleblowing policy, one member of staff was unsure what the process was. The trust advertised the Freedom to Speak Up Guardian on posters around the service.

Staff said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. Staff could join any of the staff networks which promoted equality and diversity in the trust. The trust had recruited equality and diversity champions to support this goal. Staff said they could raise any concerns without fear.

Managers had not had to performance manage any staff since the last inspection. However, we saw that the service sickness levels had been higher than the trust average over the winter period, we saw that managers reviewed this through supervisions and the levels were reducing. Managers could refer to an occupational health service if needed.

Managers tracked the service's performance against trust agreed key performance indicators and received a report where performance was low.

The team worked well together, and managers had not had to deal with any staff difficulties since the last inspection. Managers had arranged a staff away day to improve morale. Staff supervisions and appraisals included conversations about career development.

The provider recognised staff success within the service through a trust wide staff awards programme.

Governance

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

Managers had a clear framework of what to discuss at a ward or team level in meetings. This included, learning from incidents and complaints.

Staff participated in local clinical audits and reported the results to managers. We saw evidence that staff had implemented actions highlighted by these audits. Managers could review the ward's compliance against its key performance indicators on an online dashboard. At the time of the inspection compliance was 80%.

Staff understood how and when to work with other teams both internal and external, this included care co-ordinators from the local authority, education services, and benefits and housing. The ward had access to administrative support.

Management of risk, issues and performance

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

Staff had access to the ward risk register and stored a copy in a folder on the ward. Staff could request managers to add risks to it.

The service had plans for emergencies, such as basic paper files in the case of computer system failure.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. The service used systems and audits such as 'Perfect ward' to collect data from the wards, this was not overburdensome to staff. Staff agreed that the patient records system was sufficient to ensure patient care.

Staff had access to the necessary equipment and technology they needed to do their jobs. Although the occupational therapy team told us they would like to buy additional equipment to offer more activities.

Staff ensured they maintained the confidentiality of the patient records system, by locking their computers and locking paper records away. All staff had attended information governance training.

The ward manager had access to the information they needed to run the service. They accessed this information through the management dashboard provided by the trust. This information was accessible; however, we found some inaccuracies in the training database.

Staff made notifications to external bodies such as Care Quality Commission and the Local authority if needed.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system met the needs of the local population.

Staff and patients had up to date information about the service and how it worked. Staff had information available by email bulletin and a staff intranet. Staff shared information with patients' thorough noticeboards and community meetings.

Patients could give feedback about the service in community meetings and ward review meetings. Patients could complete an anonymous slip to feed back if they felt uncomfortable. Staff shared information with carers at ward meetings and all that we spoke with said staff had given them an opportunity to feedback about the service.

Managers and staff discussed feedback during team meetings and supervisions. Staff could give feedback about the service during their supervisions. Managers had recently arranged an away day where they had listened to staff about concerns and had developed an action plan. Managers attended monthly quality meetings where they could escalate issues.

Managers and staff involved patients in decisions about the design of the service. Patients had developed a service wide recovery star which detailed what they would like to see.

Patients and staff did not feel the senior leadership team were accessible to them but felt the local management team were forthcoming. Local managers had arranged for staff from the senior leadership team to attend a staff training day to make them more accessible.

Learning, continuous improvement and innovation

Managers gave staff opportunities to suggest improvements and innovation. Staff had suggested some training days on various topics to help them to support specific needs they were finding in their patient group.

Staff were not participating in any research projects.

Staff were participating quality improvement initiatives set by the clinical commissioning groups, such as the health improvements made by the 'Closing the Gap' paper written by the Department of Health.

Staff participated in national audits, they had submitted data to the Royal College of Psychiatrists for the Prescribing Observatory for Mental Health assessment of the side effects of depot antipsychotics. The service had submitted data for the national audit of psychological therapies spotlight.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust did not report any accreditations specific to this service.

MH – Child and adolescent mental health wards

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Rochford Hospital	Poplar Unit	14	Mixed
The St Aubyn Centre	Larkwood Ward	10	Mixed
The St Aubyn Centre	Longview Ward	15	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

Safety of the ward layout

Managers ensured that staff were able to maintain a safe environment. Staff did regular risk assessments of the care environment. All wards had a ligature risk assessment in the last 12 months, and managers identified ligature points on the ward. There were ligature risks on three wards within this service. Staff were able to identify ligature points on the ward and were aware of the planned mitigation.

Managers implemented assessed scenario training, to ensure that staff knew how to safely manage a ligature incident. Staff also completed a heat map which identified potential risk areas. Staff displayed this in the ward office.

The ward layouts allowed staff to observe all parts of ward. Managers installed convex mirrors in all areas that had blind spots on the ward to aid the observation of patients.

The wards complied with guidance on eliminating mixed-sex accommodation. Over the period from 1 January 2018 to 31 March 2019 there were no same sex accommodation breaches within this service. The number of same sex accommodation breaches reported in this inspection is the same as the zero reported at the time of the last inspection.

NOTE: Comparisons to 'last inspection' data often do not refer to a whole year of data.

Staff ensured that each area of the wards were single sex. Two bedrooms were available on each ward, which were separate from the main bedroom areas. Staff could change use of these two beds to accommodate male or female patients, as demand required. Staff also used these areas for transgender patients.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Longview	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Risks included in hotspots and heat maps. Tasks raised as appropriate. Actions to be agreed by the Ligature Risk Reduction Group.
Larkwood	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Risks included in hotspots and heat maps. Tasks raised as appropriate. Actions to be agreed by the Ligature Risk Reduction Group.
Poplar	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Actions signed off by the Ligature Risk Reduction Group. Risks included in hotspots and heat maps. Tasks raised as appropriate.

Staff had access to ligature cutters and access to alarms in the event of an emergency. Patients did not have access to nurse call systems, however staff were always present in ward areas. Patients on Poplar ward raised concerns regarding the noise of the alarms. Staff responded by using two-way radios wherever possible. The trust installed alarms on each bedroom door. Staff checked these weekly.

Maintenance, cleanliness and infection control

Managers ensured a safe and clean environment in most of the ward areas. Ward areas were generally clean, good furnishings and were well-maintained. However, at the time of our inspection, the kitchen surfaces on Poplar ward were unclean. The fridge was dirty, there was out of date food in the fridge and we found uncovered meat. This was raised with ward manager who raised this with housekeeping staff. Staff resolved this immediately.

The trust had been awarded a food hygiene rating of five for Poplar, Larkwood and Longview wards. The trust recently replaced the furniture on Larkwood ward. The trust ensured that all bedroom furniture was ligature free.

The sites which deliver mental health – child and adolescent mental health wards within Essex Partnership University NHS Foundation Trust were compared to other sites of the same type and the scores they received for ‘cleanliness’ and ‘condition, appearance, and maintenance’ were found to be about the same as the England average.

Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly. Patients informed us that the wards were generally clean. However, patients stated that blood marks had not always been removed in a timely manner, after an incident where a patient self-harmed.

Staff adhered to infection control principles, including handwashing. Staff were trained in infection control. Staff and patients had access to alcohol gels and used these. Staff displayed signs and prompts on the ward and in toilets, to remind staff and patients to wash their hands and use alcohol gels.

Seclusion room

There was no seclusion room on Poplar or Longview wards. The seclusion room on Larkwood psychiatric intensive care unit, allowed clear observation, two-way communication, toilet facilities and a clock. Patients had access to seclusion clothing where required.

Clinic room and equipment

Clinic rooms on the three wards were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff conducted daily checks of the clinic including resuscitation equipment, oxygen and room temperatures. Staff conducted a more detailed audit of the clinic room monthly.

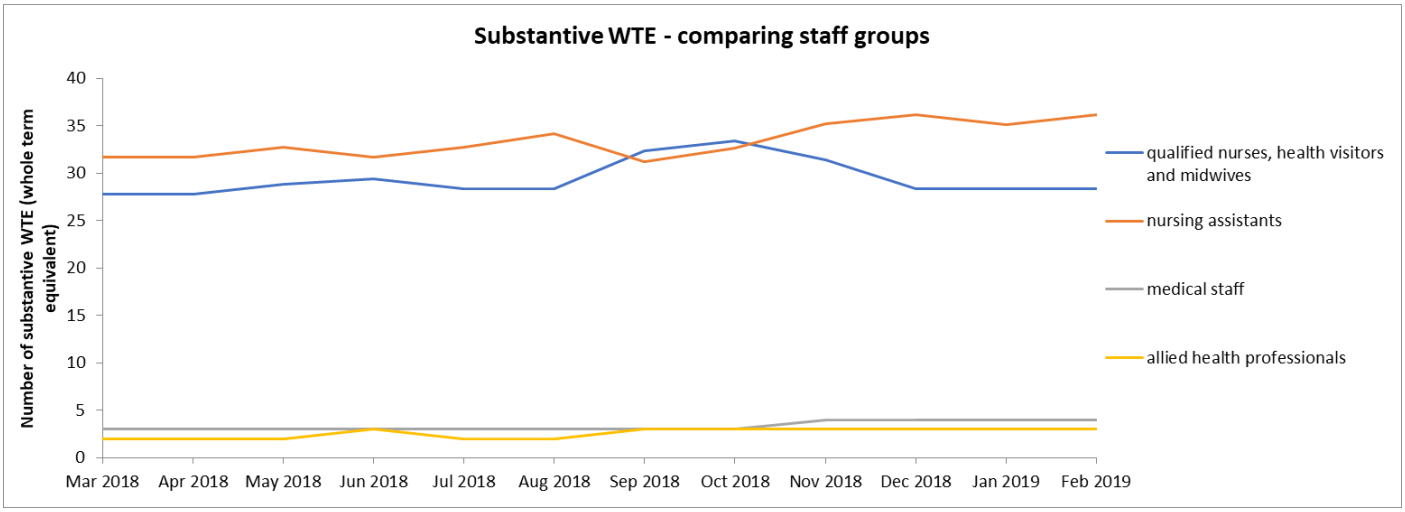
Managers identified the clinic room on Longview ward as an exemplar. Managers took photographs of the clinic and circulated these in the trust.

Staff maintained equipment well and kept it clean. Staff ensured that any ‘clean’ stickers were visible and in date. Staff provided evidence that equipment had been calibrated and well maintained.

We reviewed the fridge temperature check log which was up to date and all recordings were within the correct temperature range.

Safe staffing

The below chart shows the breakdown of staff in post WTE in this core service from March 2018 to February 2019. This data shows that whilst the number of qualified staff was the same in February 2019 as March 2018, the number of nursing assistants increased over the same period.



The below table covers staff fill rates for qualified nurses and care staff during January 2019 and February 2019.

Key:

> 125%	< 90%

	Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	January 2019				February 2019			
Longview	95	**81**	**58**	**132**	93	92	**63**	**152**
Larkwood	107	110	98	**173**	120	122	107	**236**
Poplar Ward – Rochford	100	99	100	114	96	94	100	104

Longview ward had below 90% of the planned registered nurses on night shifts across both months. There was also above 125% of the planned care staff on these shifts on both Longview and Larkwood wards. However, managers on both Longview and Larkwood wards recently appointed to all registered nurse vacancies.

Annual staffing metrics

	Core service annual staffing metrics

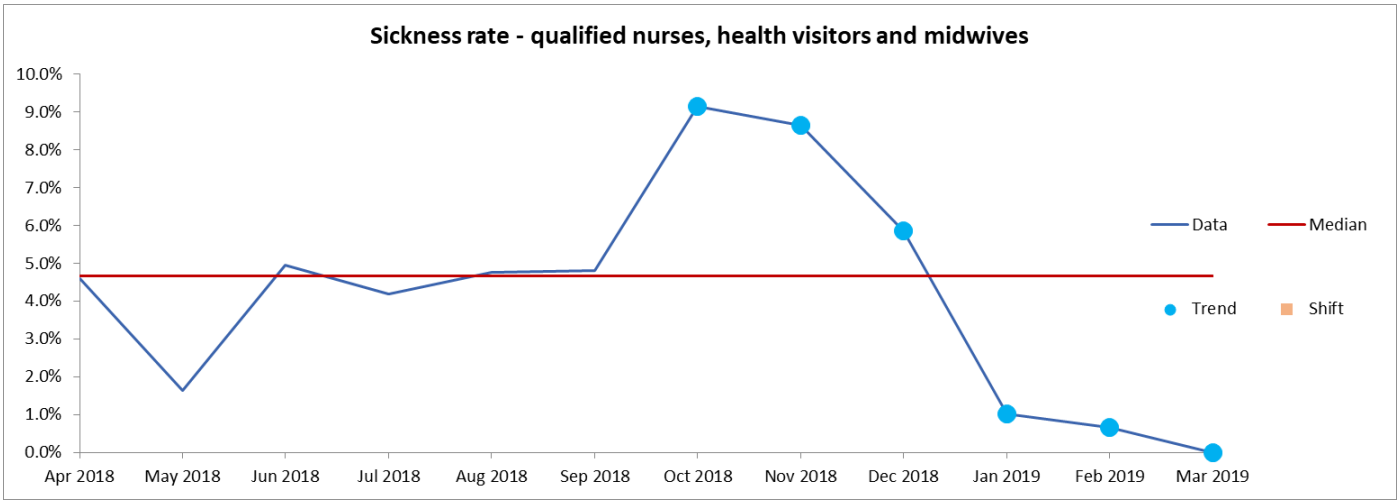
	(Vacancy, Turnover, Bank and Agency: 1 March 2018 – 28 February 2019) (Sickness: 1 April 2018 – 31 March 2019)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual "unfilled" hours (% of available hours)**
All staff	98.9	14%	6%	4.0%			
Qualified nurses	31.4	9%	7%	4.3%	14049 (24%)	2371 (4%)	1908 (3%)
Nursing assistants	37.7	18%	5%	5.7%	71559 (97%)	10352 (14%)	4776 (6%)
Medical staff	2.5	-38%	0%	0.7%	N/A	N/A	N/A
Allied Health Professionals	3.0	22%	39%	0.5%			

All Staff

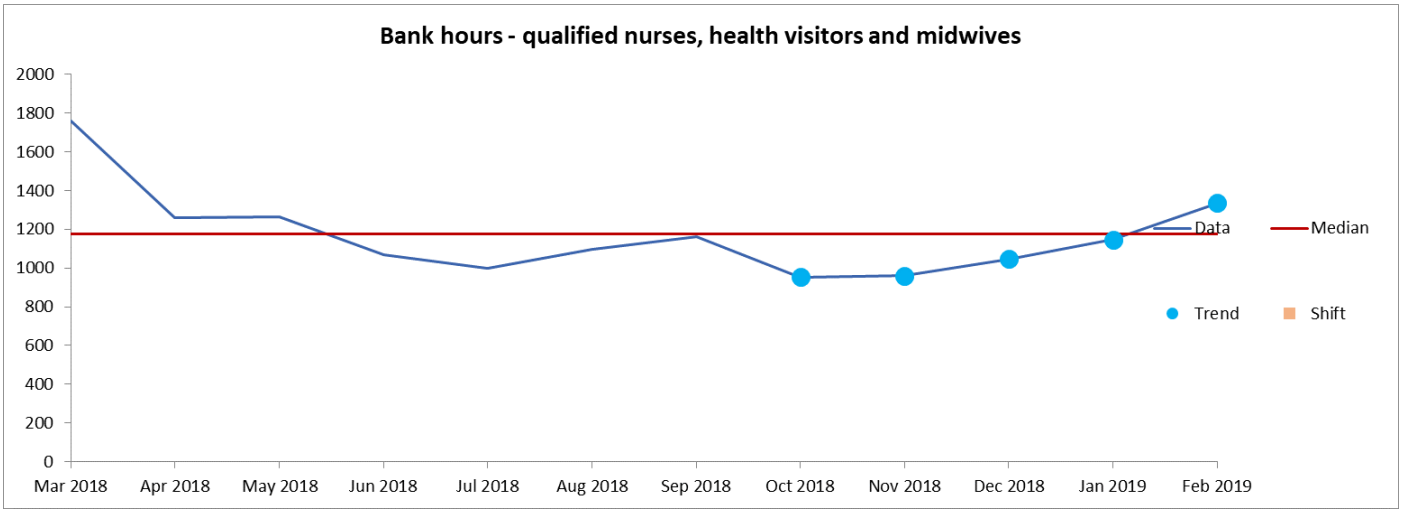
Staffing figures for all staff within this core service were compared to other similar services and annual vacancy, sickness and turnover rates were found to be about the same as the national average. Monthly staffing figures for the past 12 months were also analysed, and no indications of improvement, deterioration or change were identified.

Qualified Nurses

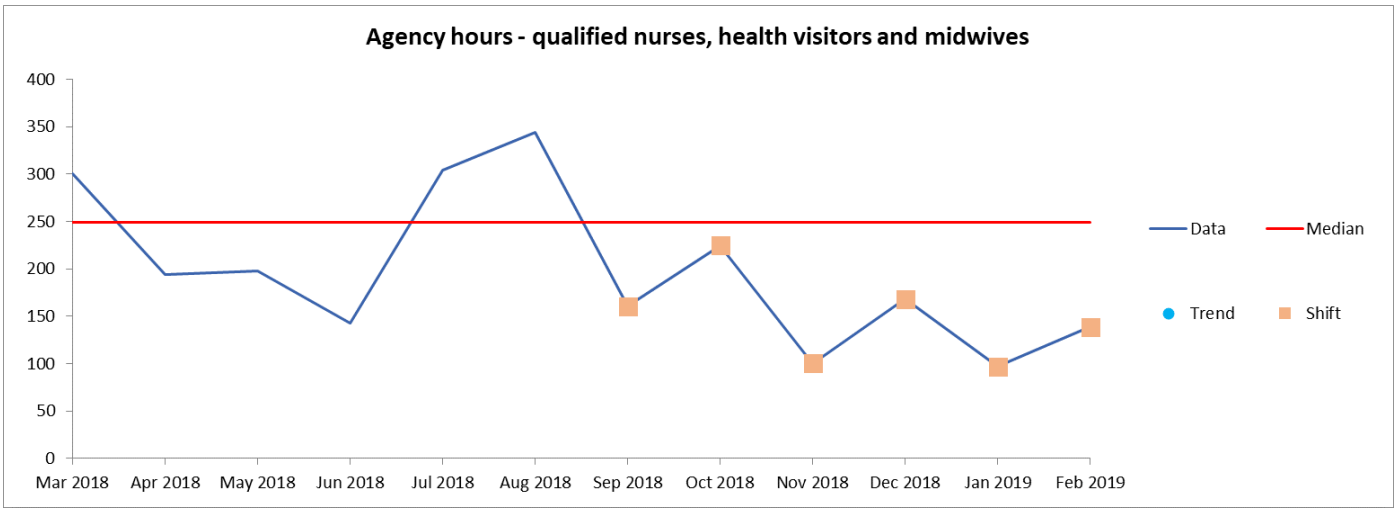
The average vacancy rate for qualified nurses was in the lowest 25% when compared to other similar core services nationally. Managers recently appointed to the remainder of the qualified nurse vacancies.



Monthly 'sickness rates' over the last 12 months for qualified nurses, health visitors and midwives show a downward trend from October 2018 to March 2019. This could be an early indicator of improvement.

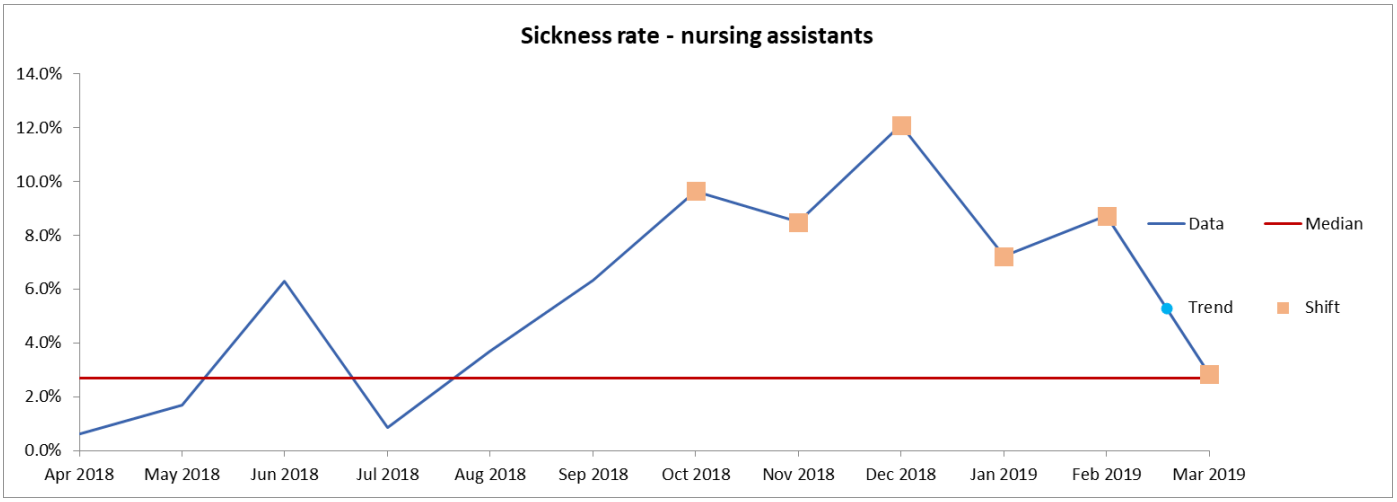


Monthly 'bank hours' over the last 12 months for qualified nurses, health visitors and midwives show an upward trend from October 2018 to February 2019. Managers told us that the main reason for increased bank usage was to cover vacancies, an increase in patient acuity and the planned reduction in qualified nurse agency staff usage.



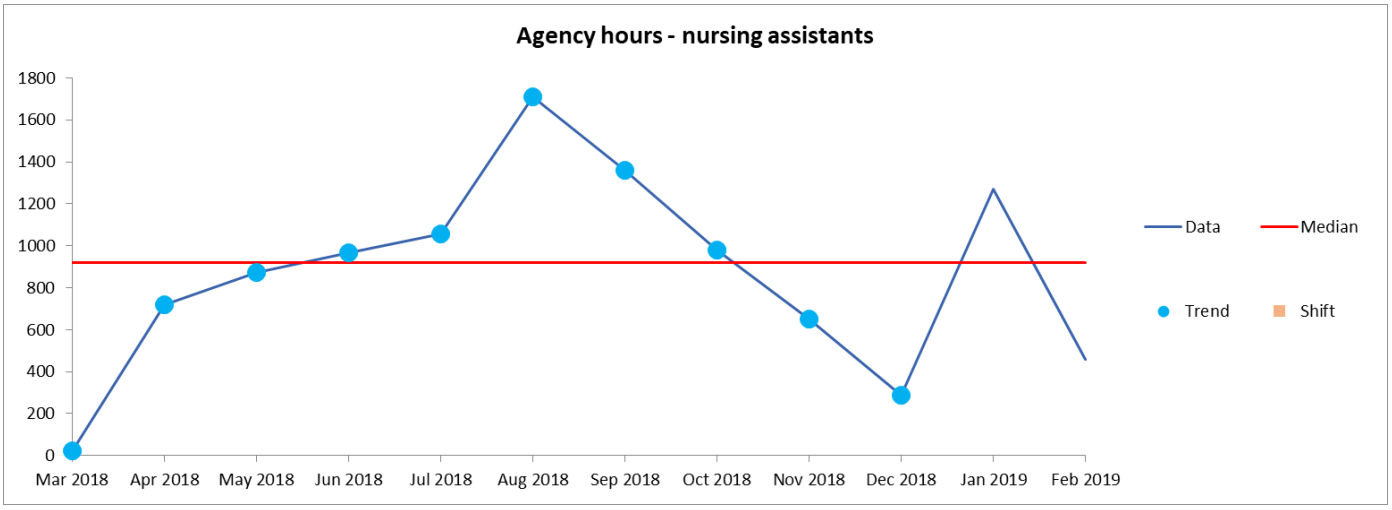
Monthly 'agency hours' over the last 12 months for qualified nurses, health visitors and midwives show a shift from September 2018 to February 2019. Managers were working towards reduction in agency use where possible. Managers used bank staff who knew the ward and patients wherever possible.

Nursing Assistants



Monthly 'sickness rates' over the last 12 months for nursing assistants shows a shift from October 2018 to March 2019. Managers told us that out of the current five percent sickness rate, four percent was due to long term health problems.

Staff turnover rate (%) in 12-month period * ‘Shift’ means a period (often 8 hours) worked by an individual staff member.



Monthly 'agency hours' over the last 12 months for nursing assistants shows an upward trend from March 2018 to August 2018. In addition, it shows a downward trend from August 2018 to December 2018.

Managers calculated the number and grade of nurses and healthcare assistants required to cover each shift. Managers told us that staffing numbers were based on a ratio of three patients to one registered nurse. The number of nurses and healthcare assistants matched this number on all shifts.

The ward manager could adjust staffing levels daily to take account of patient mix. Managers told us that they were able to book additional staff to meet demand and patient needs.

When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels.

When managers used bank and agency staff, those staff received an induction and were familiar with the ward. Managers introduced an induction for all temporary staff. Managers showed us

examples of completed temporary staff induction records. Staff fully completed these and were signed by the nurse in charge and staff member.

A qualified nurse was always present in communal areas of the ward. Staff ensured that a nurse was always observing patients in the central ward areas.

Staffing levels allowed patients to have regular one-to-one time with their named nurse. Managers introduced team nursing onto each of the three wards. Patients had a named nurse and could access any other member of the nursing team, when their named nurse was not on duty.

Staff told us that staff shortages never resulted in staff cancelling escorted leave or ward activities. Staff ensured that there was a wide range of activities available. Staff stated that activities had been delayed on rare occasions. Staff ensured that alternative activities were provided. Staff ensured that the planned activity took place as soon as possible.

There were enough staff to carry out physical interventions (for example, observations, restraint and seclusion) safely (and staff had been trained to do so). Staff ensured that patients had regular health checks including modified early warning signs (MEWS), which included patient's vital signs. Staff also ensured that where required, patient had regular electrocardiograms (ECG's), physical examinations and blood tests.

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. Staff told us that there was a first and second on-call medical rota.

Allied Health Professionals

The average sickness rate for allied health professionals was in the lowest 25% when compared to other similar core services nationally. However, the annual turnover rate for allied health professionals was in the highest 25% when compared to other similar core services nationally. Monthly staffing figures for the past 12 months were also analysed, and no indications of improvement, deterioration or change were identified.

Mandatory training

The compliance for mandatory and statutory training courses at 31 March 2019 was 83%. Of the training courses listed five failed to achieve the trust target and of those, three failed to score above 75%. The individual elements of training where rates were less than 75%, included safeguarding adults' level three and fire safety (two and three years). Managers informed us that was due to recent staff turnover.

The trust set a target of 85% for completion of mandatory and statutory training modules including: Fire Safety 3 years, Fit for work, Induction, Information Governance, and Mental Health Act. The trust set a target of 90% for completion of mandatory and statutory training modules including: Safeguarding Adults (Levels 1, 2, & 3), Fire Safety 2 years, and Safeguarding children (Level 3).

Training completion is reported as at end of reporting period.

The training compliance reported for this core service during this inspection was lower than the 85% reported in the previous year.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults (Level 1)	1	1	100%	✓	N/A
Mental Health Act	36	33	92%	✓	↓
Safeguarding Adults (Level 2)	82	73	89%	✗	↑
Induction	86	76	88%	✓	↓
Safeguarding Children (Level 3)	43	37	86%	✗	↑
Information Governance	84	71	85%	✓	↑
Fit for work	84	71	85%	✓	↑
Safeguarding Adults (Level 3)	22	16	73%	✗	↑
Fire Safety 2 years	77	55	71%	✗	↓
Fire Safety 3 years	14	8	57%	✗	↓
Total	**529**	**441**	**83%**	**-**	↓

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 24 patient care records. Staff ensured that excellent risk management assessments, ongoing reviews and documentation took place. Staff undertook a risk assessment of every patient on admission. Staff updated risk assessments at the weekly multi-disciplinary meetings and more frequently where required, including after any incident.

Staff used a recognised risk assessment tool. Staff used the risk assessment tool which was part of the electronic patient care record.

Management of patient risk

Staff were aware of and dealt with any specific risk issues. Staff completed risk management plans and positive behaviour plans for all patients. Staff formulated all risk management plans in the weekly multi-disciplinary meetings. Patients were central in the development of both risk management and behaviour support plans. Staff were aware of these and followed the agreed plans of care for any specific risk issues.

During our inspection, we observed the safe and effective management of an incident involving a distressed patient. Staff were supportive, calm and caring throughout this interaction. Staff used de-escalation techniques which assisted the patient to calm down and discuss the issue of concern.

Staff identified and responded to changing risks to or posed by patients. Staff reviewed risk management and positive behaviour support plans at least weekly and more frequently where required. Staff arranged risk huddles to discuss any identified risk issues during the shift. Patients also held risk huddles to explore any risk issues identified. Patients had access to areas such as de-escalation and chill out rooms. Patients on Longview could also access the sensory room, which contained a range of equipment including weighted blankets and visual displays.

Staff followed policies and procedures for use of patient observation (including to minimise risk from potential ligature points) and for searching patients or their bedrooms. Staff used 'pat' down techniques to search patients and used a metal detector wand where required. Staff sought patient consent prior to all searches. Staff applied the agreed protocol when patients did not provide consent. Staff would in this circumstance contact the doctor, managers and mutually agree a plan of action.

Staff were able to describe the four levels of patient observations used on the ward. Staff reviewed patient observation levels daily. Staff increased the observations of patients when required to support patients and reduce the risk they posed. Staff completed observation sheets thoroughly and we saw no gaps in the recording of patient observations. Staff completed competency training in conducting patient observations.

Staff applied blanket restrictions on patients' freedom only when clinically justified. Staff informed us that patients could access their bedrooms on their own when assessed as safe to do so. Staff on Larkwood and Longview wards advised us that patients could access the garden at any time when supervised. We saw patients freely accessing the garden, who were then followed by a staff member.

Staff on Longview advised us that due to health and safety concerns, bushes had recently been removed from the garden area. Patient's had hidden items in the bushes, which could be used to self-harm. Managers told us that since removal of the bushes patients had found items hidden in the soil. Managers requested that the existing garden be replaced with rubber flooring. Managers introduced a security nurse on shift on each of the wards. Security nurses focused on patient leave, relational security and alarms. Nurses identified as security nurses attended relational security training.

Staff on Larkwood ward identified risks associated with a ledge in the garden area. Staff informed us that two patients used this ledge as a method for getting onto the roof area. Staff therefore observed patients whilst they were in the garden area. Managers had recently reported this issue to facilities and were waiting for this risk issue to be addressed.

Staff adhered to best practice implementing a smoke-free policy as under 18-year olds cannot smoke. However, some patients smoked prior to admission. Patients were not allowed to smoke on the premises. Doctors prescribed smoking cessation interventions and ensured that nicotine placement was available for patients. Patients had access where appropriate to inhalers, patches and lozenges.

Informal patients could leave at will and were aware of this. Managers ensured that posters were visible on entry to each of the wards. Staff also ensured that patients were aware of their legal status.

This service had 609 incidences of restraint (82 different service users) and 55 incidences of seclusion between 1 January 2018 and 31 December 2018.
The below table focuses on the last 12 months' worth of data: 1 January 2018 and 31 December 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Education Department	0	1	1	0 (0%)	0 (0%)
Larkwood Ward	42	393	39	34 (9%)	43 (11%)
Longview Ward	13	215	42	12 (6%)	17 (8%)
Core service total	**55**	**609**	**82**	**46 (8%)**	**60 (10%)**

Use of restrictive interventions

The wards in this service participated in the trust's restrictive interventions reduction programme. Staff on Poplar ward also participated in the reduction in restrictive practice programme with the Royal College of Psychiatrists. However, several patients stated that they had been in discomfort during and after restraint. Managers agreed to investigate these concerns. Managers were in the process of securing restraint chairs and planning a restraint pod. Managers told us that this would assist in the management of restraint and reduce the incidents of patients adopting the prone position during restraint.

Staff followed NICE guidance when using rapid tranquilisation. Staff recorded in patients' case records when they used rapid tranquilisation and carried out physical health monitoring in line with guidance. Staff used seclusion appropriately and followed best practice when they did so.

Staff on Longview Ward kept records for seclusion in an appropriate manner.

Staff used restraint only after de-escalation failed and used correct techniques. We saw evidence of this recorded within the patients' case notes. Managers explained that a high percentage of restraints were required when providing naso-gastric feeds. However, the number of restraints had increased.

There were 46 incidences of prone restraint, which accounted for 8% of the restraint incidents. Staff told us that prone restraint was only used when patients adopted this position. Staff immediately changed the patient's position wherever possible. Over the 12 months, incidences of restraint ranged from 22 to 120. The number of incidences (609) increased from the previous 12-month period (305). The trust had a goal of zero prone restraints.

There were 60 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from zero to 15 over (1 January 2018 to 31 December 2018). The number of incidences (60) decreased from the previous 12-month period (67).

There have been zero instances of mechanical restraint over the reporting period. The number of incidences (nil) was the same as the number of incidences from the previous 12-month period (nil).

The number of restraint incidences reported during this inspection was not comparable to the last inspection.

Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. Staff assessed capacity on admission, where there was a change in the patient's presentation and at the weekly multidisciplinary review meeting.

There had been 55 instances of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from zero to 14. The number of incidences (55) decreased from the previous 12-month period (64).

The number of seclusion incidences reported during this inspection was not comparable to the last inspection

There had been 38 instances of long-term segregation over the 12-month reporting period. The number of incidences (38) increased from the previous 12-month period (eight). These were highest in Larkwood Intensive Care Unit.

The number of segregation incidences reported during this inspection was not comparable to the time of the last inspection.

Safeguarding

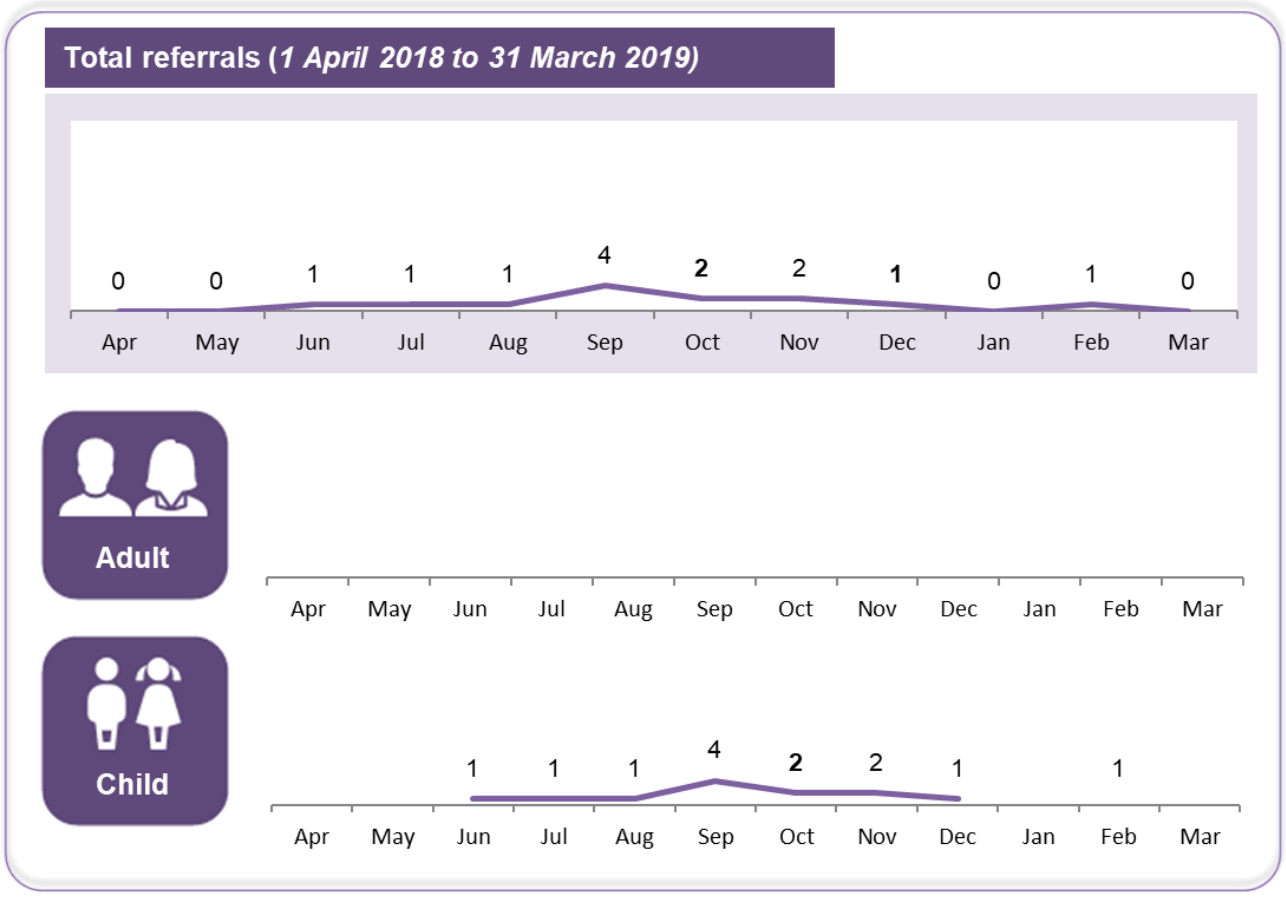
A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 13 safeguarding referrals between 1 April 2018 and 31 March 2019, of which none concerned adults and 13 children. The number of safeguarding referrals reported during this inspection was not comparable to the last inspection.

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
MH – Child and adolescent mental health wards	0	13	13

The number of child safeguarding referrals ranged from one to four (as shown below).



Staff were trained in safeguarding and had access to face to face and on-line training. Staff showed detailed knowledge of safeguarding and described how they identified and made a safeguarding referral and did that when appropriate. Managers ensured that each of the wards had two safeguarding champions, who were available to provide staff with advice and support. Staff also had easy access to a safeguarding lead, who was accessible to all staff.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff and patients introduced awareness of lesbian, gay, bisexual, transgender and questioning (LGBTQ) issues. Staff also had strong links with the Tavistock hospital and MIND charity regarding transgender and questioning issues. Staff and patients on Larkwood also introduced an anti-bullying campaign on the ward. Staff told us that this initiative reduced the number of patients reporting bullying and harassment from their peers. Patients completed anti-bullying posters as part of this anti-bullying campaign. Senior leaders from the trust judged the posters and given awards to patients.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. Managers and staff had good links with other agencies including social services, schools, and police. However, staff reported that social care services in the south of the county had high workloads and reduced capacity. We saw evidence of delayed discharges due to this reduced capacity.

Staff followed safe procedures for children visiting the ward. Staff ensured that children when visiting used the identified family visiting rooms, which were located off the main ward areas. Staff did not allow children past the air lock on either Larkwood or Longview wards.

The trust has submitted details of no serious case reviews commenced or published in the last 12 months (1 April 2018 to 31 March 2019) that relate to this service.

Staff access to essential information

Staff had access to essential information. Staff received all referral details via the regional commissioning team. Managers ensured the receipt of all key patient information at the time of the patient's referral.

All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form. This included when patients moved between teams. Staff told us that information regarding internal transfers between the north and south of the county, were e-mailed through to the relevant ward.

The trust used an electronic patient record system. Staff ensured that any paper records were scanned onto the electronic patient record system. Staff informed us that this did not cause them any difficulty in entering or accessing information. However, the trust had two separate electronic health records. Staff in the south of the county used one system and staff used a different system in the north of the county. The trust introduced an overarching IT system called 'health exchange' which aimed to reduce delays in accessing patient records. However, staff were not using this system. Staff told us that they knew little of the system and that they had not received the relevant training. One staff member told us that they were not aware that the system was 'up and running'.

Medicines management

Staff followed good practice in medicines management (that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication) and did it in line with national guidance. We reviewed 18 medication administration records and found no errors, or omissions.

Staff undertook competency training in the administration of medications every three years. Staff signed daily medications over from one shift to another.

Staff reviewed the effects of medication on patients' physical health regularly and in line with NICE guidance, especially when the patient was prescribed a high dose of antipsychotic medication. Managers told us that this addressed medication omissions and drug errors.

Track record on safety

Between 1 March 2018 and 28 February 2019 there were two serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'unauthorised absence meeting SI criteria' with two. There were no unexpected deaths in this category.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with two reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

The number of serious incidents reported during this inspection was lower than the five reported at the last inspection.

	Number of incidents reported	
Type of incident reported (SIRI)	**Unauthorised absence meeting SI criteria**	**Total**
Longview Ward	2	**2**
Total	**2**	**2**

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing future deaths.

In the last two years, there have been eight 'prevention of future death' reports sent to Essex Partnership University NHS Foundation Trust. One of these related to this service, where a patient died.

The coroner sought assurance that the trust policies around patient search were rigorous. The family also raised concern regarding the bland nature of the environment.

The following learning / recommendations were given:

Action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

Staff assured us that the identified learning and actions had taken place. The trust had recently installed a purpose build high dependency unit on the ward. Staff were fully aware of the policies and procedures in relation to the management of patients in the unit.

All staff knew what incidents to report and how to report them. Any staff member could report an incident. Managers received all incident report for information and sign off. Staff completed incident report forms fully and managers complete a final sign off.

Staff reported all incidents that they should report. Staff described an open culture of reporting.

Staff understood the duty of candour. Staff were open and transparent and gave patients and families a full explanation when things went wrong. Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss feedback from incidents. Managers communicated the outcome of investigations via team meetings, supervision sessions, de-briefing meetings and team e-mails. Managers ensured that all staff had the opportunity to discuss feedback and identified learning. Staff also had access to learning lessons forums.

There was evidence that changes had been made as a result of feedback. Staff replaced metal sanitary bins with cardboard bins, following a serious incident. Managers also replaced shower doors with curtains. Patients were risk assessed to ensure they could have access to a shower curtain.

Staff were able to provide information about improvements in safety specific to this service. Staff described the review of the safeguarding referral process, which previously led to confusion. Managers reviewed and streamlined the process. This reduced paperwork and eliminated the previous risks. Staff found the new system more streamlined and concise.

Managers offered support after a serious incident through debrief sessions. Staff told us that the trust had two types of debriefing in place. Staff described these as hot and cold debriefing sessions. Staff received an initial ‘debrief immediately following an incident. Staff described this as a ‘hot’ debrief session. Staff were then provided with a more detailed debrief a few days later, which was provided by psychological therapies. Staff described this as a ‘cold’ briefing session.

Is the service effective?

Assessment of needs and planning of care

Assessment of patient risk

There was a truly holistic approach to assessing, planning and delivering care. Staff completed comprehensive assessments for patients on admission. We looked at 24 care plans. Staff developed care plans with patients, which were up to date and reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Staff assessed patient's physical health in a timely manner on admission. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives. This included where appropriate patient's nutrition, hydration and pain relief needs. Staff conducted physical health examinations on admission to the ward. Staff recorded patient's vital signs including blood pressure, pulse, respirations, weight, height and body mass index (BMI).

Staff updated care plans when necessary. Staff reviewed care plans at a minimum of weekly during the multidisciplinary meeting. Staff held Care Programme Approach (CPA) reviews every six weeks.

Best practice in treatment and care

Doctors prescribed medication interventions recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence.

Staff provided safe use of a range of innovative approaches to care and treatment interventions suitable for the patient group, consistent with national guidance on best practice. The interventions were those recommended by, and delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE), and the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN). Staff delivered a wide range of structured psychological therapies including, one to one psychotherapy, psychoeducation, exposure work, emotional regulation, resource building and behavioural activation. Staff also provided a range of specialist interventions including sensory integration, family therapy, cognitive analytic therapy, group dialectic behavioural therapy, eye movement desensitisation, reprocessing therapy, cognitive behavioural trauma focused therapy and medication. Managers also purchased dance, music and art therapies on a sessional basis. Patients also had access to a wide range of other activities. Staff arranged for therapy dogs to visit the ward. Patients had access to a local beach hut and visited a local zoo and farm. Staff also arranged for a 'pop up' farm to be sited outside the unit, for patients who were not able to leave the hospital.

The continuing development of the staff skills competence and knowledge was recognised as being integral in providing high quality care. Staff were proactively supported and encouraged to acquire new skills. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Patients attended the education department which been rated as outstanding by Ofsted in Colchester and good in Rochford with outstanding features. Patients were able to take examinations in this department which was an appointed examination centre.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Staff used the modified early warning signs documentation to record patient vital signs weekly, or more frequently as required. Staff also ensured that patients had access to electrocardiograms and blood tests as required. Staff held a physical health clinic on Larkwood ward.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. Patients on Larkwood and Longview could be fed via a nasogastric tube. Staff undertaking nasogastric tube feeding received training and were assessed as competent to do so. The trust had an up to date policy on nasogastric tube feeding, which reflected national guidance

Staff supported patients to live healthier lives and gave advice on healthy diets, healthy living and exercise. Patients had access to physical activities including access to the gym and yoga. Staff supported patient participation in smoking cessation schemes and dealing with issues relating to substance misuse. Staff delivered training on healthier lives as part of the education curriculum.

Staff used recognised rating scales to assess and record severity and outcomes including the children's global assessment scale, observable social cognition: Staff and patients used the Health of the Nation Outcome Scale for children and adolescents.

Staff used technology to support patients effectively, including conference calls with other clinical teams. Staff were in the process of arranging online access to self-help tools, including mindfulness. Managers had purchased electronic tablets and were awaiting the relevant applications to be uploaded.

Staff participated in several clinical audits, benchmarking and quality improvement initiatives. Managers conducted audits of the Mental Health Act, record keeping, mattresses and medication management. Managers also conducted a regular detailed assessment of the ward environment.

This service participated in six clinical audits as part of their clinical audit programme 2018 – 2019.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Record Keeping / Care Planning CAMHS, Mother and Baby	Larkwood, Longview and Poplar	MH - Child and adolescent mental health wards	Clinical	ongoing	
National audit of inpatient falls	Larkwood, Longview and Poplar	MH - Child and adolescent mental health wards	Clinical	In progress	Data collection based on incidents of hip fractures, as yet none reported. Collection time frame to end December 2019
Resuscitation Audit	Larkwood, Longview and Poplar	MH - Child and adolescent mental health wards	Clinical	In progress	Report reviewed at Resuscitation Group and awaiting Executive sign off before being disseminated to services.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
National Audit of Anxiety and Depression	Poplar	MH - Child and adolescent mental health wards	Clinical	In progress	Data collection completed in April 2018. Report expected in between January and June 2019
Re audit of Seclusion and Baseline Long Term Segregation	Larkwood, Longview and Poplar	MH - Child and adolescent mental health wards	Clinical	In progress	Data collection completed, analysis in progress and report being written
Audit of completion of medication charts in the North East area of the trust	Larkwood and Longview	MH - Child and adolescent mental health wards	Clinical	01/04/2018	Present findings at Tuesday Doctors meeting, in the East Area of EPUT, in the next 6 months. Doctors should be informed that the medication cards are in great compliance with the standards, but weight, height and BMI are important as well and must be always documented. Re-audit in the following one year to see if standards are the same or have changed.'

Skilled staff to deliver care

The team included or had access to the full range of specialists required to meet the needs of patients on the ward. The multi-disciplinary team included consultant psychiatrists, speciality doctors, nurses, occupational therapists, clinical psychologists, family therapists and support workers. Managers used existing funding to employ a social worker for Larkwood and Longview. Staff had access to pharmacists, who visited the wards weekly. Staff were able to access speech and language therapists and dieticians as required.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Staff received dialectic behavioural therapy training. Staff had good access to a wide range of mandatory and specialist courses.

Managers provided new staff with a comprehensive induction (using the care certificate standards as the benchmark for healthcare assistants). Staff received both a trust and local induction. Managers ensured that all temporary staff received an induction to the ward, which was documented.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. Managers introduced a detailed supervision structure for each ward, which clearly outlined the name of each supervisor and supervisee. Managers ensured that staff had access to regular team meetings which took place monthly.

The trust's target rate for appraisal compliance is 90%. At the end of last year (1 April 2017 and 31 March 2018), the overall appraisal rate for non-medical staff within this service was 59%. This year so far, the overall appraisal rates was 82% (as at 28 February 2019). The teams with the lowest appraisal rate at 28 February 2019 were CAMH Tier 4 Unit Clinical Support with an appraisal rate of 0%, CAMH Tier 4 Unit General at 0%, and Longview Ward with 75%.

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 81% reported at the last inspection.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 28 February 2019)	% appraisals (previous year 1 April 2017-31 March 2018)
Larkwood Ward	18	18	100%	71%
Psychology - CAMHS	4	4	100%	33%
Camhs I/P Poplar Ward	24	21	88%	65%
Psychology - CAMHS North	4	3	75%	75%
Longview Ward	12	9	75%	60%
CAMH Tier 4 Unit General	4	0	0%	0%
CAMH Tier 4 Unit Clinical Support	1	0	0%	0%
Core service total	**67**	**55**	**82%**	**59%**
Trust wide	**3884**	**3172**	**82%**	**55%**

The trust did not provide data regarding appraisal compliance for permanent medical staff. Medical staff interviewed advised that they received an annual appraisal.

The trust's target of clinical supervision for non-medical staff is 90% of the sessions required. Between 1 March 2018 and 28 February 2019, the average rate across all six teams in this service was 97%.

The rate of clinical supervision reported during this inspection was higher than the 81% reported at the last inspection.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Camhs I/P Poplar Ward	228	228	100%
Larkwood Ward	180	180	100%
Psychology - CAMHS	42	42	100%

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Psychology - CAMHS North	50	50	100%
Longview Ward	123	121	98%
CAMH Tier 4 Unit Clinical Support	25	9	36%
Core service total	**648**	**630**	**97%**
Trust Total	**19802**	**19153**	**97%**

The trust did not provide data regarding clinical supervision compliance for permanent medical staff. However medical staff interviewed, advised that they were in receipt of regular supervision.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers identified these through staff appraisal and ongoing supervision with staff.

Managers ensured that staff received the necessary specialist training for their roles. Staff had access to training required for their role including substance misuse.

Managers dealt with poor staff performance promptly and effectively. Managers were able to describe the visions and values of the organisation and expected these to be evident in practice.

Multi-disciplinary and interagency team work

Staff held regular and effective weekly multidisciplinary meetings. Staff attended a daily multidisciplinary meeting at which all referrals to the team were discussed and assessed comprehensively.

Staff shared information about patients at effective handover meetings within the team. Nursing staff received a detailed handover at the commencement of each shift. Staff provided a daily structured handover to the multidisciplinary team at 09:30 am daily.

There was a holistic approach to planning patient's discharge, transition or transfer to other services. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

The ward teams had effective working relationships, including good handovers, with other relevant teams within the organisation (for example, care co-ordinators and community mental health teams,). Staff held regular conference calls with other relevant teams and invited them to multidisciplinary and care programme approach (CPA) reviews.

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

As of 31 March 2019, 92% of the workforce in this service received training in the Mental Health Act the Code of Practice and the guiding principles. The trust stated that this training is mandatory for all services for inpatient and community staff, depending upon their role.

The training compliance reported during this inspection was higher than the 79% reported at the last inspection.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were. Staff also had access to a Mental Health Act lead on each of the three wards.

The trust had relevant policies and procedures that reflected the most recent guidance. Staff were aware of these and how to access them. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy. Staff displayed posters relating to advocacy services (provided by Barnardos), and independent mental health advocacy services (provided by rethink).

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers ensured that practices around consent and records were actively monitored and reviewed, to improve how patients were involved in making decisions about their care and treatment. Managers made sure that staff could explain patients' rights to them.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. Staff had access to easy to read leaflets for young people.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted. We saw records and observed during ward round, that young people were granted leave in accordance with Section 17 as approved by the responsible clinician. Copies of paperwork were stored in the nurses' office. Staff and patients could not recall a time when authorised leave had not been facilitated.

Staff requested an opinion from a second opinion appointed doctor when necessary. Staff arranged this through the Mental Health Act administrators.

Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them. Managers informed us that original copies of patient's detention papers were stored in the Mental Health Act office. Managers explained that this created problems when patients were transferred to other organisations.

The service displayed a notice to tell informal patients that they could leave the ward freely. Staff displayed these notices on entry to the ward. Patients were aware of their rights and these were revisited at the weekly multidisciplinary review meeting.

Care plans referred to identified Section 117 aftercare services to be provided for those who were subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment where applicable.

Managers did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Good practice in applying the Mental Capacity Act

Staff had training in the Mental Capacity Act, as part of the trust's safeguarding training. As Mental Capacity Act Training is incorporated into Safeguarding Level 1 training, the data is unsuitable for analysis.

Staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles.

The trust told us that zero Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 April 2018 to 31 March 2019.

CQC received 274 direct notifications from the trust as a whole between 1 April 2018 to 31 March 2019[10]. However, the trust reported that 158 direct notifications were sent to CQC. Under HSCA legislation, all DoLS applications should also be sent to the CQC in the form of a direct notification so it is important that these numbers are different.

The number of DoLS applications made during this inspection was not comparable to the last inspection.

The trust had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff knew where to get advice from within the trust regarding the Mental Capacity Act, including deprivation of liberty safeguards.

Staff took all practical steps to enable and support patients to make their own decisions proportionate to their competence. For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis regarding significant decisions. We viewed 24 patient records. Staff documented patient capacity to consent had been recorded in all these records.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

The service had arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and acted on any learning that resulted from it.

Staff understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to patients under 16. Gillick competence (a test in medical law to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge). Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

[10] CRM

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Feedback from patients, carers and stakeholders was continually positive about how staff treated patients with compassion and kindness. Staff went the extra mile and their care and support exceeded expectations. Staff displayed a strong, visible patient centred culture. Staff were highly motivated and inspired to offer care that was kind and respected patients' privacy and dignity. Staff recognised and respected the totality of patient needs. Staff always took patient's cultural, social and religious needs into account, and found innovative ways manage their care, treatment or condition.

Staff attitudes and behaviours when interacting with patients showed that they were consistently discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. We observed staff engaging with patients in a caring and compassionate manner.

Staff actively involved patients and those close to them in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff were fully committed to working in partnership with patients and carers and made this a reality for each patient. Staff recognised that patients need to have access to, and links with, their advocacy and support networks in the community, and they supported patients to have easy access to independent advocates.

Staff always empowered patients to have a voice and realise their potential. Staff supported patients to fully understand and manage their care, treatment or condition. Patients had access to a range of information leaflets which were developed with young people and were easy read. Staff viewed the patient as central to all activities. Patients were fully informed about their care and were empowered to make decisions for themselves. Staff directed patients to other services when appropriate and, if required, supported them to access those services.

Patients said staff generally treated them well and behaved appropriately towards them. However, one patient stated that a nurse threatened to increase her level of observations and that the nurse would conduct these. This was reported to managers who took immediate steps to protect the patient and investigate the concerns raised.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. Patients had access to a spiritual lead who planned to make a room on Longview Ward into a 'zen den', which is an identified space in which to practice yoga.

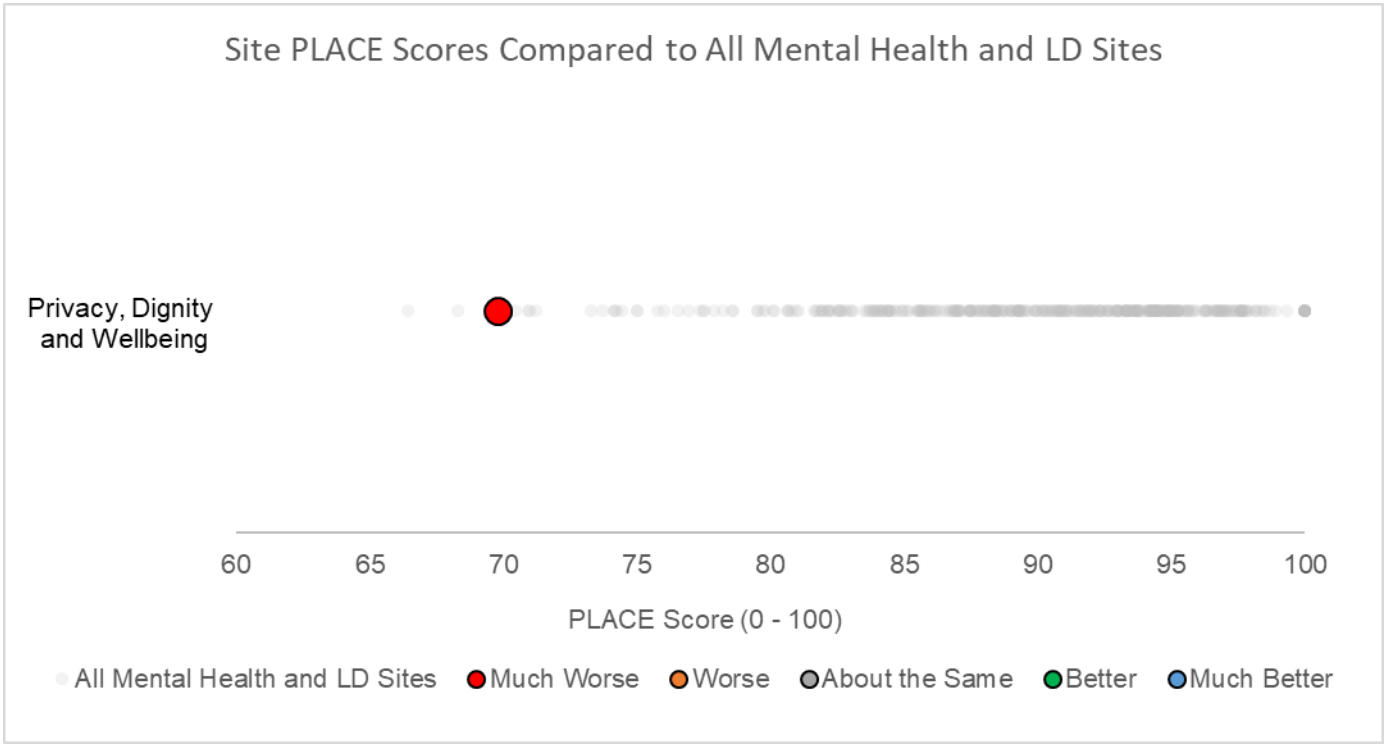
Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. Staff had access to a local 'freedom to speak up' guardian if required. However, staff told us that they had not experienced any bullying or harassment and described management as supportive and approachable.

Staff maintained the confidentiality of information about patients.

PLACE assessments aim to provide a clear message from patients on how the care environment may be improved. They are undertaken by teams of local people alongside healthcare staff and assess privacy and dignity, food, cleanliness, building maintenance and the suitability of the environment for people with disabilities and dementia.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), The St Aubyn's Centre scored much worse than the average for Mental Health and LD for privacy, dignity and wellbeing. The scores for the other site (Rochford Hospital) were found to be about the same as the England average when compared to sites of a similar type.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
The St Aubyn's Centre	MH – Child and adolescent mental health wards	69.8%
Trust overall		**89.2%**
England average (mental health and learning disabilities)		**91.0%**



Patients and staff on Poplar ward described the heat during a recent heatwave as having been 'unbearable'. Poplar ward is on the second floor therefore patients did not have immediate access to outside areas. The manager responded by visiting several supermarkets to purchase several ice lollies for the patients. The trust placed air conditioning units on Larkwood and Longview Wards. Patients stated that this had helped.

Involvement in care

Involvement of patients

Staff used the admission process to fully inform and orient patients to the ward and to the service. Staff issued patients and their families with a comprehensive guide booklet about the ward. Managers included a range of essential information including comprehensive details of the patient's

care pathway and the stages of patient assessment, formulation and treatment. Staff also provided patients and families with details of restricted items, code of conduct for patients and visitors and details of how to raise concerns.

Staff fully involved patients in care planning and risk assessments. Staff evidenced this involvement in patient evidence in care plans and documented participation in multidisciplinary team reviews. Patients were given a copy of their care plan. Patients were also issued with a document 'my care, my journey, which staff and patients used to inform care plans, risk assessment and treatment plans.

Staff found innovative ways to communicate with patients so that they fully understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Patient with communication difficulties were given a communication passport. Staff were then able to have access to a brief snapshot about the person's likes, dislikes, how they communicate and how best to communicate with them. Staff identified areas on the ward where patients could express their feelings including via blackboards and white boards. Staff issued patients with a resource box on admission. Patients could personalise the content of their resource box and use the chosen items when upset or anxious.

Staff assisted patients to maintain as much independence as possible. Staff involved patients when appropriate in decisions about the service. Patients were involved in decision about the ward including plans for ward improvement. Patients had been involved in the development of the high dependency unit on Longview and participated in the recruitment of staff. Patients had reviewed weight charts on the ward and devised the format for the community meeting agenda.

Staff enabled patients to give feedback on the service they received. Patients could provide feedback via their one to one sessions, in the multidisciplinary meetings, during ward community meetings, survey and via the 'friends and family test. Staff displayed actions from patient feedback in the form of 'you said, we did' posters within the ward.

Staff enabled patients to make advance decisions. Patients completed these as part of their ongoing risk assessment and care plans when appropriate.

Staff ensured that patients could access advocacy. Staff displayed contact details for both Barnardo's advocacy service and Rethink's independent mental health advocacy service (IMHAs).

Involvement of families and carers

Staff informed and involved families and carers appropriately and consistently provided them with support when needed. Managers ensured that there were at least weekly updates provided to families and carers. Staff provided ongoing family therapy and support to all families.

We reviewed 24 care records all of which showed evidence of family or carer involvement. Staff involved social workers and independent review officers in the care and treatment of looked after children.

Staff enabled families and carers to give feedback on the service they received via multidisciplinary reviews, and via the 'friends and family test' survey. In March 2019, 92% of respondents stated that they would recommend the trust's services.

Staff provided carers with information about how to access a carer's assessment.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for two wards in this service between 1 March 2018 to 28 February 2019.

Two of the wards within this service reported average bed occupancies ranging above the minimum benchmark of 85% over this period.

Ward name	Average bed occupancy range (1 March 2018 – 28 February 2019) (current inspection)
Larkwood Ward	68%-92%
Longview Ward	58%-98%

There was always a bed available when patients returned from leave.

The trust provided information for average length of stay for the period 1 March 2018 to 28 February 2019.

Ward name	Average length of stay range (1 March 2018 – 28 February 2019) (current inspection)
Larkwood Ward	32-86 days
Longview Ward	33-71 days

This service reported zero out area placements between 1 January 2018 to 28 February 2019.

The number of out of area placements reported during this inspection was the same as the zero reported at the time of the last inspection.

This service reported five readmissions within 28 days between 1 March 2018 to 28 February 2019. Four of readmissions (80%) were readmissions to the same ward as discharge. The average of days between discharge and readmission was five days. There were two instances whereby patients were readmitted on the same day as being discharged and there was one where a patient was readmitted the day after being discharged.

At the time of the last inspection, for the period 1 April 2017 to 31 January 2018, there were a total of two readmissions within 28 days. Of these, both were readmissions to the same ward (100%). Therefore, the number of readmissions within 28 days has increased between the two periods.

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
Longview Ward	5	4	80%	0-17 days	5 days

Patients' individual needs and preferences were central to the delivery of the service. Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and in the interests of the patient. Patients were transferred to Larkwood or Longview if

they required nasogastric tube feeding. Patients were transferred to Larkwood if they required intensive care.

Staff planned and managed discharge well. Staff adopted innovative approaches to providing integrated person-centred pathways of care. Staff proactively liaised well with services that would provide aftercare, particularly for patients with multiple and complex needs. Staff were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

When patients were moved or discharged, this happened at an appropriate time of day However, managers informed us of one transfer of a patient to an external provider which took place out of hours. Managers booked transport for earlier in day, however the transport failed to attend. The patient requested that the transfer take place in the evening due to the anxiety caused by the delay. Managers respected this decision and supported this transfer in the patient's best interest. Staff stated that there were ongoing issues with transport. Staff escalated these concerns to managers.

A bed was always available in a psychiatric intensive care unit (PICU) if a patient required more intensive care. Patients were admitted to the intensive care unit from across the region. Staff ensured that during admission, patients maintained contact with family and friends. Staff were required to contact family or carers at a minimum weekly. Managers audited this to ensure that this took place.

Discharge and transfers of care

Between 1 March 2018 to 28 February 2019 there were 74 discharges within this service. This amounts to 1% of the total discharges from the trust overall (5546).

Delayed discharges across the 12-month period ranged from zero to one, with a total of one delayed discharge. The number of delayed discharges reported during this inspection was lower than the three delays reported at the time of the last inspection.

Staff planned for patients' discharge, including proactive liaison with care managers and care co-ordinators. However, staff told us that in the south of the county, capacity in social services was stretched, which caused delays.

Discharges were not usually delayed for other than clinical reasons. However, at the time of our visit, there was one delayed discharge on the ward, due to accommodation. Staff were actively looking for an appropriate placement, however the type of accommodation required was bespoke, which caused delays.

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

The service complied with transfer of care standards including the trust's policy and the national Children and Young People Mental Health Transitions Commissioning for Quality and Innovation.

Facilities that promote comfort, dignity and privacy

The sites which deliver MH – Child and adolescent mental health wards within Essex Partnership University NHS Foundation Trust were compared to other sites of the same type and the scores they received for 'ward food' were found to be about the same as the England average.

Patients had their own bedrooms with ensuite facilities and were not expected to sleep in bed bays or dormitories. Staff locked bedrooms during the day. Patients could access their bedroom for quiet time if part of their individual care plan.

Patients could personalise bedrooms. Patients had somewhere secure to store their possessions. patients had access to storage in their bedrooms and there was a locked storage room on the ward.

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

There were quiet areas on the ward and a room where patients could meet visitors. Patients and their families had access to family rooms. Patients had access to a range of rooms including single sex sitting areas and activity rooms.

Patients could make a phone call in private. Patients were able to have mobile phones; however, Patients were not allowed free access to 'smart' phones. Staff purchased mobile phones for patients where required. Staff had systems in place to glue the back of these phones, to ensure that patients could not access the battery.

Patients on Poplar Ward did not have access to outside space, unless escorted. Staff and patients described this as a major issue. Staff raised this with the trust. Staff expressed concern that a non-clinical area were on the ground floor.

The food was not always of a good quality. Staff and patients told us that the quality of the food was the main issue on the ward. Patients had a choice of food, however the menus repeated on a two-weekly cycle. Staff told us that the choice of food for patients who were vegan, or on special diet was limited. Patients on Longview Ward could not make hot drinks and snacks unless escorted to do so. Staff told us this was due to health and safety concerns on an intensive care unit. Staff assessed this for each patient.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to education and work opportunities. There was an educational facility onsite which provide education between 9am until 1pm and 2pm until 3pm Monday to Friday.

Patients also had access to local colleges and work experience where appropriate.

Staff supported patients to maintain contact with their families and carers. Staff facilitated regular family visits on the ward.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community. Patient had access to 'smart' phones and the internet during 'technology club' and supervised sessions. Staff encouraged patient visits, which were accommodated off the ward.

Meeting the needs of all people who use the service

The sites which deliver MH – Child and adolescent mental health wards within Essex Partnership University NHS Foundation Trust were compared to other sites of the same type and the scores they received for 'disability' and dementia friendliness' were found to be about the same as the England average.

The service made adjustments for disabled patients – for example, by ensuring disabled people's access to premises. Patients could access Poplar via the lift and personal emergency evacuation plans were in place. Patients had easy access to both Larkwood and Longview which had been built to be suitable for disabled access. Patients had access to a disabled bathroom and a range

of equipment including a hoist and wheelchair. The service met patients' specific communication needs on an individual basis.

Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain. Patients had access to easy to read leaflets. The information provided was in a form accessible to the patient group.

Staff made information leaflets available in languages spoken by patients.

Staff took a proactive approach to understanding the needs and preferences of patients, including those with a protected characteristics under the equality act. Managers ensured that staff and patients had access to interpreters and/or signers. However, staff experienced delays in getting interpreters. Managers responded to this issue, and the trust secured an alternative -.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. However, staff and patients found that the level of choice was limited and repetitive.

Staff ensured that patients had access to appropriate spiritual support. Patients had access to a spiritual lead on the ward. Staff contacted relevant faith groups to request patient visits as requested.

Listening to and learning from concerns and complaints

This service received five complaints between 1 April 2018 to 31 March 2019. All five of these were partially upheld. None were referred to the Ombudsman.

Ward name	Total Complaints	Partially upheld
Larkwood Ward	**4**	4
Longview Ward	**1**	1

The service treated concerns and complaints seriously. Patients knew how to complain or raise concerns. When patients complained or raised concerns, they received feedback. Patients and carers generally raised issues verbally. Staff made steps to deal with the matter promptly and resolve the issue wherever possible.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Staff described complaints and concerns as an opportunity for learning.

Staff knew how to handle complaints appropriately and described how they supported patients to raise a concern.

Staff received feedback on the outcome of investigation of complaints and acted on the findings. We saw evidence of learning from complaints. Staff introduced a revised system for communication with carers regarding patient transfers. Managers shared learning with the whole team and the wider service.

This service received 54 compliments during the last 12 months from 1 April 2018 to 31 March 2019 which accounted for 4% of all compliments received by the trust (1252).

Is the service well led?

Leadership

Leaders were compassionate, committed, inclusive and effective at all levels. Leaders demonstrated high levels of skills, knowledge, experience, capacity and capability needed to deliver excellent and sustainable care. Leaders had a good understanding of the needs of the patients and how to address these.

Leaders had a comprehensive understanding of the services they managed. Leaders could explain clearly how the teams were working to provide high quality care. Leaders also identified areas for improvement and had plans to address these.

Leaders were visible in the service and approachable for patients and staff. Leaders had an open-door policy for both staff and patients. Staff knew who the leaders were and stated that they were approachable and helpful.

Leadership development opportunities were available, including opportunities for staff below team manager level. Leaders offered staff development on both a personal and team basis, including access to team away days. Staff described a learning culture on the wards.

Vision and strategy

Leaders introduced comprehensive and successful leadership strategies to ensure and sustain the desired culture. Staff knew and fully understood the trust's vision and values and how they were applied in the work of their team. The strategy and supporting objectives and plans, were stretching, challenging and innovative, whilst remaining achievable. During the inspection we observed staff displaying the values in their interactions with patients, carers, colleagues and staff external to the service.

The trust's senior leadership team successfully communicated the trust's vision and values to the frontline staff in this service. Staff were able to identify these and how these were displayed in care and treatment on the ward.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff had been involved in the development of a high dependency unit on two of the wards. Managers arranged away days for staff to secured staff involvement in service developments.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Leaders had developed comprehensive and successful leadership strategies to develop the desired culture. Staff felt highly respected, supported and valued by leaders.

Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff told us that they enjoyed working on the wards and were proud to be a part of the service.

Staff at all levels were actively encouraged to speak up and raise concerns. Staff consistently stated that they felt able to raise concerns without fear of retribution. Staff described an open and supportive culture.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.

Managers dealt with poor staff performance when needed. Managers dealt with areas of concern including behaviours and attitudes of staff.

Teams worked well together and where there were difficulties managers dealt with them appropriately. Staff across the three ward areas worked collaboratively as one team. Managers on Poplar Ward attended staff and clinical governance meetings in Colchester.

Staff appraisals consistently included conversations about career development and how it could be supported.

Staff reported that the trust promoted equality and diversity in its day to day work and in providing opportunities for career progression. Staff had access to a wide range of developmental opportunities including access to specialist courses and degrees.

The service's staff sickness and absence were five percent in February 2019, which was above the trust target of four percent. However, four percent of the total staff sickness was due to long term health issues.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff were also provided ongoing support for their wellbeing, including access to flexible working. Managers and staff on Larkwood Ward set up a 'recharge' station which included healthy snacks, for staff working long days.

The trust recognised staff success within the service – for example, through staff awards.

Governance

Overall, we found that there were consistently embedded systems in place to monitor the governance at core service level. Governance arrangements were proactively reviewed and reflected best practice. Wards always had sufficient numbers of staff and skill mix required to cover shifts. Wards used bank and agency staff to ensure safe numbers of staff on the wards. However, managers were working successfully to reduce the use of agency staffing. Staff were therefore able to provide consistent care and for patients to build positive relations with staff. The quality of care planning was consistently of a high standard and were always written from the patient's perspective. Staff received regular clinical and managerial supervision and were up to date with annual appraisals. All staff reported high levels of staff morale and staff described feeling proud to work for the service. There was wide access to psychology, psychological therapies, occupational therapists and family therapists. Staff followed the National Institute of Health and Care Excellence (NICE) guidance when using rapid tranquilisation.

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

There was a demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making. Managers effectively communicated from the board to ward level and vice versa.

Staff implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts. For example, metal sanitary bins had been replaced with cardboard ones.

Staff undertook or participated in a range of local clinical audits. Staff conducted daily audits of curtain hooks and weekly audits of door alarms, medications, mattresses and the clinic. The audits were sufficient to provide assurance and staff acted on the results when needed.

Staff understood the arrangements for working with other teams, both within the trust and external, to meet the needs of the patients.

Management of risk, issues and performance

There was a demonstrated commitment to best practice performance and risk management systems and processes. The trust reviews how the service functions and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required and had done so. Staff concerns matched those on the risk register.

The service had business continuity plans for emergencies – for example, adverse weather or a flu outbreak.

Where cost improvements were taking place, they did not compromise patient care.

Information management

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

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. However, there were two electronic health records in the organisation. Staff felt that the introduction of one system would assist communication and prevent unnecessary paperwork.

Information governance systems and processes ensured the appropriate protection of confidential information about patients.

Team managers had access to information to support them with their management role. This included data on bed management, length of stay, delayed discharges, incidents, complaints, and staffing data (sickness, vacancies and turnover). Managers reviewed this information and used the findings to identify areas for service improvements. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed such as clinical commissioning groups, safeguarding panels and the care quality commission in a timely manner as and when required.

Engagement

There were consistently high levels of constructive engagement with staff and patients. Staff, patients and carers had access to up-to-date information about the work of the trust and the services they used. The trust used several methods to communicate with staff, patients and carers that included its own website, bulletins, emails, displays, intranet, patients' meetings and carers' forums.

Services were developed with the participation of those who use them. Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

Managers and staff had access to the feedback from patients, carers and staff. Staff used this to make quality improvements on the wards.

Patients and carers were consistently involved in decision-making about changes to the service.

Patients and staff could meet with members of the trust's senior leadership team and governors to give feedback.

Directorate leaders and managers engaged with external stakeholders.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Core service	Service accredited
Quality Network for Inpatient CAMHS (QNIC)	MH – Child and adolescent mental health wards	Larkwood Ward (June 2018) Poplar Unit (September 2016)

There was a fully embedded and systematic approach to improvement, which made consistent use of improvement methodology. Staff were given the time and support to consider opportunities for improvements and innovation and this had led to changes. Staff had access to quality improvement champions on each of the wards.

Staff had opportunities to participate in research.

A wide range of innovations were taking place and celebrated in the service. Managers and staff were all involved in quality improvement projects. Staff used quality improvement methodology to review the role of the security nurse, introduce social media groups and introduce safety huddles for staff and patient,

Staff used quality improvement methods and knew how to apply them. Managers embedded quality improvement methodologies into every day practice.

Staff participated in a wide range of national audits relevant to the service and learned from them.

Wards participated in accreditation schemes relevant to the service and learned from them. The trust was accredited for the Quality Network for Inpatient CAMHS (QNIC). This expired at the end of May 2019. However, the trust made ongoing steps to be accredited. The trust was reassessed for accreditation in June 2019.

MH – Wards for older people with mental health problems

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Rochford Hospital	Beech Ward (Rochford)	24	Mixed
Thurrock Hospital	Gloucester Ward	22	Mixed
Thurrock Hospital	Meadowview Ward	24	Mixed
Landermere Centre Mental Health Wards	Bernard Ward	12	Male
Colchester Mental Health Wards	Henneage Ward	16	Mixed
St Margaret's Community Hospital	Kitwood Ward	16	Mixed
St Margaret's Community Hospital	Roding Ward	17	Mixed
Broomfield Hospital Mental Health Wards	Ruby Ward	17	Mixed
Broomfield Hospital Mental Health Wards	Topaz Ward	17	Mixed
Landermere Centre Mental Health Wards	Tower Ward	14	Female
	Maple Ward (CLOSED)		

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

Safety of the ward layout

Over the period from 1 January 2018 to 31 March 2019 there was one same sex accommodation breach within this service.

The number of same sex accommodation breaches reported in this inspection was higher than the zero reported at the time of the last inspection.

Henneage ward admitted both male and female patients. Two bedrooms without ensuite facilities were designated for male patients. The male patients placed in these bedrooms were required to walk past six female bedrooms to reach the shower room that was designated for both males and females. This is contrary to the Code of Practice 8.25. “All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms.” There were female only lounges in female only corridors and nobody was required to share a room.

NOTE: Comparisons to ‘last inspection’ data often do not refer to a whole year of data.

There were ligature risks on 11 wards within this service. All wards had a ligature risk assessment in the last 12 months.

For the majority of wards, patient bedroom corridors were not visible from the main nursing office. Domed mirrors were in place in bedroom corridors to increase visibility. Each bedroom had a nurse call alarm and staff carried personal alarms.

We viewed the ligature risk hotspots map that was kept in the main nursing office along with ligature cutters. Ligature risks were identified in the hotspot maps along with accompanying photographs.

Staff completed daily checks of the care environment and mitigated ligature risks in line with the trust’s observation policy. The wards held daily safety huddles to discuss key patient risks for that day. Door top sensors were placed on the bedroom doors on Ruby ward to minimise the ligature risk. We observed two clinical review meetings that demonstrated staff had detailed knowledge of the patients’ needs and the associated risks on the ward.

The trust had put in place new training for staff on ‘preventing suicide by ligature’.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Ruby Ward	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Risks included in hotspots and heat maps. Tasks raised as appropriate. Actions to be agreed by the Ligature Risk Reduction Group.
Topaz Ward	Organic older peoples ward, low risk client group	No	Risks included in hotspots and heat maps. Tasks raised as appropriate. Actions to be agreed by the Ligature Risk Reduction Group.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Roding	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Risks included in hotspots and heat maps. Tasks raised as appropriate.
Kitwood	Organic older peoples ward, low risk client group	No	Risks included in hotspots and heat maps. Tasks raised as appropriate.
Bernard	Organic older peoples ward, low risk client group	No	Risks included in hotspots and heat maps. Tasks raised as appropriate. Actions to be agreed by the Ligature Risk Reduction Group.
Henneage	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback has identified an increase in finding alternative methods.	Yes	Risks included in hotspots and heat maps. Tasks raised as appropriate.
Tower	Organic older peoples ward, low risk client group	No	Actions signed off by the Ligature Risk Reduction Group. Risks included in hotspots and heat maps. Tasks raised as appropriate.
Gloucester	This is a vulnerable group of patients who have the potential to self-harm. Due to the age and fabric of the building it is difficult to design out all potential ligature risks and as the obvious risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Risks included in hotspots and heat maps. Tasks raised as appropriate.
Beech	This is a vulnerable group of patients who have the potential to self-harm. As the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.	Yes	Risks included in hotspots and heat maps. Tasks raised as appropriate.
Meadowview	Organic older peoples ward, low risk client group	No	Risks included in hotspots and heat maps. Tasks raised as appropriate. Actions to be agreed by the Ligature Risk Reduction Group.
Maple (CLOSED)	Organic older peoples ward, low risk client group		

Maintenance, cleanliness and infection control

The sites which deliver MH – Wards for older people with mental health problems within Essex Partnership University NHS Foundation Trust were compared to other sites of the same type and the scores they received for 'cleanliness' and 'condition, appearance, and maintenance' were found to be about the same as the England average.

Cleaning schedules demonstrated that staff cleaned wards regularly, and patients and carers told us the wards were always clean.

Not all the wards were well-maintained. The communal toilet in the main lounge area on Ruby ward had been out of use for four days and staff and patients told us this was a recurring problem. On Beech ward, a toilet on the male bedroom corridors was out of use. On Ruby ward, a broken bed had been placed in the assisted bathroom in the female bedroom corridor. On Kitwood ward, the tumble dryers in the laundry room were not working and staff had reported this five days prior to our inspection.

Staff adhered to infection control principles, including handwashing. We observed a cookery group on Roding ward in which staff demonstrated these principles. Patients told us staff wash their hands and put on personal protective equipment. The infection control team conducted yearly infection control audits, along with hand hygiene audits and weekly cleaning audits.

Seclusion room

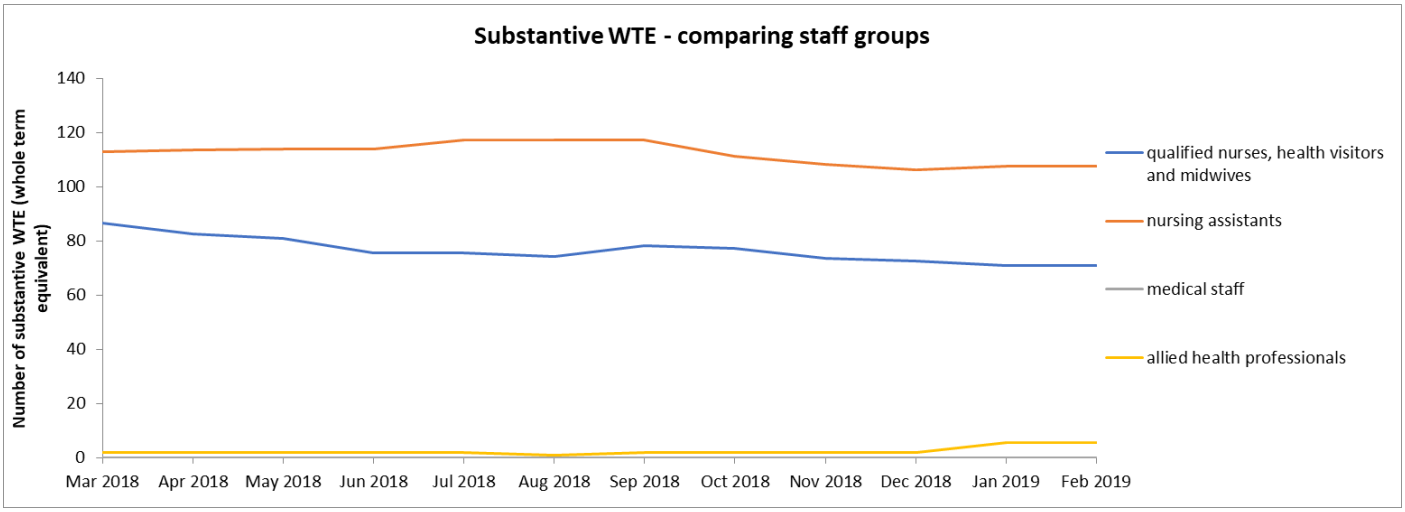
There were no seclusion rooms on any wards.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment well and kept it clean. Any 'clean' stickers were visible and in date. On Ruby ward there was a tag on the defibrillator bag that required to be cut for access which could result in a delay to patients that required emergency intervention.

Safe staffing

The below chart shows the breakdown of staff in post WTE in this core service from 1 March 2018 to 28 February 2019.



The below table covers staff fill rates for qualified nurses and care staff during January 2019 and February 2019.

Key:

> 125%	< 90%

	Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	January 2019				February 2019			
Beech - Rochford	94	93	94	111	92	103	98	**145**
Bernard	**73**	**161**	100	**145**	**70**	**129**	104	100
Gloucester	92	**86**	92	108	94	**87**	**89**	118
Henneage	99	115	**50**	**200**	99	117	**52**	**196**
Kitwood	94	**134**	**50**	**300**	100	107	**50**	**300**
Meadowview	99	105	**87**	121	100	**83**	**70**	**138**
Roding	104	**140**	100	**144**	99	**154**	104	**146**
Ruby	**80**	**203**	100	**182**	**77**	**209**	96	**204**
Topaz	98	**185**	**50**	**316**	92	**198**	**54**	**325**
Tower	**71**	**140**	**58**	**197**	**66**	**140**	**68**	**164**

Henneage, Kitwood, Meadowview, Topaz and Tower wards had below 90% fill rate of registered nurses on night shifts across both months. These night shifts tended to be accompanied by a fill rate of care staff over 125% of the planned rate. Bernard, Ruby, and Tower wards also had below 90% fill rate of registered nurses on day shifts across both months. Similarly, this was accompanied by care staff fill rates over 125% of the planned rate. Gloucester ward also had below 90% fill rate of care staff on day shifts across both months.

Ward managers and occupational therapists worked 9-5 hours.

During our inspection the staffing ratios for the ward shifts were:

Ruby ward and Topaz ward - day shift: two registered nurses and four healthcare assistants, night shift: one registered nurse and two healthcare assistants.

The staffing ratio remained in place for Topaz ward despite a reduction in patient numbers to six just prior to our inspection. When needed, a registered nurse from Topaz ward would go across to Ruby ward for part of the day shift. However, staff and patients said that Ruby ward was often short-staffed as for part of the day shift there was only one registered nurse on duty.

Bernard ward, Henneage ward, Roding ward and Kitwood ward – day shift: two registered nurses and two healthcare assistants, night shift: one registered nurse and two healthcare assistants.

Tower ward, Gloucester ward and Beech ward – day shift: two registered nurses and three healthcare assistants, night shift: two registered nurses and two healthcare assistants.

Meadowview ward – day shift: two registered nurses and four healthcare assistants, night shift: two registered nurses and three healthcare assistants.

We saw adequate staff on the wards and patients told us staff were always visible and they felt safe because of this. Staff were sometimes moved across to support other wards when needed.

Annual staffing metrics

	Core service annual staffing metrics (Vacancy, Turnover, Bank and Agency: 1 March 2018 – 28 February 2019) (Sickness: 1 April 2018 – 31 March 2019)						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual "unfilled" hours (% of available hours)**
All staff	262.9	14%	10%	5.8%			
Qualified nurses	102.0	22%	11%	5.9%	52078 (27%)	3584 (2%)	2984 (2%)
Nursing assistants	107.0	-2%	10%	6.1%	145755 (72%)	13481 (7%)	6527 (3%)
Medical staff	0.8	90%	N/A	N/A	N/A	N/A	N/A
Allied Health Professionals	8.9	27%	30%	4.2%			

NOTE: Data regarding the number of medical locum hours filled by bank and agency staff was not clearly aligned to specific teams; therefore, this data was not usable for analysis.

The following information and charts highlight specific staffing areas where there is noteworthy evidence that may prompt further investigation on site

All staff

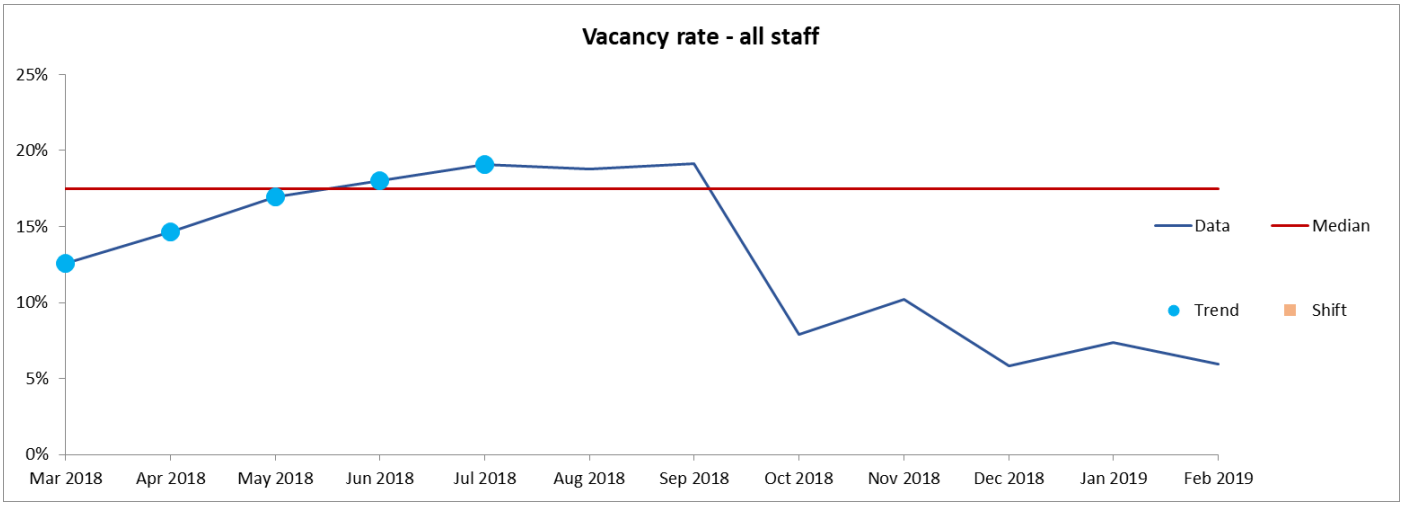


Figure 1
Monthly 'vacancy rates' over the last 12 months for all staff shows an upward trend from March 2018 to July 2018 (see figure 1). This could be an indicator of deterioration.

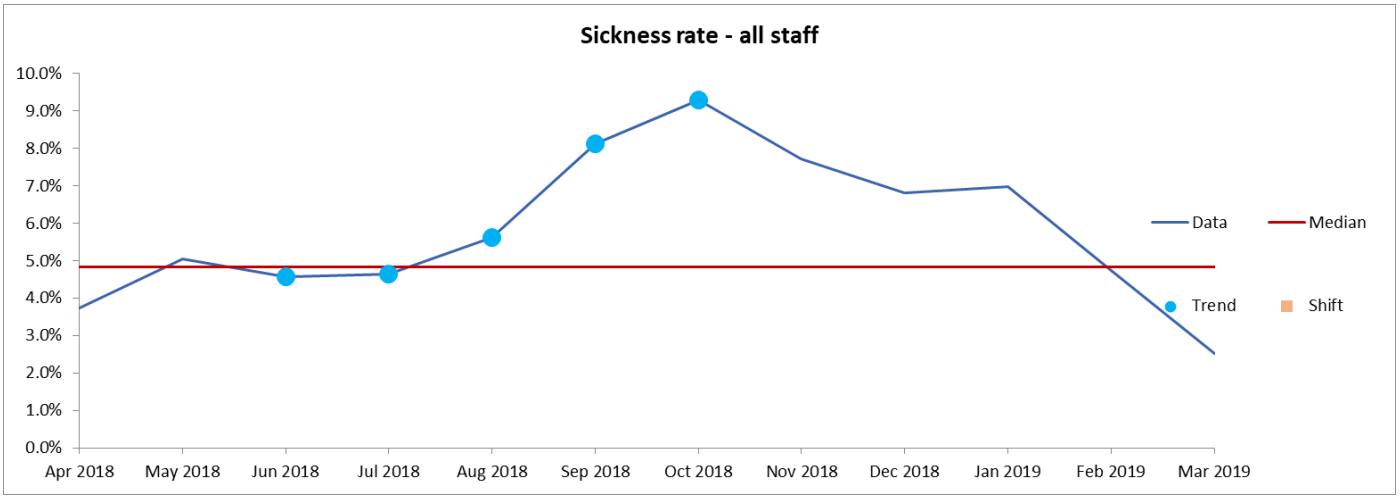


Figure 2

Monthly 'sickness rates' over the last 12 months for all staff shows an upward trend from June 2018 to October 2018. This could be an indicator of deterioration (see figure 2). However, the average sickness rate for all staff was in the lowest 25% when compared to other similar core services nationally.

Qualified Nurses

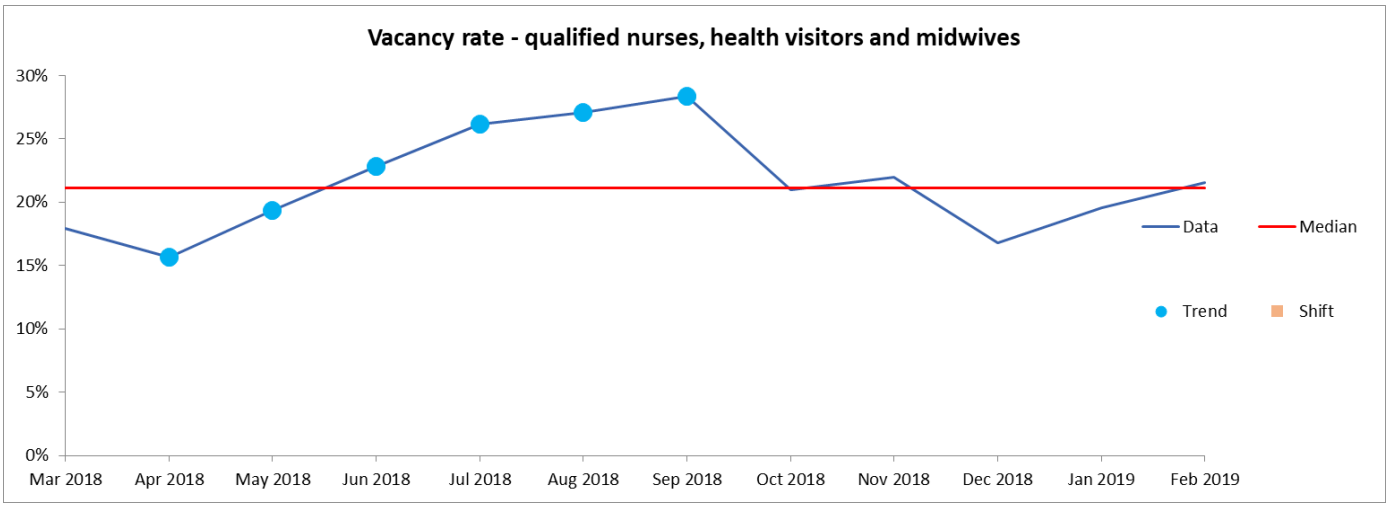


Figure 3

Monthly 'vacancy rates' over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from April 2018 to September 2018 (see figure 3). This could be an indicator of deterioration.

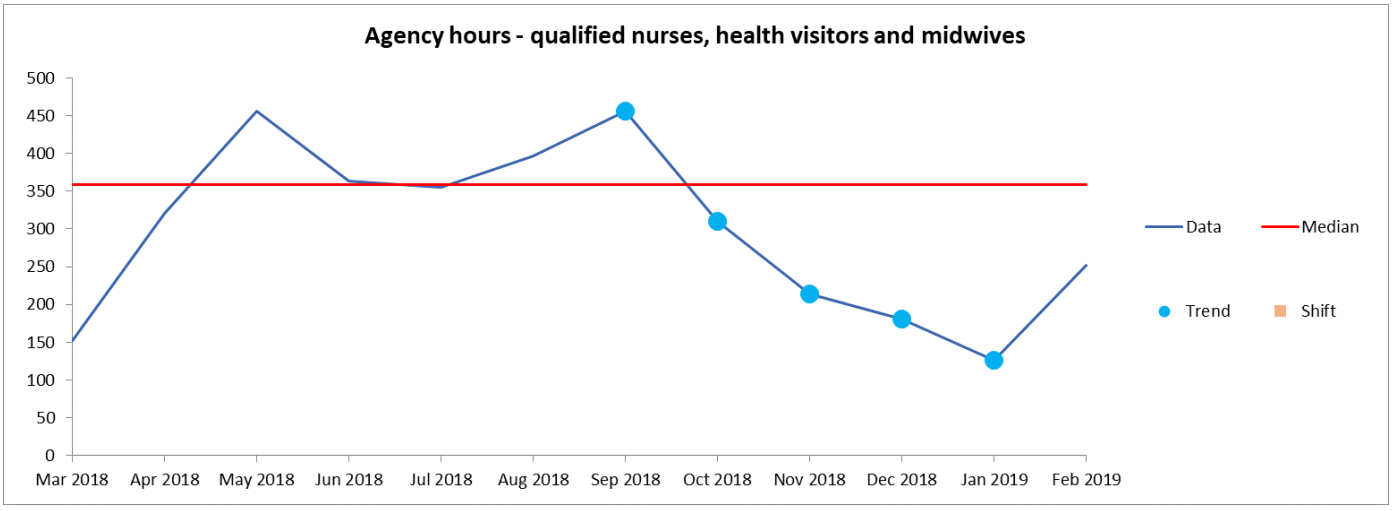


Figure 4

Monthly 'agency hours' over the last 12 months for qualified nurses, health visitors and midwives shows a downward trend from September 2018 to January 2019 (see figure 4). This could be an early indicator of improvement.

Staff on the wards told us that they had seen a decrease in the frequency of agency staff employed to work on the wards. Meadowview ward had not used agency staff for three years.

The ward managers could adjust staffing levels daily to take account of case mix and acquired additional staff to fulfil escorts or increased observation levels. Managers requested bank staff members who were already familiar with the ward, where possible.

Bank and agency staff received an induction to the wards on their first visit and given an induction booklet. We saw an agency worker guide for Bernard and Tower wards that laid out the trust values, expected behaviours and dress standards.

Nursing Assistants

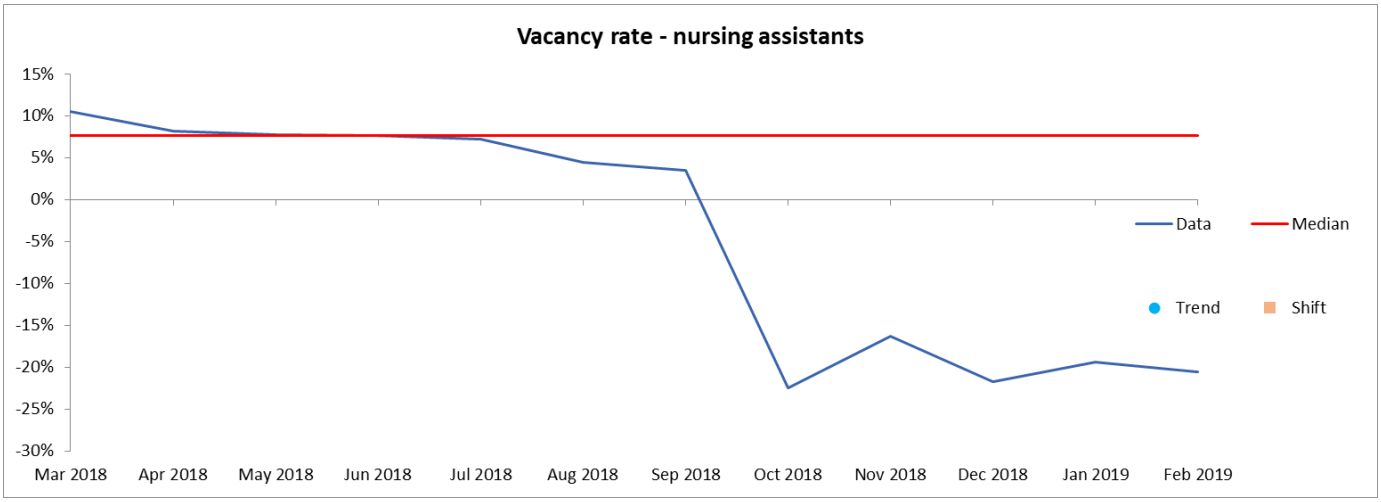


Figure 5

Monthly 'vacancy rates' over the last 12 months for nursing assistants are not stable and may be subject to ongoing change (see figure 5The average vacancy rate for nursing assistants was however in the lowest 25% when compared to other similar core services nationally.

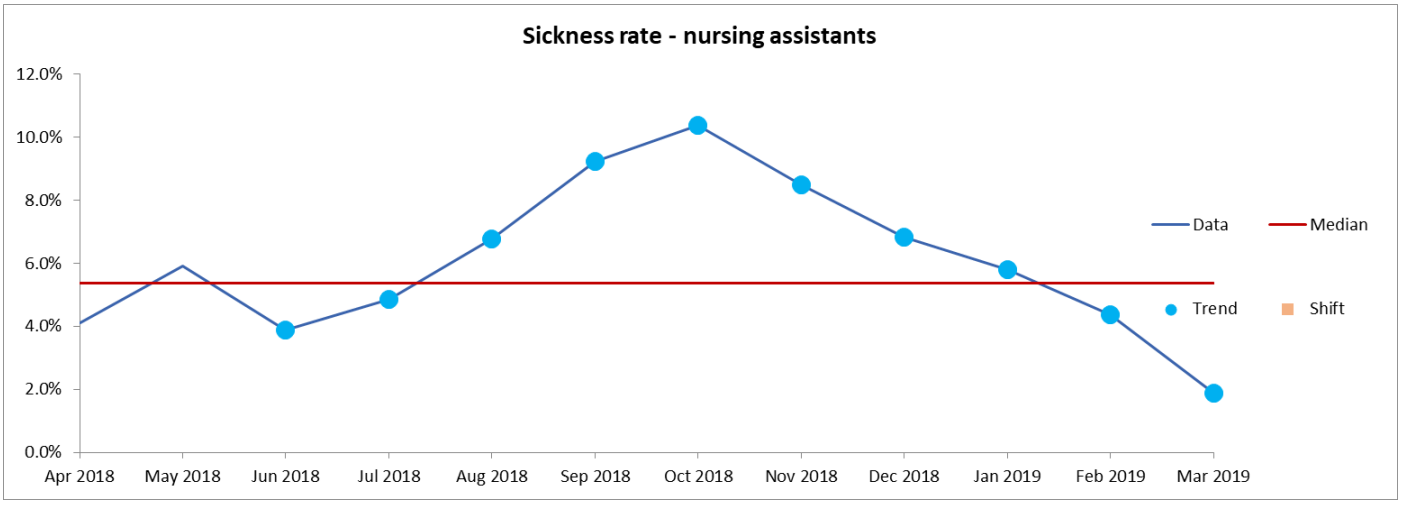


Figure 6

Monthly 'sickness rates' over the last 12 months for nursing assistants shows an upward trend from June 2018 to October 2018 (see figure 6). This could be an early indicator of deterioration. In addition, it shows a downward trend from October 2018 to March 2019 (see figure 6). This could be an early indicator of improvement.

The average sickness rate for nursing assistants was also in the lowest 25% when compared to other similar core services nationally.

Medical and Dental

The average vacancy rate for medical and dental staff was in the highest 25% when compared to other similar core services nationally.

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Allied Health Professionals

Staffing figures within this core service were compared to other similar services and annual vacancy, sickness and turnover rates were found to be about the same as the national average. Monthly staffing figures for the past 12 months were also analysed, and no indications of improvement, deterioration or change were identified.

Mandatory training

The compliance for mandatory and statutory training courses at 31 March 2019 was 92%. Of the training courses listed one failed to achieve the trust target but this course scored above 75%.

The trust set a target of 85% for completion of mandatory and statutory training modules including: Fire Safety 3 years, Fit for work, Induction, Information Governance, and Mental Health Act. The trust set a target of 90% for completion of mandatory and statutory training modules including: Safeguarding Adults (Levels 1, 2, & 3), Fire Safety 2 years, and Safeguarding Children (Level 3).

Training completion is reported as at end of reporting period.

The training compliance reported for this core service during this inspection was lower than the 97% reported in the previous year.

We saw evidence during the inspection that staff had met their mandatory training requirements.

Key:

Below CQC 75%	**Met trust target** ✓	**Not met trust target** ✖	**Higher** ↑	**No change** →	**Lower** ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Fire Safety 3 years	2	2	100%	✓	N/A
Safeguarding Adults (Level 1)	3	3	100%	✓	N/A
Safeguarding Children (Level 3)	9	9	100%	✓	N/A

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Induction	200	193	97%	✓	↓
Safeguarding Adults (Level 2)	192	184	96%	✓	↓
Information Governance	196	185	94%	✓	↑
Safeguarding Adults (Level 3)	61	57	93%	✓	↓
Fit for work	196	180	92%	✓	↓
Mental Health Act	112	101	90%	✓	↓
Fire Safety 2 years	195	162	83%	✗	↓
Total	**1166**	**1076**	**92%**	✓	↓

Assessing and managing risk to patients and staff

Assessment of patient risk

Risk assessments were comprehensive and regularly reviewed, monthly or more often if required. Staff used the risk assessment tool within the patient electronic notes system.

Management of patient risk

Staff followed policies and procedures for the use of observation. Staff placed patients on Level two observations on admission meaning that they were checked four times an hour. The multi-disciplinary team then decreased or increased the level of observation based on individual patient risk.

Contraband items were listed on ward entrance doors and a staff member was responsible for meeting and greeting patients and searching patients on their return to the ward.

Staff on Topaz ward did not update a patient's falls risk assessment and falls care plan for eight days following a serious fall. However, staff were aware of the risks and impact of patient falls and assessed the patient risk of falls on admission using a manual handling risk assessment tool. Staff were aware of the risks and impact of patient falls. Patients at risk of falls were placed on higher level of observations and staff referred patients for physiotherapy assessments. Beech ward completed falls risk assessments for all patients within 24 hours of admission.

Staff received training on falls, including new mandatory training for wards for older people with mental health problems; 'preventing falls in hospital.' Staff on Beech ward carried out an audit of the time falls were more likely to happen and found that these were more likely to occur over the weekend. Staff took the findings to the falls steering group and changes were implemented accordingly. As physiotherapists worked Monday to Friday, they trained nurses to do basic frame assessments for patients over the weekend.

Staff utilised falls prevention equipment such as anti-slip socks, mobility aids, hoists, stand aids and low-profile beds.

Staff completed body maps, turning charts and used the Waterlow chart for patients at risk of developing pressure ulcers and staff referred patients to tissue viability nurses.

Apart from Henneage and Roding wards, patients in the other eight wards could not get access to their bedrooms or bedroom corridor without staff having to unlock them. This did not seem to be individually risk assessed and we did not see evidence that this blanket restriction was subject to regular review. Henneage and Roding wards enabled individual patient swipe access to their bedrooms. Staff on the other eights wards told us that locking bedroom doors was to minimise risks and was following trust policy. Staff on Henneage ward locked the lounge between midnight to 06:00hrs to encourage good sleep hygiene. Apart from on Roding and Beech wards, the gardens were usually locked and accessed with staff or family supervision only.

Informal patients could leave the ward. We saw that staff, patients and carers had collaborative discussions about individual patient risks at ward reviews and in daily safety huddles. Patients that had escorted/unescorted leave in the hospital grounds were risk assessed prior to leave and details were recorded such as time in, time out, what they were wearing. On their return staff discussed how the leave went and this was considered in terms of future risk assessments.

Nicotine replacement therapy was available to patients via prescription from staff on wards, or the Doctor.

Use of restrictive interventions

There was minimal evidence of frequent physical restraint or rapid tranquilisation and all staff felt confident to use de-escalation effectively to reduce the needs for these interventions. Staff avoided high level holds due to the potential frailty of the patient group. Restraint was used only if de-escalation has failed. De-escalation techniques included understanding triggers, offering music, walks, toys, short-term separation from others by escorting patient to their room.

Beech ward used soft boxes that contained tools to facilitate de-escalation following the Safewards principle. Staff received TASI training (therapeutic and safe interventions) for five days followed by two-day updates. The TASI team visited the wards, assessed patients and gave advice on behavioural management.

We saw the seclusion records for a patient who had been secluded in their bedroom for a brief period. Staff used seclusion appropriately and followed best practice when they did so.

This service had 154 incidences of restraint (66 different service users) and one incident of seclusion between 1 January 2018 and 31 December 2018.
The below table focuses on the last 12 months' worth of data: 1 January 2018 to 31 December 2018.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Bernard Ward	0	19	15	0 (0%)	10 (53%)
Henneage Ward	1	22	8	2 (9%)	15 (68%)
Kitwood Ward	0	1	1	0 (0%)	1 (100%)
Roding Ward	0	2	2	0 (0%)	1 (50%)
Ruby Ward	0	25	11	0 (0%)	5 (20%)

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Beech Ward (Essex)	0	62	18	11 (18%)	11 (18%)
Gloucester Ward	0	23	11	2 (9%)	6 (26%)
Core service total	**1**	**154**	**66**	**15 (10%)**	**49 (32%)**

There were 15 incidences of prone restraint, which accounted for 10% of the restraint incidents. Over the 12 months, incidences of restraint ranged from six to 30 per month. The number of incidences (154) had decreased from the previous 12-month period (168).

There were 49 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from one to 11 per month over (1 January 2018 to 31 December 2018). The number of incidences (49) had decreased from the previous 12-month period (71).

There have been zero instances of mechanical restraint over the reporting period. The number of incidences (0) was the same as the number of incidences from the previous 12-month period (0).

The number of restraint incidences reported during this inspection was not comparable to the last inspection.

There has been one instance of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from zero to one. The number of incidences (1) had decreased from the previous 12-month period (4).

The number of seclusion incidences reported during this inspection was not comparable to the last inspection.

There has been one instance of long-term segregation over the 12-month reporting period. The number of incidences (1) was the same as the previous 12-month period (1).
The number of segregation incidences reported during this inspection was not comparable to the last inspection.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted

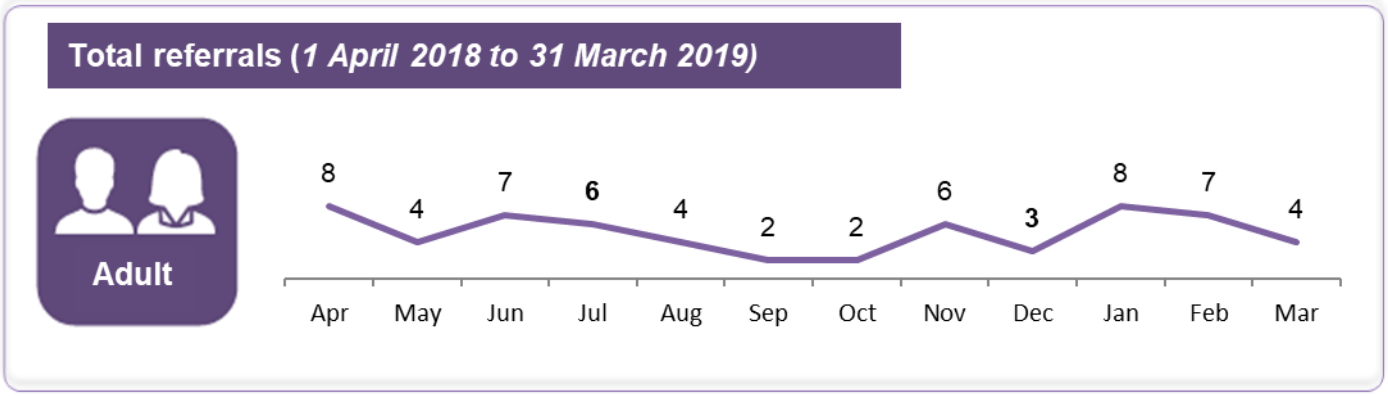
to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 61 safeguarding referrals between 1 April 2018 and 31 March 2019, of which 61 concerned adults and zero concerned children. The number of safeguarding referrals reported during this inspection was not comparable to the last inspection.

During the inspection we saw evidence of appropriate safeguarding referrals, that staff were trained and confident in how to raise a concern and what constituted abuse. Staff followed safe procedures for children visiting the ward.

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
MH – Wards for older people with mental health problems	61	0	61

The number of adult safeguarding referrals in month ranged from two to eight (as shown below).



The trust has submitted details of zero serious case reviews commenced or published in the last 12 months (1 April 2018 and 31 March 2019) that relate to this service.

Staff access to essential information

All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form. Staff in teams described difficulties accessing the health information exchange when patients transferred from north to south. Staff in the north and south used different electronic patient records and the health information exchange was a system used to share patient information relating to risk and treatment information.

Medicines management

Staff followed good practice in relation to medicine management with regular pharmacy support. All medicine we saw was in date. However, on one of the wards, two empty oxygen cylinders had not been returned which the Care Quality Commission had identified at a previous inspection in March 2019. Bernard ward and Gloucester ward clinic rooms had some out of date items such as blood drawing needles and blood collection bottles.

Staff on the wards wore a red tabard to make sure they were not disturbed by other staff when administering medicines. Staff carried out weekly medicine audits and any gaps were sent for actioning. Pharmacists and pharmacy assistants gave advice and attended ward reviews if a patient was on a range of complex medicine.

Medicine charts included patient photographs where appropriate and allergies. Where medicines were needed to be given covertly to patients, this was decided as part of a best interests meeting involving the pharmacist and relatives of the patient. Covert medicines were given by staff as medicine disguised in food or drink, when a patient was too unwell to understand why they needed to take it.

Prescribed medicine followed National Institute for Health and Care Excellence recommended guidelines and were within British national formulary limits. We saw evidence of cardio-metabolic monitoring for antipsychotic medicine. On Ruby ward a patient who was admitted with a diagnosis of adjustment disorder was referred for psychological treatment as medicine was not indicated as a primary treatment.

However, six medicine charts across both Ruby and Topaz wards did not record patients' mental health act status and had not been selected for the random medicine audit. On Kitwood ward, two of nine medicine charts did not record mental health act status, although details were recorded in the patients' electronic notes. On Henneage ward five of 16 medicine charts did not have mental health act status recorded, however, a T3 form was in place for one of these.

Track record on safety

Between 1 March 2018 and 28 February 2019 there were eight serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'slips/trips/falls meeting SI criteria' with five. There were no unexpected deaths within this core service.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with eight reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

The number of serious incidents reported during this inspection was lower than the 21 reported at the last inspection.

	Number of incidents reported				
Type of incident reported (SIRI)	**Apparent/actual/ suspected self-inflicted harm meeting SI criteria**	**Slips/trips/falls meeting SI criteria**	**Other**	**Pressure ulcer meeting SI criteria**	**Total**
Beech			1	1	**2**
Henneage	1	1			**2**
Kitwood		1			**1**
Tower		1			**1**
Topaz		1			**1**
Ruby		1			**1**
Total	**1**	**5**	**1**	**1**	**8**

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing future deaths.

In the last two years (since April 2017), there have been eight 'prevention of future death' reports sent to Essex Partnership University NHS Foundation Trust. None of these related to this service.

Managers ensured that learning from incidents was disseminated, discussed in team meetings and we saw evidence of learning in practice. Shared learning was stored on the shared drive. We saw several examples of changes being made to practice following learning from an incident. On one ward, a patient had a sacral pressure area. Staff identified lessons learnt, such as more thorough body mapping, checking for redness, two-hourly turn charts, monthly weight chart reviews and Waterlow chart reviews.

Staff identified learning in practice following the unexpected death of a patient shortly after discharge from one of the wards. This included the practice of not discharging patients on a Friday and understanding that patients sometimes required more time on the ward to adapt to a diagnosis of dementia.

Is the service effective?

Assessment of needs and planning of care

There was good evidence of assessment and ongoing physical health care of patients. Doctors completed a physical examination of patients, including electro-cardiogram (ECG) and bloods, within 24 hours of admission. Staff carried out daily safety huddles where they reviewed key physical health issues for that day. On Beech ward doctors had prescribed physical exercise and this led to an increase in patient uptake. Some wards, such as Ruby and Topaz, had separate physical health care rooms for monitoring and assessment and there were ECG machines on the wards. Healthcare assistants could access 'enhanced emergency skills' training (defibrillation/oxygen), phlebotomy training and ECG. Staff used the modified early warning score daily to identify the degree of illness of patients.

There were link nurses on the wards that specialised and supported staff in different key areas such as physical health monitoring, falls, health and safety, infection control, safeguarding and manual handling.

Care plans, particularly on the wards for patients with a functional diagnosis, were comprehensive, holistic and recovery-oriented. There was a multidisciplinary approach to care that was reflected in the care plans and the multidisciplinary attendance at weekly ward reviews. Care plans were reflective of patient needs and completed within 72 hours of admission. Care plans were updated every two weeks or more frequently as appropriate. Care plans were personalised and collaborative.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group and there was a multidisciplinary approach to care. Occupational therapists worked with occupational therapy assistants to meet the needs of the patient group. This included both ward and home assessments, groupwork and 1:1 work with patients.

Staff collaboratively offered a range of activities on the wards. When we observed activities, we saw good engagement with patients and a multi-disciplinary approach in place. Patients were encouraged to attend walking groups and staff tried to meet individual patient interests where possible. Staff on Beech ward set up a photography group for patients with an interest in photography. On the wards that had pets as therapy activities, these were valued by staff and patients as a source of stress reduction. On Kitwood ward staff set up a 'beach bar' in the lounge area with a beach pictorial background, beach music and soft drinks. Staff on Henneage ward had arranged for a professional musician to attend the ward weekly. Staff on Roding ward brought in fruit and assisted patients to make fruit smoothies or fruit salads in the warm weather.

Not all wards offered structured activities over the weekend, there were no weekend activities on Kitwood, Henneage or Beech wards. Other wards ran a more limited weekend timetable of activities.

Activity timetables were placed on the walls by the main patient communal area, but these were not always easy to see as the writing was small. They were also difficult to interpret easily as different disciplines held different activities, sometimes at the same time as each other. Activities varied across the wards in terms of consistency and these were not evaluated to assess whether they met patients interests or needs. Staff did not evaluate which activities were accepted,

declined or cancelled. During our inspection some activities on Kitwood and Ruby wards had been cancelled or the subject of the activity changed.

There was patient and staff access to psychologists on the wards. Psychologists offered group work and sometimes 1:1 with patients as well as mindfulness sessions for patients and staff on some wards. On Beech ward the psychologist facilitated a monthly open forum for patients and carers.

Physiotherapists split their time across the wards and carried out assessments, exercise groups and contributed to care plans. Staff could access community physiotherapists if unable to access the ward physiotherapy team.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. Staff assessed patients on admission using the malnutrition universal screen tool, a five-step screening tool to identify adults who are malnourished or at risk of malnutrition. Staff weighed patients weekly and kept food and hydration charts for those patients identified as at risk. During hot weather Beech ward and Topaz wards commenced hydration charts for all patients on those wards.

Staff referred patients to a dietician or speech and language therapist as needed. Dieticians also assisted patients in linking healthy eating and the impact on mental health. Staff identified special dietary needs on white boards in ward kitchens. Staff supported patients at mealtimes with support from speech and language therapists if appropriate, and we saw that graded spoons were used. We observed positive and encouraging interactions between staff and patients and this was particularly evident on Beech ward, where the atmosphere was convivial.

Staff used technology to support patients effectively. The wards used a falls prevention 'traffic light system' that indicated the level of mobility assistance patients required. Some bedrooms on Kitwood, Topaz and Henneage wards were fitted with motion detectors to prevent falls. On Beech ward the alarm was sent directly to staff pagers with the location. This meant that the alarm did not disturb other patients and staff could quickly identify where to go.

This service participated in 11 clinical audits as part of their clinical audit programme 2018 – 2019.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Record Keeping / Care Planning MH Older Adult	Beech, Bernard, Gloucester, Henneage, Kitwood, Meadowview, Roding, Ruby, Topaz, Tower	MH - Wards for older people with mental health problems	Clinical	ongoing	Audit results shared in Quality and Safety Committees. Results appear on the performance dashboards in each unit. Areas scoring below 90% in overall compliance to develop action plans to address the issues around recording necessary information.
Mental Health Clinical Handover	Beech, Bernard, Clifton Lodge, Gloucester, Henneage, Kitwood, Meadowview,	MH - Wards for older people with mental health problems	Clinical	18/02/2019	Findings shared with services, for them to develop appropriate action plans based on results

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
	Roding, Ruby, Topaz, Tower				
National audit of inpatient falls	Beech, Bernard, Gloucester, Henneage, Kitwood, Meadowview, Roding, Ruby, Topaz, Tower	MH - Wards for older people with mental health problems	Clinical	In progress	Data collection based on incidents of hip fractures, as yet none reported. Collection time frame to end December 2019
Physical Health and MEWS in Older Adult	Beech, Bernard, Gloucester, Henneage, Kitwood, Meadowview, Roding, Ruby, Topaz, Tower	MH - Wards for older people with mental health problems	Clinical	12/02/2019	The audit results were presented to the Physical Health Action and Implementation Group. Report was also shared with the service quality and safety committee to review.
Resuscitation Audit	Beech, Bernard, Gloucester, Henneage, Kitwood, Meadowview, Roding, Ruby, Topaz, Tower	MH - Wards for older people with mental health problems	Clinical	In progress	Report reviewed at Resuscitation Group and awaiting Executive sign off before being disseminated to services.
National Audit of Anxiety and Depression	Roding, Beech, Gloucester	MH - Wards for older people with mental health problems	Clinical	In progress	Data collection completed in April 2018. Report expected in between January and June 2019
National Audit of Psychological Therapies Spotlight	Beech, Bernard, Gloucester, Henneage, Kitwood, Meadowview, Roding, Ruby, Topaz, Tower	MH - Wards for older people with mental health problems	Clinical	In progress	Data submission completed. Report due to be published Summer 2019
Physical health assessment on admission /transfer to	Ruby and Topaz	MH - Wards for older people with mental	Clinical	In progress	Data collection in progress

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
MH older adult wards		health problems			
Audit of completion of medication charts in the North East area of the trust	Bernard, Tower, Henneage	MH - Wards for older people with mental health problems	Clinical	01/04/2018	Present findings at Tuesday Doctors meeting, in the East Area of EPUT, in the next 6 months. Doctors should be informed that the medication cards are in great compliance with the standards, but weight, height and BMI are important as well and must be always documented. Re-audit in the following one year to see if standards are the same or have changed
Pattern of referrals to general hospital and the quality of information exchanged between professionals	Inpatient Older Adult services: Ruby and Topaz	MH - Wards for older people with mental health problems	Clinical	01/06/2018	A standardised referral form (as above) can be considered, presentation of findings from audit to Physical Health Steering Group and academic teaching meeting to create awareness amongst local doctors. Liaise with the local A&E clinical lead with findings and discuss options of overcoming the delay of communicating the information
VTE Risk Assessment	Roding, Kitwood Wards	MH - Wards for older people with mental health problems	Clinical	In progress	Data collection in progress

Skilled staff to deliver care

The team included or had access to the full range of specialists required to meet the needs of patients on the ward. This included doctors, nurses, occupational therapists, clinical psychologists, social workers, pharmacists, physiotherapists, speech and language therapists, dieticians, diabetic nurses and tissue viability nurses.

Staff had access to specialist training other than mandatory. Some staff had completed additional training in physical health care. On Beech ward a staff member had accessed funding to complete training in Eye Movement Desensitization and Reprocessing (EMDR), is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories. Some staff had accessed training to become nurse prescribers.

Managers provided staff with supervision and appraisal of their work performance. There was evidence of regular and meaningful supervision and staff knew when their next supervision date was.

Not all wards held regular team meetings. On Topaz and Henneage wards there was a gap of four months between team meetings just prior to our inspection. Where team meetings didn't occur frequently, managers kept staff updated by email. We saw minutes of team meetings on the wards and when the meetings took place, they were thorough and included detailed discussions on incidents, learning from complaints, safeguarding, audits, physical health and patient feedback. The meetings followed the structure of the Care Quality Commission domains of safe, effective, caring, responsive and well-led.

The trust's target rate for appraisal compliance is 90%. At the end of last year (1 April 2017 and 31 March 2018), the overall appraisal rate for non-medical staff within this service was 52%. This year so far, the overall appraisal rates was 80% (as at 28 February 2019). The teams with the lowest appraisal rate were Kings Wood Centre General with an appraisal rate of 20%, Ruby Ward with 64%, and Roding Ward with 76%.

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 83% rate reported at the last inspection.

Ward name	**Total number of permanent non-medical staff requiring an appraisal**	**Total number of permanent non-medical staff who have had an appraisal**	**% appraisals (as at 28 February 2019)**	**% appraisals (previous year 1 April 2017-31 March 2018)**
Landermere Centre General	1	1	100%	0%
Crystal Centre Administration	3	3	100%	100%
Administration Clacton Elderly	3	3	100%	0%
Meadowview Ward	15	15	100%	67%
Central Housekeeping OP IP	4	4	100%	75%
Beech Ward	16	15	94%	36%
Hotel Services MHU SMH	14	12	86%	25%
Gloucester Ward	21	18	86%	38%
Kitwood Ward	18	15	83%	50%
Topaz Ward	10	8	80%	56%
Tower Ward	15	12	80%	58%
Bernard Ward	14	11	79%	58%
Henneage Ward	18	14	78%	53%
Roding Ward	17	13	76%	44%
Ruby Ward	14	9	64%	73%
Kings Wood Centre General	10	2	20%	89%
Core service total	**193**	**155**	**80%**	**52%**
Trust wide	**3884**	**3172**	**82%**	**55%**

The trust did not provide data regarding appraisal compliance for permanent medical staff.

The trust's target of clinical supervision for non-medical staff is 90% of the sessions required. Between 1 March 2018 and 28 February 2019, the average rate across all 11 teams in this service was 99%.

The rate of clinical supervision reported during this inspection was higher than the 80% rate reported at the last inspection.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Beech Ward	212	212	100%
Meadowview Ward	178	178	100%
Physiotherapy Inpatients	23	23	100%
Roding Ward	175	175	100%
Kitwood Ward	172	172	100%
Ruby Ward	159	158	99%
Gloucester Ward	197	194	98%
Bernard Ward	190	187	98%
Henneage Ward	210	205	98%
Tower Ward	188	184	98%
Topaz Ward	125	123	98%
Core service total	**1829**	**1811**	**99%**
Trust Total	**19802**	**19153**	**97%**

The trust did not provide data regarding clinical supervision compliance for permanent medical staff.

Multi-disciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings. Along with members of the multidisciplinary team, care co-ordinators and social workers were invited to ward reviews. Staff on the wards for patients with an organic diagnosis invited external organisations on to the ward to work with patients, including the Alzheimer society members. Staff on the wards had effective working relationships with GPs regarding patient medication and staff contacted GPs after discharge as part of the 48 hour-follow-up.

Handovers took place twice a day and were attended by members of the multidisciplinary team. Handover sheets demonstrated that key risks were fed back to staff on the oncoming shift. On Beech ward ligature audits were taken into handover for bank staff new to the ward.

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

Where patients were subject to the Mental Health Act 1983, their rights were protected, and staff complied with the MHA Code of Practice. Staff knew who their Mental Health Act administrators were. Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted. Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them. The wards displayed a notice to tell informal patients that they could leave the ward freely.

On Gloucester ward a patient had been illegally detained for over 12 hours under Section 2 of the Mental Health Act 1983 whilst waiting for a Mental Health Act assessment for a Section 3. Staff had not informed the patient of the change in their Mental Health Act status in the 12-hour period that they were informal. During our inspection staff took the appropriate measures to resolve the situation. A Mental Health Act assessment was carried out and the patient was placed under a Section 3 of the Mental Health Act 1983. Staff apologised to the patient and ward staff and Mental Health Act administrators completed an incident form. Staff amended handover template sheets to capture this information and to minimise the risk of it occurring again.

There was good access to advocacy across most of the wards, with advocacy leaflets available in the main ward corridors. We saw evidence that staff had referred patients to advocacy and of family involvement in a referral for an independent mental capacity advocate. Advocates were invited to patient ward reviews. However, on Henneage ward, patients told us they were not aware that they had access to an advocate.

As of 31 March 2019, 90% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and community staff, depending upon their role.

The training compliance reported during this inspection was higher than the 83% reported at the last inspection.

Good practice in applying the Mental Capacity Act

As Mental Capacity Act Training is incorporated into Safeguarding Level 1 training, this data is unsuitable for analysis.

Staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles. We saw evidence that, for patients who might have had impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions. Staff carried out best interest discussions and decisions were made with recognition of the importance of the person’s wishes, feelings, culture and history. Staff took all practical steps to enable patients to make their own decisions.

During this inspection, we found that staff had applied for Deprivation of Liberty Safeguards in a timely way and they monitored the progress of applications to supervisory bodies. We did not find any gaps between the dates where patients who were detained under the Mental Health Act had become informal while waiting for Deprivation of Liberty Safeguards to be applied.

The trust told us that 238 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 April 2018 to 31 March 2019.

The greatest number of DoLS applications were made in August 2018 with 26.

CQC received 274 direct notifications from the trust as a whole between 1 April 2018 to 31 March 2019[11]. However, the trust reported that 158 direct notifications were sent to CQC, 123 of these direct notifications were in relation to this core service. Under HSCA legislation, all DoLS applications should also be sent to the CQC in the form of a direct notification so it is relevant that these numbers are different.

The number of DoLS applications made during this inspection was higher than the 209 reported at the last inspection.

	Number of 'Standard' DoLS applications made by month												
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
Standard applications made	11	12	25	23	26	22	23	19	21	21	19	16	**238**
Standard applications approved	5	1	3	2	8	7	4	7	10	5	2	0	**54**

[11] CRM

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We saw staff interventions that demonstrated compassionate and personalised care of patients and staff spoke about patients with compassion and respect. Patients told us they felt cared for and had high regard for the care they received. Patients told us staff were respectful during personal care. However, we overheard a staff member on Kitwood ward talking to a patient in front of others about wetting their pad and that it required changing. This did not demonstrate respect or dignity.

Patients told us they felt safe on the wards. Patients and carers spoke highly of the cleanliness of the wards and of the personal care of patients. Carers felt their relatives had enough food and drink and were supervised well. A carer praised the physical health care their relative received on Beech ward and that their relative's bloods were checked regularly for changes in blood sugar.

Patients on Ruby ward commented that sometimes there was not enough staff and sometimes staff moved between wards. They felt they had to ask staff for everything they wanted on the ward. On the same ward, patients and their carers told us it was sometimes too cold. However, we saw staff asking patients if they were too cold and staff provided extra blankets on beds if requested.

Patients spoke highly of the choice, quality and portion size of food on the ward. Staff offered patients a choice of food. The wards offered sandwiches and soup for either lunch or dinner. Patients told us they got tired of sandwiches and these were often thrown away at the end of the day.

We observed that staff knew the individual patients and their needs. Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. On Beech ward, we saw that staff had completed a care plan that focussed on the patient's religious beliefs. It included reminders that staff should be mindful of religious holidays and should accommodate this by allowing visiting outside of normal hours, so the patient could celebrate them with their family. It also included a reminder that staff should be mindful if the patient was fasting in line with their belief and to support them with this.

On the wards for patients with organic diagnoses, staff had placed memory aid signs in patient bedrooms called 'Have I remembered' with pictures of personal items such as hearing aids, vision glasses, mobility aids and footwear.

Staff tried to meet the individual needs of patients. We saw that to avoid delay, staff offered to deliver take away medicines for a patient who had been discharged from Kitwood ward. On Roding ward, staff arranged for the ward to pay for a taxi for a patient who had been waiting for a lift home. A patient on Gloucester ward told us that staff accompanied him to a public area that reminded him of his wife at his request. During the accompanied visit, he found staff supportive, not intrusive and they allowed him to go at his own pace. When the same patient visited home, staff made two reassurance telephone calls to him which he found very helpful.

Staff, patients and carers collaborated on the 'my care, my recovery' personalised booklets that encouraged staff to find out more about patients by talking to them about their history and their likes/dislikes. On Bernard ward we saw a patient voluntarily assisting a housekeeper with light cleaning chores and the patient appeared to enjoy this.

However, not all staff were aware of how to put subtitles on the television screen for patients with hearing impairment and there were no subtitles visible on the screens on both Roding and Kitwood wards.

Patients told us they understood what medicines they were on and the potential side effects and felt that their voice was heard regarding their treatment.

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

Staff maintained the confidentiality of information about patients. On Topaz ward we witnessed staff having a safety huddle in the main patient area which meant that other patients were privy to personal information. Patient names and their legal status was placed on a white board in the nursing office on some of the wards and was visible to other patients. We raised these two confidentiality issues with staff at the time.

Patients on Ruby ward told us that staff did not knock to enter their bedrooms apart from when they were having personal care. On Ruby ward we observed that staff did not always knock first before entering patients' bedrooms. Patients on the wards were able to close the viewing panels in their doors for privacy.

PLACE assessments aim to provide a clear message from patients on how the care environment may be improved. They are undertaken by teams of local people alongside healthcare staff and assess privacy and dignity, food, cleanliness, building maintenance and the suitability of the environment for people with disabilities and dementia.

Involvement in care

Involvement of patients

Patients had a copy of their care plan or knew they could have access to it if they wanted. Patients told us they knew about their care when they attended clinical reviews.

Apart from Kitwood ward, staff held regular community meetings for patients to attend, but minutes from the meetings were not always recorded in a way that ensured staff oversight that any actions had been taken, when and by who. We saw a community meeting on Topaz ward where occupational therapy staff had incorporated gentle chair exercises into the meeting.

Patients were able to leave comments in the suggestion boxes on the wards and staff demonstrated changes made based on patient feedback on the 'you said, we did' boards. We saw an example of an action following a patient comment that they wanted to see the garden tidied up. The staff response was that following the gardening group flowers had been planted. We saw that staff offered patients the 'how did we do?' survey on discharge.

Involvement of families and carers

Carers told us that they were kept informed of treatment and medicine changes and that they have been kept up to date with patient's care plan. A carer for a patient on Meadowview ward said that staff met her and introduced themselves on her first visit and they explained the ward process to her. Carers were invited to contribute to the 'my care, my recovery' booklets when patients were admitted to wards for patients with organic diagnoses. On Topaz ward staff introduced carers to the discharge co-ordinator who then worked with them to ensure a smooth discharge. Staff on the wards gave out friends and family surveys to carers.

Some wards such as Kitwood, Roding and Beech held groups for carers. We looked at minutes from the group held on Beech ward which included sharing experiences, how carers care for

themselves and it showed evidence of support from staff. Staff communicated with community mental health teams to request carer assessments.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for seven wards in this service between 1 March 2018 to 28 February 2019.

Seven of the wards within this service reported average bed occupancies ranging above the minimum benchmark of 85% over this period.

Bed occupancy was lower than expected during this inspection:

Ruby ward had 17 beds and 17 patients on the ward

Topaz ward had 17 beds and 6 patients on the ward

Bernard ward had 12 beds and 9 patients on the ward

Tower ward had 14 beds and 7 patients on the ward

Roding ward had 14 beds and 14 patients on the ward

Kitwood ward had 16 beds and 12 patients on the ward

Gloucester ward had 22 beds and 14 patients on the ward

Meadowview ward had 24 beds and 17 patients on the ward

Beech ward had 24 beds and 22 patients on the ward

Henneage ward had 16 beds and 16 patients on the ward

Ward name	**Average bed occupancy range (1 March 2018 – 28 February 2019) (current inspection)**
Bernard	79%-98%
Henneage	90%-115%
Kitwood	77%-100%
Roding	97%-105%
Ruby Ward	96%-116%
Topaz Ward	92%-104%
Tower	58%-98%

The trust provided information for average length of stay for the period 1 March 2018 to 28 February 2019 to date.

Ward name	**Average length of stay range (1 March 2018 – 28 February 2019) (current inspection)**
Bernard	40-115 days
Henneage	23-69 days
Kitwood	51-90 days

Ward name	Average length of stay range (1 March 2018 – 28 February 2019) (current inspection)
Roding	51-95 days
Ruby Ward	67-159 days
Topaz Ward	122-332 days
Tower	34-82 days

Discharge and transfers of care

Between 1 March 2018 to 28 February 2019 there were 753 discharges within this service. This amounts to 14% of the total discharges from the trust overall (5548).

Delayed discharges across the 12-month period ranged from one to nine per month, with a total of 47 delayed discharges.

The proportion of delayed discharges reported during this inspection was lower than the 144 delays reported at the time of the last inspection.

Discharges were planned from admission with the assistance of the discharge co-ordinators who worked with patients and their carers to facilitate a smooth discharge.

The target for the average length of stay for each ward was a maximum of 76 days and this was reviewed as a potential delayed discharge at 40 days. There were no delayed discharges on Gloucester and Meadowview wards. The reasons given for delayed discharges on the wards were that the patient was not well enough for discharge or that there were funding, accommodation or placement issues. Staff sought support from the discharge co-ordinator, the clinical commissioning group and also social services if the patient was self-funding or was without finances.

Staff took part in daily situational report meetings (SITREP) bed management calls and patients could be moved to more appropriate wards. Wards for patients with a functional diagnosis could accept patients with an organic diagnosis if this was considered more appropriate, as in the cases with patients who had early onset dementia. All staff working on older adult wards had received dementia training as mandatory. Senior staff also took part in a weekly displaced patient conference call to discuss patients waiting to come on to a ward.

Facilities that promote comfort, dignity and privacy

The sites which deliver MH – Wards for older people with mental health problems within Essex Partnership University NHS Foundation Trust were compared to other sites of the same type and the scores they received for ‘ward food’ were found to be about the same as the England average.

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories.

With the exception of Meadowview, patient bedrooms on the wards for patients with an organic diagnosis were not personalised. There was some confusion among staff as to whether this practice was to be discouraged due to infection control and health and safety concerns. There was no evidence to suggest that trust policy specifically discouraged this practice.

Although patients could not make their own hot drinks on the wards, there was access to hot drinks and snacks when they wanted them. Wards had set times for the provision of hot drinks, but staff and patients told us that outside of these times hot drinks could be requested. Staff put out jugs of cold drinks for patients on the wards throughout the day.

Wards had an activity room and either an activity of daily living kitchen or access to one just off the ward. Patients had access to musical instruments. Patients had access to quiet rooms or multi-faith rooms. Some wards had ward mobile phones or allowed staff to use the office phone. On Beech and Bernard wards there were fixed ward telephone in the quiet rooms for patient use.

Patients on the wards had access to gardens attached to the wards. Staff on Beech and Roding wards assisted patients to grow vegetables from seed and patients could eat what they grew. Some staff had received horticultural training to facilitate this.

Patients' engagement with the wider community

Staff supported patients to maintain contact with their families and carers. Prior to our inspection Beech ward had held a party on the ward for patients, family and friends.

Meeting the needs of all people who use the service

The sites which deliver MH – Wards for older people with mental health problems within Essex Partnership University NHS Foundation Trust were compared to other sites of the same type and the scores they received for 'disability' and dementia friendliness' were found to be about the same as the England average.

Most of the wards for patients with organic diagnoses had aspects that were not dementia friendly. There was no or little evidence of colour zoning or pictorial signage on the wards. The flooring in the main patient area of Topaz ward consisted of two different colours which caused patients to hesitate as they stepped. Staff were aware of this and had requested a replacement. Apart from sensory boards on the walls that patients could touch to feel different textures, patient access to different types of sensory stimulation varied across the wards.

On Topaz ward, there were pictorial signs in the main communal area but not on rooms in patient bedroom corridors. On Kitwood ward there were no pictures or photographs on doors to visually assist patients with dementia. On this ward patient names were placed high up on bedroom doors and difficult to see. A carer told us these had been placed there the day before. The digital clock in the main lounge of Kitwood ward showed the wrong date. On Topaz ward three newspapers were out of date.

However, on the wards for patients with organic diagnoses, there were age appropriate word search puzzles, large playing cards and on Topaz ward we saw staff engaging with patients in these activities. On Meadowview ward staff had placed posters beside patient bedroom doors that indicated what the patient enjoyed doing.

There was good facilities and access for people with physical disabilities.

Patients had a choice of foods to meet their dietary or religious requirements, food options such as vegetarian, vegan, diabetic and halal were available.

Staff supported patients to access the trust's telephone interpreting service via a conference call and staff could book in advance for face to face interpreter input.

Listening to and learning from concerns and complaints

This service received 15 complaints between 1 April 2018 to 31 March 2019. One of these was upheld, 12 were partially upheld and two are still under investigation. None were referred to the Ombudsman.

Patients knew how to complain or raise concerns. There were leaflets on how to complain set out in the main ward corridor. Staff knew how to handle complaints appropriately.

However, during our inspection, a patient on Kitwood ward raised a complaint about a personal item going missing on the ward. We could not find any evidence that staff had escalated or dealt with this.

Ward name	Total Complaints	Fully upheld	Partially upheld	Under Investigation
Ruby Ward	**5**	1	4	
Bernard Ward	**2**		2	
Gloucester Ward	**2**		1	1
Topaz Ward	**2**		2	
Henneage Ward	**1**		1	
Kitwood Ward	**1**		1	
Meadowview Ward	**1**		1	
Tower Ward	**1**			1

This service received 156 compliments during the last 12 months from 1 April 2018 to 31 March 2019 which accounted for 12% of all compliments received by the trust as a whole (1252).

Is the service well led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles and staff had access to leadership development opportunities like the NHS step leadership programme.

Staff knew who the senior managers were and told us that their service managers and modern matrons were visible and occasionally visited the wards.

Vision and strategy

Staff knew the organisation's values and we saw the values displayed throughout the wards. Staff felt confident to tell us that the trust had a strong focus on older adults and that a key focus of the trust was to reduce the risk of falls.

Culture

Staff felt supported and valued, they told us they felt happy and enjoyed their work. We saw that there appeared to be a culture on the wards that was patient focussed, multidisciplinary and staff had a good understanding of the service they provided.

Staff could utilise a system called 'I'm worried about' that allowed them to send an anonymous concern directly to the trust's chief executive officer, and we saw that this had been responded to.

Staff felt able to raise concerns without fear of retribution and knew how to use the whistle-blowing process.

Staff told us that a unified culture of working was still evolving following the trust merger in 2017. Staff were adapting to shift pattern changes and identified staff morale issues around the management of complex patients who fell regularly.

Governance

There was a clear framework to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. We saw evidence of good governance on the wards, that learning was shared by several means and we saw detailed team meeting minutes that demonstrated an oversight of governance requirements.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.

Ward managers attended monthly in-patient safety meetings that included governance, performance, serious incidents, safeguarding, physical health, safety alerts and trust wide learning. Managers disseminated this information to ward staff in emails, team meetings and staff supervision.

Doctors had recently started to attend the nurse led ‘older peoples’ inpatient wards’ operational meetings for a more joined up approach.

Staff on Beech ward carried out an audit of the time falls were more likely to happen and found that these were more likely to occur over the weekend. Staff took the findings to the falls steering group and changes were implemented accordingly with staff input.

Management of risk, issues and performance

Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required.

Information management

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form. However, staff in the south and north regions within the trust used different electronic systems for patient records. The trust’s information sharing portal mitigated this to an extent by allowing key risk information to be shared. If staff needed to view patient details on the other system, key risk information was accessible via the portal. This potentially meant that if a patient was transferred from one part of the trust to another, supporting information could be missed.

Engagement

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an

accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust did not report any accreditations specific to this service.

The trust had implemented work to reduce falls on wards for older people with a mental health problem. Falls prevention work included a falls steering group, four falls prevention nurses within the trust, and a traffic light system on the wards to indicate different levels of patient mobility. Ward occupational therapists and assistants completed ward and home assessments.

Kitwood and Roding wards were piloting the 'perfect ward;' a new auditing system that was due to be rolled out across the wards. This system allowed staff to use a touch screen tablet to feedback audit results directly to the quality improvement team for quick actioning.

Bernard and Tower wards working towards accreditation under the Gold Standard Framework, a systematic, evidence-based approach to optimising care for all patients approaching the end of life.

Assistive technology for falls prevention was in place on the wards. Bernard and Tower wards had put in a bid for Reminiscence Interactive Therapy Activities (RITA), an all in one touch screen tablet that allows patients with a cognitive impairment to create life story books, watch films, play interactive games and it also monitors mood and wellbeing. RITA was already acquired on Meadowview ward.

MH – substance misuse

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Trust Head Office	Essex STaRS (West)	0	Mixed
Trust Head Office	Essex STaRS (Mid)	0	Mixed
Trust Head Office	Essex STaRS (North East)	0	Mixed
Trust Head Office	Essex STaRS (South)	0	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

The service locations were owned by a partner agency. Areas that people using the service had access to were clean, comfortable and well-maintained.

The trust had up to date environmental risk assessments and ligature risk assessments in place for staff and client safety. Staff had identified risks and acted to mitigate them where possible.

Each service had a clinic room where staff could see clients. Clinic rooms were clean and adequately furnished to facilitate physical examinations. Clinic rooms had up to date cleaning records. Staff documented that equipment was regularly checked and calibrated. Clinical waste disposal was organised by a partner agency.

Emergency equipment at Mid Essex STaRS and North East Essex STaRS was in date, regularly tested and ready to use. Staff at South Essex STaRS had access to adrenaline but there was no other emergency equipment available.

Safety of the ward layout

The trust does not provide inpatient services for Substance Misuse therefore there is no data regarding same sex accommodation breaches.

NOTE: Comparisons to 'last inspection' data often do not refer to a whole year of data.

The trust does not provide inpatient services for Substance Misuse therefore there is no data regarding ligature risks.

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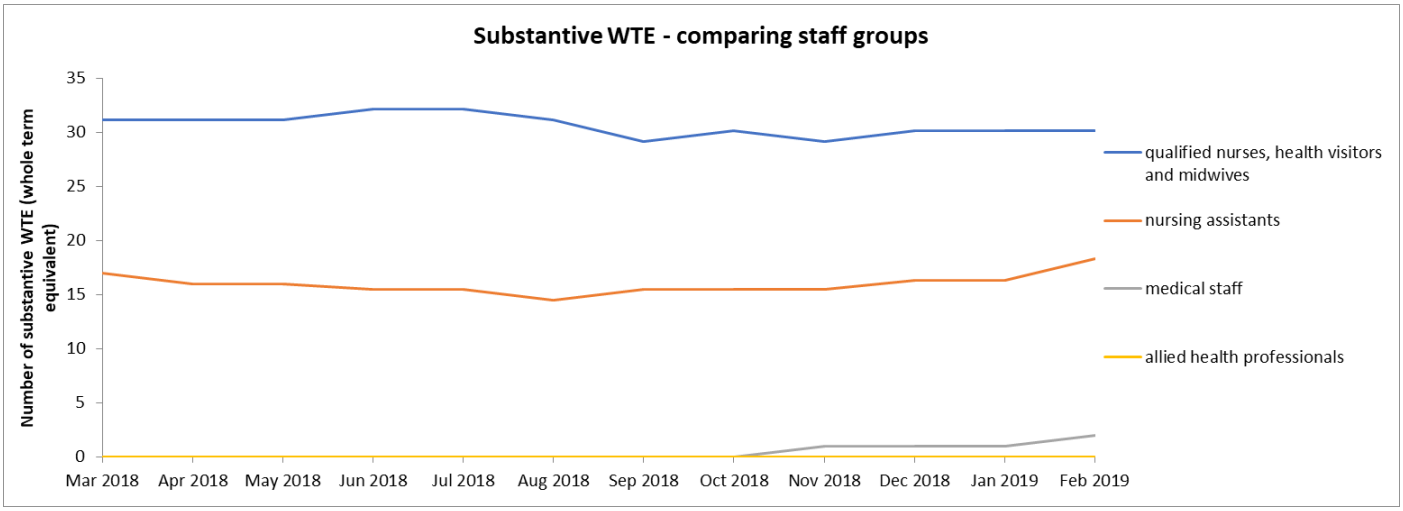
Safe staffing

The below chart shows the breakdown of staff in post WTE in this core service from 1 March 2018 to 28 February 2019.



Annual staffing metrics

	Core service annual staffing metrics (Vacancy, Turnover, Bank and Agency: 1 March 2018 – 28 February 2019) (Sickness: 1 April 2018 – 31 March 2019)						
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (%	Annual agency hours	Annual "unfilled" hours

					of available hours)	(% of available hours)	(% of available hours)
All staff	58.8	15%	11%	4.4%			
Qualified nurses	36.2	13%	8%	5.0%	1930 (2%)	5682 (7%)	0 (0%)
Nursing assistants	10.2	7%	14%	3.6%	1946 (7%)	0 (0%)	0 (0%)
Medical staff	3.0	76%	0%	0.0%	N/A	N/A	N/A

NOTE: Data regarding the number of medical locum hours filled by bank and agency staff was not clearly aligned to specific teams; therefore, this data was not usable for analysis.

The following information and charts highlight specific staffing areas where there is noteworthy evidence that may prompt further investigation on site

All Staff

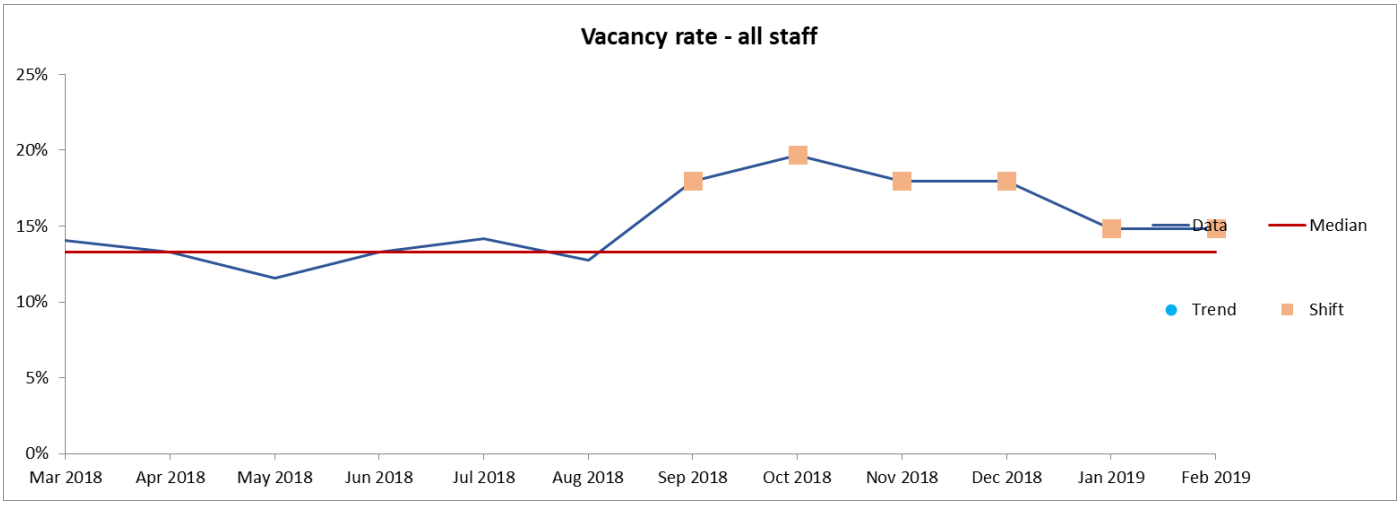


Figure 1

Monthly 'vacancy rates' over the last 12 months for all staff shows an upward shift from September 2018 to February 2019 (see figure 1).

The average vacancy rate for all staff was also in the highest 25% when compared to other similar core services nationally.

Qualified Nurses

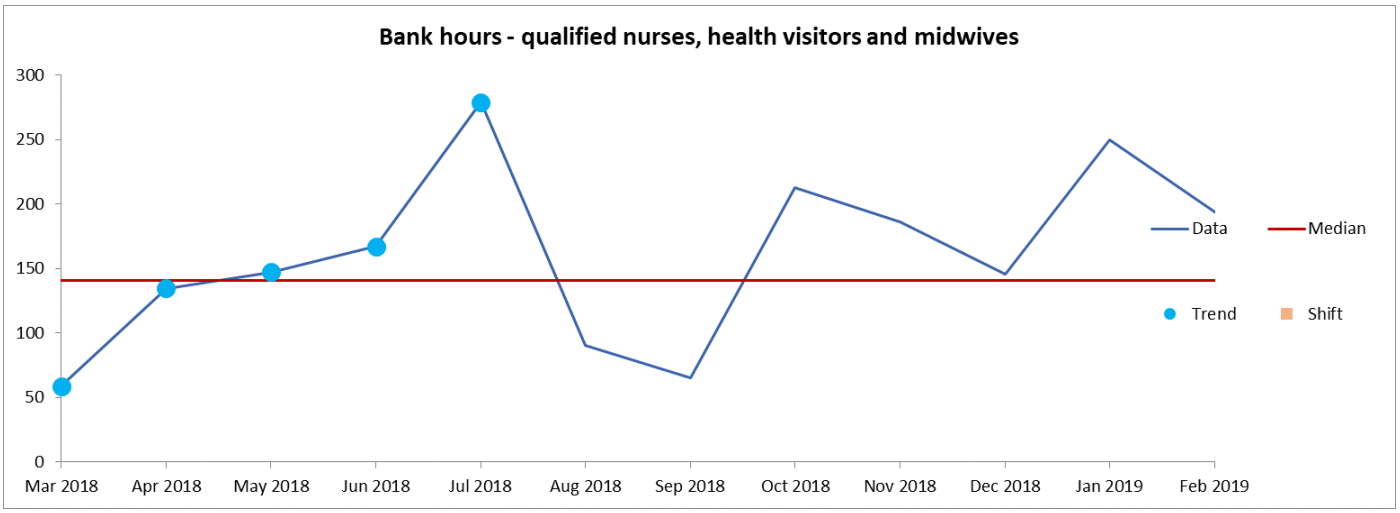


Figure 2

Monthly 'bank hours' over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from March 2018 to July 2018 (see figure 2).

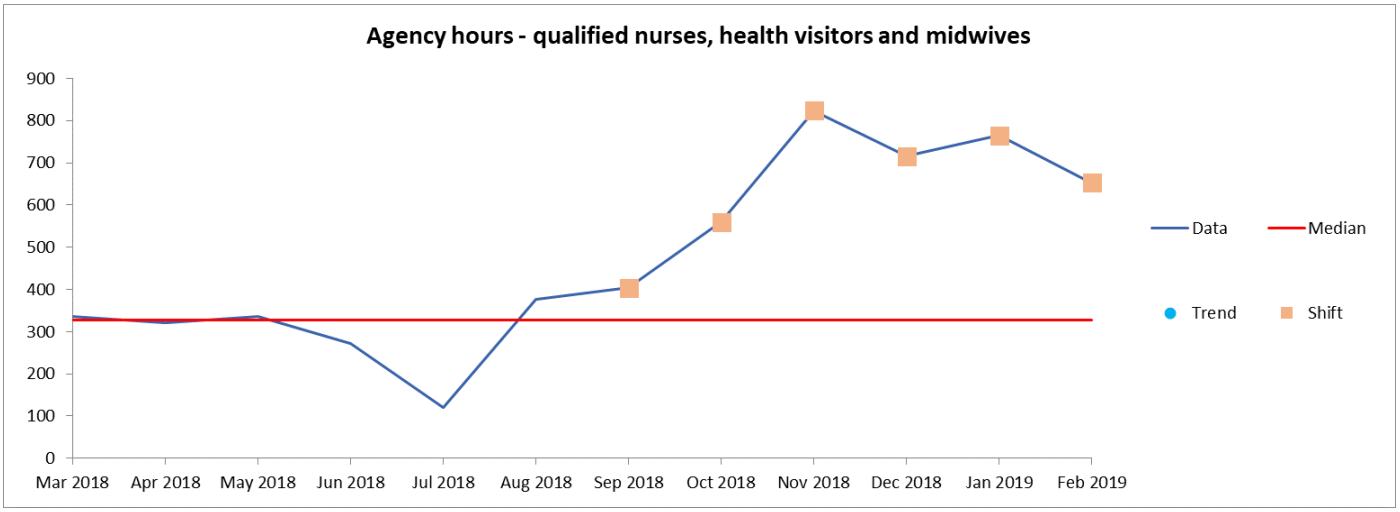


Figure 3

Monthly 'agency hours' over the last 12 months for qualified nurses, health visitors and midwives shows an upward shift from September 2018 to February 2019 (see figure 3).

Nursing Assistants

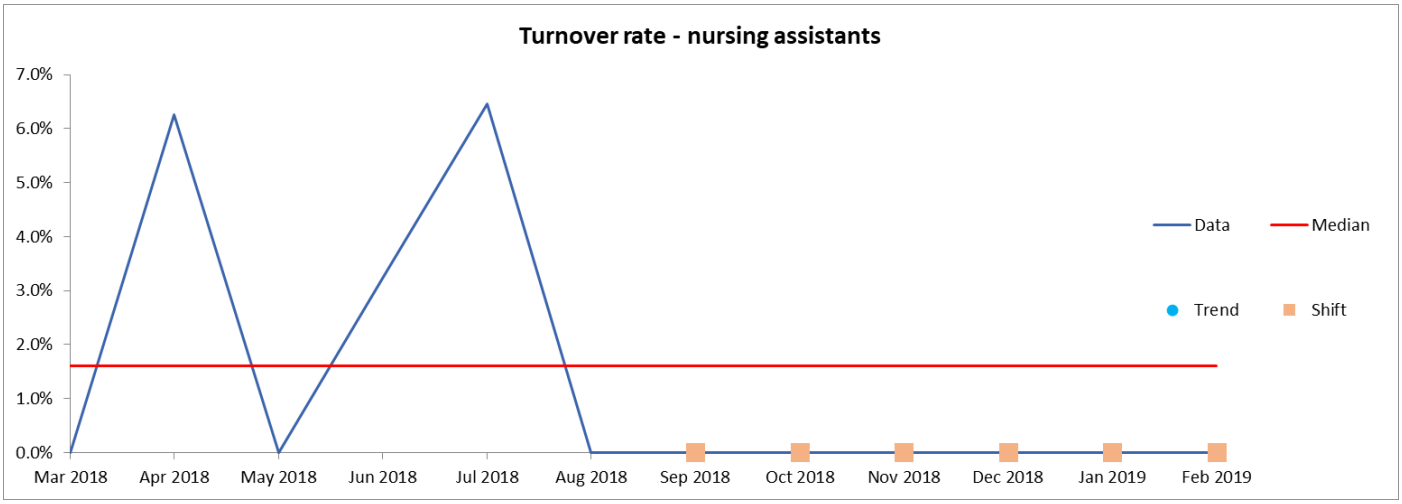


Figure 4

Monthly 'turnover rates' over the last 12 months for nursing assistants shows a downward shift from September 2018 to February 2019 (see figure 4).

The service used regular bank and agency nurses to cover any vacant shifts to provide continuity of treatment for clients.

Managers were able to utilise STaRS staff from across the four main hubs to cover for sickness, leave and vacant posts to ensure client safety.

Staff had access to alarms when based in offices and lone working devices when in the community or at satellite hubs.

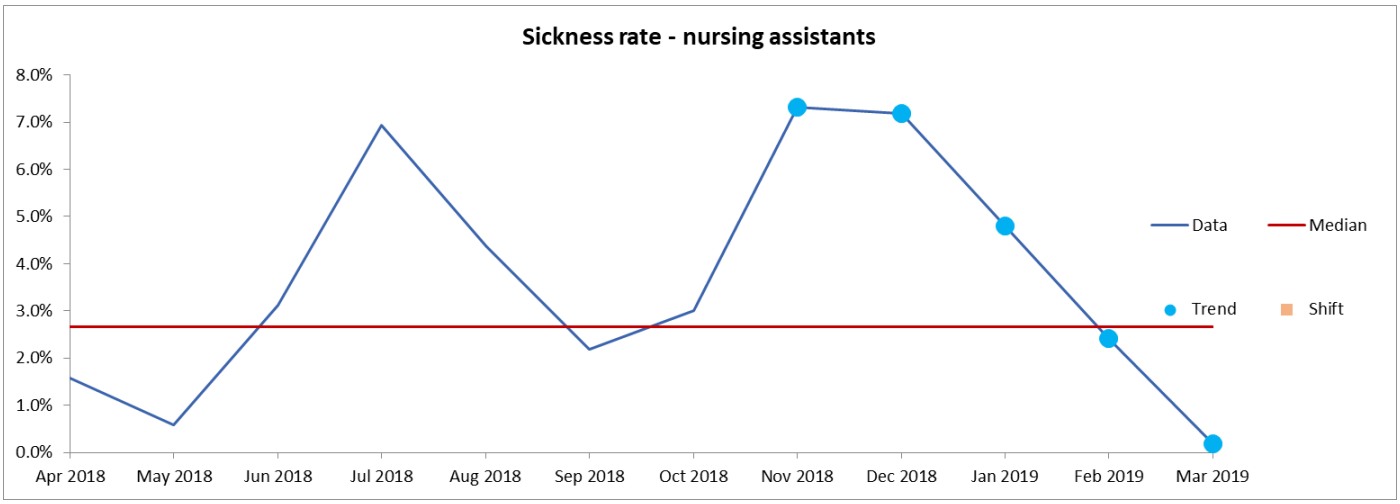


Figure 5

Monthly 'sickness rates' over the last 12 months for nursing assistants shows a downward trend from November 2018 to March 2019 (see figure 5).

Medical and Dental

The average sickness and turnover rates for medical and dental staff were in the lowest 25% when compared to other similar core services nationally. Despite this, the average vacancy rate for medical and dental staff was in the highest 25% when compared to other similar core services nationally.

Essex County Council commissioned the service as a nurse led service and funded two consultant posts, both consultant posts were filled at the time of inspection.

Mandatory training

The compliance for mandatory and statutory training courses at 31 March 2019 was 90%. Of the training courses listed one failed to achieve the trust target but this course scored above 75%.

The trust set a target of 85% for completion of mandatory and statutory training modules including: Fire Safety 3 years, Fit for work, Induction, Information Governance, and Mental Health Act. The trust set a target of 90% for completion of mandatory and statutory training modules including: Safeguarding Adults (Levels 1, 2, & 3), Fire Safety 2 years, and Safeguarding children (Level 3 & 4).

Training completion is reported as at end of reporting period.

The training compliance reported for this core service during this inspection was higher than the 83% reported in the previous year.

Mandatory training rates had improved since our previous inspection. Managers had developed a database to track staff compliance with mandatory training.

Key:

Below CQC 75%	**Met trust target** ✓	**Not met trust target** ✘	**Higher** ↑	**No change** →	**Lower** ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Safeguarding Adults (Level 2)	27	27	100%	✓	→
Fire Safety 2 years	1	1	100%	✓	N/A
Mental Health Act	10	10	100%	✓	N/A
Safeguarding Adults (Level 3)	36	34	94%	✓	↓
Safeguarding Children (Level 3)	37	34	92%	✓	↑
Fit for work	56	50	89%	✓	↓
Induction	57	51	89%	✓	↑
Fire Safety 3 years	110	96	87%	✓	↓
Information Governance	56	48	86%	✓	↓
Safeguarding Adults (Level 1)	10	8	80%	✘	N/A
Total	**400**	**359**	**90%**	✓	↑

Assessing and managing risk to patients and staff

Assessment of patient risk

A partner agency completed risk assessments for all clients, these were available for trust staff to access on a shared electronic recording system.

Management of patient risk

The service did not operate waiting lists and so did not need to monitor client risk during waiting times.

Staff made clients aware of harm minimisation and the risks of continued substance misuse during appointments.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

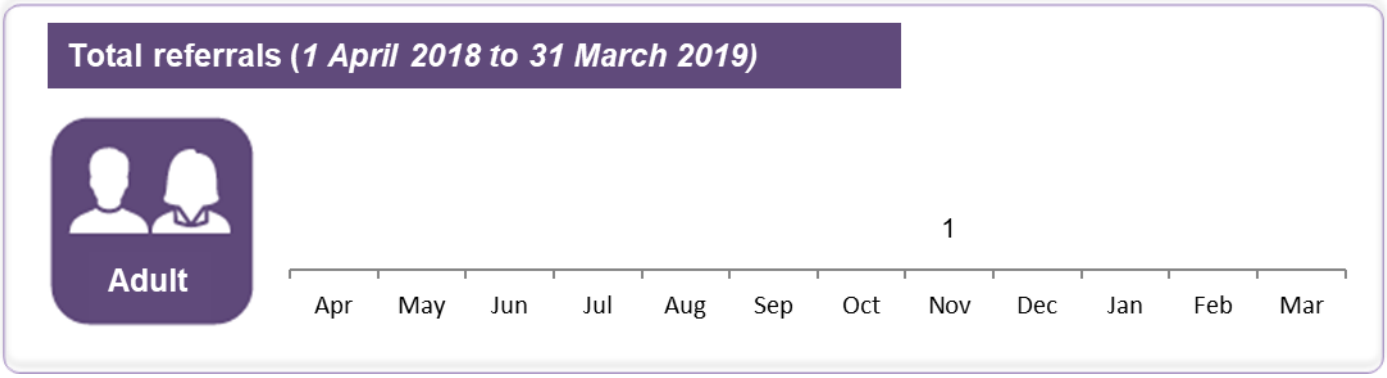
This core service made one safeguarding referral between 1 April 2018 and 31 March 2019, of which one concerned adults and zero concerned children. The number of safeguarding referrals reported during this inspection was not comparable to the last inspection.

Staff knew how to identify adults and children at risk of significant harm. This included working in collaboration with partner agencies. Staff we spoke with told us that staff from partner agencies took the lead on safeguarding as case managers for clients.

The trust employed two family practitioners who worked with clients whose children had been identified as at risk by social services due to substance misuse. The family practitioners worked closely with social workers and families.

	Number of referrals		
Core service	**Adults**	**Children**	**Total referrals**
MH – Substance misuse services	1	0	1

The number of adult safeguarding referrals in month ranged from zero to one (as shown below).



The trust has submitted details of zero serious case reviews commenced or published in the last 12 months (1 April 2018 to 31 March 2019) that relate to this service.

Staff access to essential information

The trust used electronic client records. Partner agencies used the same recording system as well as other electronic recording systems and paper recording. Being able to see a client's full treatment journey was dependant on all agencies involved in the client's care keeping the recording system and partner agencies up to date.

Medicines management

Staff had effective policies, procedures and training related to medication and medicines management including prescribing, detoxification and take-home medication, including naloxone.

We saw good medicines management across all teams including the transportation, storage, dispensing, administration and recording of medication in line with national guidance. Teams had access to pharmacy support from the trust pharmacy team who carried out regular checks and audits of medication.

Prescription administrators logged and tracked prescriptions and kept a detailed record of all voided prescriptions. Each STaRS location had a prescription champion working within the team.

Staff reviewed the effects of medication on clients' physical health regularly and in line with National Institute for Health and Care Excellence guidance, including completing annual physical health reviews.

Track record on safety

Between 1 March 2018 and 28 February 2019 there was one serious incident reported by this service. This incident type was 'apparent/actual/suspected self-inflicted harm meeting SI criteria.' There were no unexpected deaths in this core service.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with one reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

The number of serious incidents reported during this inspection was higher than the zero reported at the last inspection.

	Number of incidents reported	
Type of incident reported (SIRI)	Apparent/actual/suspected self-inflicted harm meeting SI criteria	**Total**
Essex STARs	1	**1**
Total	**1**	**1**

The trust policy was not to report the death of clients accessing substance misuse services as a serious incident.

Managers reported there had been 82 client deaths between May 2018 and May 2019.

Managers working within STaRS attended a bi-monthly mortality review group where 16 client's deaths had been discussed and reviewed.

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing future deaths.

In the last two years (since April 2017), there have been eight 'prevention of future death' reports sent to Essex Partnership University NHS Foundation Trust. None of these related to this service.

The service used an electronic reporting system for incidents, and staff were aware of what incidents should be reported internally. Incidents reported included aggression, assault, client deaths, self-harm and the fridge temperature going above the optimum range.

Staff discussed learning from incidents at local level and shared this across all STaRS locations. However, this was not shared with other core services within the trust.

An incident report would be created for a client death, but the incident would not be reviewed or investigated until the cause of death had been identified. One record we looked at showed a five-week delay between the client's death and it being reviewed. This meant there was a delay in learning from client deaths.

Staff gave examples of improvements in the service from learning, including increasing electrocardiogram monitoring for all clients and sending treatment information to GPs.

Managers and staff were aware of the duty of candour. Duty of candour is a legal duty to inform and apologise to clients if there have been mistakes in their care that have led to significant harm. Managers and staff told us they felt supported to be candid with clients.

Is the service effective?

Assessment of needs and planning of care

A partner agency completed initial client assessments which trust staff accessed using the shared electronic system. Following the assessment clients were seen by healthcare assistants for further discussion on drug use and to complete urine drug screening. Healthcare assistants completed basic health checks including blood pressure, temperature and oxygen levels.

Staff contacted the clients' GP for a patient summary and to arrange an appointment with the non-medical prescriber who would conduct a further urine drug screen and physical health check before commencing a prescribing regime.

Staff from partner agencies developed care plans with clients and saved them to the shared electronic record. Trust staff had a key performance indicator to contribute to clients care plans within three months of the care plan commencing. We looked at data between April and June 2019 which showed an average of 81% of care plans had been contributed to by STaRS staff.

A partner agency completed risk assessments and risk management plans with clients.

Best practice in treatment and care

The trust delivered clinical substance misuse treatment as part of a commissioned service in partnership with other organisations.

We reviewed 31 client records and found that staff prescribed medications in line with National Institute for Health and Care Excellence guidance.

Staff completed blood borne virus testing and vaccination and offered monthly clinics with a liver specialist nurse.

The service offered take home naloxone to all patients to reverse the effects of an opiate overdose. The service was in the process of training dispensing pharmacies to be able to dispense take-home naloxone.

The service offered additional physical health clinics for patients with complex needs, including a monthly clinic with the regional liver nurse and a monthly clinic for pregnant patients.

managers conducted local audits of their services, including safe and secure handling of medicines, clinic room cleaning, emergency equipment and a weekly medication audit.

This service participated in two clinical audits as part of their clinical audit programme 2018 – 2019.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Resuscitation Audit	STaRS (West), STaRS (Mid), STaRS (North East) and STaRS (South), Marginalised Vulnerable Adults,	MH - substance misuse	Clinical	In progress	Report reviewed at Resuscitation Group and awaiting Executive sign off before being disseminated to services.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
	Integrated Drug Treatment Service				
Essex STaRS independent non-medical prescriber governance, client reviews and general health checks	Essex STaRS (Mid), Essex STaRS (North East), Essex STaRS (West), Essex STaRS (South)	MH - substance misuse	Clinical	01/07/2018	12 weekly medication reviews to be completed for each OST client, performance to be monitored. NMP's to write to GPs after F2F reviews. Patient summaries to be requested. Physical health template to be developed and implemented

Skilled staff to deliver care

All staff we spoke with, including bank and agency staff had attended the trust induction.

Non-medical prescribers had individual folders to evidence qualifications, continuing professional development, competency frameworks and clinical and managerial supervision.

Staff had access to regular individual and group supervision.

We saw evidence in staff supervision files that poor staff performance was addressed promptly and effectively.

The trust's target rate for appraisal compliance is 90%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for non-medical staff within this service was 55%. This year so far, the overall appraisal rates was 85% (as at 28 February 2019). The wards with the lowest appraisal rate at 28 February 2019 were Essex Stars - East with an appraisal rate of 64%, Essex Stars - South with an appraisal rate of 71%% and Essex Stars - Hub at 94%.

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 55% reported at the last inspection.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 28 February 2019)	% appraisals (previous year 1 April 2017 to 31 March 2018)
Essex Stars - Mid	7	7	100%	43%
Drugs & Alcohol Essex	1	1	100%	0%
Essex Stars - West	4	4	100%	0%
Essex Stars - Hub	17	16	94%	44%
Essex Stars - South	7	5	71%	67%
Essex Stars - East	11	7	64%	100%

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 28 February 2019)	% appraisals (previous year 1 April 2017 to 31 March 2018)
Core service total	**47**	**40**	**85%**	**55%**
Trust wide	**3884**	**3172**	**82%**	**55%**

The trust did not provide data regarding appraisal compliance for permanent medical staff.

Appraisal compliance had improved following our last inspection. STaRS East had the lowest appraisal compliance rate at 64%. The trust provided updated training figures during the inspection which showed 100% of staff at STaRS East had received an appraisal.

The trust's target of clinical supervision for non-medical staff is 90% of the sessions required. Between 1 March 2018 and 28 February 2019, the average rate across all six teams in this service was 98%.

The rate of clinical supervision reported during this inspection was higher than the 44% reported at the last inspection.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, so it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Essex Stars - Mid	49	49	100%
Essex Stars - South	81	80	99%
Essex Stars - Hub	163	162	99%
Essex Stars - East	106	102	96%
Essex Stars - West	31	29	94%
Core service total	**430**	**422**	**98%**
Trust Total	**19802**	**19153**	**97%**

The trust did not provide data regarding clinical supervision compliance for permanent medical staff.

Multi-disciplinary and interagency team work

Staff attended morning meetings daily with their partner organisations to discuss any client risks, clients who had not attended appointments and any planned daily activities. However, no minutes were recorded for these meetings and staff were expected to update the client electronic records with the information discussed. It was not clear whose responsibility it was to update the client's electronic records with any risks discussed at the morning meeting.

Staff liaised with clients GPs to advise them about starting substitute prescribing or when there were any changes in prescribing.

Staff offered outreach clinics at local mother and baby units, children's centres and women's refuges. Staff facilitated joint appointments for pregnant clients with a midwife.

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

As of 31 March 2019, 100% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and community staff, depending upon their role.

The training compliance reported during this inspection was higher than the 60% reported at the last inspection.

Good practice in applying the Mental Capacity Act

As Mental Capacity Act Training is incorporated into Safeguarding Level 1 training, the data is unsuitable for analysis.

The trust told us that zero Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 April 2018 to 31 March 2019.

CQC received 274 direct notifications from the trust as a whole between 1 April 2018 to 31 March 2019[12]. However, the trust reported that 158 direct notifications were sent to CQC. Under HSCA legislation, all DoLS applications should also be sent to the CQC in the form of a direct notification so it is relevant that these numbers are different.

The number of DoLS applications made during this inspection was not comparable to the last inspection.

[12] CRM

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

There is no PLACE data for these community-based services.

We spoke with 15 clients who were using the STaRS prescribing service. Clients told us they had not experienced any cancelled appointments, they had regular access to a doctor when required and that staff were respectful, polite and they felt listened to.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients without fear of the consequences. Staff we spoke with were aware of the whistleblowing policy said they felt confident on using it if needed.

Staff directed clients to other services when appropriate and, if required, supported them to access those services. Clients told us they felt supported to access other services when needed.

Staff maintained the confidentiality of client's information by storing all records on a secure electronic recording system. prescription charts were kept in a locked cabinet.

Involvement in care

Involvement of patients

Partner agencies developed client care plans. The STaRS service had a key performance indicator to input into client care plans within three months of the care plan being developed. We looked at data form April 2019 to June 2019 which showed overall an average of 81% of care plans had been contributed to by STaRS staff.

Clients told us they were involved in setting their prescribing goals at their clinical assessment and during clinical reviews. Where clients disagreed with advice of staff, the non-medical prescribers gave advice on safe treatment, but clients made the decision about whether to reduce or maintain their prescription.

The service had introduced feedback forms for clients to complete during treatment. We looked at 74 feedback forms across three STaRS locations for July 2019. Overall, 71 said they found care received and friendliness of staff as very good or excellent and three reported care received ad friendliness of staff as good.

Involvement of families and carers

The service encouraged family and carer involvement in care by offering clients the opportunity to invite family or friends to attend appointments.

Family and carers could complete a 'friends and family test' questionnaire to feedback on the service received.

Is the service responsive?

Access and discharge

A partner agency completed all initial assessments and where appropriate referred to STaRS for prescribing. There was no waiting list to access prescribing services.

STaRS services held daily 'did not attend' clinics for clients who had missed their appointment to ensure that clients always had access to treatment.

The service offered some flexibility in times and locations of appointments. The service offered satellite clinics so that patients did not have to travel long distances to attend reviews. All services opened until 7pm on a Tuesday, meaning that clients did not have the opportunity to attend later evening appointments or later appointments on any other day during the week.

Staff informed the partner agency of any clients who did not attend an appointment in the following daily meeting for them to contact the client.

The service recorded that 6% of patients who used opiates successfully completed treatment between May 2018 and May 2019, which was below the top quartile range nationally of 8-11%. The service did not record representations to treatment and told us this would be recorded by a partner agency.

Facilities that promote comfort, dignity and privacy

The service had a range of rooms and equipment to support treatment and care including clinic rooms to conduct physical examinations. Each location had a separate designated bathroom for conducting urine drug screening tests that maintained the privacy and dignity of people who used services.

All service locations had comfortable and spacious waiting rooms. Clients could access hot and cold drinks and snacks whilst waiting for appointments.

Group rooms and interview rooms had privacy screens on doors to maintain confidentiality. Most rooms were sound proofed. However, we could overhear an appointment taking place in one of the interview rooms at Basildon STaRS.

Patients' engagement with the wider community

A partner agency worked with patients to address their employment, accommodation and social needs.

Meeting the needs of all people who use the service

All locations had facilities available for disabled people who used the service, although not all rooms were accessible to people with reduced mobility or wheelchair users due to locations being based over different floors with no lift available. The service offered satellite clinics or home visits for disabled people or those not able to travel to the main hub sites.

Leaflets were available at all services on information about treatment, local services, substance misuse information and patients' rights.

Listening to and learning from concerns and complaints

This service received two complaints between 1 April 2018 to 31 March 2019. None of these were upheld, one was partially upheld, and one was not upheld. None were referred to the Ombudsman.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Essex STaRS (West)	1		1					
Essex STaRS (South)	1			1				

Both complaints had been investigated fully and learning disseminated to staff through team meetings.

Staff were able to tell us about changes made through learning from complaints, including increasing family and carer engagement.

All clients we spoke with knew how to make a complaint.

This service received three compliments during the last 12 months from 1 April 2018 to 31 March 2019 which accounted for 0.2% of all compliments received by the trust as a whole (1252)

Is the service well led?

Leadership

Local leaders were visible within the service and regularly visited each team, including attending team meetings. Staff told us that above local leader level they had not been visited by the senior management team.

During inspection we spoke with two hub managers. Managers had a clear oversight of team performance, client risks and staff safety and a clear understanding of the service they managed.

The service did not have a clear definition of recovery. Staff we spoke with were unable to tell us how they were working towards client's recovery set out in the Drug misuse and dependence: UK guidelines on clinical management. Staff told us that recovery support for clients was offered by partner agencies.

Vision and strategy

Staff were aware of the trust values, which were being open, compassionate and empowering and told us how they could demonstrate these values when working with clients. STaRS did not have any visions or values specific to substance misuse services.

Culture

Staff felt respected, supported and valued by local managers and hub managers. Staff felt disconnected from the trust senior management team. Staff felt positive and said they had low levels of stress.

Staff felt positive and proud about working for their team. Staff gave examples about how the trust provided opportunities for career progression, including training non-medical prescribers and offering management courses.

Staff told us they could raise concerns without fear to their managers and knew how to use the whistleblowing process if needed.

Governance

Managers had addressed the low levels of mandatory training, supervision and appraisal rates across the service from our previous inspection. Managers kept local databases for their own assurance.

There was a clear framework of what must be discussed at a team meetings to ensure that essential information, such as learning from incidents was shared across partner agencies and STaRS services.

Managers told us there had been 82 client deaths between May 2018 and May 2019. The trust policy was not to report the death of clients accessing substance misuse services as a serious incident. Overall, 16 deaths had been reviewed at the bi-monthly mortality meeting meaning that no lessons had been learnt or disseminated for 66 of the client deaths.

Staff undertook local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. Following our last inspection, a hub manager was tasked with completing audits across the STaRS services to identify issues and make improvements to governance systems.

Managers shared lessons learned from incidents across all sites. Teams discussed any local incidents and outcomes from their site, this was shared with the other teams through the service manager.

Management of risk, issues and performance

Staff were not aware of any items on the risk register relating to their service, hub managers had no oversight of the risk register and told us this was managed by the services manager.

The service had a ‘major incident response plan’ in place in case of emergency and a ‘business continuity plan’ for any incidents that might impact on service delivery.

Information management

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, usually worked well.

Partner agencies used the same electronic recording system as the trust as well as other electronic recording systems and paper records. This meant it could be difficult to see a clear timeline of a person’s treatment.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the trust and the services they used through the trust intranet and bulletins.

Clients could feedback on the service they received using a feedback form given to them throughout treatment. We looked at 74 feedback forms across three STaRS locations for July 2019. Overall, 71 said they found care received and friendliness of staff as very good or excellent and three reported care received ad friendliness of staff as good.

Patients and carers had opportunities to give feedback on the service they received via a ‘Friends and Family test’.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust did not report any accreditations specific to this service.

The trust had a staff award and recognition scheme.