North Essex Partnership University NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Chelmer and Stort mental health wards	RRDX1
Acute wards for adults of working age and psychiatric intensive care units	Shannon House	RRD18
Acute wards for adults of working age and psychiatric intensive care units	The Linden Centre mental health wards	RRDY3
Acute wards for adults of working age and psychiatric intensive care units	The Christopher unit	RRDY6
Acute wards for adults of working age and psychiatric intensive care units	The Lakes mental health wards	RRDX1
Acute wards for adults of working age and psychiatric intensive care units	Peter Bruff mental health ward	RRDY8
Community-based mental health services for adults of working age.	The Gables	RRDW11

Summary of findings

Community-based mental health services for adults of working age.	Reunion House	RRDX11
Community-based mental health services for adults of working age.	Herrick House	RRDX10
Community-based mental health services for adults of working age.	Rectory Lane	RRDW13
Community-based mental health services for adults of working age.	Aylmer House	RRDW6
Community-based mental health services for adults of working age.	Latton Bush	RRDW4
Community-based mental health services for adults of working age.	C&E Centre	RRDW5
Mental health crisis services and health-based places of safety.	The Lakes	RRDX1
Mental health crisis services and health-based places of safety.	The Derwent Centre	RRDX6
Mental health crisis services and health-based places of safety.	The Linden Centre	RRDY3
Mental health crisis services and health-based places of safety.	St Aubyn Centre	RRDY1
Mental health crisis services and health-based places of safety.	Shannon House	RRD18
Specialist community mental health services for children and young people	Trust Headquarters	RRD
Specialist community mental health services for children and young people	Holmer Court	RRDC2
Specialist community mental health services for children and young people	St Aubyn Centre	RRDY1
Child and adolescent mental health wards.	St Aubyn Centre	RRDY1
Community-based mental health services for older people	Landmere Centre	RRDB7
Community-based mental health services for older people	The Crystal Centre	RRD16

Summary of findings

Community-based mental health services for older people	Trust Headquarters	RRD
Wards for older people with mental health problems	Landmere Centre	RRDB7
Wards for older people with mental health problems	St Margaret's Hospital	RRD15
Wards for older people with mental health problems	The Crystal Centre	RRD16
Wards for older people with mental health problems	The Kingswood Centre	RRDY7
Forensic In Patient/Secure	Edward House	RRDAC
Long stay rehabilitation wards	439 Ipswich Road	RRDA1

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

Summary of findings

Ratings

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

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

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

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

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

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Overall summary

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

We rated North Essex Partnership University NHS Foundation Trust as requires improvement overall because:

- On the acute admission wards there were 25 incidents relating to the use of a ligature attached to a fixed object. One patient attempted to strangle themselves with a ligature during our inspection. This was in spite of serious concerns identified to the trust by the Care Quality Commission as part of our ongoing regulatory inspections. Two deaths due to self-ligature had happened over the past 12 months .There were a number of similar deaths in the previous years. The trust had made ligature risk assessments and had plans to address these but there were still an unacceptable number of ligature risks identified during the inspection.

- Finchingfield, Gosfield and Peter Bruff wards, Christopher unit and Shannon House failed to provide segregated accommodation for men and women when the Department of Health said this should no longer happen.

- Some care records and risk assessments did not contain enough detail.They were not personalised or kept up to date. This meant that staff did not know the full or current risks of the patients that they were caring for.

- Restrictive practices were seen on the wards. Patients could not always go to the toilet freely, get into the garden area, or have food and drink when they wanted while they were being nursed by the trust.

- The trust had very high bed occupancy rates. Patients were regularly admitted to beds reserved for patients on leave or patients were sent to hospitals out of the area. This meant that patients could be nursed a long way from home. Patients returning from a period of leave may not have a bed to return to if they needed one.

- The trust's leadership style did not promote sufficient grip or pace to bring about changes where necessary in a manner that showed stakeholders or internal staff that there was any urgency about improvements. Changes took a long time to implement and consultations on improvements were not given the urgency necessary to give confidence that matters would be resolved. Ligature free doors had not been installed or even commissioned despite these having been agreed some time ago.

- The trust did not have robust governance processes, particularly in the assessment and management of clinical risks, assessment of the quality of care plans, and the management of environmental risks. For example, although the trust had a comprehensive risk management framework that informed management decisions in the identification, assessment, treatment and monitoring of risk, we found little record of the trust acting on these findings. While throughout 2014/15 regular reports were provided to the risk and governance executive, the quality and governance committee and the board of directors, there was little record of action taken to reduce risks to patients.

- The Care Quality Commission and Mental Health Act reviewers have inspected the trust several times over the last five years. Each time they identified areas where the trust must act. For example, around safety on both the Linden centre and the Lakes locations. Each time the trust made assurances that they would make changes. Senior managers and board directors could not explain why the trust had not addressed the problems.

However:

- The trust spent two years planning and consulting for the community transformation programme. They

Summary of findings

started running this fully in April 2015. Patients confirmed that these changes had led to improved community mental health care and treatment delivery by the trust.

- We found some good examples of positive multidisciplinary work and individual staff support for patients.
- Front line staff consistently demonstrated good morale.
- There was highly visible, approachable and supportive local leadership within some of the services we visited. For example, in the child and adolescent mental health service and community mental health services for adults.

Following this inspection, we identified that the trust was not meeting Regulations 9,10,12 and 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We carried out enforcement action with the trust and told them to ensure compliance by 30 November 2015. The trust sent us their action plan to meet the regulation and we will check further on this.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Inadequate

We rated North Essex Partnership University NHS Foundation Trust as inadequate for safe because:

- On the acute admission wards there were 25 incidents relating to the use of a ligature attached to a fixed object. One patient attempted to strangle themselves with a ligature during our inspection. This was in spite of serious concerns identified to the trust by the Care Quality Commission as part of our ongoing regulatory inspections.
- Two deaths due to self-ligature had happened over the past 12 months .There were a number of similar deaths in the previous years. The trust made ligature risk assessments and had plans to address these but there were still an unacceptable number of ligature risks identified during the inspection.
- The trust did not have robust systems to share lessons learnt from incidents and teams did not integrate these into their practice. We found that nothing had been done to identify best practice elsewhere to support local action.
- Some care records and risk assessments did not contain enough detail.They were not personalised or kept up to date. This meant that staff did not know the full or current risks presented by the patients that they were caring for.
- Finchingfield, Gosfield and Peter Bruff wards, Christopher unit and Shannon House failed to provide segregated accommodation for men and women when the Department of Health said this should no longer happen.
- Some seclusion rooms were not fit for purpose and breached guidance. For example, this facility on Ardleigh ward did not have an ensuite facility.On Peter Bruff ward, the seclusion room contained ligature points, including toilet rails and taps on the sink.
- On the acute admission wards there were 114 incidents of restraint in the six months before the inspection. Of these, in 36 incidents (representing 32% of incidents) patients were restrained in the prone position. Prone position restraint is when a patient held in a face down position on a surface and is physically prevented from moving out of this position. The latest Department of Health guidance stated that if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible.

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The trust informed us that they were taking steps to reduce the use of prone restraints in line with best practice guidelines issued by the Department of Health to reduce the use of outdated restrictive practices and published as 'positive and proactive care' (April 2014). For example through the 'lessons learnt' trust patient safety committee. Each incident of restraint was also recorded using the trust's incident reporting system and reviewed through the trust's incident management system.

- We found restrictive practices on some wards. For example, on Larkwood ward, where stuffed toys and personal blankets were banned due to being identified as a fire risk following a fire risk assessment by the local fire service. On Finchingfield ward, a number of patients told us about some restrictive practices that were impacting upon the quality of their care. Patients told us that they had limited access to the kitchen and had set hot drinks times which did not allow hot drinks outside of these set times. Patients also told us that they had limited access, and had to ask, to access the toilet. They were particularly concerned that they had to wait sometime to access these.
- A total of 4249 shifts were filled by bank or agency staff to cover sickness, absence or other vacancies within the acute admission wards over the past twelve months. We noted that 239 shifts had not been filled by bank or agency staff where there was sickness, absence or vacancies. This meant that there was an over-reliance on the use of bank and agency staff and, on occasion, wards operated short of staff, or the ward manager would undertake the shift. This had an adverse effect on care continuity and the consistency of nursing approach.
- The trust reported 1,565 substantive staff in post on 30th April 2015 with 268 leavers in the past 12 months. The trust reported staff turnover as 14%. This was above the national average for similar sized mental health trusts. This meant that the quality and consistency of care could have been adversely affected as a result.
- Staff took patients' preferences into account when administering medicines, but did not always note the arrangements in the patient's care plan so may not have followed them consistently.

However:

- Staff could describe the system to report incidents and their role in the reporting process. Each core service had access to an electronic system to report and record incidents and near misses.

Summary of findings

- Most ward areas were clean and tidy. Patients and staff said the trust had good cleaning services.
- Managers could adjust staffing levels daily to take into account increased clinical needs. This included increased level of observation or patient escort. Some requested hours were due to staff sickness and vacancies.
- The pharmacy team provided a clinical service to ensure people were safe from harm from medicines. Nursing staff had good links with the pharmacy team who made ward visits and could provide advice, including out of hours.

Are services effective?

Requires improvement

We rated North Essex Partnership University NHS Foundation trust as requires improvement for effective because:

- The trust's national audit of schizophrenia found that the monitoring and interventions for risk factors such as, diabetes and heart disease were poor. Patients who did not respond to standard antipsychotic medications had to wait too long to start clozapine. The availability of family therapies or cognitive behavioural therapy had large gaps. There was not enough information or support for carers. The trust had only monitored 40% of patients for current alcohol consumption. This meant that some patients with schizophrenia were not receiving care in accordance with best practice guidelines.
- The majority of care plans were not personalised and did not include patients' views. They did not cover the full range of patients' problems and needs. For example, on Chelmer and Ardleigh wards, care plans were not recovery orientated. They did not include the patients' strengths and goals. Most patients did not get a copy of their care plan. This meant that staff did not receive clear guidance as to how to care for individual patients.
- Between November 2014 and May 2015 there were 215 re-admissions within 90 days on 20 wards. The highest number of re-admissions was on Peter Bruff (29), Finchingfield, Gosfield (28) and Galleywood (28). Whilst this was in line with similar sized mental health trusts, it meant that there was an increased pressure on the trusts acute in patient services and increased distress for patients and their families linked to becoming seriously ill shortly after discharge.

Summary of findings

- Staff did not always complete the prescribing charts properly. Missing information, such as how long patients took antibiotics for, or the reason for prescribing a medicine, meant we were unsure if patients received medicines consistently or as the prescriber intended.
- Seven patients from this trust were in 'out of area' beds between June and July 2015, and nine were out of area during the inspection. This meant that patients were being cared for away from their home area and families and friends may have some distance to travel to visit them. Data from the health and social care information centre (HSCIC) showed that nationally 14,300 patients were receiving non-specialist inpatient care at the end of Mat 2015. Of these, 2,107 patients, or 15%, were in 'out of area' beds - defined by the HSCIC as a bed at a hospital that is not the patient's 'usual provider'.
- From May 2014 to June 2015 the trust failed to meet their own target of 90% of staff who had completed all their mandatory training with only 84% of staff meeting this target. This meant that not all staff had received the required level of refresher training.
- Mental Health Act reviewer visits carried out by the Care Quality Commission over the past 12 months highlighted nine issues regarding patients not being advised or aware of their legal rights and five concerns regarding lack of patient involvement in their care plan.

However:

- In-patients had a physical healthcare check completed by medical staff on admission and their physical healthcare needs were being met by front line staff. Most patients had a care plan that showed staff how to meet these physical healthcare needs.
- Between November 2014 and May 2015 there were 84 delayed discharges across the trust in five locations. Two wards, Stort Ward (34) and Kitwood Ward (31) accounted for the majority of these. Staff reported that most of these were due to the difficulty in finding appropriate community care and placements for some patients. This was in line with other similar sized mental health trusts.
- Throughout the trust, multidisciplinary meetings helped staff share information about patients and review their progress.

Summary of findings

- The trust spent two years planning and consulting for the community transformation programme. They started running this fully in April 2015. Patients confirmed that these changes had led to improved community care and treatment delivery by the trust.

Are services caring?

Good

We rated North Essex Partnership University NHS Foundation Trust as good for caring because:

- We observed many examples of staff treating patients with care, compassion and communicating effectively. We saw that staff engaged with patients in a kind and respectful manner throughout the trust.
- Patients felt comfortable approaching the ward offices and positive interactions between front line staff and patients were observed. We saw staff knock before entering patients' rooms and that they spoke positively with patients.
- Most staff understood the personal, cultural and religious needs of patients and we saw examples of actions to meet these needs. On the older people mental health wards, staff had completed 'This is me 'profiles to help them understand each patient's risks, likes, and dislikes.
- Patients told us they could keep in contact with their family where appropriate. The trust had dedicated visiting hours and areas. They also had special arrangements for child visitors.

However:

- The trust's overall score during their patient led assessment of the care environment assessments for dignity, privacy and respect was 77%. This was below the England average of 87%.
- There had been 14 comments on Share Your Experience between March 2014 and March 2015. All of these were negative. For example, relating to staff attitude and poor communication.
- Three patients on the acute admission wards reported that their dignity and privacy was compromised at times whilst receiving care. Seven patients on the acute admission wards told us that they were not involved in devising their care plan or had not received a copy of their care plan. There was limited evidence of patients' involvement in the care planning process throughout the trust. This was supported by those trust care and treatment records reviewed and our meetings with individual patients.

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Are services responsive to people's needs?

Requires improvement

We rated North Essex Partnership University NHS Foundation Trust as requires improvement for responsive because:

- Trust wide bed occupancy was 99%. Gosfield (126%), Ardleigh (122%), Chelmer, Derwent (117%) wards had experienced the highest bed occupancy in the six months up to 30th April 2015. Peter Bruff ward had 129% bed occupancy during the inspection. The latest guidance from the Department of Health is that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the running of the service.
- Staff told us they often had problems finding beds for patients who needed admission. They frequently had to admit other patients into the beds of patients who were on short term leave. When we reviewed the information the trust had sent us, the average bed occupancy on 31 August 2015, was 117%, which confirmed they used leave beds for new admissions. This meant that patients who returned from leave and required a bed may not have one.
- Care delivery within some wards was not individualised. For example, patients told us they could not lock their rooms. This was because much of the accommodation in the acute wards was dormitory style, with up to four patients sleeping in one dormitory. There were curtains between the beds but these did not give enough privacy. There were some single rooms. Patients did have lockable storage space but they did not have the keys so had to ask a member of staff for these. This was not based on assessed risk.
- Complaints to the trust had increased by 35% from 2012/13 to 2014/15. The trust informed us that 28% of the total had been upheld in 2013/2014. The top three themes for complaints during 2014/15 were 'clinical treatment', 'staff attitude', and 'access to services'. The trust told us that 159 moderate complaints were made between March 2014 and March 2015. This was in line with similar sized mental health trusts. However, there was no evidence of trust wide learning from complaints being shared with front line staff.

However:

- Information on treatments, local services, patients' rights, advocacy and how to complain were available in all reception areas and wards. These were available in different languages. The trust provided interpreters and signers when required.

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- There was a trust wide chaplaincy service to support patients with a diverse range of spiritual and religious needs. Ruby and Topaz ward had a multi-faith room in the entrance area of the ward with religious texts.
- The trust received 349 written compliments during 2014/15.An increase of 83 compliments from 2013/2014. We saw evidence of thank you cards and letters throughout the trust.
- Front line staff were able to access the trust's complaints system. Information about the complaints process was available on notice boards throughout the trust. Patients knew how to make complaints.

Are services well-led?

Requires improvement

We rated North Essex Partnership NHS Foundation Trust as requires improvement for well led because:

- The trust did not have robust governance processes, particularly in the assessment and management of ligature risks, assessment of the quality of care plans, and the management of local risks. For example, although the trust had a comprehensive risk management framework that informed management decisions in the identification, assessment, treatment and monitoring of risk. We found little record of the trust acting on these findings. While throughout 2014/15 regular reports were provided to the risk and governance executive, the quality and governance committee and the board of directors, there was little record of action taken to reduce risks to patients. For example, during the inspection, we identified concerns with unmanaged ligature risks, the use of prone restraints and breaches of Department of Health guidance around gender separation.
- The Care Quality Commission and Mental Health Act reviewers have inspected the trust several times over the last five years. Each time they identified areas where the trust must act. For example, around the safety and welfare of patients on both the Linden centre and the Lakes locations. Each time the trust made assurances that they would make changes. The trust did not address the concerns fully even though patients had died by self-ligature while on the wards. One patient attempted to strangle themselves with a ligature during our inspection. Senior managers and board directors could not explain why the trust had not addressed these concerns fully.
- The trust's risk register assurance framework dated March 2015 and their strategic risk assurance action plans dated April 2015

had 11 out of 18 risks which were rated as 'serious' or 'major' (scoring 12 or above). For example, it highlighted a high risk that the Trust failed to specify, deliver and obtain benefits from major change programmes effectively. It was not clear what definite actions the trust were taking to address these identified risks.

- We found the leadership of the trust to be lacking in strength to give assurance that failings would be acted upon with necessary urgency. Outstanding actions were not prioritised or given sufficient importance which meant that the trust remained non-compliant for up to 5 years on major failings of safety. Several board members and senior managers were unclear about the trust vision and strategy.
- The leadership style did not promote sufficient grip or pace to bring about changes where necessary in a manner that showed stakeholders or internal staff that there was any urgency about improvements. Changes took a long time to implement and consultations on improvements were not given the urgency necessary to give confidence that matters would be resolved. Ligature free doors had not been installed or even commissioned despite these having been agreed some time ago.
- According to the NHS Staff Survey 2014 the trust performed worse than the national average. It also showed they were in the bottom 20% of all mental health trusts in three areas. First, the percentage of staff working extra hours in the last 12 months. Second, the fairness of incident reporting systems, witnessing and reporting errors at work and finally receiving abuse from relatives or the public in the last 12 months. This also showed that the trust performed worse than the national average for questions relating to staff recommending the trust as a place to work or receive treatment.

However:

- The NHS Staff Survey 2014 showed that the trust compared favourably to the national average and was in the top 20% of all mental health trusts for the percentage of staff receiving job-relevant training, learning or development in last 12 months; and in the percentage of staff able to contribute to work improvement and staff motivation at work. The trust performed similar to the national average regarding staff agreeing that feedback from patients was used to make informed decisions.
- A number of locally led service improvements had been made. For example, the trust's crisis team had taken proactive steps to engage with people who found it difficult or were reluctant to

engage with mental health services. For example, by arranging flexible appointments and proactive support mechanisms. People told us that appointments ran on time and that they were kept informed if there were any changes.

Summary of findings

Our inspection team

Chair: Professor Moira Livingston

Team Leader: Julie Meikle, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Peter Johnson, Inspection Manager, mental health hospitals, CQC

The team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers and support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who used the type of services we were inspecting.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and consistent with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about North Essex Partnership University NHS Foundation Trust and asked other organisations to share what they knew.

We carried out an announced visit to the trust between 24 and 28 August 2015, and an unannounced inspection to the Chelmer and Stort, and Shannon House locations on 9 September 2015.

Prior to and during the visit the team:

- held service user focus groups and met with local user forums
- held 33 staff focus groups in three locations attended by 143 staff
- met with 195 patients and 32 carers and family members
- attended 14 community treatment appointments
- inspected the care and treatment records of 220 patients
- reviewed the Mental Health Act legal documentation including the records of people subject to community treatment orders
- observed how staff were caring for people
- interviewed 319 frontline staff including senior and middle managers
- interviewed 18 senior trust leaders including the trust chair, chief executive officer and medical director
- met with the MHA hospital managers
- reviewed information we had asked the trust to provide
- attended multi-disciplinary team meetings

Summary of findings

- collected feedback from patients using comment cards. We received 39 completed comment cards. 20% were positive 50% were negative and 30% were mixed.

Information about the provider

North Essex Partnership University NHS Foundation Trust employed over 2,000 staff working across 113 teams from 78 sites serving a population of over one million. The Trust provided mental health services to people living in over 1,000 square miles of North Essex, as well as some specialist services to Suffolk, East Hertfordshire and South Essex.

The main clinical commissioning groups for the trusts were Mid, North East, West Essex and East of England specialist commissioning group.

The broad range of services and individual care provided can be categorised around six groups of people – children and adolescents, young adults, acute adults, older adults, adults who misuse substances and adult rehabilitation. The trust had 334 in-patient beds.

The Trust became a Foundation Trust on 1st October 2007and had a total of 23 locations registered with CQC.

The trust had been inspected 22 times across 14 locations since registration in April 2010. Six locations were non-compliant following their most recent inspection:

- the Linden Centre Mental Health Wards (20/02/2015): Non-compliant against outcomes 9 (person-centred care) and 12 (safe care and treatment)
- Kitwood and Roding Mental Health Wards (20/11/2013): Non-compliant against outcome 2 (Consent to care and treatment)
- 439 Ipswich Road 13 (08/01/2014): Non-compliant against outcomes 2 (Consent to care and treatment) 4 (Care and welfare of people who use services), 14 (Supporting workers) and 21 (Records)
- Edward House (10/02/2014): Non-compliant against outcome 2 (Consent to care and treatment)
- Tower Mental Health Ward (11/06/2013): Non-compliant against outcome 2 (Consent to care and treatment)
- The King's Wood Centre (13/01/2014): Non-compliant against outcomes 2 (Consent to care and treatment) and 4 (Care and welfare of people who use services).

  During this inspection we reviewed all of these breaches and the trust's action plans to address these.

  The trust had received 17 Mental Health Act (MHA) review visits between June 2014 and July 2015. The main issues highlighted were regarding capacity and consent not being considered, patients not being advised or made aware of their legal rights, lack of patient involvement in care plans and lack of occupational therapy or other specialised day activities.

  Peter Bruff Mental Health Ward where 12 issues were found during two visits had the highest number of concerns identified by MHA reviewers.

What people who use the provider's services say

The majority of patients we spoke with were mostly positive about the staff, and their experience of care on the wards. Patients and their families or carers had the opportunity to be involved in discussions about their care.

Many felt their mental health had improved as a result of the service they received from the trust.

Summary of findings

People receiving care from community services told us that their appointments generally ran on time and they were informed if there were any unavoidable changes. Some told us they saw different members of staff which meant they had to repeat information.

People knew how to raise concerns and make a complaint. They felt they could raise a concern if they had one and believed that staff would listen to them.

However, three patients on the acute admission wards reported that their dignity and privacy was compromised at times whilst receiving care. Seven patients on the acute admission wards told us that they were not involved in devising their care plan or had not received a copy of their care plan. There was limited evidence of patients' involvement in the care planning process throughout the trust.

Good practice

- The community child and adolescent mental health crisis team designed an educational programme, which they delivered to schools in areas of highest need. The aim was to promote good mental health and self-esteem, and to reduce the incidents of self-harm and attempted suicides.
- Staff in the child and adolescent mental health wards supported young people to challenge blanket restrictions and the stigma associated with mental health. For example, managers and staff supported young people in writing a letter to challenge a recent ban on cuddly toys and personal blankets.
- Ten staff from across community teams were training to participate with patients in a multi-site, national research project implementing the 'open dialogue approach', led by University College London.
- The community teams used a family group conferencing as a good practice model for working with whole families. The approach used a facilitated group conferencing process to bring together all significant people in a person's life to contribute to devising a support plan.
- Through the trust's links with the University of Essex and Anglia Ruskin University, staff had been able to access a range of specialised training. Staff spoke highly of this resource.
- Some unqualified trust staff were being supported by the trust to take specialist training required for the post of associate practitioner. They were then supported to undertake their nursing qualification.
- The trust's innovative partnership with the Samaritans provided telephone support for people in emotional distress or experiencing feelings of suicide. Trust-provided information showed that the Samaritans had successfully contacted 74% of the service users referred to them.
- The introduction of street triage provided in partnership with an adjoining trust improved access to mental health assessments for people who had come to the attention of the police and who may have had mental health needs. Four vehicles were staffed by police officers and mental health professionals. The trust provided information that showed that 33 detentions under S136 were prevented in the period April to June 2015.

Areas for improvement

Action the provider MUST take to improve

- The trust must have effective systems in place for the safe prescribing and administration of medication.
- The trust must ensure that medical equipment is working effectively and stored.
- The trust must ensure that action is taken to remove identified ligature risks and to mitigate where there are poor lines of sight.
- The trust must ensure that it complies with Department of Health guidance in relation to mixed sex accommodation.

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- The trust must proactively address any practices that could be considered restrictive, for example, the use of the Hub, access to toilets, access to the gardens, and access to snacks and beverages.
- The trust must ensure there are sufficient experienced staff on duty at all times to provide skilled care to meet patients' needs.
- The trust must carry out assessments of each patient's mental capacity where concerns have been identified and record these in the care records.
- The trust must improve their governance and assurance systems relating to the assessment and management of ligature risks, the quality of care plans and the assessment of the quality of the ward activities programme provided.
  - The trust must address the identified safety concerns in the health-based places of safety.
  - The trust must address the security of the doors within the Edward House.

Action the provider SHOULD take to improve

- The trust should ensure that systems are in place for the effective recruitment and retention of staff.
- The trust should ensure that care and treatment records, including risk assessments, are sufficiently detailed, personalised and kept up to date.
- The trust should review the efficacy of the electronic record system in community bases and ensure accurate inputting of data.
- The trust should ensure all Mental Health Act documentation is readily available and in good order.
- The trust should ensure that all informal complaints are logged and reported centrally.
- The trust should ensure all staff receive training in the Mental Capacity Act 2005.
- The trust should formally review each restraint involving the prone position.
- The trust should ensure that patients who are detained under the Mental Health Act 1983 have information on how to contact the CQC.
  - The trust should ensure that policies, procedure and practice on the use of S136 adhere to the MHA Code of Practice.
  - The trust should review its staffing arrangements for the health based place of safety to ensure sufficient staff are available promptly without impacting on other services.
- The trust should identify a lead for the health based place of safety in the St Aubyn Centre and the Christopher Unit adjacent to the Linden Centre.
  - The trust should ensure learning from some serious incidents is shared across the three access, assessment and brief intervention teams.
  - The trust should agree target times for assessment for all access and brief intervention teams.
  - The trust should ensure that all staff receive supervision, appraisals and training. This should be fully recorded.

North Essex Partnership University NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

The trust had received 17 Mental Health Act (MHA) review visits between June 2014 and July 2015. The main issues highlighted were regarding capacity and consent not being considered, patients not being advised or made aware of their legal rights, lack of patient involvement in care plans and lack of occupational therapy or other specialised day activities.

The trust had processes in place to ensure compliance with the MHA and adherence to the guiding principles of the MHA Code of Practice were found to be generally good during this inspection. However, we found examples where a patient appeared not to have been provided with a copy of their section 17 leave authority. Section 17 leave forms were unclear about the type of leave that was being authorised, and the designation and numbers of the escorts were not always specified.

Most patients had received their rights (under section 132 of the MHA) and these were repeated at regular intervals. MHA paperwork had been completed correctly, was up to date and held appropriately. The MHA record keeping and trust scrutiny was satisfactory.

Posters were displayed throughout the trust informing patients of how to contact the independent mental health advocate.

Most staff had received training in the MHA via e-learning. Front line staff had a good working knowledge of the MHA.

The relevant legal documentation was completed appropriately for those people detained under S136 in the health-based place of safety. However, the trust's new policy on their Section136 service did not reflect the requirements of the MHA Code of Practice in monitoring that the Act was being applied correctly in relation to this service.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust included training on the Mental Capacity Act (MCA) with their safeguarding training.

Front line staff had varying degrees of knowledge about the MCA and Deprivation of Liberty Safeguards (DOLS).

Care and treatment records showed that patients' mental capacity to consent to their care and treatment was not always assessed on their admission or on an ongoing basis.

Detailed findings

Inadequate

Are services safe?

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

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

Summary of findings

We rated North Essex Partnership University NHS Foundation Trust as inadequate for safe because:

- On the acute admission wards there were 25 incidents relating to the use of a ligature attached to a fixed object. One patient attempted to strangle themselves with a ligature during our inspection. This was in spite of serious concerns identified to the trust by the Care Quality Commission as part of our ongoing regulatory inspections.
- Two deaths due to self-ligature had happened over the past 12 months. There were a number of similar deaths in the previous years. The trust made ligature risk assessments and had plans to address these but there was still an unacceptable number of ligature risks identified during the inspection.
- The trust did not have robust systems to share lessons learnt from incidents and teams did not integrate these into their practice. We found that nothing had been done to identify best practice elsewhere to support local action.
- Some care records and risk assessments did not contain enough detail.They were not personalised or kept up to date. This meant that staff did not know the full or current risks presented by the patients that they were caring for.
- Gosfield and Peter Bruff wards, Christopher unit and Shannon House failed to provide segregated accommodation for men and women when the Department of Health said this should no longer happen.
- Some seclusion rooms were not fit for purpose and breached guidance. For example, this facility on Ardleigh ward did not have an ensuite facility.On Peter Bruff ward, the seclusion room contained ligature points, including toilet rails and taps on the sink.
- On the acute admission wards there were 114 incidents of restraint in the six months before the inspection. Of these, in 36 incidents (representing 32% of incidents) patients were restrained in the prone position. Prone position restraint is when a patient held in a face down position on a surface and is physically prevented from moving out of this position. The latest Department of Health guidance stated that if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible. The trust informed us that they were taking steps to reduce the use of prone restraints in line with best practice guidelines issued by the Department of Health to reduce the use of outdated restrictive practices and published as 'positive and proactive care' (April 2014). For example through the 'lessons learnt' trust patient safety committee. Each incident of restraint was also recorded using the trust's incident reporting system and reviewed through the trust's incident management system.

Detailed findings

- However, we found restrictive practices on some wards. For example, on Larkwood ward, where stuffed toys and personal blankets were banned due to being identified as a fire risk following a fire risk assessment by the local fire service. On Finchingfield ward, a number of patients told us about some restrictive practices that were impacting upon the quality of their care. Patients told us that they had limited access to the kitchen and had set hot drinks times which did not allow hot drinks outside of these set times. Patients also told us that they had limited access, and had to ask, to access the toilet. They were particularly concerned that they had to wait sometime to access these.
- A total of 4249 shifts were filled by bank or agency staff to cover sickness, absence or other vacancies within the acute admission wards over the past twelve months. We noted that 239 shifts had not been filled by bank or agency staff where there was sickness, absence or vacancies. This meant that there was an over-reliance on the use of bank and agency staff and, on occasion, wards operated short of staff, or the ward manager would undertake the shift. This had an adverse effect on care continuity and the consistency of nursing approach.
- The trust reported 1,565 substantive staff in post on 30th April 2015 with 268 leavers in the past 12 months. The trust reported staff turnover as 14%. This was above the national average for similar sized mental health trusts. This meant that the quality and consistency of care could have been adversely affected as a result.
- Staff took patients' preferences into account when administering medicines, but did not always note the arrangements in the patient's care plan so may not have followed them consistently.

However:

- Staff could describe the system to report incidents and their role in the reporting process. Each core service had access to an electronic system to report and record incidents and near misses.
- Most ward areas were clean and tidy. Patients and staff said the trust had good cleaning services.
- Managers could adjust staffing levels daily to take into account increased clinical needs. This included increased level of observation or patient escort. Some requested hours were due to staff sickness and vacancies.
- The pharmacy team provided a clinical service to ensure people were safe from harm from medicines. Nursing staff had good links with the pharmacy team who made ward visits and could provide advice, including out of hours.

Our findings

Track record on safety

- On the acute admission wards there were 25 incidents relating to the use of a ligature attached to a fixed object. This was despite serious concerns identified to the trust by the Care Quality Commission as part of our ongoing regulatory inspections. Whilst the trust had undertaken ligature risk assessments, and had plans to address these, an unacceptable number of ligature risks remained.
- Two people had absconded from the Colchester health based place of safety service in the period from 1 September 2013 to 31 August 2015 by jumping over the fence.
- The trust reported that there had been seven serious incidents in the period from 1 April 2014 and 31 March 2015 relating to the access, assessment and brief intervention teams. The findings from the reviews of these incidents had been used to improve safety. Examples included introducing seven day follow up for people completing brief intervention in Colchester and contacting carers of people who used the service in Chelmsford to assess any risks before discharge.
- The trust provided CQC with a report on all of their serious incidents for the 2014 / 2015 year. They reported a total of 93 serious incidents which required investigation between April 2014 and March 2015. The majority of incidents reported were categorised as "death" (50) followed by "substance misuse death" (15) and "other".

Detailed findings

- A total of 2,301 incidents were reported to the National Reporting and Learning Service (NRLS) between 1 June 2014 and 31 May 2015. There were three incidents categorised as deaths during the period which accounted for 0.1% of all the incidents reported. The majority of incidents resulted in no harm (62%) or low harm (34%) to the patient. A total of 4% of incidents resulted in moderate harm and 0.1% resulted in severe harm. This was in line with similar sized mental health trusts. However, it was not clear how trust wide learning from these was disseminated to front line staff.
- The trust took an average of 38 days to report incidents to NRLS. This was above the average for similar sized mental health trusts.The incident category which was most frequently reported was 'self-harming behaviour' (46%), followed by 'patient accident' (32%) and 'disruptive, aggressive behaviour (includes patient-to-patient) (13.0%).

Learning from incidents

- The trust had a high percentage of delayed incident investigations. This meant that there was a potential delay in identifying the learning from these. For example, 51% of the serious incident investigations were ongoing and of these, 86% were overdue at July 2015.The oldest serious incident ongoing had been open for over 12 months created on 24th April 2014 and was a 'suicide by outpatient'.
- Staff described the system to report incidents and their role in the reporting process. Each core service had access to an electronic system to report and record incidents and near misses.
- The trust did not have robust systems to share lessons learnt from incidents and teams did not integrate these into their practice. We found that nothing had been done to identify best practice elsewhere to support local action.

Duty of candour

- In November 2014 a CQC regulation was introduced that required NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong. As part of the trust's quality account for 2014/2015, the trust had reviewed and embedded their revised 'being open and duty of candour' policy. Most staff were aware of the duty of candour requirements in relation to their role.
- Care and treatment records were reviewed where patients had experienced a notifiable event to check that staff had been open and honest in their dealings with patients and carers. We found that the trust was meeting its duty of candour responsibilities.

Safeguarding

- Staff safeguarding training was provided in line with individual staff's job description. 84% of staff had received training in safeguarding adults and 89% in safeguarding children. Front line staff described different types of abuse and the trust protocol for making safeguarding referrals. Care records demonstrated appropriate referrals being made to local safeguarding teams. Additional support was available from the trust's central safeguarding team who acted as a resource for front line staff.
- One hundred and thirty-five deprivation of liberty safeguarding (DoLS) applications were submitted by the trust. The Linden Centre Mental Health Ward submitted the most (39) followed by Kitwood and Roding Mental Health Wards (29) and The Lakes Mental Health Wards (18).

Assessing and monitoring safety and risk

- Some risk assessment in care records did not contain enough detail.They were not personalised or kept up to date. This meant that staff did not know the full or current risks of the patients that they were caring for.
- Although the trust had an assurance framework and risk registers were in place at service and locality, we found little record of the trust acting on these findings.
- The trust's own mandatory training target of 90% was not met when it came to managing risks to patients. This meant that not all staff had received the required level of refresher training. We found that only 77% of staff working within the acute admission wards had received training in control and restraint, which included basic life support (resuscitation) and inpatient observation.

- In-patient wards gave informal patients information on their rights and were told they could leave at any time they wished.
- The trust used some assistive technology on older people mental health wards to reduce the risk of falls. For example by the use of pressure mats.

Safe and clean environments and equipment

- Some of the wards did not meet the Department of Health's requirement that trusts provide segregated accommodation for men and women. Finchingfield, Gosfield and Peter Bruff wards, Christopher unit, Shannon House and the Hub failed to provide segregated accommodation for men and women when the Department of Health said this should no longer happen. On Finchingfield ward, one female double bedroom, without ensuite facilities, opened directly onto a communal corridor. This meant that female patients using this bedroom had to enter the communal corridor to access the female only bathroom and toilet. A female lounge was available in Finchingfield ward. Gosfield ward was a single sex male ward. However, there were three female beds located on the ward, in which three female patients were receiving care. Peter Bruff ward consisted of mixed sex accommodation. We saw that only two bedrooms had ensuite accommodation. We saw male bedrooms next to female bedrooms. Female patients had to pass by male areas to access the bathrooms. The male designated toilet was in the designated female section of the ward. In the Hub, during our unannounced inspection, we observed a male patient sleeping in the female lounge within the Hub. We also saw a consultant psychiatrist used the female lounge to interview a male patient in the afternoon.
- Some seclusion rooms were not fit for this purpose. For example, on Ardleigh ward. This was a small room. If a patient was to stand on the mattress, they could reach the electric apparatus on the ceiling (for example, the smoke detector). There was no ensuite facility. The observation window of the seclusion room door could not be opened and there was no intercom. Observation of the room was achieved from another room, the Section 136 suite, off the ward. There were blind spots (where the patient could not be observed at all times) from this observation point. In Peter Bruff ward, the seclusion room was not fit for purpose. We saw square corners on the door frame and prominent screw heads on the window frame. There was no clock or intercom available. The smoke detector and CCTV camera were breakable. There were blind spots where the patient could not be observed at all times. There were ligature points, including toilet rails and taps on the sink.
- Frontline staff were aware of the risks to patients' safety caused by the layout of some wards and had assessed patients' individual risks and increased their observation as needed. Ligature cutters were available on each acute admission ward and were accessible in the event of an emergency occurring. However, individual staff on both Finchingfield and Galleywood wards were not immediately aware of where the ligature cutters were located.
- Environmental risks were identified in the three health based places of safety (HBPoS) used for adults. This included potential ligature points and a limited ability to observe people who were detained under S136 of the MHA.
- Most ward areas were clean and tidy. Patients and staff said the trust had good cleaning services.

Potential risks

- Incidents were reported on the trust electronic recording system. Each incident was reviewed and investigated by the management team.
- The trust had emergency contingency plans in place for dealing with foreseeable emergencies. For example, within community services for adults, staff were clear about appropriate procedures to follow if people did not attend their appointments. These included telephone contact, making home visits and sending letters.

Restrictive practice, seclusion and restraint

- The trust's quality report dated May 2015 demonstrated that the number of seclusions had decreased from 78 to 49 during the previous year. There had been a total of 1002 control and restraint incidents and this was a 17% reduction on the previous year's figure of 1208. However, there had been a 23% increase in the use of rapid tranquilisation; the total number for the year was 419 compared to 340 the previous year. On the acute admission wards there were114 incidents of restraint in the six months before the inspection. Of these, in 36

incidents (representing 32% of incidents) patients were restrained in the prone position. Prone position restraint is when a patient held in a face down position on a surface and is physically prevented from moving out of this position. The latest Department of Health guidance stated that if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible. The trust informed us that they were taking steps to reduce the use of prone restraints in line with best practice guidelines issued by the Department of Health to reduce the use of outdated restrictive practices and published as 'positive and proactive care' (April 2014). For example through the 'lessons learnt' trust patient safety committee and reviewed through the trust's incident management system.

- Staff told us that de-escalation and other interventions were tried before using 'rapid tranquilisation' treatment for agitation or aggression, in line with national guidance, but this was not always recorded on the trust's monitoring tool. This meant that the trust was not fully informed of the use of de-escalation and other techniques by their staff.
- Some patients told us they could not lock their rooms. This was because much of the accommodation in the acute wards was dormitory style, with up to four patients sleeping in one dormitory. There were curtains between the beds but these did not give enough privacy. There were some single bedrooms. Patients did have lockable storage space but they did not have the keys so had to ask a member of staff for these. This was not based on assessed risk.
- There were restrictive practices on some wards. For example, on Larkwood ward, where stuffed toys and personal blankets were banned due to being identified as a fire risk following a fire risk assessment by the local fire service. On Finchingfield ward, a number of patients told us about some restrictive practices that were impacting upon the quality of their care. Patients told us that they had limited access to the kitchen and had set hot drinks times which did not allow hot drinks outside of these set times. Patients also told us that they had limited access, and had to ask, to access the toilet. They were particularly concerned that they had to wait sometime to access these.
- Restrictive practices were identified regarding the use of the Hub during the day for patients from Chelmer and Stort wards. For example, patients were not given the choice as to whether to attend this service or not.

Safe staffing

- From May 2014 to June 2015 the trust failed to meet their own target of 90% of staff who had completed all their mandatory training with only 84% of staff meeting this target. This meant that not all staff had received the required level of refresher training. There was a variety of mandatory training available for staff. This included courses in, the care programme approach (CPA) and clinical risk management, dual diagnosis, "making experiences count" (including incident reporting, complaints and claims, and record keeping standards), and information governance. The trust included training on the Mental Capacity Act with their safeguarding training.
- The trust sickness rate was slightly less than the England average (5%) for mental health and learning disability trusts in March 2014 at 4.2% and 4.7% in December 2014.
- Safer staffing levels have been reported monthly on the trust's website since May 2014. The trust told us that a total of 4249 shifts were filled by bank or agency staff to cover sickness, absence or other vacancies within the acute admission wards. We noted that 239 shifts had not been filled by bank or agency staff where there was sickness, absence or vacancies. This meant that there was an over-reliance on the use of bank and agency staff and, on occasion, the acute admission wards operated short of staff, or the ward manager would undertake the shift. This had an adverse effect on care continuity and the consistency of nursing approach. Managers were able to adjust staffing levels daily to take into account increased clinical needs. This included, for example, increased level of observation or patient escort. Some requested hours were due to staff sickness and vacancies. The trust reported 1,565 substantive staff at 30th April 2015 with 268 leavers in the preceding 12 months. The percentage of staff turnover reported by the trust was 14%. This was above the national average for similar sized mental health trusts.

Medicines management

Detailed findings

- Medicines were stored at suitable temperatures to maintain their quality, but on Stort ward the refrigerator thermometer had not been re-set after each reading so we could not be certain that suitable temperatures were maintained at all times. Medicines, including controlled drugs, were stored securely. Controlled drugs were medicines which are stored in a special cupboard and their use recorded in a special register.
- The pharmacy team provided a clinical service to ensure people were safe from harm from medicines. Nursing staff had good links with the pharmacy team who made ward visits and could provide advice, including out of hours.
- Pharmacy staff had recorded interventions which guided staff in the safe prescribing and administration of medicines. Pharmacy staff held regular patient group sessions to discuss general medicines issues and provide leaflets and other information. They were available to speak to patients individually if required. Patients were encouraged to attend these sessions which gave them an opportunity to discuss concerns.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them while in hospital.
- On the child and adolescent mental health wards; two patients were prescribed medication which did not have the necessary authorised consent to treatment documentation in place. This had been addressed promptly by nursing staff when the pharmacy service had identified these concerns.
- Staff did not always complete the prescribing charts properly. Missing information, such as how long patients took antibiotics for, or the reason for prescribing a medicine, meant we were unsure if patients received medicines consistently or as the prescriber intended.
- On the older people mental health wards we found that pharmacists were involved in ward clinical meetings and that they provided information on suitable formulations to use when medicines needed to be administered covertly. Covert administration is when medicines are given in a disguised form, for example in food or drink, to someone who is assessed as not able to decide whether to accept them.
- Staff took patients' preferences into account when administering medicines, but did not always note the arrangements in the patient's care plan so may not follow them consistently.

Requires improvement

Are services effective?

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

Summary of findings

We rated North Essex Partnership University NHS Foundation trust as requires improvement for effective because:

- The trust's national audit of schizophrenia found that the monitoring and interventions for risk factors such as, diabetes and heart disease were poor. Patients who did not respond to standard antipsychotic medications had to wait too long to start clozapine. The availability of family therapies or cognitive behavioural therapy had large gaps. There was not enough information or support for carers. The trust had only monitored 40% of patients for current alcohol consumption. This meant that some patients with schizophrenia were not receiving care in accordance with best practice guidelines.
- The majority of care plans were not personalised and did not include patients' views. They did not cover the full range of patients' problems and needs. For example, on Chelmer and Ardleigh wards, care plans were not recovery orientated. They did not include the patients' strengths and goals. Most patients did not get a copy of their care plan. This meant that staff did not receive clear guidance as to how to care for individual patients.
- Between November 2014 and May 2015 there were 215 re-admissions within 90 days on 20 wards. The highest number of re-admissions was on Peter Bruff (29), Finchingfield, Gosfield (28) and Galleywood (28). Whilst this was in line with similar sized mental health trusts, it meant that there was an increased pressure on the trusts acute in patient services and increased distress for patients and their families linked to becoming seriously ill shortly after discharge.
- Staff did not always complete the prescribing charts properly. Missing information, such as how long patients took antibiotics for, or the reason for prescribing a medicine, meant we were unsure if patients received medicines consistently or as the prescriber intended.
- Seven patients from this trust were in 'out of area' beds between June and July 2015, and nine were out of area during the inspection. This meant that patients were being care for away from their home area and families and friends may have some distance to travel to visit them.
- From May 2014 to June 2015 the trust failed to meet their own target of 90% of staff who had completed all their mandatory training with only 84% of staff meeting this target. This meant that not all staff had received the required level of refresher training.
- Mental Health Act reviewer visits carried out by the Care Quality Commission over the past 12 months highlighted nine issues regarding patients not being advised or aware of their legal rights and five concerns regarding lack of patient involvement in their care plan.

However:

- In-patients had a physical healthcare check completed by medical staff on admission and their physical healthcare needs were being met by front line staff. Most patients had a care plan that showed staff how to meet these physical healthcare needs.
- Between November 2014 and May 2015 there were 84 delayed discharges across the trust in five locations. Two wards, Stort Ward (34) and Kitwood Ward (31) accounted for the majority of these. Staff reported that most of these were due to the difficulty in finding appropriate community care and placements for some patients. This was in line with other similar sized mental health trusts.
- Throughout the trust, multidisciplinary meetings helped staff share information about patients and review their progress.

Requires improvement

Are services effective?

- The trust spent two years planning and consulting for the community transformation programme. They started running this fully in April 2015. Patients confirmed that these changes had led to improved community care and treatment delivery by the trust.

Our findings

Assessment of needs and planning of care

- The trust participated in the national audit of schizophrenia for community patients. This showed that the trust was performing worse than average in the following areas:

1. The monitoring and interventions for risk factors such as, diabetes and heart disease were poor.
2. Patients who did not respond to standard antipsychotic medications had to wait too long to start clozapine.
3. The availability of family therapies or cognitive behavioural therapy had large gaps.
4. There was not enough information or support for carers.
5. The trust had only monitored 40% of patients for current alcohol consumption.

- However, in-patients had a physical healthcare check completed by clinical staff on admission and their physical healthcare needs were being met by front line staff. Physical health examinations and assessments were documented by medical staff following the patient's admission to the ward. Ongoing monitoring of physical health problems was taking place. Most patients had a care plan that showed staff how to meet these physical healthcare needs.
- The majority of care plans throughout the trust were not personalised and did not include patients' views. They did not cover the full range of patients' problems and needs. For example, on Chelmer and Ardleigh wards, care plans were not recovery orientated. They did not include the patients' strengths and goals. Most patients did not get a copy of their care plan throughout the in-patient areas.
- There were gaps in the care and treatment records maintained by the trust. For example, 28 out of 54 care records reviewed on the acute admission wards and psychiatric intensive care unit wards were incomplete relating to patients' mental capacity to consent to treatment. Some information was missing in many of the S136 records we reviewed. This included physical health, whether the person had a learning disability, the person's language and the times the doctors or AMHPs were called or assessed the person. An electronic record system had been recently introduced across the trust. Information, contained within this system, could be shared between the wards, home treatment teams and other community teams. However some paper records still existed. Some information was duplicated between paper and computerised health records.

Best practice in treatment and care

- Between November 2014 and May 2015 there were 215 re-admissions within 90 days on 20 wards. Peter Bruff (29), Finchingfield, Gosfield and Galleywood (28 each) had the highest number. While this was in line with similar sized mental health trusts, this meant that there was an increased pressure on the trust's acute in patient services and increased distress for patients and their families linked to becoming seriously ill shortly after discharge.
- Only 12% of patients were followed up by the community mental health teams within seven days between December 2013 and December 2014. This meant that patients were potentially at risk following discharge. The trust report that this was due to data collection issues during the trust's 'journeys' community services transformation programme.
- The trust performed better than the England average for similar trusts relating to the percentage of staff receiving job-relevant training, learning or development from the NHS Staff Survey 2014.
- Outcomes for patients using the services were monitored and audited by the trust. This included the monitoring of key performance indicators such as length of stay, the use of control and restraint, and rapid tranquilisation. However, it was not clear what actions had been taken by the trust as a result of these audits.
- There was a range of psychology led interventions available. For example, we saw that psychological

interventions were available in the STEPPS (systems training for emotional predictability and problem solving) approach which was available in a group programme to assist adults using the trust's community services in their recovery.

- Community based staff were using 'family group conferencing' as a good practice model for working with whole families. The approach used a facilitated group conferencing process to bring together the significant people in a person's life to contribute to devising a support plan.

Skilled staff to deliver care

- New permanent staff underwent a formal induction period. This involved attending a corporate induction, learning about the ward and trust policies and a period of shadowing existing staff before working alone. A number of newly qualified nurses told us of a well-structured and in-depth preceptorship programme. Preceptorship was a period of time in which to guide and support all newly qualified practitioners to make the transition from student to develop their practice further.
- The trust had positive links with local universities and staff reported that they were supported to attend external courses where this was part of their personal development plan. We found that non-qualified staff were being supported to gain further qualifications to enable them to apply for nurse training.
- Appraisal and supervision rates varied across the trust. For example, 69% of staff on the acute and admission wards had an up to date personal development plan. Seventy percent of staff across the older people mental health wards had received an annual appraisal. Eighty five percent of community staff had received regular one to one supervision and an annual appraisal. Managers told us that supervision and appraisal sessions were used to address performance issues, to reflect on practice and to discuss development needs of Individual staff. Staff described receiving support and debriefing from within their team following serious incidents.

Multi-disciplinary and inter-agency team work

- The trust scored worse than the England average relating to effective team working from the NHS Staff Survey 2014. However, we found effective multi-disciplinary meetings took place that enabled staff to share information about patients and review their progress. We found that different professionals worked together effectively to assess and plan patients' care and treatment.
- The trust spent two years planning and consulting for the community transformation programme. They started running this fully in April 2015. Patients confirmed that these changes had led to improved community care and treatment delivery by the trust. Most staff said that they felt increasingly settled and integrated and felt that the new arrangements were working well for patients.

Adherence to the MHA and MHA Code of Practice

- The trust had received 17 Mental Health Act (MHA) review visits between June 2014 and July 2015. The main issues highlighted were regarding capacity and consent not being considered, patients not being advised or made aware of their legal rights, lack of patient involvement in care plans and lack of occupational therapy or other specialised day activities.
- The trust had processes in place to ensure compliance with the MHA and adherence to the guiding principles of the MHA Code of Practice were found to be generally good during this inspection. However, we found examples were a patient appeared not to have been provided with a copy of their section 17 leave authority. Section 17 leave forms were unclear about the type of leave that was being authorised, and the designation and numbers of the escorts were not always specified.
- Most patients had received their rights (under section 132 of the MHA) and these were repeated at regular intervals. MHA paperwork had been completed correctly, was up to date and held appropriately. The MHA record keeping and trust scrutiny was satisfactory.
- Posters were displayed throughout the trust informing patients of how to contact the independent mental health advocate.
- Most staff had received training in the MHA via e-learning. Front line staff had a good working knowledge of the MHA.

Requires improvement

Are services effective?

- The minutes of the trust's mental health act managers meeting in March 2015 identified topics including staff changes, service level agreements with acute trusts, issues with the production of activity reports and the stance regarding detention of under 18's on adult wards.
- The relevant legal documentation was completed appropriately for those people detained under S136 in the health-based place of safety. However, the trust's new policy on their Section136 service did not reflect the requirements of the MHA Code of Practice in monitoring that the Act was being applied correctly in relation to this core service.

Good practice in applying the MCA

- The trust included training on the Mental Capacity Act (MCA) with their safeguarding training. Front line staff had varying degrees of knowledge about the MCA and Deprivation of Liberty Safeguards (DOLS).
- Care and treatment records showed that patients' mental capacity to consent to their care and treatment was not always assessed on their admission or an ongoing basis if required.
- The trust had submitted 91 Deprivations of Liberty Safeguards (DoLS) applications in the last six months, 1st October 2014 to 31st March 2015. These occurred within 18 patient wards, units or teams. A total of 135 DoLS applications were submitted by the trust to the CQC since 1st June 2014.
- A total of 230 DoLS applications were made by the trust to the Local Authority.Thirty-one percent of these were declined, 20% were authorised and 49% were pending decision. Tower Ward and Kitwood Ward raised the most DoLS applications with 53.
- MHAR visits highlighted issues regarding capacity and consent not being considered on ten occasions in the last 12 months.

Good

Are services caring?

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

Summary of findings

We rated North Essex Partnership University NHS Foundation Trust as good for caring because:

- We observed many examples of staff treating patients with care, compassion and communicating effectively. We saw that staff engaged with patients in a kind and respectful manner throughout the trust.
- Patients felt comfortable approaching the ward offices and positive interactions between front line staff and patients were observed. We saw staff knock before entering patients' rooms and that they spoke positively with patients.
- Most staff understood the personal, cultural and religious needs of patients and we saw examples of actions to meet these needs. On the older people mental health wards, staff had completed 'This is me 'profiles to help them understand each patient's risks, likes, and dislikes.
- Patients told us they could keep in contact with their family where appropriate. The trust had dedicated visiting hours and areas. They also had special arrangements for child visitors.

However:

- The trust's overall score during their patient led assessment of the care environment assessments for dignity, privacy and respect was 77%. This was below the England average of 87%.
- There had been 14 comments on Share Your Experience between March 2014 and March 2015. All of these were negative. For example, relating to staff attitude and poor communication.
- Three patients on the acute admission wards reported that their dignity and privacy was compromised at times whilst receiving care. Eleven patients on the acute admission wards told us that they were not involved in devising their care plan or had not received a copy of their care plan. There was limited evidence of patients' involvement in the care planning process throughout the trust. This was supported by those trust care and treatment records reviewed and our meetings with individual patients.

Our findings

Kindness, dignity, respect and support

- We observed many examples of staff treating patients with care, compassion and communicating effectively. We saw that staff engaged with patients in a kind and respectful manner throughout the trust. For example, on the CAMHS wards staff managed distressed young people in a calm and responsive way and supported them to talk about the issues affecting them. Staff knew the young people very well and their preferences and interests.
- Patients felt comfortable approaching the ward offices on the acute admission wards and positive interactions between front line staff and patients were observed. We saw staff knock before entering patients' rooms and that they spoke positively with patients throughout all of the in-patient areas.
- Most staff understood the personal, cultural and religious needs of patients and we saw examples of actions to meet these needs. On the older people mental health wards, staff had completed 'This is me 'profiles to help them understand each patient's risks, likes, and dislikes.
- Staff were aware of the need to ensure a person's confidential information was kept securely. Staff access to electronic case notes was protected.
- However, some patients on the acute admission wards felt that they did not receive appropriate protected time with their key nurse. They complained of feeling bored particularly at the weekend.
- The trust's overall score during their patient led assessment of the care environment assessments for dignity, privacy and respect was 77%, which was well

Good

Are services caring?

below the England average of 87%. There have been 14 comments on Share Your Experience between 02/03/2014 and 16/03/2015. All of these were negative; for example, relating to staff attitude and poor communication.

- Individual feedback from the completed comment cards during the inspection was mixed. We received 39 completed comment cards. 20% were positive 50% were negative and 30% were mixed.

The involvement of people in the care they receive

- Most patients and their carers told us that patients were orientated to their ward on admission and were shown around the ward by staff. They had received an information leaflet relating to the trust.
- Patients told us they could keep in contact with their family where appropriate. The trust had dedicated visiting hours and areas. They also had special arrangements for child visitors.
- Carers were invited to attend discussions with their relatives within the adult community service. This provided an opportunity for the carer to be involved with any potential changes to the care being planned. Carers had been offered the opportunity of a carer's assessment.
- A number of patients were participating and involved in groups to help with mood stabilisation, others who had joined groups to learn about recovery principles, health and wellbeing and to help build self-esteem and confidence.
- Patients were invited to the multi-disciplinary reviews along with their family where appropriate.
- There was limited evidence of patients' involvement in the care planning process throughout the trust. This was supported by those trust care and treatment records reviewed and our meetings with individual patients.

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

We rated North Essex Partnership University NHS Foundation Trust as requires improvement for responsive because:

- Trust wide bed occupancy was 99%. Gosfield (126%), Ardleigh (122%), Chelmer, Derwent (117%) wards had experienced the highest bed occupancy in the six months up to 30th April 2015. Peter Bruff ward had 129% bed occupancy during the inspection. The latest guidance from the Department of Health is that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the running of the service.
- Staff told us they often had problems finding beds for patients who needed admission. They frequently had to admit other patients into the beds of patients who were on short term leave. When we reviewed the information the trust had sent us, the average bed occupancy on 31 August 2015, was 117%, which confirmed they used leave beds for new admissions. This meant that patients who returned from leave and required a bed may not have one.
- Care delivery within some wards was not individualised. For example, patients told us they could not lock their rooms. This was because much of the accommodation in the acute wards was dormitory style, with up to four patients sleeping in one dormitory. There were curtains between the beds but these did not give enough privacy. There were some single rooms. Patients did have lockable storage space but they did not have the keys so had to ask a member of staff for these. This was not based on assessed risk.
- Complaints to the trust had increased by 35% from 2012/13 to 2014/15. The trust informed us that 28% of the total had been upheld in 2013/2014. The top three themes for complaints during 2014/15 were 'clinical treatment', 'staff attitude', and 'access to services'. The trust told us that 159 moderate complaints were made between March 2014 and March 2015. This was in line with similar sized mental health trusts. However, there was no evidence of trust wide learning from complaints being shared with front line staff.

  However:
- Information on treatments, local services, patients' rights, advocacy and how to complain were available in all reception areas and wards. These were available in different languages. The trust provided interpreters and signers when required.
- There was a trust wide chaplaincy service to support patients with a diverse range of spiritual and religious needs. Ruby and Topaz ward had a multi-faith room in the entrance area of the ward with religious texts.
- The trust received 349 written compliments during 2014/15.An increase of 83 compliments from 2013/2014. We saw evidence of thank you cards and letters throughout the trust.
- Front line staff were able to access the trust's complaints system. Information about the complaints process was available on notice boards throughout the trust. Patients knew how to make complaints.

Our findings

Access, discharge and bed management

- The trust had not set any performance targets regarding the number of days from initial assessment to onset of treatment. This meant that performance targets were not being monitored by the trust in this area. We found that this varied from 29 days within the dementia and memory services; followed by CAMHS at 17 days; community adults at 14 days and community older adults at 12 days.

Requires improvement

Are services responsive to people's needs?

- However, the trust had met their targets for the times from referral to assessment by the crisis team for those people in the accident and emergency departments of the local acute hospitals.
- The trust proportion of admissions to acute wards gate kept by the CRHT Team fell below the England average in Q4 2013/2014 and again in Q2 2014/15 where it remained throughout Q3 and Q4 of 2014/15. .
- Between November 2014 and May 2015 there were 84 delayed discharges across the trust in five locations. Stort Ward – Derwent Centre (34) and Kitwood Ward – St Margaret's (31) accounted for the majority of delayed discharges. This was consistently below the England average and peaked through Nov 14 - Jan 15 at 15. The three main reasons for delayed discharges were 'public funding', 'housing – patient not covered by NHS and Community Care Acts', and 'awaiting nursing home placement or availability'.
- Trust wide average bed occupancy was 99%. The acute admission wards; Gosfield (126%), Ardleigh (122%), Chelmer, Derwent (117%) wards had experienced the highest bed occupancy in the six months up to 30th April 2015. Peter Bruff ward had 129% bed occupancy during the inspection. The latest guidance from the Department of Health is that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the running of the service.
- Staff told us they often had problems finding beds for patients who needed treatment in an acute admission ward. They frequently had to admit other patients into the beds of patients who were on short term leave. The trust reported that their average bed occupancy in the acute admission wards at 31 August 2015 was 117%, which confirmed they used leave beds for new admissions. This meant that patients who returned from leave and required a bed may not have one.
- A risk had been flagged for the 'occupancy ratio, looking at the average daily number of available and occupied beds open overnight', with an overall score of 93% score across the Trust. This was based on data from the Department of Health between January and December 2014.
- One patient on Finchingfield ward told us that one week prior to our inspection that they were only able to access a bed when another patient was transferred to an independent hospital. They were being nursed in an activity room overnight.This meant that patients who required an acute admission bed were being nursed in an unsuitable area of the ward while waiting for a vacant bed on the main ward.
- Proactive steps were taken by the health based place of safety team to engage with people who found it difficult or were reluctant to engage with mental health services. Patients knew how to get help from mental health services in a crisis. The trust's innovative partnership with the Samaritans and the introduction of street triage in partnership with an adjoining trust had improved access to services for people with a mental health crisis.

The service environment optimises recovery, comfort and dignity

- The trust's overall score during their patient led assessment of the care environment assessments was better than the England average for other similar trusts for cleanliness and condition and appearance and maintenance.
- Most patients told us that the food was good. However the trust score for food was below the England average for similar trusts. The Linden Centre was the worst performing location with a score of 80%.
- Activity programmes for patients were available on each ward. However, some patients complained of boredom and a lack of activities especially at weekends. During our unannounced visit to the acute admission wards, we spoke with a senior member of staff, who had been recently appointed, with responsibility for undertaking a review of the activities programme. They informed us that they were looking into improving this provision throughout the trust
- Payphones were provided to enable patients to make a phone call. Patients could also use their own mobile phones, following a risk assessment. We observed that on Finchingfield ward that the patient telephone was located between two double doors and patients had no means of regaining access to the ward once they had concluded their call. However, we found that staff helped patients on the older people mental health wards to make calls.
- All the acute admission wards had access to garden areas in which patients could get fresh air.

Requires improvement

Are services responsive to people's needs?

Meeting the needs of all people who use the service

- The in-patient services were fully accessible for people requiring disabled access.This included the provision of wheelchair access to bedrooms and assisted bathrooms.
- Information on treatments, local services, patients' rights, advocacy and how to complain were available in all reception areas and wards. These were available in different languages. The trust provided interpreters and signers when required.
- There was a trust wide chaplaincy service to support patients with a diverse range of spiritual and religious needs. Ruby and Topaz ward had a multi-faith room in the entrance area of the ward with religious texts.
- Meals that needed to be thickened or liquidised were provided based on an individual nutritional needs assessment. Staff supported patients to eat and drink adequate amounts where this was required.

Listening to and learning from concerns and complaints

- Complaints to the trust had increased by 35% from 2012/13 to 2014/15. The trust informed us that 28% of the total had been upheld in 2013/2014. The top three themes for complaints during 2014/15 were 'clinical treatment', 'staff attitude', and 'access to services'. The trust told us that 159 moderate complaints were made between March 2014 and March 2015. This was in line with similar sized mental health trusts. However, there was no evidence of trust wide learning from complaints being shared with front line staff.
- The trust's patient advice and liaison service managed and recorded low risk concerns which were resolved at local level. A total of 703 enquiries were received by this service during the period of April 2014 to March 2015. This was an 11% increase on 2013-14.
- The trust received 349 written compliments during 2014/15. An increase of 83 compliments from 2013/2014. We saw evidence of thank you cards and letters throughout the trust.
- Front line staff were able to access the trust's complaints system. Information about the complaints process was available on notice boards throughout the trust. Patients knew how to make complaints.
- Complaints were recorded using the trust's computerised incident reporting system. This recorded how the issues were investigated, what outcomes and any learning were. Individual ward managers told us they shared learning from complaints within their own service amongst their staff at ward based meetings.

Requires improvement

Are services well-led?

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

Summary of findings

We rated North Essex Partnership NHS Foundation Trust as requires improvement for well led because:

- The trust did not have robust governance processes, particularly in the assessment and management of ligature risks, assessment of the quality of care plans, and the management of local risks. For example, although the trust had a comprehensive risk management framework that informed management decisions in the identification, assessment, treatment and monitoring of risk. We found little record of the trust acting on these findings. While throughout 2014/15 regular reports were provided to the risk and governance executive, the quality and governance committee and the board of directors, there was little record of action taken to reduce risks to patients. For example, during the inspection, we identified concerns with unmanaged ligature risks, the use of prone restraints and breaches of Department of Health guidance around gender separation.
- The Care Quality Commission and Mental Health Act reviewers have inspected the trust several times over the last five years. Each time they identified areas where the trust must act. For example, around the safety and welfare of patients on both the Linden centre and the Lakes locations. Each time the trust made assurances that they would make changes. The trust did not address the concerns fully even though patients had died by self-ligature while on the wards. One patient attempted to strangle themselves with a ligature during our inspection. Senior managers and board directors could not explain why the trust had not addressed these concerns fully.
- The trust's risk register assurance framework dated March 2015 and their strategic risk assurance action plans dated April 2015 had 11 out of 18 risks which were rated as 'serious' or 'major' (scoring 12 or above). For example, it highlighted a high risk that the Trust failed to specify, deliver and obtain benefits from major change programmes effectively. It was not clear what definite actions the trust were taking to address these identified risks.
- We found the leadership of the trust to be lacking in strength to give assurance that failings would be acted upon with necessary urgency. Outstanding actions were not prioritised or given sufficient importance which meant that the trust remained non-compliant for up to 5 years on major failings of safety. Several board members and senior managers were unclear about the trust vision and strategy.
- The leadership style did not promote sufficient grip or pace to bring about changes where necessary in a manner that showed stakeholders or internal staff that there was any urgency about improvements. Changes took a long time to implement and consultations on improvements were not given the urgency necessary to give confidence that matters would be resolved. Ligature free doors had not been installed or even commissioned despite these having been agreed some time ago.
- According to the NHS Staff Survey 2014 the trust performed worse than the national average. It also showed they were in the bottom 20% of all mental health trusts in three areas. First, the percentage of staff working extra hours in the last 12 months. Second, the fairness of incident reporting systems, witnessing and reporting errors at work and finally receiving abuse from relatives or the public in the last 12 months. This also showed that the trust performed worse than the national average for questions relating to staff recommending the trust as a place to work or receive treatment.

  However:

- The NHS Staff Survey 2014 showed that the trust compared favourably to the national average and was in the top 20% of all mental health trusts for the

Requires improvement

Are services well-led?

percentage of staff receiving job-relevant training, learning or development in last 12 months and in the percentage of staff able to contribute to work improvement and staff motivation at work. The trust performed similar to the national average regarding staff agreeing that feedback from patients was used to make informed decisions.

- A number of locally led service improvements had been made. For example, the trust's crisis team had taken proactive steps to engage with people who found it difficult or were reluctant to engage with mental health services. For example, by arranging flexible appointments and proactive support mechanisms. People told us that appointments ran on time and that they were kept informed if there were any changes.

Our findings

Vision, values and strategy

- The trust's core purpose was - "At NEP we work in partnership to enable people to be at their best in mind and body" and summarised by their new strapline: "All together, better".
- The trust's values were 'humanity, strive for excellence, our cause, our passion, commercial head and community heart, creative collaboration and keep it simple'.
- The trust's vision and values poster was on display throughout the trust and was available on the trust's intranet. However, several board members and senior managers were unclear about the trust's vision and strategy. There was a low level of front line staff's knowledge and understanding of the trust's vision and strategy.
- The trust provided their 'draft priority improvements 2015-16' – these detailed trust strategic plans under three main areas (better communication and information, implementation of the journeys programme and patient and carer experience). Details of how these plans were to be monitored was provided.
- Senior staff within the trust had visited some wards and community services. These included the trust chairman, the chief executive and various executive directors.

Good governance

- The trust did not have robust governance processes, particularly in the assessment and management of ligature risks, assessment of the quality of care plans, and the management of local risks. While the trust had a comprehensive risk management framework, we found little evidence of the trust acting on these findings. For example, throughout 2014/15 regular reports were provided to the risk and governance executive, the quality and governance committee and the board of directors. There was little record of actions being taken to reduce risks to patients. For example, during the inspection, we identified concerns with unmanaged ligature risks, the use of prone restraints and breaches of Department of Health guidance around gender separation.
- The Care Quality Commission and Mental Health Act reviewers have inspected the trust several times over the last five years. Each time they identified areas where the trust must act. For example, around the safety and welfare of patients on both the Linden centre and the Lakes locations. Each time the trust made assurances that they would make changes. The trust did not address the concerns fully even though patients had died by self-ligature while on the wards. One patient attempted to strangle themselves with a ligature during our inspection. Senior managers and board directors could not explain why the trust had not addressed the problems.
- The trust's risk register assurance framework dated March 2015 and their strategic risk assurance action plans dated April 2015 had 11 out of 18 risks which were rated as 'serious' or 'major' (scoring 12 or above). For example, it highlighted a high risk that the Trust failed to specify, deliver and obtain benefits from major change programmes effectively. It was not clear what definite actions the trust were taking to address these identified risks.
- The trust was rated as 'Satisfactory' in the 2013/14 Information Governance Toolkit. However, a risk had been flagged for the 'Proportion of Mental Health

Requires improvement

Are services well-led?

Minimum Data Set (MHMDS) records with missing NHS numbers' with an observed value of 2%. This was based on mental health and learning disabilities statistics between January and December 2014.

- The trust had achieved level 1 of the NHS Litigation Authority 'risk management standards for mental health trusts'. This was based on a rating of zero to three, with three being good.

Leadership and culture

- We found the leadership of the trust to be lacking in strength to give assurance that failings would be acted upon with necessary urgency. Outstanding actions were not prioritised or given sufficient importance which meant that the trust remained non-compliant for up to 5 years on major failings of safety.
- The leadership style did not promote sufficient grip or pace to bring about changes where necessary in a manner that showed stakeholders or internal staff that there was any urgency about improvements. Changes took a long time to implement and consultations on improvements were not given the urgency necessary to give confidence that matters would be resolved. Ligature free doors had not been installed or even commissioned despite these having been agreed following a patient death in February 2015.
- According to the NHS Staff Survey 2014 the trust performed worse than the national average. It also showed they were in the bottom 20% of all mental health trusts in three areas. First, the percentage of staff working extra hours in the last 12 months. Second, the fairness of incident reporting systems, witnessing and reporting errors at work and finally receiving abuse from relatives or the public in the last 12 months. The trust performed worse than the national average for questions relating to staff recommending the trust as a place to work or receive treatment.
- There was no clear trust clinical lead for the HBPoS in the St Aubyn Centre and the Christopher Unit adjacent to the Linden Centre. This meant that front line staff in these areas lacked effective clinical leadership.
- The NHS Staff Survey 2014 showed that the trust compared favourably to the national average and was in the top 20% of all mental health trusts for the percentage of staff receiving job-relevant training, learning or development in last 12 months, and percentage of staff able to contribute to work improvement and staff motivation at work.
- Front line staff confirmed that local managers were visible, approachable and supportive. We were impressed with the morale of the staff during our inspection and found that local teams were cohesive and enthusiastic.

Engagement with the public and with people who use services

- At the start of 2015, a questionnaire was sent to 850 people who received community mental health services. This was part of the Care Quality Commission's 2015 community mental health survey. Responses were received from 288 people who had used trust services. These showed that the trust was scoring worse than other trusts in eight out of ten categories and about the same for two out of ten categories.
- The NHS Staff Survey 2014 showed that the trust performed similar to the national average regarding staff agreeing that feedback from patients was used to make informed decisions.
- The feedback received from focus groups held with patients and carers prior to the inspection was mixed. Some people praised the support offered by staff whilst others felt that care delivery was inconsistent and communication with them was poor.
- Patient-Led Assessments of the Care Environment' (PLACE) visits had taken place to a number of inpatient services. This was a self-assessment process undertaken by teams including patients and representatives of Healthwatch.
- Most inpatient services had ward meetings or forums to engage patients in the planning of the service and to capture feedback. Patients were able to raise concerns in these and told us that they felt involved. Carers in older people mental health services reported their satisfaction with the level of involvement and support received.
- Patients and their families or carers were engaged by staff in community health care groups using a variety of

Requires improvement

Are services well-led?

methods. We saw that there was information available throughout the trust and via its website about how to provide feedback on the specific services received by people.

- The trust's carer strategy 2014 /2017 listed the actions required by the trust. These included an updated trust information leaflet, increased number of carers on the involvement database, and improved carer satisfaction via surveys and feedback.

Quality improvement, innovation and sustainability

- The NHS Staff Survey 2014 showed that the trust compared favourably to the national average and was in the top 20% of all mental health trusts for the percentage of staff able to contribute to work improvement and staff motivation at work.
- The trust had a research strategy and had participated in a wide range of trust clinical effectiveness and quality audits. These included dementia care pathways, ward review records, patient safety data quality and safeguarding practice. However it was not clear how the learning from these was disseminated to front line staff.
- We found a number of locally led service improvements being made. For example, staff from across community teams were undergoing training to participate with patients to implement the open dialogue approach, led by University College London.
- The community child and adolescent mental health crisis team designed an educational programme, which they delivered to schools in areas of highest need. The aim was to promote good mental health and self-esteem, and to reduce the incidents of self-harm and attempted suicides.
- The trust's innovative partnership with the Samaritans and the introduction of street triage in partnership with an adjoining trust had improved access to services for people with a mental health crisis.
- A senior member of staff at the Derwent Centre had been instrumental in setting up a group, "Friends of the Derwent Centre". The group had undertaken various activities to raise money for the Derwent Centre and to raise awareness of mental illness in the local community.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The trust did not ensure that all of the care it provided treated patients with dignity and respect. • Finchingfield, Gosfield and Peter Bruff wards, Christopher unit and Shannon House failed to provide segregated accommodation for men and women when the Department of Health said this should no longer happen. • Restrictive practices were seen on the wards. Patients could not always go to the toilet freely, get into the garden area, or have food and drink when they wanted while they were being nursed by the trust. • There were curtains between the beds in dormitory wards on the acute admission wards but these did not give enough privacy. Patients did have lockable storage space but they did not have the keys so had to ask a member of staff for these. This was not based on assessed risk. This was a breach of Regulation 10 (1) (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The trust did not ensure that all of the care it provided was patient centred.

This section is primarily information for the provider

Requirement notices

- Not all care records and risk assessments contained enough detail. They were not personalised or kept up to date. This meant that staff did not know the full or current risks presented by the patients that they were caring for.
- The trust had very high bed occupancy rates. Patients were regularly admitted to beds reserved for patients on leave or patients were sent to hospitals out of the area. This meant that patients could be nursed a long way from home. Patients returning from a period of leave often did not have a bed to return to if they needed one.
- Care delivery within some wards was not individualised. For example, patients told us they could not lock their rooms. This was because much of the accommodation in the acute wards was dormitory style, with up to four patients sleeping in one dormitory.

This was a breach of Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The trust did not protect patients against the risks associated with the unsafe management of medicines.** • Staff did not always complete the prescribing charts properly. Missing information, such as how long patients took antibiotics for, or the reason for prescribing a medicine, meant it was unclear if patients received medicines consistently or as the prescriber intended. This was in breach of Regulation 13 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The trust did not protect patients from the risks associated with unsafe or unsuitable premises by means of suitable design and layout.** • On the acute admission wards there were 25 incidents relating to the use of a ligature attached to a fixed object. One patient attempted to strangle themselves with a ligature during our inspection. This was in spite of serious concerns identified to the trust by the Care Quality Commission as part of our ongoing regulatory inspections. Two deaths due to self-ligature had happened over the past 12 months. There were a number of similar deaths in the previous years. The trust had made ligature risk assessments and had plans to address these but there were still an unacceptable number of ligature risks identified during the inspection. • Some seclusion rooms were not fit for purpose. For example, this facility on Ardleigh ward did not have an ensuite facility. On Peter Bruff ward, the seclusion room contained ligature points , including toilet rails and taps on the sink. **This was in breach of Regulation 15 (1) (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The trust did not take appropriate steps to ensure there were sufficient numbers of staff.** • A total of 4249 shifts were filled by bank or agency staff to cover sickness, absence or other vacancies within the acute admission wards over the past twelve months. We noted that 239 shifts had not been filled by bank or agency staff where there was sickness, absence or vacancies. This meant that there was an insufficient number of staff. • The trust reported 1,565 substantive staff in post on 30th April 2015 with 268 leavers in the past 12 months. The trust reported staff turnover as 14%. This was

This section is primarily information for the provider

Requirement notices

above the national average for similar sized mental health trusts. This meant that the quality and consistency of care could have been adversely affected as a result.

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The trust did not protect patients, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the trust to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.** • The trust did not have robust governance processes, particularly in the assessment and management of ligature risks, assessment of the quality of care plans, and the management of local risks. • The trust did not have robust systems to share lessons learnt from incidents and teams did not integrate these into their practice. We found that nothing had been done to identify best practice elsewhere to support local action. **This was a breach of Regulation 10 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The trust were not ensuring that the care and treatment of patients is appropriate, meets their needs, and reflects their preferences. • Overall, care plans were not personalised and did not include patients' views, nor were they recovery orientated, for example, they did not include the patients' strengths and goals. • A number of patients told us that they had not been involved in devising their care plan and had not received a copy of their care plan. • There was a blanket restriction in place at the Derwent Centre, whereby each patient had to attend the Hub each day at 10am. • We observed, and patients told us that there was a lack of meaningful activities taking place on a number of the wards and in the Hub. **Regulations 9(1)(a)-(c), 9(3)(a)-(b), 9(3)(d) and 9(3)(f).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The trust were not ensuring that patients are treated with dignity and respect.

This section is primarily information for the provider

Enforcement actions

- The bedroom windows, on Gosfield ward, faced onto the garden of Ardleigh ward. There was no privacy film on the windows and the curtains did not fully cover the entire window.
- Two patients expressed concern about a lack of privacy and dignity.
- The Hub offered little space for patients to have privacy.
- One patient did not want a male keyworker, though had been allocated one.

Regulations 10(1) and 10(2)(a).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust were not ensuring that care and treatment is provided in a safe way for patients, by assessing the risks to the health and safety of patients of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. • Not all wards within this core service complied with guidance on same sex accommodation. • Wards had potential ligature points that had not been fully managed or mitigated. • Observation was not clear within some of the acute wards. • The seclusion facilities on two acute wards did not have safe and appropriate environments. **Regulations 12(1), 12(2)(a)-(d) and 12(2)(g)-(h).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients who may be at risk which arise from the carrying on of the regulated activity, and systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services), are not operating effectively.

- Systems to check the quality of the care plans systems did not identify and remedy the limitations in the quality of the care plans.
- Systems to provide patients with activities did not identify and remedy the limitations in the activities provided.
- Systems to identify and manage ligature risks in the patient care areas did not identify all the risks relating to ligatures.

Regulations 17(1), 17(2)(a)-(c) and 17(2)(f).