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. (Acute Wards or PICU)	Chelmer and Stort mental health wards The Linden Centre Mental Health wards The Christopher Unit	RRDX1 RRDY3 RRDY6
Wards for older people with mental health problems	The King's Wood Centre Kitwood and Roding Mental Health Wards	RRDY7 RRD15

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.

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We found the following issues that the trust needs to improve:

- We were concerned about the safety of some of the ward environments. Many of these were issues that we had raised at our last inspection. Staff did not always assess risks on wards or manage risk from ligature points well; including on wards with poor lines of sight. The Christopher unit and older people wards that admitted both men and women did not comply with the requirement to provide same-sex accommodation. The Christopher unit's seclusion room did not meet the standards outlined in the Mental Health Act Code of Practice. Staff subjected patients to blanket restrictions on acute wards. The trust was not sharing learning from incidents effectively with staff and the trust's incident reporting policy and procedures needed updating to reflect national guidance.
- The trust did not ensure wards were fully staffed as wards staffing shifts were unfilled due to staff sickness or leave; all wards had staffing vacancies, and were using bank and agency staff. The trust did not ensure that staff received clinical supervision and training regularly.
- The trust did not ensure a consistent approach to staff administration and storage of medication across acute and older people wards as we found gaps in staff records and problems with medication storage.
- Staff did not check the equipment and environment in line with trust policy. Refurbishment work and repairs were not always finished to a high standard.
- Fifteen percent of patients' records did not contain detailed information which included risks and they had not been updated regularly.
- Staff had recorded 26% of staff restraints on patients on these wards were in a prone position.
- The trust staff survey action plan did not detail how the trust was responding to the key issues from the 2015 results.

However we found the following areas of good practice:

- Ninety five percent of patients gave positive feedback about the staff, and their experience of care on the wards. Eighty seven percent of patients and 66% of carers said they were involved in discussions about their or their relatives care. Seven wards used 'my care, my recovery' booklets to capture this involvement. Staff and patients spoke positively about the restraint training staff used and said the new techniques made them feel safe and less fearful.
- Ward staff used regular agency and bank staff to ensure that patients received consistent staff care.
- Ninety one percent of patients had comprehensive and detailed risk assessments.
- Managers at Chelmer and Stort Mental health wards gave examples of effective performance management of staff. The trust had an independent 'Guardian Service' for staff to contact regarding any matters relating to patients' care and safety, and staff concerns.
- Staff on older people's wards were proud of their work and felt supported to deliver care. They were changing to use a 'functional model' with reference to the 'new ways of working' initiative led by the Royal College of Psychiatrists and the National Institute of Mental Health in England.

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?

We found the following issues that the trust needs to improve:

- The trust did not monitor that actions from the last inspection had been completed effectively. Staff's management of ward ligature point risks and ward risk assessments still varied across services. Acute and psychiatric intensive care unit (PICU) ward assessments still held limited details of how staff managed risks. Six wards did not have clear lines of sight for staff to observe patients. Galleywood staff were not using mirrors in place to aid their observation.
- The trust did not adhere to guidance on mixed sex accommodation. Patients' did not have separate sleeping and bathroom areas on the PICU and older people's wards, and patients had to walk through an area occupied by another sex to reach toilets or bathrooms.
- The trust did not ensure that the seclusion room for use by the Christopher unit met the standards outlined in the Mental Health Act Code of Practice. It was dark, noisy and patients did not have easy access to a toilet.
- Staff did not check the equipment and environment in line with trust policy. Refurbishment work and repairs were not always finished to a high standard.
- Staff subjected patients to blanket restrictions. For example on PICU and acute wards, patients did not have easy access to drinks, toilets and the garden.
- The trust did not ensure wards were fully staffed as wards had staffing vacancies, and whilst bank and agency staff were used staffing shifts were unfilled due to staff sickness or leave. Chelmer and Stort ward staff said the service they gave was affected by this.
- The trust did not effectively share learning from reported incidents with staff to reduce future risks at the Linden Centre mental health wards and older people's wards. The trust incident reporting policy and procedures did not give clear information for staff reference for reporting and investigating incidents and did not reflect current national guidance
- The trust did not ensure a consistent approach to staff administration and storage of medication across acute and older people wards as we found gaps in staff records and problems with medication storage.

Summary of findings

- Fifteen percent of patients' care records did not contain detailed information which included risks and they had not been updated regularly.
- Staff had recorded 26% of staff restraints on patients on these wards as in a prone position.

However, we found the following areas of good practice:

- Ward staff used regular agency and bank staff to ensure that patients received consistent staff care.
- Ninety one percent of patients had comprehensive and detailed risk assessments.
- Staff and patients spoke positively about the restraint training staff used and said the new techniques made them feel safe and less fearful.

Are services caring?

We found the following areas of good practice:

- Ninety five percent of patients gave positive feedback about the staff, and their experience of care on the wards. Ninety five percent of patients said they were able to approach staff to talk about any issues they had.
- Eighty seven percent of patients and 66% of carers said they were involved in discussions about their or their relatives care. Seven wards used 'my care, my recovery' booklets to capture this involvement.

However, we found the following issues that the trust needs to improve:

- Heneage ward staff did not record their involvement of patient or carers in care planning. Christopher Unit patients were not aware that they could have advance decisions to give their views on how staff should support them in the event their mental health deteriorated. Two carers for relatives on Chelmer ward said they were not effectively involved in discharge planning.
- One patient and two carers for patients on Chelmer ward told us that some staff were rude. Four patients on Galleywood ward told us that bank and agency staff were not as helpful as permanent staff.

Are services well-led?

We found the following issues that the trust needs to improve:

- The trust did not monitor that actions from the last inspection had been completed effectively. Their systems for overseeing

Summary of findings

governance did not identify and respond to all the risks previously identified. Examples of risks for these services related to the management of ligature risks, mixed sex accommodation, maintaining environments and equipment and staffing.
- The trust did not ensure that staff received clinical supervision and training regularly.
- The trust did not ensure that the staff survey action plan detailed how they were responding to the key issues from the 2015 results. Staff morale was lower on Chelmer and Stort wards.

However ,we found the following areas of good practice:

- Managers at Chelmer and Stort Mental health wards gave examples of effective performance management of staff.
- The trust had an independent 'Guardian Service' for staff to contact regarding any matters relating to service users care and safety, and staff concerns.
- Staff on older people's wards were proud of their work and felt supported to deliver care. They were changing to use a 'functional model' on older peoples wards with reference to the 'new ways of working' initiative led by the Royal College of Psychiatrists and the National Institute of Mental Health in England.

Summary of findings

Our inspection team

Our inspection team was led by:

Team leader: Victoria Green, inspection manager, mental health hospitals.

Lead inspector: Kiran Williams, inspector, mental health hospitals.

The team included four CQC inspectors and two inspection managers. We were supported by an expert by experience that had personal experience of using the type of service we were inspecting and specialist advisors consisting including two nurses and a social worker.

Why we carried out this inspection

We originally inspected this trust in August 2015. We found that significant improvements were required and issued a Section 29A Warning Notice. Our subsequent monitoring highlighted a number of concerns and we decided to carry out a focused inspection to examine these. These concerns included whether the trust was learning from incidents and taking action to prevent reoccurrence, whether the trust was safeguarding patients adequately, whether it was involving patients and carers in their care, staff morale as we had received concerns about bullying and the support staff received, and concerns about the ward environments.

The inspection focused on three key questions, safe, caring and well led. The CQC focused the inspection on two core services and five locations:

- Acute wards for adults of working age and psychiatric intensive care units: Chelmer and Stort mental health wards; The Linden Centre Mental Health wards and The Christopher Unit.
- Wards for older people with mental health problems: The King's Wood Centre and Kitwood and Roding Mental Health Wards.

Following the focused inspection, the CQC identified that whilst the trust had made various improvements since our last inspection, the trust's governance systems still needed significant improvement. Areas for improvement included the trust's assessment and management of risks for fixed ligature points on wards; the minimisation of blanket restrictions, ensuring that segregated accommodation for men and women was provided; that seclusion rooms met the Mental Health Act code of practice and that learning of lessons was shared with staff following incidents.

The CQC issued a further section 29A warning notice for regulation 17 good governance, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the trust.

We carried out an unannounced visit on 14 and 15 of September 2016.

During the visit we

- visited the eight wards at five locations
- spoke with 24 patients using the service
- spoke with six carers or relatives of patients
- spoke with 27 staff members; including nurses, healthcare assistants, doctors, occupational therapists, administration staff, a pharmacist and arts therapist
- spoke with 11 managers, including ward managers and other senior staff including the trust safeguarding lead and medical director
- reviewed 46 care and treatment records relating to patients.
- observed a staff handover and a patient community meeting

Summary of findings

- observed how staff were caring for people
- reviewed information we had asked the trust to provide
- reviewed a range of policies, procedures and other documents relating to the running of the service.

Information about the provider

North Essex Partnership University NHS Foundation Trust provides mental health, substance misuse and social care services and support for over 17,000 people and their families in north Essex. They have over 70 sites. The interim chief executive is Christopher Butler.

The trust is registered with the CQC for 39 locations and the following regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury.

CQC has inspected the trust 22 times across 14 locations since registration in April 2010.

In August 2015, the CQC carried out a comprehensive inspection of the trust and rated the trust overall as 'requires improvement'.

The core service 'acute wards for adults of working age and psychiatric intensive care units' was overall rated as 'inadequate'. The core service 'wards for older people with mental health problems' was overall rated as 'requires improvement'.

A section 29A warning notice was issued by the CQC for the trust to make significant improvements. These related to regulation 9 person-centred care; regulation 10 dignity and respect; regulation12 safe care and treatment and regulation 17 good governance , The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with a date for making the significant improvements by 30 November 2015.

The trust sent the CQC action plans for addressing the warning notice and other requirement notices and a quality summit meeting took place February 2016.

The CQC has been notified that the trust is due to merge with South Essex Partnership University NHS Foundation Trust in April 2017.

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

Chelmer and Stort mental health wards are based near the Princess Alexandra hospital in Harlow:

- Stort ward has 16 beds for men aged 18 years and over; 16 beds were occupied during our visit.
- Chelmer ward has 16 beds for women aged 18 years and over and a four bed annexe; 16 beds were occupied during our visit.

The Linden Centre Mental Health Wards are based near Broomfield Hospital, Chelmsford and has two wards:

- Galleywood ward has 24 beds for women aged 18 years and over, including one detoxification bed; 18 beds were occupied during our visit.
- Finchingfield ward has 23 beds for men aged 18 years and over; 17 beds were occupied during our visit.

The Christopher Unit is near the Linden Centre Mental Health Wards. It is described as a psychiatric intensive care unit with eight beds catering for men and women. However, the trust had recently increased to 10 beds and eight beds were occupied during our visit.

Wards for older people with mental health problems

The King's Wood centre is near Colchester Hospital. It has one assessment and treatment ward of older adults with functional disorders, mixed sex ward:

- Heneage ward has 15 beds for men and women. However, we found there are 17 beds, with 16 beds occupied during our visit.

Kitwood and Roding Mental Health Wards are near St Margaret's hospital, Epping and have two assessment and treatment wards for older people, both are mixed sex:

- Kitwood ward has 16 beds for people with an organic illness; 15 beds were occupied during our visit.
- Roding ward has 14 beds for people with a functional illness; 12 beds were occupied during our visit.

Summary of findings

What people who use the provider's services say

Ninety five percent of patients were positive about the staff, and their experience of care on the wards. Patients and their families or carers were involved in discussions about their care except on Heneage ward staff did not record this involvement for six patients. Christopher Unit patients were not aware that they could have advance decisions to give their views on how staff should support them in the event their mental health deteriorated. Two patients said that staff only offered them medication as a treatment as opposed to being offered other therapy.

Two carers for relatives on Chelmer ward told us that patients were being discharged too soon and that staff did not effectively involve carers in discharge planning for them.

Ninety five percent of patients said they felt safe on wards and carers said the older people's wards were safe, clean and tidy. Four women on Galleywood ward said they did not feel safe using the communal dining room with a male ward.

Ninety five percent of patients said they were able to approach staff to talk about any issues they had. One patient said staff was rude. Two carers for patients on Chelmer ward told us some staff were rude and staff did not always support and supervise patients. On Galleywood ward four patients told us that bank and agency staff were not as helpful as permanent staff.

Twelve percent of patients told us that staff did not orientate them to the ward when they first arrived. Two Christopher Unit patients said that staff did not tell them about the ward rules and staff had an inconsistent approach with them.

Good practice

- The trust had arranged for Essex floating support service provided by Family Mosaic to visit Chelmer and Stort wards and gave support to inpatients such as regarding housing, employment and benefits advice.

Areas for improvement

Action the provider MUST take to improve

- The trust must improve their governance and assurance systems relating to the assessment and management of risk such as ligature risks, mixed sex accommodation and learning from incidents.
- 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 the Christopher unit seclusion room is fit for purpose.
- The trust must ensure that it complies with Department of Health guidance in relation to mixed sex accommodation.
- The trust should ensure learning from serious incidents is shared with teams to ensure future risks are mitigated.
- The trust must ensure that emergency equipment is fit for use.
- The trust must have effective systems in place for the safe administration and storage of medication.
- The trust must ensure there is sufficient staff on duty at all times to provide skilled care to meet patients' needs.
- The trust must ensure that all staff receive regular supervision, and training.

Summary of findings

- The trust must proactively address any practices that could be considered restrictive, for example, access to toilets, access to the gardens, and access to snacks and beverages.
- The trust must ensure that wards ensure dignity and comfort for patients and that maintenance is completed in a timely manner.
- The trust must ensure that policies and procedures give clear information for staff reference when reporting incidents. That policies and procedures are updated to reflect current national guidance.
- The trust must ensure that wards have sufficient bathrooms for patients to bathe or shower in.

Action the provider SHOULD take to improve

- The trust should ensure that care and treatment records, including risk assessments, are sufficiently detailed, personalised and kept up to date.
- The trust should formally review each restraint involving the prone position.
- The trust should ensure that their action plans clearly state how they are addressing issues raised from the NHS staff survey.

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 found the following issues that the trust needs to improve:

- The trust did not monitor that actions from the last inspection had been completed effectively. Staff's management of ward ligature point risks and ward risk assessments still varied across services. Acute and psychiatric intensive care unit (PICU) ward assessments still held limited details of how staff managed risks. Six wards did not have clear lines of sight for staff to observe patients. Galleywood staff were not using mirrors in place to aid their observation.
- The trust did not adhere to guidance on mixed sex accommodation. Patients' did not have separate sleeping and bathroom areas on the PICU and older people's wards, and patients had to walk through an area occupied by another sex to reach toilets or bathrooms.
- The trust did not ensure that the seclusion room for use by the Christopher unit met the standards outlined in the Mental Health Act Code of Practice. It was dark, noisy and patients did not have easy access to a toilet.
- Staff did not check the equipment and environment in line with trust policy. Refurbishment work and repairs were not always finished to a high standard.
- Staff subjected patients to blanket restrictions. For example on PICU and acute wards, patients did not have easy access to drinks, toilets and the garden.
- The trust did not ensure wards were fully staffed as wards had staffing vacancies, and whilst bank and agency staff were used staffing shifts were unfilled due to staff sickness or leave. Chelmer and Stort ward staff said the service they gave was affected by this.
- The trust did not effectively share learning from reported incidents with staff to reduce future risks at the Linden Centre mental health wards and older people's wards. The trust incident reporting policy and procedures did not give clear information for staff reference for reporting and investigating incidents and did not reflect current national guidance
- The trust did not ensure a consistent approach to staff administration and storage of medication across acute and older people wards as we found gaps in staff records and problems with medication storage.
- Fifteen percent of patients' care records did not contain detailed information which included risks and they had not been updated regularly.
- Staff had recorded 26% of staff restraints on patients on these wards as in a prone position.

However we found the following areas of good practice:

- Ward staff used regular agency and bank staff to ensure that patients received consistent staff care.
- Ninety one percent of patients had comprehensive and detailed risk assessments.
- Staff and patients spoke positively about the restraint training staff used and said the new techniques made them feel safe and less fearful.

Our findings

Safe and clean environment

- Six ward layouts did not allow staff to easily observe all parts of the ward. Since our last inspection the trust ensured that Galleywood ward now had mirrors to aid staff's observation of the ward. However, staff were not aware of their purpose which still posed a risk of patients not being observed and there were still unobservable areas on the ward such as a corridor. For

older people wards, Heneage ward had introduced mirrors to aid visibility of patients. The Christopher Unit and some acute wards have limited closed circuit television (CCTV) in some communal areas to aid staff visibility of patients in these areas.

- Ligature points remained across all wards and included high level door closers, door handles, radiators and window handles. The trust said they would take actions to make improvements to reduce and manage ligature risk. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The trust had taken some actions to reduce ligature points such as changing bedroom furniture and some furnishings. Patients had individual risk management plans for self-harm. Wards had identified bedrooms with less ligature risks for patients with higher risk of self-harm. Wards had ligature cutters available in the event of an emergency and staff knew where these were. Staff gave examples of how they used observations to reduce the risks of patient using ligatures. Ligature points presented a risk in two toilets on Stort ward that staff kept locked and opened on request. Staff left open three toilets that had no ligature points for patients to use. The psychiatric intensive care unit (PICU) and acute wards had top door sensors to reduce the risk of a patient using them as a ligature point with plans to install them for older people's wards. Finchingfield ward staff's weekly checks of these did not take place for these as we only found one for August 2016.
- Trust data from April to September 2016 showed 20 incidents involving a patient using a ligature on the PICU and acute wards, showing that patients still presented with high risk of self-harm. Two of these incidents related to a patient trying to tie the ligature to a fixed point such as a chair and a door. The highest amount of incidents was for Finchingfield ward with six incidents and Stort had two. The Christopher unit had three incidents and older people's ward had none.
- The trust did not ensure that all risks for ligature points were reduced and managed by staff in a consistent way. The quality of ward staff assessments of ligatures varied. Some ward assessments held limited or conflicting information about the actions staff should take. For example, Chelmer ward's ligature action plan gave an area a 'serious' risk rating whereas the audit action plan July 2016 gave a 'moderate' rating. Stort ward's ligature assessment gave a staff action of 'adjust clinical practice to mitigate the risk' for various low, medium and high risks without differentiation. Some wards had pictures of relevant ligature 'hotspot' areas to help staff identify the need for more observation of those areas, yet the Christopher Unit for higher risk patients did not. For acute wards, Galleywood ward had fire safety equipment in a corridor which was not easily observable by staff as it was behind a corner. It was rated as a 'medium' risk and staff said they completed hourly checks of the area.
- The trust did not adhere to guidance on mixed sex accommodation. Four wards did not meet the Department of Health's requirement that trusts provide segregated accommodation for men and women. Information from the trust showed they did not report any recent breaches. Since our last inspection, the trust ensured that the Christopher Unit had separate bedroom areas for men and women. Five bedrooms did not have ensuite bathrooms but men shared a bathroom. However, due to the demand of patients needing admission, men were in the women's area and the only woman was moved to a bedroom near the nursing station. This meant that men would have to pass by her room to get to their bedrooms or bathroom. The ward's risk register highlighted this risk. The women's lounge had no television or radio which we had highlighted at our last inspection.
- Heneage ward had mixed sex accommodation. There was no separate female lounge. Bedrooms did not have ensuite bathrooms except for the initial assessment room and rooms had washbasins. There were not designated male and female bedroom areas. There were separate toilets. Sixteen patients shared one bathroom, which was not sufficient for the number of patients on the ward. One patient raised this with us during our visit. We saw other complaints by patients about this raised in community meetings and from the family and friends test feedback forms for March 2016. Kitwood and Roding also were mixed sex wards and the women's lounges were not in use as items were stored there. Roding's room was not set up as a lounge; instead it had a large table with art and crafts resources around the room. There were no designated grouped male and female bedroom areas however the ward design had clearer lines of sight for staff to observe patients.

Are services safe?

- Finchingfield (male) and Galleywood (female) wards used a communal dining room and four women told us they did not feel safe using it. When we visited the dining room we saw staff needed to support a man when he became aggressive.
- The trust had ensured that patients at Chelmer and Stort wards had choices about if they went to communal area for activities known as 'the hub'. It was still occasionally used by patients from Chelmer and Stort wards and staff said this was at patients' choice. This meant men and women may be in the area at the same time. However, we saw that each patient had an individualised care plan for this.
- Staff did not check the equipment and environment in line with trust policy. For Chelmer and Stort acute wards staff gave inconsistent information whether the cardiac arrest trolley should have weekly or daily checks. We found gaps from 08 September to 14 September 2016 records which had previously shown daily checks. The defibrillator and thermometer required servicing. This was of concern as following an incident in March 2016 the local acute hospital had given the wards one of their trolleys to replace an old one and training for staff regarding equipment. Stort ward had an oxygen mask that was not in a sterile bag.
- For older people's wards there was a gap in Roding wards staff weekly treatment room checks from April to September 2016. There were seven entries indicating checks were now monthly but none for August. Heneage ward's electro cardiogram machine did not have a service sticker for when it was last checked. At this inspection, we again found that Kitwood had an oxygen cylinder which had expired which we brought to staff's attention.
- The trust did not ensure that the seclusion room for use by the Christopher unit met the standards outlined in the Mental Health Act Code of Practice. The two way intercom for patients and staff was from the room to the nurses' office and if a staff member was outside the seclusion door it would be difficult to hear a person even if shouting. There was CCTV available in the staff office. During our visit it was a hot day and the room was hot with no ventilation, a loud humming noise was present which could be distressing to patients. There was no clock, the room was painted dark green and one light was not working which made the room dark. The toilet was not accessible from the room. The trust informed us that upgrade work was currently taking place and would be completed by March 2017.
- Wards were clean. However, refurbishment work and repairs were not always finished to a high standard. For the acute wards, on Finchingfield ward a bathroom was refurbished but a shelf was not secured which could pose a risk to patients or others. Refurbishment was still taking place at the Derwent centre so existing wards were shabby as wards were due to move. Chelmer ward had damp in some corridors. The clinic wash basin was dirty. On Stort ward some windows did not open which made areas hot, the temperature when we visited was above 25 degrees Celsius. At the Linden Centre, Galleywood ward shower curtain rails were being replaced to minimise risk of ligature points. However the manager was not fully aware of the rationale for this and could not identify if current ones in place met national guidance requirements.
- The trust had daily environmental staff checklists. For the older people's wards, Heneage staff did not complete these checklists three times a day as required from 4 September to 10 September 2016; instead one daily check was made. One of the lights in the bathroom was not working; a lounge door could not be closed. One of two wash basins in the initial assessment room was not working and there was a stain on the floor. Kitwood's washing machine was broken for two weeks. A disabled toilet was out of use due to flooding the previous day by a patient but other toilets were available. Ceiling tiles were damaged and stained and one was missing in the female lounge following a recent flood which showed exposed pipework. Wards were being decorated with panelling to prevent adjustable beds from marking walls. Maintenance staff attended whilst we were visiting.
- The trust did not ensure that wards had adequate storage. For example, items were stored in the emergency equipment room for Chelmer and Stort wards, a large beanbag prevented easy access to the emergency trolley. Heneage ward's sluice room and staff room stored patients belongings, three mattresses were stored in a doctor's office and the assisted bathroom also had equipment stored. Office space was limited so staff went off the ward for daily handover meetings.

Are services safe?

- Older people's wards had nurse call systems in patients' rooms and across all wards staff had alarms to summon assistance if required.
- Patients had room key access unless a risk assessment identified they should not. Kitwood patients did not have key access to their rooms and staff would open their room at their request. A Galleywood patient said they had lost property as cleaners left their door open and staff did not give them a list of their property on admission.
- Ward telephones were not in a private area for the Christopher Unit and Heneage ward but staff said patients had their own mobile telephones.

Safe staffing

- The trust did not ensure that wards were fully staffed as wards had staffing vacancies. Whilst bank and agency staff were used, staffing shifts were unfilled due to staff sickness or leave. Chelmer and Stort ward staff said the service they gave was affected by this. Ward staff told us they tried to use regular bank or agency staff, except Stort and Heneage wards where they said it was difficult to get staff to work with suitable skills.
- The trust did not have sufficient permanent nursing staff to cover all shifts working on the wards. A sample of staffing rotas for the previous six weeks showed wards as regularly needing bank or agency staff to ensure adequate staffing. The trust had particular staffing challenges over the August bank holiday weekend. The psychiatric intensive care unit rota showed no permanent staff on duty for two nights, 01 and 02 August 2016. For acute wards, Stort ward had no permanent qualified nurses for 24 hours on 28 August 2016 other than the ward manager during the day. On Finchingfield there was no permanent staff on duty at night for 01 and 02 August 2016, and the bank holiday weekend.
- Information from the trust for June to August 2016 for bank and agency nursing staff usage showed the Christopher Unit PICU as having the highest amount of bank shifts with 206 and 94 agency shifts for June. Chelmer had the highest bank use for acute wards with 204 in August and Stort had the highest agency shift use with 156 in June. Kitwood ward had the highest use for older people's wards with 181 bank shifts and 44 agency shifts in June.
- Trust staff did not cover all nursing staff shifts for the wards and they had shortfalls in nursing shifts being filled. The Christopher Unit had 27 shifts unfilled. For acute wards Chelmer ward had the highest amount with 71 unfilled shifts, Stort had 45, Galleywood had 33 and Finchingfield had 31. For older peoples wards Heneage had the highest amount with 56 unfilled shifts, Kitwood had 25 and Roding had 14 unfilled shifts.
- The trust had developed recruitment plans which included considering recruitment opportunities abroad with another trust. However all wards had staffing vacancies. The Christopher Unit PICU had five nurse vacancies. For acute wards, Galleywood had five nurse whole time equivalent (wte) and two healthcare assistant (HCA) vacant posts; Finchingfield had two nurse and HCA vacancies with two staff on maternity leave which were not backfilled. Stort had 5.5 wte nurses and 0.5 wte HCA vacancies; Chelmer ward had one nurse and two HCA vacancies and used five regular agency staff to ensure consistency of approach with patients. Older people's wards had less staffing vacancies. Heneage had one nurse vacancy, Kitwood had one HCA vacancy and Roding had two nurse vacancies.
- Staff detailed staffing concerns on ward risk registers for the Christopher unit, Chelmer, Stort, Galleywood and Finchingfield and Heneage wards.
- The trust had developed nursing associate roles across wards for healthcare assistants to have increased roles and responsibilities to help meet patients' needs.
- The trust were piloting 'safe care' on information technology tablets to give real time up to date staffing information to ensure wards have the right staff with the right skills available. Stort were due to use this in October.
- Ward staff said they had adequate medical cover in the day and at night.
- The trust did not ensure that the staff mandatory training target of 85% was met. This meant that not all staff had received the required level of refresher training.
- Out of a maximum of 24 subjects, Christopher Unit staff did not achieve 10 training targets. For acute wards, Chelmer did not achieve 16, Stort did not meet nine targets, Galleywood did not meet six targets and

Finchingfield did not achieve three. Kitwood and Heneage ward staff did not achieve 15 mandatory training targets and Roding ward did not achieve two. Medical staff did not achieve trust training targets for 18 out of 20 subjects.

Assessing and managing risk to patients and staff

- The trust reported that in the last six months there were two episodes of seclusion on the Christopher Unit and one on Heneage ward (where a distressed patient was managed in their bedroom). There were no reported episodes for other wards. One patient's seclusion record did not have the end date, for another patient's record the time of the second review was blank, for another record the patient reference number was missing, and the primary review time was not recorded.
- The trust reported that in the last six months the Christopher Unit had 21 reported restraints with six patients restrained in the prone position. Prone position restraint is when a patient is 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. Staff informed us that they had taken 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). Staff spoke positively about therapeutic and safe interventions 'TASI' training and staff said they these de-escalation techniques initially and restraint was only used as a last resort. Patients confirmed this, although one Christopher Unit patient and some patients on Galleywood said when they were restrained in the past some staff were "rough" in their approach.
- The trust reported that in the last six months for acute wards that Galleywood ward had 42 patient restraint occasions with 15 as prone; Finchingfield had 11 with one prone restraint. Chelmer ward had eight with one prone restraint. Stort ward had seven restraints with one as prone. Of these incidents, staff had restrained 26% of acute ward patients in the prone position. Heneage staff had made 24 restraints with one in prone position. Kitwood ward staff had made one restraint and Roding staff had made four restraints none were in the prone position.
- On Chelmer ward, staff had not detailed a patient's views on the restraint in records. Staff had not recorded on another patient's record in August 2016, if staff had used verbal de-escalation techniques.
- Staff did not update a patient's risk assessment following a restraint incident 12 August 2016. Staff had inaccurately completed an incident form in June 2016 which showed staff held them to prevent them self-harming but it was not recorded as restraint.
- The trust had ensured that since our last inspection, ward staff had achieved over the 85% trust target for TASI/personal safety (including restraint and breakaway) but had not ensured that the target for TASI/personal safety was achieved. The lowest was Chelmer ward with 27% compliance. Heneage ward manager said it was difficult to get TASI staff training places locally and the alternative was to travel to Harlow which staff considered was too far to travel to.
- The trust had ensured that most patients had up to date comprehensive, detailed risk assessments and care plans across wards. However, on Chelmer ward staff had not updated a patient's care plan since May 2016 and a risk assessment updated 19 July was not fully completed. Staff did not complete two patients' risk assessment within 72 hours of admission. Heneage ward staff did not complete a specific care plan for a patient with diabetes; another care plan was not present for a patient relating to their medication being stopped. Whilst the trust used electronic patient records, older people's wards also used paper folders. On Roding ward staff did not update one patient's care plan by the given review date of 04 September 2016. Heneage staff had recently identified completion of documentation and risk assessments on their risk register as there was not a single place for holding records. This posed a risk of staff being unable to find them when needed. For this ward a trust audit 01 September 2016 sampled five records. Two showed no multi-disciplinary team involvement in the risk assessment but showed links between the risk assessment and care plan.

Are services safe?

- The trust performance dashboard as of 14 September 2016 showed 100% inpatients had a crisis plan in place in the event of their mental health relapsing.
- Staff subjected patients to blanket restrictions. For example on the Christopher Unit, Finchingfield and Galleywood patients did not have access to make their own drinks (hot or cold). Chelmer and Stort ward staff restricted all patients' access to cigarettes and lighters rather than considering individual's risks.
- The trust had not ensured a consistent approach towards searching patients. Their policy gave a list of items not allowed in inpatient wards but in contrast stated that restricted items and searches would be subject to professional assessment. Wards had lists of restricted items for patients and this varied across services. For example, plastic bags were banned on Heneage ward following incidents of attempted patient self-harm. This is not detailed in the patient guide. In contrast Kitwood and Roding ward information leaflets held limited details regarding restricted items. A staff member on the PICU ward told us they had a system for searching patients. Finchingfield patients said they were searched by staff who took harmful things away. One relative said Chelmer ward staff did not routinely search patients' possessions to reduce risk items being brought onto the ward, despite an action from a serious incident that staff should improve their processes.
- We checked a sample of staff observations records of patients. For three patients on Heneage ward we found gaps for some entries 02 to 09 September 2016 with either no coded entry showing the patient location when checked or staff signature confirming they had observed the patient.
- The trust did not ensure a consistent approach to staff administration and storage of medication across acute and older people wards. We found some gaps in staff records relating to medicines management. On Chelmer ward, a staff entry for controlled drugs was made twice on two different pages. There was a missing second signature on a record for administration of a patient's pain relief medication which staff signed in front of us when we brought it to their attention (as opposed to the when it was administered with the patient). There were ten missing staff signatures on records to confirm administration of medication to patients. For Stort there were four missing staff signatures on medication administration records, two related to anti-psychotic medication. A Roding patient had two prescription records as they were refusing oral medication and were prescribed an injection. The doctor did not cancel the first one.
- Additional storage issues included, on Chelmer an emergency medication for patients with diabetes was not sealed, which staff replaced when we brought to their attention. There were five records in September 2016 when room temperatures exceeded 25 degrees Celsius and two fridge temperatures were recorded by staff as over eight degrees with no actions recorded as taken to ensure that medication was not affected. Stort ward's medication stock cupboard was unlocked; a first aid box saline solution had expired. Products with limited life did not have opening dates detailed for Finchingfield, Galleywood and the Christopher Unit. Heneage ward's medication fridge was unlocked when we initially inspected but was later locked.
- We had previously identified that the national institute for health and care excellence (NICE) guidance and medication prescribing relating to falls was not being followed on some older people's wards. At this inspection, we checked patient's prescription cards and care plans and found no issues. On Chelmer and Stort staff monitored the health of patients receiving high dose anti-psychotic medication.
- The trust had systems for staff to report safeguarding concerns and staff told us they could contact the trust leads. They had access to the trust's safeguarding intranet site to gain information or reported issues directly to the safeguarding leads.
- The trust target for staff completing safeguarding adult and children training was 95%. Wards varied with their staff compliance for example, latest training data provided by the trust showed for the psychiatric intensive care unit, 92% completion of level one, 81% level two and 64% level three training. For acute wards Chelmer ward showed 93% compliance for level one, 90% level two and 56% level three training. For wards for older people, Heneage ward had achieved 100% for level one and two and 89% for level three training.
- The trust safeguarding lead showed us their process for monitoring safeguarding concerns that staff reported and ensuring that investigations took place. We also

saw them visiting wards giving out posters to promote safeguarding processes. They talked to managers about staff training and development issues. A clinical safeguarding specialist attended a handover meeting at The Christopher Unit to contribute to the team discussion.

- Kitwood ward manager gave an example where they had raised an issue with senior staff for an identified variation in the trust training data which showed approximately 60% ward staff attendance with training, whereas their ward records showed over 90% compliance. They had also raised a safeguarding concern within the trust September 2015 which they expressed concern that was not investigated until January 2016 and no feedback was given on the outcome. They had reported this to their managers.
- The trust had requested an independent review of staff practices for serious safeguarding incidents reported in 2015 which related also to Chelmer and Stort wards. Following this, managers met to identify actions and processes to share learning with staff to prevent future risks but had not developed a specific action plan to address issues.

Track record on safety

- The trust informed us that from October 2015 to September 2016 there were two reported serious incidents (SIs) for the psychiatric intensive care unit (PICU). There were nine SIs for acute wards for adults of working age, six for Chelmer and three for Galleywood wards. There were four SIs for wards for older people with mental health problems, two each for Heneage and Kitwood wards.
- The trust had not reported any 'never events'. These are serious incidents that are preventable as guidance or safety recommendations should have been implemented by all healthcare providers.
- The trust had received a prevention of a future death report relating to another location, The Lakes Mental Health Wards, in the acute wards for adults of working age core service. The trust had shared information and learning across those wards we visited and actions were taken to minimise future risks.
- The trust had reported seven incidents of patient reported injuries, diseases and dangerous occurrences in health and social care (RIDDORS), for these wards in 2016. Five related to Heneage ward at the Kingswood Centre, one was for the Linden Centre Mental Health Wards and one for Chelmer and Stort Mental Health Wards.

Reporting incidents and learning from when things go wrong

- The trust ensured that staff knew how to report incidents. Staff and patients gave examples of when incidents had occurred and had been reported and we saw examples of this. The trust had displayed posters to encourage this for example at the Kingswood Centre encouraging staff and patients to report incidents.
- However, we found variations in the management of incidents, once reported. Heneage ward had 48 outstanding incident reports from July 2016 requiring a management review because of the ward manager's leave and unavailability due to other off site work. Five records did not have an identified patient name completed by staff which was time consuming for the manager as they had to investigate patient care records further to identify who the incident related to.
- The trust had not ensured that staff always had up to date information to refer to their work. We saw two different examples of the trust incident reporting policy and procedure, one dated 2014 on the wards and a revised version sent to us by the trust dated September 2016. Both had not been updated to reflect national guidance from the NHS England never events list 2015/16. This posed a risk that staff may not have knowledge on what should be reported as a never event and could not be following the correct procedure.
- The trust process for investigating, sharing learning from incidents and ensuring that actions were completed, needed improvements.
- Six SI meeting minutes showed that whilst the quality of investigation reports was discussed at the meeting, minutes did not give hold sufficient detail on staff actions taken to ensure they met the required standard. Root cause analysis in investigation reports seen varied and was not in line with the NHS England serious incident framework 2015 guidance. This was also identified from a recent external report commissioned by the trust.

Are services safe?

- The trust notified us of incidents where patients had got onto the roof at the Linden Centre. The trust sent us their action plans to reduce the risk of reoccurrence. However, we received a further notification of a similar incident for Galleywood July 2016 where a patient sustained an injury, showing that the trust process for learning from incidents and actions being taken to reduce risks was not effective. Finchingfield ward staff had changed their observation of patients in the garden following an incident where a patient climbed onto the roof. Patients now had an inflexible restriction of hourly garden access.
- The trust had not ensured that outcomes and learning from SIs and complaints were always shared with older people's ward staff. For example, following a serious incident and death in January 2016 relating to Kitwood ward and a coroners hearing, the trust did not inform staff of the outcome of the hearing. A panel investigation had taken place at the trust's request and the trust did not give ward staff the report or the outcome of this with any recommendations for their learning, improving practice or for mitigating future risks.
- Trust SI action plans to reduce the risk of incidents recurring were not fully completed by staff. Heneage ward had an action plan for a serious incident relating to a patient's death in October 2015. However one action was not completed relating to 'my care my support care plan' involving patients and carers in carers planning. Additionally staff did not complete an SI action plan where a patient fell and sustained an injury in June 2016.
- On Kitwood ward a SI investigation for an incident April 2016 was completed and sent to the ward. However there was a delay in completion of the report as the local clinical commissioning group had not "signed off" the completion of the report as satisfactory and a date for the trust investigator to formally share their report with the team was awaited. Some of the recommendations in the report were actioned.
- We checked the processes for management and prevention of patient falls. The trust had not reported three RIDDORs appropriately as they were identified as unavoidable.
- The trust had not automatically investigated falls incidents on older people's wards as a SI despite there being a serious injury and suspicion of being avoidable. A manager told us they understood that the trust policy was being updated to ensure all falls with injuries were investigated as a serious incident. The trust did not update their incident policy dated September 2016 to make this more explicit.
- There was no rationale available for why the trust had prioritised Kitwood and Roding wards above Heneage as needing assistive technology. On Heneage a patient had a fall and gained an injury. The initial incident report detailed that the patient had two falls in 72 hours prior to the incident and staff did not increase their level of observations. They subsequently had a further fall. An action was detailed that staff had 'escalated' a request for assisted technology. This was not in place at our visit seven months after the incident in February 2016. The manager told us they had requested assistive technology to help in protecting patients and reducing the risk of falls since January 2015. Trust data from April to September 2016 showed Heneage ward as having 38 slips incidents of 'slips, trips and falls'. Whereas Kitwood ward had eight and Roding ward had seven reported incidents. Kitwood and Roding wards had assistive technology in place for some rooms such as pressure bed sensors despite patients having less serious injuries from falls.
- The trust held weekly serious incident (SI) panel meetings where staff reviewed all reported serious incidents. It communicated information about incident investigations and deaths to staff and to other governance meetings. The trust had identified the need to improve staff investigation training for staff. They had developed case conferences for sharing of learning from SI investigations with staff.
- The trust had arranged debriefs for staff across these core services following incidents. Heneage ward had a debrief planned following a recent coroner's inquest.
- The trust had shared some learning from incidents as staff on the psychiatric intensive care unit and acute wards, gave us various examples as to how they learnt from them. Stort ward staff referred to getting trust emails and safety alerts with learning from incidents.
- On Roding ward an incident took place in August 2016 where a patient barricaded themselves in their room

and the police were called for assistance. Ten doors for this ward were not anti-barricade doors. Ward staff had identified this as a risk on their risk register for staff to be aware of.

- Heneage ward staff showed us actions they had taken to ensure that risk assessments were updated and that their community leave forms were revised following a patient's death and feedback from the coroner's court.
- For older people's wards, the trust service improvement plan detailed falls focus with a deadline of October 2016. Ward risk registers identified patient falls as a 'high' risk on Heneage, Kitwood and Roding wards. The trust had made changes to ensure that bedroom furniture was firmly fixed to walls to prevent accidents. Wards had rails in corridors and adjustable beds to assist with patients' mobility. The trust had a falls analysis and falls management group. Staff had identified that the falls risk assessment on the electronic patient record was not fit for purpose and used a paper version, uploaded onto the system.
- On Kitwood ward a patient had a specialist care plan with family and other agency involvement to prevent falls and injuries. One patient had a fall 11 September 2016 but did not have a comprehensive falls risk assessment stating how staff would care for the person to prevent future risks. We raised this with staff who took action to address the issue.
- The trust has systems for staff investigators to contact carers as part of the serious incident investigation process and once the investigation was completed they would offer to meet with the carers and share the investigation findings.
- The trust had requested an external investigation report following a serious incident in October 2015. This report was shared with us after the focused inspection and it identified recommendations for the trust to make improvements to information sharing with carers and offer a greater openness and transparency about the investigation remit and processes. Senior trust staff said an action plan would be developed to achieve this.

Are services caring?

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

Summary of findings

We found the following areas of good practice:

- Ninety five percent of patients gave positive feedback about the staff, and their experience of care on the wards. Ninety five percent of patients said they were able to approach staff to talk about any issues they had.
- Eighty seven percent of patients and 66% of carers said they were involved in discussions about their or their relatives care. Seven wards used 'my care, my recovery' booklets to capture this involvement.

However, we found the following issues that the trust needs to improve:

- Heneage ward staff did not record their involvement of patient or carers in care planning. Christopher Unit patients were not aware that they could have advance decisions to give their views on how staff should support them in the event their mental health deteriorated. Two carers for relatives on Chelmer ward said they were not effectively involved in discharge planning.
- One patient and two carers for patients on Chelmer ward told us that some staff were rude. Four patients on Galleywood ward told us that bank and agency staff were not as helpful as permanent staff.

Our findings

Dignity, respect and compassion

- We observed that staff treated patients with kindness, dignity and support and patience.
- Ninety five percent of patients gave us positive feedback about the staff, and their experience of care on the wards. One Christopher Unit patient said they were not able to approach staff to talk about any issues they had.
- Carers for patients on Kitwood ward told us that visiting times were flexible as staff allowed them to visit outside the identified times.
- However, we had mixed feedback from patients on the PICU ward as one patient said staff were rude. Two carers for relatives on Chelmer ward told us that some staff were rude. They said that staff did not always support and supervise patients.
- Two PICU patients told us that staff did not orientate them to the ward when they first arrived and did not tell them about the ward rules. They said that staff had an inconsistent approach. Ward staff gave us information on how they welcomed patients on admission and gave them information. We noted that PICU communal areas were bare and had limited information for patients on display.
- Four patients on Galleywood told us that bank and agency staff were not as helpful as permanent staff. One patient said that staff did not orientate them to the ward on admission. One patient said that staff were not always available to talk to.

Involvement of people using services

- Ninety one percent of patients told us they had opportunities to give their views on the care and treatment and were involved in care planning.
- The trust had introduced 'my care my recovery or support' plans across wards, since the last inspection. These encouraged patients to give their views on their care and treatment. However, on Heneage ward staff were not recording patients or carer's views and involvement on six records seen.
- The trust monitored that ward staff had shared care plans with patients. Their performance dashboard showed 96% achievement, above the trust target of 95%.
- Kitwood ward staff contacted carers to gain their feedback on the patients' care plan. Carers said they were involved in their relatives care when their relative had difficulty giving information and making decisions themselves.

Are services caring?

- The trust had developed your life your health', booklets with other stakeholders to encourage patients to improve their physical health and give them information. We saw these on acute wards.
- The trust had leaflets with carers' information such as how to obtain support and a carer's assessment on older people wards.
- The trust had ensured that patients had access to a local advocacy service. Suitable information was displayed on ward notice boards on how to access these services.
- However the trust had not effectively communicated to Christopher Unit patients that they could have advance decisions. This would give their views on how staff should support them in the event their mental health deteriorated.
- We found other examples of staff and patient communication difficulties as one patient said staff could have started planning for their discharge earlier. Two patients said that staff only offered them medication as a treatment as opposed to being offered other therapy. Two carers for relatives on Chelmer ward told us that patients were discharged too soon and they were not effectively involved in discharge planning.

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 found the following issues that the trust needs to improve:

- The trust did not monitor that actions from the last inspection had been completed effectively. Their systems for overseeing governance did not identify and respond to all the risks previously identified. Examples of risks for these services related to the management of ligature risks, mixed sex accommodation, maintaining environments and equipment and staffing.
- The trust did not ensure that staff received clinical supervision and training regularly.
- The trust did not ensure that the staff survey action plan detailed how they were responding to the key issues from the 2015 results. Staff morale was lower on Chelmer and Stort wards.

However we found the following areas of good practice:

- Managers at Chelmer and Stort Mental health wards gave examples of effective performance management of staff.
- The trust had an independent 'Guardian Service' for staff to contact regarding any matters relating to service users care and safety, and staff concerns.
- Staff on older people's wards were proud of their work and felt supported to deliver care. They were changing to use a 'functional model' on older peoples wards with reference to the 'new ways of working' initiative led by the Royal College of Psychiatrists and the National Institute of Mental Health in England.

Our findings

Vision, values and strategy

- The trust had ensured that senior staff visited wards such as Stort, Finchingfield and the Christopher Unit to check that ward staff followed the trusts vision, values and were aware of the trust strategy. This included the new interim chief executive and various executive directors.
- The trust had ensured that staff were aware of the merger with another trust due to take place from April 2016. We learnt that work was already taking place with staff groups from both trusts to identify a joint vision and values.

Good governance

- The trust did not monitor effectively that actions from the last inspection had been completed. We found examples of good practice but areas where the trust had failed to have oversight of wards to ensure consistency of approach across services. Their systems for overseeing governance did not identify and respond to all the risks previously identified. Examples of risks for these services related to the management of ligature risks, mixed sex accommodation, maintaining environments and equipment. Also risks relating to staffing and the support and development of staff posed a risk that patients may not get adequate care and support from staff.
- The trust had systems for monitoring ward staff compliance with supervision. However they had not ensured that staff received regular supervision to ensure they had the right skills for their role and support. Staff supervision rates still varied across the trust. Trust information for April to August 2016 showed for the PICU a variation of 50% May and 90% achievement for August. For acute wards Chelmer ward had the lowest achievement with none for April and May, Stort had 12% compliance for June and Finchingfield ward had the highest compliance with 90% for August and Galleywood 83% compliance for May. For older people Heneage ward had the lowest achievement with 36% May and Kitwood had the highest achievement with 94% for July and August 2016. Ward staff told us appraisals were taking place.

Are services well-led?

- The trust had systems for monitoring ward staff rates of sickness for the last three months. Sickness varied across wards. For acute ward staff, Chelmer had the highest with 7.7% in July and Stort had 6.3% both above the national average. The PICU and older peoples ward staff sickness rates were below the national average. Managers told us that there were no identifiable themes regarding staff sickness. A staff injury by a patient on Kitwood ward was reported under 'Reporting of injuries, diseases and dangerous occurrences regulations 2013' to the Health and Safety Executive. The manager explained the support given to the staff member.
- The trust had systems for monitoring ward staff turnover. For acute wards Stort had the highest with 9.3%, as of August 2016. For older peoples wards Roding had the highest with 7.7%. The PICU had no staff turnover. Medical staff turnover was 8.1%. Managers told us that there were no identifiable negative themes regarding staff leaving.
- The trust had recently changed their management of three geographical areas to become two 'inpatient 'and 'community' directorates. Staff spoke positively about this stating it should give more consistency of approach throughout the trust. Some governance meetings were not taking place as processes were realigning to the new model.
- Managers had systems for passing on information from governance meetings to their team. This was documented in team meeting minutes. However,Heneage ward did not have staff team meetings. The manager said they disseminated key information via staff handover meetings but records did not capture this.
- Wards had key performance indicators (KPIs) and productivity metrics to measure their performance against others. Kitwood manager told us they kept their own staff training record as trust data was not up to date.
- Managers had identified ward staff links to lead on key issues such as health and safety.

Leadership and culture

- Six staff told us that they had low morale, four related to Chelmer and Stort wards. We discussed this with a senior manager and managers gave examples of effective performance management of staff. One member of staff spoke positively about the support the trust had given them when they experienced bullying at work.
- We checked how the trust was responding to staff concerns. The trust did not ensure that the staff survey action plan detailed how they were responding to key issues from the 2015 results. The trust had Workforce Race Equality Standard (WRES) metrics but did not provide us with further information on how they were addressing the issues identified.
- The trust had not made contingency arrangements for management cover whilst Heneage ward manager was on leave and completing some work off site. Since January 2016, managers for the Christopher unit and Galleywood wards had changed.
- Staff told us that the refurbishment of the Christopher unit had taken place without initial consultation. Staff had now given feedback to managers regarding wanting a nursing observation area.
- A trust staff consultation about changing nursing shift patterns was taking place. A manager told us initial feedback was given and the trust was now revising the proposal. The trust service improvement programme showed a deadline for the consultation ending by October 2016.
- Older people ward staff and senior managers referred to wards changing to use a 'functional model' relating to the 'new ways of working' initiative led by the Royal College of Psychiatrists and the National Institute of Mental Health in England. This is where wards had dedicated consultant time to avoid inconsistency of approach by having multiple consultants working with the teams.
- Staff said they were proud of their work individually and as part of a team. Most told us that they were able to raise concerns with managers if required. They were aware of whistleblowing processes.
- Staff on older people's wards had positive morale and were positive about their immediate manager's leadership.

Are services well-led?

- The trust had posters displayed in locations and on their website about an independent 'Guardian Service' for staff to contact regarding any matters relating to patients' care and safety, whistleblowing, bullying and harassment, and work grievances.
- Kitwood ward manager referred to the ward being registered for the national NHS 'releasing time for care' ensuring staff had protected care time and designated paperwork time. In contrast Heneage ward identified challenges with staff having sufficient time to complete paperwork.
- Four staff said that since the last CQC visit the trust had made improvements such as revising the patients' complaints leaflet and introducing my care my recovery care planning documents. The trust had ensured that the last CQC ratings of inspection were displayed at locations for patients, staff and others to see.
- Kitwood ward staff kept a record of student nurses feedback and we saw seven positive feedback responses for 2016.

Engaging with the public and with people who use services

- The trust had ensured that Chelmer and Stort wards had held development days in July 2016 to gain staff and patient feedback to improve their service.
- The trust had systems in place for arranging patient community meetings across acute and PICU wards with positive feedback. However, the PICU minutes did not show staff actions and timeframes. 'You said, we did' notice boards were also on wards showing staff actions taken.
- The trust had other ways for patients and others to give feedback via comments cards, the family and friends test, discharge surveys and via the website. The trust had a developed a range of leaflets that they displayed in public areas encouraging concerns, complaints and compliments feedback, including giving anonymous feedback.
- The trust encouraged patients and others to complete the 'Family and friends' test and discharge surveys. The feedback seen for wards was mostly positive.
- The trust had improved the range of patient activities and most patients were positive about the activities available to them, and said they were at evenings and weekends. Stort ward had developed following engagement with staff and patients, a 'chill out' box which included sensory items such as aromatherapy oils and lights to help patients relax.
- However, Christopher unit patients said that more meaningful activities could be offered to them. Staff said they did not have structured activities now in response to previous patient feedback and a request by patients to make decisions on the day. Heneage ward staff reported difficulties covering occupational therapy (OT) work and activities when their OT assistant was on leave.
- The trust had not ensured that community meetings were regularly taking place on Heneage and Kitwood wards, and ward staff had not developed 'you said, we did' boards to show how staff had responded to patient or carer feedback. One Christopher unit patient told us that sometimes things did not get done when patients asked for things. Another said that managers higher up in the trust who made the decisions did not involve patients. On Galleywood ward, patients were awaiting the trust's response as they had given feedback that there was only one shower for 18 women and they preferred to use it rather than have a bath.

Quality improvement, innovation and sustainability

- The trust had ensured that most wards had clinical improvement meetings, and staff reflective meetings, for example, on Chelmer and Stort wards to encourage improvement and innovation. The trust had a service improvement plan which identified priorities for improving services.
- The trust had developed a system for peer reviewer visits to audit services and check on actions from learning.
- The trust had started piloting the use 'smart' technology electronic boards for ward staff to review and easily show information.
- The trust had developed a quality star and on Heneage ward staff actively used this to write their suggestions for improving services which they planned to feedback via staff meetings.

Are services well-led?

- The trust had arranged for 'Essex floating support service' provided by Family Mosaic to visit Chelmer and Stort wards. This included housing, employment and benefits advice to inpatients.
- The trust had supported a clinical psychologist on Chelmer and Stort wards in adapting the use of 'EssenCES' on the ward with patients. This is a short questionnaire for assessing the social climate of forensic psychiatric wards to help improve the ward climate for patients.
- The trust had encouraged staff to be creative in their approach to patient's care and treatment. For example in older peoples' wards, Kitwood ward staff had developed signs to prompt patients and staff to ensure dental care was being completed. The occupational therapy and nursing team had developed a memory café and staff had gained pinafores to wear and help create a traditional café atmosphere as part of encouraging reminiscence. Kitwood and Roding wards had a shared nurse liaison post with another trust to improve community nursing care for patients' physical health needs.

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 15 HSCA (RA) Regulations 2014 Premises and equipment • The trust must ensure that wards have sufficient bathrooms for patients to bathe or shower in. • The trust must ensure that wards ensure dignity and comfort for patients and that maintenance is completed in a timely manner. **This was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 15 (1) (c) (e).**

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 must proactively address any practices that could be considered restrictive, for example, access to toilets, access to the gardens, and access to snacks and beverages. **This was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 9 (1) (3) (d).**

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 • The trust must ensure that policies and procedures give clear information for staff reference when reporting incidents. That policies and procedures are updated to reflect current national guidance.

This section is primarily information for the provider

Requirement notices

This was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17 (2) (d) (i).

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 17 HSCA (RA) Regulations 2014 Good governance • The trust must improve their governance and assurance systems relating to the assessment and management of risk such as ligature risks, mixed sex accommodation and learning from incidents. • 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 the Christopher unit seclusion room is fit for purpose. • The trust must ensure that it complies with Department of Health guidance in relation to mixed sex accommodation. • The trust should ensure learning from serious incidents is shared with teams to ensure future risks are mitigated. • The trust must ensure that emergency equipment is fit for use. • The trust must have effective systems in place for the safe administration and storage of medication. • The trust must ensure there is sufficient staff on duty at all times to provide skilled care to meet patients' needs. • The trust must ensure that all staff receive regular supervision, and training. Significant improvements were needed for The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17 (1) (2)(a)(b)(f).