Inadequate

North Essex Partnership University NHS Foundation Trust

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

Quality Report

North Essex Partnership University NHS Foundation Trust
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRDPA	Chelmer and Stort Mental Health Wards	Chelmer Ward Stort Ward	CM20 1QX
RRD18	Shannon House	Shannon House	CM20 1QX
RRDAH	The Linden Centre Mental Health Wards	Finchingfield Ward Galleywood Ward	CM1 7LF
RRDY6	The Christopher Unit	The Christopher Unit	CM1 7LF
RRDX1	The Lakes Mental Health Wards	Ardleigh Ward	CO4 5JL

Summary of findings

		Gosfield Ward	
RRDY8	Peter Bruff Mental Health Ward	Peter Bruff Ward	CO15 1LH

This report describes our judgement of the quality of care provided within this core service by North Essex Partnership University NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement 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.

Where applicable, we have reported on each core service provided by North Essex Partnership University NHS Foundation Trust and these are brought together to inform our overall judgement of North Essex Partnership University NHS Foundation Trust.

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 the service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Requires improvement**
Are services responsive?	**Inadequate**
Are services well-led?	**Inadequate**

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

Overall we rated acute wards for adults of working age and psychiatric intensive care units as 'inadequate' because:

- Some ward environments were unacceptable. Improvements were needed to make them safer, including reducing ligatures and improving lines of sight and ensuring the safety and dignity of patients. This was despite previous concerns being raised through CQC inspections and Mental Health Act review visits.
- Some wards did not meet the Department of Health guidance and Mental Health Act 1983 Code of Practice in relation to the arrangements for mixed sex accommodation. We found that Finchingfield, Gosfield and Peter Bruff wards, and the Hub, did not meet the Department of Health's guidance on eliminating mixed sex accommodation.
- The seclusion room on Ardleigh ward and Peter Bruff ward was not fit for purpose, due to the design and layout.
- Restrictive practices were evident during our inspection. These included, for example, the use of the Hub, access to toilets, access to the gardens, and access to snacks and beverages.
- Patients did not have personalised or holistic care plans. Seven patients told us they did not have a copy of their care plan and ten patients told us that staff gave them a copy just before the inspection. We saw limited evidence of patients' involvement in the care planning process in the care records we reviewed.
- Mental capacity was not always assessed on admission or on an ongoing basis.
- Bed occupancy rates were consistently very high, with out of area beds and beds of patients on leave used frequently to admit new patients to.
- The Trust had not complied with the three requirements in place, from April 2015, at the Lakes Mental Health Wards (Ardleigh and Gosfield wards) which related to good governance, safety and suitability of premises, and dignity and respect.

However:

- We found positive multidisciplinary work and saw staff supported patients.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as 'inadequate' because:

- We found numerous ligature risks within most of the ward environments, which were not effectively managed. This was despite previous concerns being raised through CQC inspections and Mental Health Act review visits.
- The layout of wards meant staff could not observe all areas with a clear line of sight.
- Privacy and dignity for patients and arrangements for mixed sex accommodation were not good enough in some areas. We found that Finchingfield, Gosfield and Peter Bruff wards, and the Hub, did not meet the Dpartment of Health's guidance on eliminating mixed sex accommodation.
- The seclusion room on Ardleigh ward and Peter Bruff ward was not fit for purpose, due to the design and layout.
- Restrictive practices were evident during our inspection. These included, for example, the use of the Hub, access to toilets, access to the gardens, and access to snacks and beverages.
- Some prescription and medicine administration records contained instances of missed signatures against some prescribed medications. This meant we could not be assured that the patient had been administered their medication as prescribed.

However:

- There were clear systems in place for reporting incidents within the trust.

Are services effective?

Requires improvement

We rated effective as 'requires improvement' because:

- Patients did not have personalised or holistic care plans.
- Care records showed that patients' mental capacity to consent to their care and treatment was not always assessed when required.
- Patients could not understand their care plans because they were not written in plain English.

However:

- There was good evidence of multi-disciplinary team working, enabling staff to share information about patients and review their progress.

Summary of findings

Are services caring?

Requires improvement

We rated caring as 'requires improvement' because:

- Patients gave mixed feedback about the quality of their care.
- Four patients told us staff compromised patients' dignity and privacy at times.
- Seven patients told us they did not have a copy of their care plan and ten patients told us that staff gave them a copy just before the inspection.
- Eleven patients said staff did not involve them in their care plan.
- We saw limited evidence of patients' involvement in the care planning process in the care records we reviewed.
- However:
- We observed many examples of staff treating patients with care, compassion and communicating effectively.
- We saw staff engage with patients in a kind and respectful manner on all of the wards.

Are services responsive to people's needs?

Inadequate

We rated responsive as 'inadequate' because:

- Bed occupancy rates were consistently very high, with out of area beds and beds of patients on leave used frequently to admit new patients. One patient had slept on a mattress on a floor due to no beds being available. Patients returning from leave could not always access their bed immediately.
- Not all ward environments optimised patients' safety, privacy and dignity. Much of the accommodation was dormitory style with curtains separating bed space offering little privacy, with some single rooms. Patients were unable to lock their rooms.
- Whilst the wards had activity programmes, we saw, and were told of, very little activities taking place in the Hub. We were told a few activities taking place on Finchingfield and Galleywood wards.

However:

- The menu had a range of choices catering for patients' dietary, religious and cultural needs.

Are services well-led?

Inadequate

We rated well-led as 'inadequate' because:

Summary of findings

- We were concerned about the robustness of the governance systems relating, particularly, to the assessment and management of ligature risks, assessment of the quality of care plans and the ward activities programme.
- The Trust had not complied with the three requirements in place, from April 2015, at the Lakes Mental Health Wards (Ardleigh and Gosfield wards) which related to good governance, safety and suitability of premises, and dignity and respect.

However:

- Staff consistently demonstrated good morale.
- There was highly visible, approachable and supportive local leadership.

Summary of findings

Information about the service

The acute wards for adults of working age are based in four hospital sites, namely in Chelmsford, Colchester, Harlow and Clacton On Sea, in Essex. All acute wards provide inpatient mental health assessment and admission services for adults aged18 and over.

The trust also provides two psychiatric intensive care units (PICUs) for adults aged 18 and over. These are based in Chelmsford and Harlow in Essex.

North Essex Partnership University NHS Foundation Trust has been inspected 22 times since registration in April 2010. Of these, twelve inspections looked at the acute wards for adults of working age and psychiatric intensive care unit.

At the time of our inspection, there were three requirement notices in place, from April 2015, at the Lakes Mental Health Wards (Ardleigh and Gosfield wards). These were in relation to:

- Good governance.
- Safety and suitability of premises.
- Dignity and respect.

During this inspection we reviewed whether North Essex Partnership University NHS Foundation Trust were now meeting these fundamental standards, following the requirement notices.

Our inspection team

Our inspection team was led by:

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 inspection team for this core service consisted of two CQC inspectors, a consultant psychiatrist, four mental health nurses, an occupational therapist, two Mental Health Act reviewers, and an expert by experience. Experts by experience are people who have direct experience of care services we regulate, or are caring for someone who has experience of using those services.

The team would like to thank all those who met and spoke with inspectors during the inspection and were open and balanced 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 provider:

- 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

Summary of findings

Foundation Trust and asked other organisations to share what they knew. We carried out an announced visit from 25 to 28 August 2015. We also carried out an unannounced inspection on 09 September 2015.

During the inspection visit, the inspection team:

- visited all nine wards and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 62 patients who were using the service
- spoke with the ward managers for each of the wards
- spoke with 40 other staff members, including doctors, nurses and occupational therapists
- interviewed senior clinical and operational management staff with responsibility for these services
- interviewed the estates manager
- attended and observed one hand-over meeting and three multi-disciplinary meetings
- collected feedback from six patients using comment cards
- looked at the medication charts of 96 patients
- carried out a specific check of the medication management on two wards
- looked at the care records of 54 patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We received mixed feedback from patients, through speaking with them and reviewing the comment cards, about the care they received.

On Finchingfield ward, patients largely felt that staff were caring and helpful. However, they also felt that there were limited staff-patient interactions. Patients told us that staff spent much of their time in the office, which we observed during our inspection. We were also told that staff took considerable time to respond to patients' needs.

From the six comments cards, we received three positive and three negative comments. For example, one patient commented that they were well cared for on Finchingfield ward. However, another patient commented about the poor attitude of staff on Galleywood ward.

We received mixed feedback from patients about their involvement in the care they receive. The majority of patients told us that that they had been involved in their care. However, a number of patients told us that they had not been involved in their care and had not received a copy of their care plan. Most patients told us that there were not always enough staff on duty and they did not always receive one-to-one time with their primary nurse because of this.

Areas for improvement

Action the provider MUST take to improve

- The trust must take action to remove identified ligature risks and to mitigate where there are poor lines of sight.
- The trust must comply with Department of Health guidance in relation to mixed sex accommodation.
- The trust must review any restrictive practices, for example, the use of the Hub, access to toilets, access to the gardens, and access to snacks and beverages.
- The trust must review the meaningful activities programme for patients.

Summary of findings

- The trust must ensure there are sufficient, experienced, staff on duty at all times to provide care to meet patients' needs.
- The trust must have appropriate arrangements are in place so medicines are administered as prescribed.
- The trust must carry out assessments of each patient's mental capacity when required and record these in the care records.
- The trust must ensure that patients' privacy and dignity are maintained at all times.
- The trust must ensure that patients are actively involved in the planning of their care and treatment.
- The trust must review governance systems relating to the assessment and management of ligature risks, the assessment of the quality of care plans, and the ward activities programme provided.

Action the provider SHOULD take to improve

- The trust should formally review any 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.

North Essex Partnership University NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Chelmer Ward Stort Ward	Chelmer and Stort Mental Health Wards
Shannon House	Shannon House
Finchingfield Ward Galleywood Ward	The Linden Centre Mental Health Wards
The Christopher Unit	The Christopher Unit
Ardleigh Ward Gosfield Ward	The Lakes Mental Health Wards
Peter Bruff Ward	Peter Bruff Mental Health Ward

Mental Health Act responsibilities

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

Systems in place to ensure compliance with the MHA and adherence to the guiding principles of the MHA Code of Practice were good. However, we found one instance where a patient appeared not to have been provided with a copy of their section 17 leave authority. We also found that two

section 17 leave authorities were unclear about the type of leave that was being authorised, and the designation and numbers of the escorts were not always specified on the leave authority.

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 scrutiny was satisfactory.

Posters were displayed informing patients of how to contact the independent mental health advocate (IMHA).

84% of staff members working within this core service had received training in the MHA via e-learning. The staff we spoke with had a good working knowledge of the MHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

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

When we spoke with staff there were varying degrees of knowledge about the MCA and Deprivation of Liberty Safeguards (DOLS).

None of the patients receiving care and treatment during our inspection were under a DoLS.

The care records we viewed showed that patients' mental capacity to consent to their care and treatment was not always assessed when required.

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

Our findings

Acute Wards

Safe and clean environment

- Each ward had undertaken, and updated when necessary, ligature risk assessments. Control measures in place, to minimise the risk to patients, included patient risk assessments and use of observations, increased staff supervision of environmental areas and to lock the relevant room when not in use. However, an unacceptable number of ligature risks remained on the wards. We found numerous ligature points throughout the wards including, for example, taps on sinks, window and door handles, and radiators.
- Staff were aware of the risks to patients' safety caused by the layout and had assessed patients' individual risks and increased their observation as needed. Wards had ligature cutters available in the event of an emergency. However, some staff on Finchingfield and Galleywood wards did not know where to find these. There were numerous ligature points in the toilets in the Hub (where a serious incident had recently occurred). In relation to the partition, as a result of the incident, we saw on our unannounced inspection that the partition had been filled in so a ligature could no longer be attached. However, the ligature risk had not previously been identified on the ligature risk assessment. In the Hub, the air hockey table had a long electrical flex attached to it, which had not been assessed as part of the ligature risk assessment. A serious incident recently occurred in Galleywood ward in which a TV aerial lead was used as a ligature. This ligature risk had not previously been identified on the ligature risk assessment.
- We saw a number of blind spots in the corridors of Chelmer, Finchingfield and Galleywood wards, and in the Hub. This meant that there were places for patients to hide and not be immediately visible to members of staff. Whilst some blind spots had been negated by mirrors, others had not.
- In Chelmer and Stort wards, there were a number of doors which had "D" shaped handles on both sides. These were featured on fire doors and on some dormitory doors. A patient would be able to barricade themselves inside of the room, and staff would struggle to get in due to doors only opening one way.
- Most wards had accommodation consisting of dormitory sleeping areas, with some single rooms. We found that Finchingfield, Gosfield and Peter Bruff wards, and the Hub, did not meet the Department of Health's guidance on eliminating mixed sex accommodation. This compromised the privacy and dignity of patients using these wards and the Hub. In 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. However, we were informed by a member of staff that care programme approach (CPA) meetings, for male and female patients, also take place in this room. 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. We also saw a consultant psychiatrist used the female lounge to interview a male patient in the afternoon. In the Hub, two female patients told us that they felt quite intimidated being with the male patients, and some of the female patients also made them feel intimidated.
- The seclusion room on Ardleigh ward was not fit for purpose. It 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.

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There were blind spots (where the patient could not be seen) from the 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. There were ligature points, including toilet rails and taps on the sink.

- In a sleeping area of Chelmer ward, we found there was a cleaning product, a detergent, labelled as corrosive. This was not securely stored in line with COSHH regulations and could present a risk to patients if ingested. We drew this to the attention of a member of staff; who immediately removed the items and addressed the issue.
- In Finchingfield ward, we saw a smoke detector in a bathroom was obscured by a rubber glove. We drew this attention to a member of staff.
- Practices were in place to ensure infection control and staff had access to protective personal equipment such as gloves and aprons. All of the wards were generally clean and tidy and we were told by staff the cleaning services were good.
- All the wards had resuscitation trolleys that were clean and checked on a regular basis. In Stort ward, there were two expired airways in the emergency equipment bag. The dates of expiry were June 2015 and July 2015 respectively. Whilst replacements were present in the bag, the expired airways had not been removed. We found portable oxygen was not immediately available in the Hub, for use in the event of an emergency. However, we drew this to the attention of the executive director of nursing who resolved this issue during our unannounced inspection. Staff described how they would use the emergency equipment and what the local procedures were for calling for assistance in medical emergencies.However, in the Hub, one member of staff was not immediately aware of where to locate the emergency equipment.
- Patients were required to leave Chelmer and Stort ward at 10am each morning to attend the Hub. This was a blanket restriction, in order to move the patients to a less nosier area of the premises whilst building works were taking place. This was not personalised to patients' individual needs. We observed that patients using the Hub appeared to be unmotivated to carry out the limited activities being provided. Patients were either lying around on sofas and chairs, or not engaging with either each other or the staff, or any meaningful activities. A senior member of staff told us that the Hub was used due to the incredibly noisy and disruptive atmosphere on the wards due to the building works. The member of staff told us that patients usually "lounged around" and slept on sofas in the hub. They told us that they were unable to see the purpose of the hub. Two patients told us that they had to come to the Hub, they did not get a choice. They said there was little choice of activity.
- Patients had access to drinks and snacks at any time on the majority of the wards, however this was not the case of Finchingfield ward.
- On Finchingfield ward, a number of patients told us about 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. Two patients told us of instances when they had missed the drinks break and staff refused to allow them access to a hot drink. Patients also told us that they had limited access, and had to ask, to access the toilet. Patients were particularly concerned that they had to wait sometime to access the toilet area. One patient told us "I haven't had to ask to use the toilet since I was at primary school".
- Wards had locks on the main entrances with entry and exit controlled by staff. Staff carried personal alarms. During our inspection, we were offered personal alarms on some wards, but not other wards.
- We saw the gardens leading from each ward. They provided a spacious area for patients to be able to access fresh air. The access to the gardens was locked at midnight, though patients could request to go for a cigarette after this time, but were accompanied by a member of staff.

Safe Staffing

- On the seven wards we visited, staff told us that there were generally enough staff on duty to meet the needs of the patients. From the information the trust provided us, we saw in the last twelve months a total of 4249

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shifts were filled by bank or agency staff to cover sickness, absence or other vacancies. 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.

- The ward managers told us that they 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 existing staff sickness and vacancies. From the information provided by the trust, we saw the average staff vacancy rate, per ward, for the past twelve months, was 16%. The average staff turnover rate for the same period was 8.5%.
- The staff we spoke with told us there was a heavy reliance on the use of bank agency staff. Staff told us, and the duty rotas we saw confirmed that there was always an experienced member of staff on duty on the ward. Most patients told us that there were not always enough staff on duty and they did not always receive one-to-one time with their nurse because of this.
- When we checked duty rotas for week commencing 24 August 2015, we found that the safe staffing levels were being met. We saw that a combination of permanent, bank and agency staff were covering the shifts to ensure that the correct number of staff were on duty.
- We were informed by various members of staff and ward managers that the staffing difficulties arose from a combination of staff sickness, along with staff recruitment and retention. From the information we saw, the staff sickness average was 4% for the past twelve months.
- We were informed that if a patient was too unwell to leave the ward to attend the Hub, or had attended the Hub but wished to return to the ward, this could be facilitated, however it had implications on the staffing levels within the Hub as consideration had to be given to the lone working policy and procedures. This meant that staff would need to leave the Hub, reducing the staffing levels in the Hub, to accompany, and remain with, the patient if they chose to remain on the ward or return to the ward.
- Processes were in place to manage staff sickness, which included the involvement of human resources and occupational health departments. We were told that recruitment to vacant positions was ongoing and a number of newly qualified nurses had recently been appointed.
- We found that 77% of the staff working within this core service had received training in control and restraint, which included basic life support (resuscitation) and inpatient observation.
- We found that there was a variety of mandatory training available for staff. This included courses in, for example, 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.

Assessing and managing risk to patients and staff

- Patients had individualised risk assessments. Staff told us that where particular risks were identified, such as a risk to self or to others, measures were put in place to ensure that the risk was managed. For example, the level and frequency of observations of patients by staff was increased. Overall, the individualised risk assessments we reviewed had taken into account the patient's previous history as well as their current mental state, and were detailed. However, we found this was not the case on Finchingfield ward, where we found the risk assessments lacked comprehensive details. Most patients' risk assessments covered aspects of their health including medication, psychological therapies, physical health and activities. These were usually updated at ward reviews, care programme approach (CPA) meetings or after an incident.
- Medicines were stored at suitable temperatures to maintain their quality on the majority of the wards. However, on Stort ward we saw the refrigerator thermometer had not been re-set after each reading so we could not be certain that certain temperatures were maintained at all times. Medicines, including controlled drugs, were stored securely. Controlled drugs are 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 told us that they had good links with the pharmacy team and in addition to ward visits, they were available to provide advice including out of hours. We saw that 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 also available to speak to patients individually if required. Nursing staff told us that patients were encouraged to attend these sessions which gave them an opportunity to discuss concerns. Pharmacy staff told us they planned to increase their attendance at consultant ward reviews.

- We looked at the prescription and medicine administration records for 84 patients on seven wards. Overall, appropriate arrangements were in place for recording the administration of medicines. However, we found 31 instances of missed signatures against some prescribed medications. This meant we could not be assured that the patient had been administered their medication as prescribed. We saw that one person was administering their own medicines, and the arrangements for this were clearly documented. If patients were allergic to any medicines this was recorded on their prescribing and medication administration record. 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.
- Staff had access to up to date information about medications through the electronic BNF (the British National Formulary, a book providing comprehensive information about all medications).
- The majority of staff (82%) had completed safeguarding vulnerable adults training and 80% of staff had safeguarding vulnerable children training. Staff were able to describe what actions could amount to abuse. They were able to apply this knowledge to the patients who used the service and described in detail what actions they were required to take in response to any concerns.
- The trust provided information stating there had been 14 incidents of the use of seclusion within the last six months. Peter Bruff and Ardleigh wards had seclusion facilities. Gosfield, Stort, Chelmer, Galleywood and Finchingfield wards did not.
- The trust provided information stating there had been 114 incidents of use of restraint in the six months prior to our inspection across the 7 wards. Of these, in 36 incidents (representing 31.6% of incidents) patients were 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 states if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible. Each incident of restraint was recorded using the trust's incident reporting system.

Track record on safety

- From the information the trust provided, we saw that there had been 25 incidents relating to the use of a ligature attached to a fixed object. We were aware of two deaths occurring within this core service in the past 12 months, and a number of deaths prior to this, as a result of a use of a ligature from a fixed object. Whilst the trust had undertaken ligature risk assessments, and had plans to address these, an unacceptable number of ligature risks remained on the wards.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were able to describe the electronic system to report incidents and their role in the reporting process. We saw each ward had access to an online electronic system to report and record incidents and near misses.
- Staff were able to describe the various examples of serious incidents which had occurred within the services. The trust told us that there was a local governance process in place to review incidents.
- Discussions had occurred locally at monthly team meetings about trust-wide incidents. There were weekly multi-disciplinary meetings which included a discussion of potential risks relating to patients, and how these risks should be managed.
- Each of the ward managers we spoke with told us how they provided feedback in relation to learning from incidents to their teams.

Psychiatric intensive care units

Safe and clean environment

- We saw the wards had undertaken, and updated when necessary, ligature risk assessments. We saw that

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control measures in place, to minimise the risk to patients included patient risk assessments and observations, increased staff supervision of environmental areas and to lock the relevant room when not in use. Staff we spoke with were aware of the risks to patients' safety caused by the layout and had assessed patients' individual risks and increased their observation as needed. The wards had ligature cutters available which were accessible in the event of an emergency occurring. In Shannon House, there were numerous ligature points throughout the ward, including taps on sinks and window handles.

- We found that Christopher unit and Shannon House did not meet the Department of Health's guidance on eliminating mixed sex accommodation. In the Christopher unit, due to imminent building works, a female patient had had to change bedrooms, which meant they had to use a bathroom in a male corridor. This patient told us that they felt isolated, especially as the female lounge was locked but "in any case, had no TV or radio in it". In Shannon House, whilst we were informed of, and saw, a female only lounge, we were told by patients that it was never used as a female lounge. Moreover, it was used for interviews. We were further informed that a male patient had slept in the female lounge for one night, immediately prior to our inspection. None of the bedrooms were ensuite. As a result, female patients would have to cross the area used by male patients, and vice versa, to access bathrooms.
- The seclusion room on the Christopher unit was fit for purpose. There was an observation panel to view the patient, along with CCTV and a two way communication intercom. The seclusion room allowed access to a toilet and shower. A clock was prominently displayed. We saw a de-escalation area in the same area as the seclusion room. This area allowed access to fresh air. We were informed that Shannon House did not have a seclusion room. Moreover, a member of the medical staff informed us that there had been previous incidents where the police had been called to assist in the management of a disturbed patient, and an occasion when the patient had been removed from the ward to the Section 136 suite.
- Practices were in place to ensure infection control and staff had access to protective personal equipment such as gloves and aprons. Both wards were generally clean and tidy and we were told by staff the cleaning services were good.
- Both wards had resuscitation trolleys that were clean and checked on a regular basis. Staff described how they would use the emergency equipment and what the local procedures were for calling for assistance in medical emergencies.
- The wards had locks on the main entrances with entry and exit controlled by staff. An air lock system operated, where one door could not be opened, whilst the other door was open. Staff carried personal alarms.
- We saw the gardens leading from each ward. They provided a spacious area for patients to be able to access fresh air.

Safe staffing

- On the two wards we visited, staff told us that there were generally enough staff on duty to meet the needs of the patients. From the information the trust provided us, we saw in the last twelve months a total of 1712 shifts were filled by bank or agency staff to cover sickness, absence or other vacancies. We noted that 24 shifts had not been filled by bank or agency staff where there was sickness, absence or vacancies.
- The ward managers told us that they are 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 existing staff sickness and vacancies. From the information provided by the trust, we saw the average staff vacancy rate, per ward, for the past twelve months, was 32%. The staff turn-over rate for the same time period was 14% for Christopher unit and 0% for Shannon House.
- The staff we spoke with told us that there was a heavy reliance on the use of bank agency staff. Staff told us, and the duty rotas we saw confirmed, that there was always an experienced member of staff on duty on the ward. Most patients told us that there were generally enough staff on duty. However, patients told us that they had experienced Section 17 leave being cancelled due to a shortage of staff.

Inadequate

Are services safe?

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

- When we checked duty rotas for week commencing 24 August 2015, we found that the safe staffing levels were being met. We saw that a combination of permanent, bank and agency staff were covering the shifts to ensure that the correct number of staff were on duty.
- We were informed by various members of staff and ward managers that the staffing difficulties arose from a combination of staff sickness, along with staff recruitment and retention. From the information we saw, the staff sickness average was 6% for past twelve months.
- Processes were in place to manage staff sickness, which included the involvement of the human resources and occupational health departments. We were told that recruitment to vacant positions was on-going.
- We found that 97% of the staff working within this core service had received training in control and restraint, which included basic life support (resuscitation) and inpatient observation.
- We found that there was a variety of mandatory training available for staff. This included courses in, for example, 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.

Assessing and managing risk to patients and staff

- Patients had individualised risk assessments. Staff told us that where particular risks were identified, such as a risk to self or to others, measures were put in place to ensure that the risk was managed. For example, the level and frequency of observations of patients by staff was increased. Overall, the individualised risk assessments we reviewed had taken into account the patient's previous history as well as their current mental state, and were detailed. We found one risk assessment on each ward (Shannon House and Christopher unit) which was not up to date, reflecting the patients' current risks. Most patients' risk assessments covered aspects of their health including medication, psychological therapies, physical health and activities. These were usually updated at ward reviews, care programme approach (CPA) meetings or after an incident.

Safe and clean environment

- We saw the wards had undertaken, and updated when necessary, ligature risk assessments. We saw that control measures in place, to minimise the risk to patients included patient risk assessments and observations, increased staff supervision of environmental areas and to lock the relevant room when not in use. Staff we spoke with were aware of the risks to patients' safety caused by the layout and had assessed patients' individual risks and increased their observation as needed. The wards had ligature cutters available which were accessible in the event of an emergency occurring. In Shannon House, there were numerous ligature points throughout the ward, including taps on sinks and window handles.
- We found that Christopher unit and Shannon House did not meet the Department of Health's guidance on eliminating mixed sex accommodation. In the Christopher unit, due to imminent building works, a female patient had had to change bedrooms, which meant they had to use a bathroom in a male corridor. This patient told us that they felt isolated, especially as the female lounge was locked but "in any case, had no TV or radio in it". In Shannon House, whilst we were informed of, and saw, a female only lounge, we were told by patients that it was never used as a female lounge. Moreover, it was used for interviews. We were further informed that a male patient had slept in the female lounge for one night, immediately prior to our inspection. None of the bedrooms were ensuite. As a result, female patients would had to cross the area used by male patients, and vice versa, to access bathrooms.
- The seclusion room on the Christopher unit was fit for purpose. There was an observation panel to view the patient, along with CCTV and a two way communication intercom. The seclusion room allowed access to a toilet and shower. A clock was prominently displayed. We saw a de-escalation area in the same area as the seclusion room. This area allowed access to fresh air. We were informed that Shannon House did not have a seclusion room. Moreover, a member of the medical staff informed us that there had been previous incidents where the police had been called to assist in the management of a disturbed patient, and an occasion when the patient had been removed from the ward to the Section 136 suite.

Inadequate

Are services safe?

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

- Practices were in place to ensure infection control and staff had access to protective personal equipment such as gloves and aprons. Both wards were generally clean and tidy and we were told by staff the cleaning services were good.
- Both wards had resuscitation trolleys that were clean and checked on a regular basis. Staff described how they would use the emergency equipment and what the local procedures were for calling for assistance in medical emergencies.
- The wards had locks on the main entrances with entry and exit controlled by staff. An air lock system operated, where one door could not be opened, whilst the other door was open. Staff carried personal alarms.
- We saw the gardens leading from each ward. They provided a spacious area for patients to be able to access fresh air.

Safe staffing

- On the two wards we visited, staff told us that there were generally enough staff on duty to meet the needs of the patients. From the information the trust provided us, we saw in the last twelve months a total of 1712 shifts were filled by bank or agency staff to cover sickness, absence or other vacancies. We noted that 24 shifts had not been filled by bank or agency staff where there was sickness, absence or vacancies.
- The ward managers told us that they are 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 existing staff sickness and vacancies. From the information provided by the trust, we saw the average staff vacancy rate, per ward, for the past twelve months, was 32%. The staff turn-over rate for the same time period was 14% for Christopher unit and 0% for Shannon House.
- The staff we spoke with told us that there was a heavy reliance on the use of bank agency staff. Staff told us, and the duty rotas we saw confirmed that there was always an experienced member of staff on duty on the ward. Most patients told us that there were generally enough staff on duty. However, patients told us that they had experienced Section 17 leave being cancelled due to a shortage of staff.
- When we checked duty rotas for week commencing 24 August 2015, we found that the safe staffing levels were being met. We saw that a combination of permanent, bank and agency staff were covering the shifts to ensure that the correct number of staff were on duty.
- We were informed by various members of staff and ward managers that the staffing difficulties arose from a combination of staff sickness, along with staff recruitment and retention. From the information we saw, the staff sickness average was 6% for past twelve months.
- Processes were in place to manage staff sickness, which included the involvement of the human resources and occupational health departments. We were told that recruitment to vacant positions was ongoing.
- We found that 97% of the staff working within this core service had received training in control and restraint, which included basic life support (resuscitation) and inpatient observation.
- We found that there was a variety of mandatory training available for staff. This included courses in, for example, 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

Assessing and managing risk to patients and staff

- Patients had individualised risk assessments. Staff told us that where particular risks were identified, such as a risk to self or to others; measures were put in place to ensure that the risk was managed. For example, the level and frequency of observations of patients by staff was increased. Overall, the individualised risk assessments we reviewed had taken into account the patient’s previous history as well as their current mental state, and were detailed. We found one risk assessment on each ward (Shannon House and Christopher unit) which was not up to date, reflecting the patients’ current risks. Most patients' risk assessments covered aspects of their health including medication, psychological therapies, physical health and activities. These were usually updated at ward reviews, care programme approach (CPA) meetings or after an incident.

Inadequate

Are services safe?

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

- Medicines were stored at suitable temperatures to maintain their quality. Medicines, including controlled drugs, were stored securely. Controlled drugs are medicines which are stored in a special cupboard and their use recorded in a special register.
- We found that the pharmacy team provided a clinical service to ensure people were safe from harm from medicines. Nursing staff told us that they had good links with the pharmacy team and in addition to ward visits, they were available to provide advice including out of hours. We saw that pharmacy staff had recorded interventions which guided staff in the safe prescribing and administration of medicines. They were also available to speak to patients individually if required.
- We looked at the prescription and medicine administration records for 12 patients on two wards. We found that appropriate arrangements were in place for recording the administration of medicines. If patients were allergic to any medicines this was recorded on their prescribing and medication administration record. 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.
- Staff had access to up to date information about medications through the electronic BNF (the British National Formulary, a book providing comprehensive information about all medications).
- The majority of staff (97%) had completed safeguarding vulnerable adults training and 96% of staff had safeguarding vulnerable children training. Staff were able to describe what actions could amount to abuse. They were able to apply this knowledge to the patients who used the service and described in detail what actions they were required to take in response to any concerns.
- The trust provided information stating there had been two incidents of the use of seclusion within the last six months. The Christopher unit had seclusion facilities, however Shannon House did not.
- The trust provided information stating there had been 81 incidents of use of restraint in the six months prior to our inspection. Of these, in 45 incidents (55%) 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 states if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible. Each incident of restraint was recorded using the trust's incident reporting system.

Track record on safety

- The trust provided CQC with a report on all of their serious incidents for the 2014 / 2015 year. They reported that a total of 93 serious incidents which required further investigation occurred between April 2014 and March 2015. The majority of incidents reported were categorised as "Death" (50) followed by "Substance misuse death" (15) and "Other".
- There was little evidence of trust wide learning from incidents having been previously shared with staff in order to change practice.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were able to describe the electronic system to report incidents and their role in the reporting process. We saw each ward had access to an online electronic system to report and record incidents and near misses.
- Staff were able to describe the various examples of serious incidents which had occurred within the services. The trust told us that there was a local governance process in place to review incidents.
- Discussions had occurred locally at monthly team meetings about trust-wide incidents. There were weekly multi-disciplinary meetings which included a discussion of potential risks relating to patients, and how these risks should be managed.
- Each of the ward managers we spoke with told us how they provided feedback in relation to learning from incidents to their teams.

Are services effective?

Requires improvement

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.

Our findings

Acute Wards

Assessment of needs and planning of care

- We looked at 41 care plans for patients receiving care and treatment in the acute wards. Patients' needs were assessed. However, 37 of the care plans we saw were not personalised and did not include patients' views. These care plans were not holistic, for example, they did not include the full range of patients' problems and needs. We found on Chelmer and Ardleigh wards that the care plans were not recovery orientated, for example, they did not include the patients' strengths and goals.
- Patients' physical health needs were identified. The majority of patients spoken with told us, and records sampled showed, that patients had a physical healthcare check completed by the doctor on admission and their physical healthcare needs were met. 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 usually taking place. All records we sampled included a care plan that showed staff how to meet patients' physical needs. However, two patients told us that they did not think their physical healthcare needs had been sufficiently or appropriately addressed.
- Of the 37 care records, we saw two occasions where patients had been given a copy of their care plan. On Peter Bruff ward we found the four care plans, we reviewed, to be satisfactory. They were personalised including patients' views, holistic including the full range of the patients problems and recovery orientated. We saw, on this ward, that patients had been given a copy of their care plans.
- 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.

Best practice in treatment and care

- We saw multi-disciplinary team meetings and ward rounds provided opportunities to assess whether the care plan was achieving the desired outcome for patients.
- We were informed by both medical and nursing staff that relevant national guidance was followed when providing care and treatment. This included relevant guidance from the National Institute for Health and Care Excellence (NICE) and prescribing guidance.
- Outcomes for patients using the services were monitored and audited by the service. This included the monitoring of key performance indicators such as length of stay, the use of control and restraint, and rapid tranquilisation.

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 is 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.
- We were told that bank and agency staff underwent a basic induction including orientation to the ward, emergency procedures such as fire and a handover about patients and current risks.
- We saw 69% of staff had an up to date personal development plan in place at the time of our inspection. Staff told us they had access to supervision on a regular basis. The ward managers and staff also told us that informal supervision took place regularly, though this was not documented.
- Staff described receiving support and debriefing from within their team following any serious incidents. Additionally, we were informed that a psychologist lead a debrief following a serious incident.
- Staff told us there were regular team meetings and staff felt well supported by their immediate managers and colleagues on the wards. Staff also told us they enjoyed good team working as a positive aspect of their work on the wards.

Are services effective?

Requires improvement

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.

Multi-disciplinary and inter-agency team work

- We observed some meetings during our inspection and found these effective in enabling staff to share information about patients and review their progress. Different professionals worked together effectively to assess and plan patients' care and treatment.
- Occupational therapists and psychologists worked as part of each team and we saw that they worked closely with patients. The patients we talked with spoke positively about this. However, we were told that, at the time of our inspection, there was no psychologist working at the Derwent centre. However, contingency arrangements were in place involving a community psychologist so that individual service users could be referred.

Adherence to the MHA and MHA Code of Practice

- We checked whether systems were in place to ensure compliance with the Mental Health Act 1983 (MHA) and adherence to the guiding principles of the MHA 1983 Code of Practice 2015. We found three discrepancies in relation to this.
- On Finchingfield ward, whilst there was good evidence that patients were provided with a copy of their section 17 leave authority, we found one instance were a patient appeared not to have been provided with a copy of their section 17 leave authority. Section 17 leave is where leave section of the MHA. We also found that two section 17 leave authorities were unclear about the type of leave that was being authorised, and the designation and numbers of the escorts were not always specified on the leave authority.

Assessment of needs and planning of care

- We looked at 41 care plans for patients receiving care and treatment in the acute wards. Patients' needs were assessed. However, 37 of the care plans we saw were not personalised and did not include patients' views. These care plans were not holistic, for example, they did not include the full range of patients' problems and needs. We found on Chelmer and Ardleigh wards that the care plans were not recovery orientated; for example, they did not include the patients' strengths and goals.
- Patients' physical health needs were identified. The majority of patients spoken with told us, and records sampled showed, that patients had a physical healthcare check completed by the doctor on admission and their physical healthcare needs were met. 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 usually taking place. All records we sampled included a care plan that showed staff how to meet patients' physical needs. However, two patients told us that they did not think their physical healthcare needs had been sufficiently or appropriately addressed.
- Of the 37 care records, we saw two occasions where patients had been given a copy of their care plan. On Peter Bruff ward care we found the four care plans, we reviewed, to be satisfactory. They were personalised including patients' views, holistic including the full range of the patients' problems and recovery orientated. We saw, on this ward, that patients had been given a copy of their care plans.
- 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.

Best practice in treatment and care

- We saw multi-disciplinary team meetings and ward rounds provided opportunities to assess whether the care plan was achieving the desired outcome for patients.
- We were informed by both medical and nursing staff that relevant national guidance was followed when providing care and treatment. This included relevant guidance from the National Institute for Health and Care Excellence (NICE) and prescribing guidance.
- Outcomes for patients using the services were monitored and audited by the service. This included the monitoring of key performance indicators such as length of stay, the use of control and restraint, and rapid tranquilisation.

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-

Are services effective?

Requires improvement

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.

structured and in-depth preceptorship programme. Preceptorship is 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.

- We were told that bank and agency staff underwent a basic induction including orientation to the ward, emergency procedures such as fire and a handover about patients and current risks.
- We saw 69% of staff had an up to date personal development plan in place at the time of our inspection. Staff told us they had access to supervision on a regular basis. The ward managers and staff also told us that informal supervision took place regularly, though this was not documented.
- Staff described receiving support and debriefing from within their team following any serious incidents.Additionally, we were informed that a psychologist lead a debrief following a serious incident.
- Staff told us there were regular team meetings and staff felt well supported by their immediate managers and colleagues on the wards. Staff also told us they enjoyed good team working as a positive aspect of their work on the wards.

Multi-disciplinary and inter-agency team work

- We observed some multi-disciplinary meetings during our inspection and found these effective in enabling staff to share information about patients and review their progress. Different professionals worked together effectively to assess and plan patients' care and treatment.
- Occupational therapists and psychologists worked as part of each team and we saw that they worked closely with patients. The patients we talked with spoke positively about this. However, we were told that, at the time of our inspection, there was no psychologist working at the Derwent centre. However, contingency arrangements were in place involving a community psychologist so that individual service users could be referred.
- The consultant and medical staff were a regular presence on the wards and were present at times during our inspection. We observed good interaction between the ward staff and medical teams on the wards.
- We saw how community teams were invited and attended discharge planning meetings, and patients we spoke with told us these were supportive.
- We observed a well-structured and detailed handover from one day shift to another.

Adherence to the MHA and MHA Code of Practice

- We checked whether systems were in place to ensure compliance with the Mental Health Act 1983 (MHA) and adherence to the guiding principles of the MHA 1983 Code of Practice 2015. We found three discrepancies in relation to this.
- On Finchingfield ward, whilst there was good evidence that patients were provided with a copy of their section 17 leave authority, we found one instance were a patient appeared not to have been provided with a copy of their section 17 leave authority. Section 17 leave is where the responsible clinician may authorise the patient to leave the hospital for a certain time even though the patient is detained under section of the MHA. We also found that two section 17 leave authorities were unclear about the type of leave that was being authorised, and the designation and numbers of the escorts were not always specified on the leave authority.
- We saw evidence that patients had received their rights (under section 132 of the MHA) and these were repeated at regular intervals.
- On each ward, we found that MHA paperwork had been completed correctly. There was administrative support to ensure paperwork was up to date and held appropriately. There was a clear process for scrutinising and checking the receipt of MHA paperwork. We found overall that the MHA record keeping and scrutiny was satisfactory.
- We saw posters were displayed informing patients of how to contact the independent mental health advocate (IMHA). However, we did not see any information for patients who were detained under the MHA about how they could contact the CQC.
- We saw that 79.7% of staff members had received training in the MHA via e-learning. The staff we spoke with had a good working knowledge of the MHA.

Good practice in applying the MCA

- The trust included training on the Mental Capacity Act (MCA) with their safeguarding training.
- When we spoke with staff there was varying degrees of knowledge about the MCA and Deprivation of Liberty Safeguards (DoLS).
- None of the patients receiving care and treatment during our inspection were under a DoLS.

Are services effective?

Requires improvement

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.

- The care records we viewed showed that patients' mental capacity to consent to their care and treatment was not always assessed when required. Whilst there was good documentation of the assessment of mental capacity in 25 care records, 16 care records had a poor level of documentation with little evidence of the mental capacity of the patient having being assessed.

Psychiatric intensive care units

Assessment of needs and planning of care

- We looked at 13 care plans for patients receiving care and treatment in the psychiatric intensive care unit (PICU) wards. Patients' needs were assessed. However, we saw the care plans were not personalised and did not include patients' views. The care plans were not holistic, for example, they did not include the full range of patients' problems and needs. We found the care plans were not recovery orientated, for example, they did not include the patients' strengths and goals.
- We saw no evidence on Shannon House that patients had been given a copy of their care plan; however on Christopher unit each patient had been given a copy of their care plan. However, six patients told us they had been given a copy of their care plan two days prior to our inspection. One patient showed us their care plan. We noted that it was a formal template with medical jargon and terminology, which the patient told us they did not understand. We were concerned to note that a different patient's care plan had also been attached to the care plan.
- 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.
- Patients' physical health needs were identified. The majority of patients spoken with told us, and records sampled showed, that patients had a physical healthcare check completed by the doctor on admission and their physical healthcare needs were met. 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 usually taking place. All records we sampled included a care plan that showed staff how to meet patients' physical needs. However, one patient in Shannon House was concerned about weight gain, due to a lack of activity.

Best practice in treatment and care

- We saw multi-disciplinary team meetings and ward rounds provided opportunities to assess whether the care plan was achieving the desired outcome for patients.
- We were informed by both medical and nursing staff that relevant national guidance was followed when providing care and treatment. This included relevant guidance from the National Institute for Health and Care Excellence (NICE) and prescribing guidance.
- Outcomes for patients using the services were monitored and audited by the service. This included the monitoring of key performance indicators such as length of stay, the use of control and restraint, and rapid tranquilisation. We received mixed feedback from the patients we spoke with about the quality of the care and treatment they had received. Overall, the feedback was positive.

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.
- We were told that bank and agency staff underwent a basic induction including orientation to the ward, emergency procedures such as fire and a handover about patients and current risks.
- We saw 94% of staff had an up to date personal development plan in place at the time of our inspection. Staff told us they had access to supervision on a regular basis. The ward managers and staff also told us that informal supervision took place regularly, though this was not documented.
- Staff described receiving support and debriefing from within their team following any serious incidents.
- Staff told us there were regular team meetings and staff felt well supported by their immediate managers and colleagues on the wards. Staff also told us they enjoyed good team working as a positive aspect of their work on the wards.

Are services effective?

Requires improvement

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.

Multi-disciplinary and inter-agency team work

- Multi-disciplinary meetings took place which staff felt were effective in enabling staff to share information about patients and review their progress. We were told that different professionals worked together effectively to assess and plan patients' care and treatment.
- Occupational therapists and psychologists worked as part of each team and we saw that they worked closely with patients. The patients we talked with spoke positively about this. However, one patient told us that there was very limited occupational therapy and psychology input on Shannon House.
- The consultant and medical staff were a regular presence on the wards and were present at times during our inspection. We observed good interaction between the ward staff and medical teams on the wards.

Adherence to the MHA and MHA Code of Practice

- We checked whether systems were in place to ensure compliance with the Mental Health Act 1983 (MHA) and adherence to the guiding principles of the MHA 1983 Code of Practice 2015.
- On each ward, we found that MHA paperwork had been completed correctly. There was administrative support to ensure paperwork was up to date and held appropriately. There was a clear process for scrutinising and checking the receipt of MHA paperwork. We found overall that the MHA record keeping and scrutiny was satisfactory.
- We saw evidence that patients had received their rights (under section 132 of the MHA) and these were repeated at regular intervals.
- We saw posters were displayed informing patients of how to contact the independent mental health advocate (IMHA). However, we did not see any information for patients who were detained under the MHA about how they could contact the CQC.
- We saw that 88% of staff members working had received training in the MHA via e-learning. The staff we spoke with had a good working knowledge of the MHA.

Good practice in applying the MCA

- The trust included training on the Mental Capacity Act (MCA) with their safeguarding training.
- When we spoke with staff there was varying degrees of knowledge about the MCA and Deprivation of Liberty Safeguards (DoLS).
- None of the patients receiving care and treatment during our inspection were under a DoLS.
- The care records we viewed showed that patients' mental capacity to consent to their care and treatment was not always assessed when required. Whilst there was good documentation of the assessment of mental capacity in one set of care record out of 13 reviewed. The remaining 12 care records had a poor level of documentation with little evidence of the mental capacity of the patient having being assessed.

Requires improvement

Are services caring?

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

Our findings

Acute Wards

Kindness, dignity, respect and support

- We spoke with 47 patients receiving care and treatment in the acute wards. We observed how staff interacted with patients throughout the three days of our inspection. We received mixed feedback from patients, through speaking with them and reviewing the comments cards, about the care they received.
- From the six comment cards, we receive three positive and three negative comments. For example, one patient commented that Finchingfield ward was "the best ward" they had stayed on and it was "a refreshing change to be treated as a human rather than an inconvenience". However, another patient commented about the poor attitude of staff on Galleywood ward.
- On Gosfield ward, we found a relaxed, friendly environment on the ward. We saw how patients were treated with respect and sensitivity. We also heard how staff spoke to each other about patients in a very caring and considerate way. However, we saw 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. This compromised the privacy and dignity of patients on Gosfield ward.
- On Finchingfield ward, patients largely felt that staff were caring and helpful. However, they also felt that there were limited staff-patient interactions. Patients told us that staff spent much of their time in the office, which we observed during our inspection. We were also told that staff took considerable time to respond to patients' needs. We were told, by patients, that following initial assessment they "were left to get on with it".
- On Stort ward, one patient told us that staff do not respect privacy. They told us that they were getting changed and the bedroom curtains were opened. They also told us that the shower door was opened whilst they were having a shower. Another patient told us that they slept in dormitory accommodation which had been recently reduced from four to three beds. We were told by this patient that the curtains had only just been hung between the beds.
- In the Hub, a patient told us they would like more privacy than what is offered at the Hub. We found the Hub had a large dining/seating area, smaller lounge area and large TV lounge. Additionally, we saw a female only lounge. However, we found that the Hub offered little space for patients to have privacy.
- On Galleywood ward, a patient told us that they "don't work with males". However, they had been allocated a male key worker.
- We observed many examples of staff treating patients with care, compassion and communicating effectively. We saw staff engaging with patients in a kind and respectful manner on all of the wards. However, on our initial inspection of the Hub, we found staff spent much of their time observing the patients, as opposed to participating in conversation. On our announced inspection, during our afternoon visit to the Hub, we saw a number of activities taking place and good interaction between staff and patients.
- We saw patients felt comfortable approaching the ward office and we saw positive interactions between the staff and patients. We observed staff knocked before entering patients' rooms, and speaking positively with patients.
- Staff had an understanding of the personal, cultural and religious needs of patients who used the service and we saw examples of actions taken to meet these needs.

The involvement of people in the care they receive

- We received mixed feedback from patients about their involvement in the care they receive. The majority of patients told us that they had been involved in their care. However, 11 patients told us they had not been involved in their care and had not received a copy of their care plan. For example, in Stort ward, three patients told us they had not received a copy of their care plan. In Finchingfield ward, two patients told us they had not received a copy of their care plan. In Galleywood ward, four patients told us they had been given a copy of their care plan immediately prior to our inspection, despite being in hospital sometime before the inspection. Two patients in Ardleigh ward did not have a copy of their care plan; one patient was unaware that they could have a copy of their care plan.

Requires improvement

Are services caring?

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

- We saw very limited evidence of patients' views being clearly evident in their care plans.
- Patients were invited to the multi-disciplinary reviews along with their family where appropriate.
- All patients spoken with told us they had opportunities to keep in contact with their family where appropriate. Visiting hours were in operation. We saw dedicated areas for patients to see their visitors.

Psychiatric intensive care units

Kindness, dignity, respect and support

- We spoke with 15 patients receiving care and treatment. We observed how staff interacted with patients. We received mixed feedback from patients about the care they received. A number of patients spoke positively about their admission to the PICU wards. For example, two patients told us how their admission had "turned their life around", and they felt really listened to. Six patients on Christopher unit whom we spoke with complained that they were bored. They told us there were no activities during the evenings and weekends. The gym had not been in use for many months and the table tennis, which they had previously had on the ward, had not been replaced.
- We observed many examples of staff treating patients with care, compassion and communicating effectively. We saw staff engaging with patients in a kind and respectful manner on all of the wards.
- We saw patients felt comfortable approaching the ward office and we saw positive interactions between the staff and patients. We observed staff knocked before entering patients' rooms, and speaking positively with patients.
- Staff had an understanding of the personal, cultural and religious needs of patients who used the service and we saw examples of actions taken to meet these needs.

The involvement of people in the care they receive

- We received mixed feedback from patients about their involvement in the care they receive. We saw no evidence on Shannon House that patients had been given a copy of their care plan. On Christopher unit each patient had been given a copy of their care plan, though six patients told us they had been given a copy of their care plan two days prior to our inspection.
- We saw very limited evidence of patients' views being clearly evident in their care plans.
- Patients were invited to the multi-disciplinary reviews along with their family where appropriate.
- All patients spoken with told us they had opportunities to keep in contact with their family where appropriate. Visiting hours were in operation. We saw dedicated areas for patients to see their visitors.

Are services responsive to people's needs?

Inadequate

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

Our findings

Acute Wards

Access and discharge

- The trust had a bed management system. During day, a bed management team co-ordinated the admissions. However, at night, this responsibility fell to the night bleep holder.
- Staff told us that there was often a problem finding beds for patients who needed an admission. We were shown supporting data which gave the bed occupancy on the wards as very often above 100% capacity. It was frequently necessary 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, we saw the average bed occupancy, as at 31 August 2015, was 116.5%, with Peter Bruff ward having 129% bed occupancy. This confirmed that leave beds were being used for admission. Patients returning from leave could not always access their bed immediately.
- Staff told us there could be delays when patients needed to be transferred to more appropriate care facilities, such as a psychiatric intensive care unit (PICU) if there were no beds available there.
- We were informed by a senior member of staff that there were, at the time of our inspection, nine patients in out of area beds (that is, beds which are not within the trust's catchment area).

The facilities promote recovery, comfort and dignity and confidentiality

- Patients told us they were unable to lock their rooms. This was because much of the accommodation in this core service was dormitory style, with up to four patients sleeping in one dormitory. Curtains were provided between the beds but this did not provide the privacy required. There were some single rooms. Whilst patients had access to lockable storage space, they did not have the keys for such storage and had to approach a member of staff and this was not based on assessed risk.
- We saw each ward had an activity programme. This programme included activities such as creative crafts, relaxation, community meetings, baking, gardening and managing emotions. However, when we visited the Hub at the Derwent centre, we saw very few activities taking place, until the afternoon of our unannounced visit. Two patients told us there were absolutely no activities taking place in the Hub. Patients also told us of a lack of activities on Finchingfield and Galleywood wards. When we spoke with a member of staff, they confirmed that activities did take place in the week, though did not during the weekend. During our unannounced visit, we spoke with a senior member of staff, who had been recently appointed, with responsibility for undertaking a review of the activities programme across the trust.
- Payphones were provided on each ward where patients could 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.
- All the wards had access to garden areas in which patients could smoke. However, there were no smoking shelters (particularly for use in inclement weather).
- Patients told us the food on the wards was generally good.

Meeting the needs of all people who use the service

- We saw that spiritual care and chaplaincy was provided when requested.
- We saw there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.
- Staff told us that interpreters were available using a local interpreting service or language line. These services had been used previously to assist in assessing patients' needs and explaining their care and treatment.

Listening to and learning from concerns and complaints

- All the wards accessed the trust's complaints system. Information about the complaints process was available on notice boards. Patients we spoke with knew how to make a complaint.
- Complaints were recorded using the trust's computerised incident reporting system. We saw it

Are services responsive to people's needs?

Inadequate

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

evidenced how the issues were investigated, what outcomes and any learning were. The ward managers told us they shared learning amongst their staff via staff meetings and communications.

Psychiatric intensive care units

Access and discharge

- Staff told us that there was sometimes a problem finding beds for patients who needed an admission. When we reviewed the information the trust had sent us, we saw the average bed occupancy, as at 31 August 2015, was 87.5%.
- The trust provided information to tell us that the average length of stay on Christopher unit was two days and 18 days on Shannon House.

The facilities promote recovery, comfort and dignity and confidentiality

- We saw each patient had their own sleeping accommodation. We saw that patient' bedrooms were unlocked, meaning patients could access their bedroom at any time.
- We saw each ward had an activity programme. This programme included activities such as creative crafts, relaxation, community meetings, baking, gardening and managing emotions. However, when we spoke with patients, a number told us that there was a lack of activities particularly during the evenings and at weekends.
- Payphones were provided on each ward where patients could make a phone call.
- The wards had access to a garden area in which patients could enjoy fresh air. However, there was no smoking shelter (particularly for use in inclement weather).
- In the Christopher unit, the patients' garden was directly next to a public car park. Only a fence, where items could be passed through, separated the garden and the car park. We observed a family arriving to park their car in direct view of the garden leading to a lack of privacy for patients.
- Patients told us the food on the ward was generally good.

Meeting the needs of all people who use the service

- We saw that spiritual care and chaplaincy was provided when requested.
- We saw there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.
- Staff told us that interpreters were available using a local interpreting service or language line. These services had been used previously to assist in assessing patients' needs and explaining their care and treatment.
- Patients had access to drinks and snacks at any time. However, on Shannon House, patients had to approach a member of staff for hot water.

Listening to and learning from concerns and complaints

- Both of the wards accessed the trust's complaints system. Information about the complaints process was available on notice boards. Patients we spoke with knew how to make a complaint.
- Complaints were recorded using the trust's computerised incident reporting system. We saw it evidenced how the issues were investigated, what outcomes and any learning were. The ward managers told us they shared learning amongst their staff via staff meetings and communications.

Are services well-led?

Inadequate

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.

Our findings

Acute Wards

Vision and values

- Staff we spoke with told us they were aware of the trust vision and values. We were told by staff that these were available on the trust's intranet system.
- Staff we spoke with were able to tell us who the most senior managers in the trust were. Staff told us that senior staff within the trust had visited the wards. These included the trust chairman, the chief executive and various executive directors.

Good governance

- Governance committees and mechanisms were in place which had supported the delivery of the service. Lines of communication, from the board and senior managers, to the frontline services were clear at a local level.
- Incidents were reported through Datix (the trust's electronic incident reporting system). We saw examples of records to show that this recording was effective, through reviewing individual specific events and incidents.
- We saw little evidence of trust wide learning from incidents and complaints being shared with staff in order to change to practice.
- The ward managers they have sufficient authority to manage their ward and also received administrative support. They told us they received a good level of support from their immediate manager and other senior managers.
- We had concerns about the robustness of the governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. Whilst ligature risk assessments and action plans were in place, they did not address all ligature risks and an unacceptable number of ligature risks remained on the wards.
- We had concerns about the robustness of the governance arrangements in relation to assessing, monitoring and improving the quality of care plans. Whilst we saw regular care plan audits were undertaken, the results of the audit did not improve practice. For example, we saw limited evidence of patients' involvement in care plans and some patients reported that they did not have a copy of their care plan.
- We had concerns about the robustness of the governance arrangements in relation to assessing, monitoring and improving the quality of meaningful activities. Although the trust had a ward activity programme, a number of patients told us there were limited activities taking place. We observed this during our inspection.
- We found the governance system, in place, relating to the Mental Health Act 1983 (MHA) was robust. MHA paperwork had been completed correctly, was up to date and held appropriately. The MHA record keeping and scrutiny was satisfactory.
- The acute wards for adults of working age had not complied with the three requirements in place, from April 2015, at the Lakes Mental Health Wards (Ardleigh and Gosfield wards) which related to good governance, safety and suitability of premises, and dignity and respect.

Leadership, morale and staff engagement

- On a day to day basis, the wards appeared to be well managed. We were told by staff that the ward managers were highly visible on the wards, approachable and supportive. We were impressed with the morale of the staff we spoke with during our inspection and found that the local teams were cohesive and enthusiastic.
- Staff we spoke with told us that they felt part of a team and received support from each other.
- All staff we spoke with said they felt well supported by their immediate manager and felt their work was valued by them. Generally we saw a positive working culture within the teams which we inspected.
- The ward managers on all wards confirmed that there were no current cases of bullying and harassment involving the staff.

Are services well-led?

Inadequate

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.

Commitment to quality improvement and innovation

- The ward managers and senior managers were able to provide us with an up to date picture of how the wards were performing and had a good understanding of where improvements were required. They were making improvements in the quality of the service.
- We saw that patients' views were gathered through feedback upon discharge. We saw how these results were analysed by the individual ward managers to provide an overview of the service.
- We were impressed with the efforts of a senior member of staff at the Derwent Centre, who 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.

Psychiatric intensive care units

Vision and values

- Staff we spoke with told us they were aware of the trust vision and values. We were told by staff that these were available on the trust's intranet system.
- Staff we spoke with were able to tell us who the most senior managers in the trust were. Staff told us that senior staff within the trust had visited the wards. These included the trust chairman, the chief executive and various executive directors.

Good Governance

- Governance committees and mechanisms were in place which had supported the delivery of the service. Lines of communication, from the board and senior managers, to the frontline services were clear at a local level.
- Incidents were reported through Datix (the trust's electronic incident reporting system). We saw examples of records to show that this recording was effective, through reviewing individual specific events and incidents.
- We saw little evidence of trust wide learning from incidents and complaints being shared with staff in order to change practice.
- The ward managers confirmed they have sufficient authority to manage their ward and also received administrative support. They told us that they received a good level of support from their immediate manager and other senior managers.
- We had concerns about the robustness of the governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. Whilst ligature risk assessments and action plans were in place, an unacceptable number of ligature risks remained on the Shannon House.
- We had concerns about the robustness of the governance arrangements in relation to assessing, monitoring and improving the quality of care plans. Whilst we saw regular care plan audits were undertaken, the results of the audit did not improve practice. For example, we saw limited evidence of patients' involvement in care plans and some patients reported that they did not have a copy of their care plan.
- We had concerns about the robustness of the governance arrangements in relation to assessing, monitoring and improving the quality of meaningful activities. Although the trust had a ward activity programme, a number of patients told us there were limited activities taking place. We observed this during our inspection.
- We found the governance system, in place, relating to the Mental Health Act 1983 (MHA) was robust. MHA paperwork had been completed correctly, was up to date and held appropriately. The MHA record keeping and scrutiny was satisfactory.

Leadership, morale and staff engagement

- On a day to day basis,the wards appeared to be well managed. We were told by staff that the ward managers were highly visible on the wards, approachable and supportive. We were impressed with the morale of the staff we spoke with during our inspection and found that the local teams were cohesive and enthusiastic.
- Staff we spoke with told us that they felt part of a team and received support from each other.
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Are services well-led?

Inadequate

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.

- The ward managers on all wards confirmed that there were no current cases of bullying and harassment involving the staff.

Commitment to quality improvement and innovation

- The ward managers and senior managers were able to provide us with an up to date picture of how the wards were performing and had a good understanding of where improvements were required. They were making improvements in the quality of the service.
- We saw that patients' views were gathered through feedback upon discharge. We saw how these results were analysed by the individual ward managers to provide an overview of the service.

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 9 HSCA (RA) Regulations 2014 Person-centred care The trust were not effectively ensuring that the care and treatment of patients was appropriate, met their needs, and reflected their preferences. • There were blanket restrictions in place on some wards. These included access to toilets, access to the gardens, and access to snacks and beverages. **Regulations 9(1)(a)-(c).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Need for consent.** The trust were not ensuring that care and treatment of service users must only be provided with the consent of the relevant person. • In 28 out of 54 care records reviewed, we found poor documentation relating to patients' mental capacity to consent to treatment. **Regulation 11(1).**

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 **Regulation 12: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

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	**Safe care and treatment.** The trust did not have robust systems in place to ensure the proper and safe management of medicines. We found 31 instances of missed signatures against some prescribed medications, which meant we could not be assured that the patient had been administered their medication as prescribed. **Regulation 12(2)(g).**
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 **Regulation 18: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Staffing.** The trust did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff. • There was an over-reliance on bank and agency staff across all of the acute wards. **Regulation 18(1).**

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 **Regulation 9: Health and Social Care Act 2008 (Regulated Activities) 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 **Regulation 10: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Dignity and respect.**

This section is primarily information for the provider

Enforcement actions

The trust are not effectively ensuring that patients are treated with dignity and respect.

- 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 receiving the care and treatment and doing all that is reasonably practicable to mitigate any 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 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).