Essex Partnership University NHS Foundation Trust

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

Quality Report

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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)
R1LY9	Basildon Mental Health Unit	The Hadleigh unit MH assessment unit Thorpe ward Grangewater ward	SS16 5NL
R1LX7	Broomfield Hospital Mental Health Wards	The Christopher unit Finchingfield ward Galleywood ward	CM1 7LF
R1LX9	Chelmer & Stort Mental Health Wards	Chelmer ward Stort ward	CM20 1QX
R1LZ9	Rochford Hospital	Cedar ward	SS4 1RB

Summary of findings

This report describes our judgement of the quality of care provided within this core service by 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 Essex Partnership University NHS Foundation Trust and these are brought together to inform our overall judgement of Essex Partnership University NHS Foundation Trust.

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

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Overall summary

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

- The trust governance systems were not effective since the merger because we found quality and safety risks for patients and others that the trust had not identified. Trust systems were not effective for sharing information with staff, because the trust had not taken action to ensure that staff had easy access to the latest comprehensive ligature risk assessments for their wards. We identified environmental risks such as poor lines of site on wards, which posed risks to patients or others. Ward team meeting minutes did not demonstrate how the trust was sharing information and learning from serious incident investigations and complaints with staff to prevent reoccurrence.
- The trust had not completed actions for issues highlighted at our 2015 and 2016 inspections of North Essex Partnership University NHS Foundation Trust. For example, the trust had not removed some ligature point risks such as window handles in communal areas on Finchingfield and Galleywood wards. A ligature point is a fixed item to which a person could tie something for the purpose of self-strangulation.
- The trust had not always ensured sufficient staffing for the wards. The trust had not covered 7,369 hours of nursing staff shifts. All wards reported staffing vacancies, with several wards using a high amount of bank and agency staff across wards (above 40%). Ward staff reported difficulties getting staffing to cover increased observation of patients with higher risks. Eight wards had a staff sickness rate above the national average (4.3%) and the trust target of 4.5%.
- The trust had not always protected patients' privacy and dignity because patients on Grangewater and Thorpe wards still shared dormitories. Dormitories cannot always guarantee patients' dignity. The trust had not fully complied with the Department of Health and Mental Health Act 1983 code of practice in relation to the arrangements for eliminating mixed sex accommodation across all wards. For example, the Hadleigh unit did not have an identified female patients lounge.
- Patients did not always have their own bed to come back to if their community leave was unsuccessful. The trust had challenges managing high bed occupancy levels on acute wards. From April to August 2017, 143 patients were in out of area placements.
- The trust had not taken adequate action to support two patients with diabetes care at Basildon Mental Health Unit.
- Staff had not updated eight patients' care plans and risk assessments.
- Staff had not fully completed records and checks of patients in seclusion on the Christopher Unit.
- Staff still carried out restrictive practices, for example, assessment unit patients could not access bedrooms in the morning after 09:30 hours.

However, we found the following areas of good practice:

- Twenty-four patients spoke positively about the care and support staff gave them. Patients told us staff involved them in their care and treatment.
- We observed staff interacting with patients in a caring manner treating them with, respect and dignity and giving them time to talk. Staff had a good understanding of patients' individual needs.
- Thirty-nine staff had good morale and felt supported by their team and managers. They said the trust had effectively communicated with them about the trusts' merger.
- The trust had ensured that ward staff had achieved over 75% compliance with mandatory training. Over 75% of staff had received an appraisal. Eight wards had ensured that 70% or more staff had regular supervision for their role.

Summary of findings

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

Are services safe?

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

- The trust governance systems were not effective since the merger because we found quality and safety risks for patients and others that the trust had not identified.
- The trust had not ensured that staff had easy access to the latest comprehensive ligature risk assessments for their wards. This was despite the trust identifying ligature risk management as a priority following the merger. Some wards had environmental risks, such as poor lines of site on wards and delayed maintenance repairs, which posed risks to patients or others.
- The trust governance systems were not effective for sharing information with staff. Ward team meeting minutes did not demonstrate how the trust was sharing information and learning from serious incident investigations and complaints with staff to prevent reoccurrence. Ward staff had a differing approach to searching patients and managing items that might pose a risk. Despite the trust receiving feedback from the coroner about risks for this following the death of a patient in 2015 on Finchingfield ward.
- The trust had not always ensured sufficient staffing for the wards. There were 7,369 hours when staffing was below the identified trust level for managing the wards safely (wards in the north had the highest amount of unfilled shifts in August 2017). All wards reported staffing vacancies; with several wards using a high amount of bank and agency staff across wards, (Thorpe had 50% September 2017). Ward staff reported difficulties getting staffing to cover increased observation of patients with higher risks.
- The trust had not taken adequate action to support two patients with diabetes care at Basildon Mental Health Unit.
- Staff had not fully completed records and reviews of five patients in seclusion the Christopher Unit.
- The trust had not fully complied with the Department of Health and Mental Health Act 1983 code of practice in relation to the arrangements for eliminating mixed sex accommodation across all wards. For example Hadleigh unit did not have an identified female patients lounge.
- Staff still carried out some restrictive practices, for example, patients on the assessment unit could not access bedrooms in the morning after 09:30 hours.

Summary of findings

- The trust had not completed actions for issues highlighted at our 2015 and 2016 inspections of North Essex Partnership University NHS Foundation Trust. For example, the trust had not removed some ligature point risks such as window handles in communal areas on Finchingfield and Galleywood wards.
- Staff had not updated eight patients' risk assessments across four wards, staff had inaccurately completed nursing observation charts.
- The trust had a policy and procedure in place to guide staff to safely manage disturbed behaviour, which states planned prone restraint should not be used other than in exceptional circumstances. During inspection, staff were not able to tell inspectors prone restraint would happen in exceptional circumstances.

However, we found the following areas of good practice:

- The trust had ensured that most ward areas were clean, had good furnishings and were well maintained.
- Staff had completed information in care plans about how to support patients when relapsing or when in crisis.
- The trust had ensured that nine wards had good medicines management practice (transport, storage, dispensing, and medicines reconciliation).

Are services effective?

We found the following areas of good practice:

- The trust had systems in place for monitoring Mental Health Act compliance.
- The trust had ensured that all wards had achieved the trust target of 90% compliance for staff completing the Mental Health Act 1983/2007 training.

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

- The trust had not ensured that staff had regularly informed five patients detained under Mental Health Act 1983/2007 on the Christopher Unit of their legal rights.
- Staff had not ensured that eight patients' care plans were updated.

Are services caring?

We found the following areas of good practice:

- Twenty-four patients spoke positively about the care and support staff gave them.
- Patients told us staff involved them in their care and treatment.

Summary of findings

- The trust had ensured that staff were using a booklet 'my care my recovery' to gain feedback from patients about their needs.
- Twenty three patients were complimentary about the care given by ward staff.
- We observed staff interacting with patients in a caring manner treating them with, respect and dignity and giving them time to talk. Staff had a good understanding of patients' individual needs.

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

- Five patients on Thorpe and Grangewater wards gave some negative feedback about night staff.
- The trust had not ensured that community meetings regularly took place across wards.

Are services responsive to people's needs?

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

- The trust had challenges managing high bed occupancy levels on acute wards which meant patients did not always return to the same ward if community leave was unsuccessful.
- Trust data for April to August 2017 showed clinical commissioning groups had funded 142 patients out of area placements; the trust had funded one. This included 106 patients placed over 30 miles away from family and friend support networks.
- The trust had not always protected patients' privacy and dignity because patients on Grangewater and Thorpe wards still shared dormitories. Dormitories cannot always guarantee patients' dignity.
- Ten out of 31 patients said there should be more activities, including at weekends.
- The trust had not ensured that ward team meeting minutes demonstrated how information and learning from complaints was shared with staff to prevent reoccurrence.

However, we found the following areas of good practice:

- Following our last CQC inspection, staff told us the use of the 'hub' on Chelmer and Stort mental health wards had changed and patients had choices to attend. Male and female patients at Broomfield Hospital Mental Health Wards now had separate mealtimes in the communal dining room.
- The trust ensured that wards had suggestion boxes and complaints information for patients. They encouraged patients to give feedback via discharge surveys and the 'family and friends' test.

Summary of findings

Are services well-led?

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

- The trust's governance systems had not ensured robust management of ligature risks and assessment for these wards.
- The trust had delayed taking action to address some other environmental risks highlighted by ward staff. For example removing window handles in communal areas and the replacement of Chelmer ward's bathroom door despite being on trust risk registers since 2016.
- The trust had not ensured that a sufficient number of staff of the right grades and experience covered all staffing shifts. Eight wards' had a staff sickness rate above the national average and the trust target of 4.5%.
- The trust had not ensured that managers had easy access to key performance indicators and data to gauge the performance of their team and wards.
- The trust had not ensured that systems to share feedback from investigation of incidents with staff were robust. Not all staff were aware of learning from incidents and complaints across the trust.

However, we found the following areas of good practice:

- Most staff had good morale and felt supported by their team and managers.
- The trust had effectively communicated with staff about the trusts' merger. Staff had opportunities to meet and ask questions of senior managers such as the Chief Executive or deputy Chief Executive.
- The trust had ensured that ward staff had achieved over 75% compliance with mandatory training. Over 75% of staff had received an appraisal. Eight wards had ensured that 70% or more staff had received regular supervision for their role.

Summary of findings

Information about the service

Acute wards

Basildon Mental Health Unit

- Mental Health assessment unit is a 20 bedded, mixed sex ward
- Thorpe ward is a 20 bedded, mixed sex ward
- Grangewater ward is a 28 bedded, mixed sex ward

Broomfield Hospital Mental Health Wards

- Finchingfield is a 17 bedded ward for men
- Galleywood 18 bedded ward for women

Chelmer and Stort Mental Health Wards

- Chelmer ward is a 16 bedded ward for women
- Stort ward is a 16 bedded unit with the ability to 'flex up' and increase beds.

Rochford Hospital

- Cedar ward is a 24 bedded, mixed sex ward

Colchester Hospital Mental Health Wards

We carried out a focused inspection to Ardleigh, Gosfield and Peter Bruff wards at this location in August 2017. Therefore, we did not visit these wards during this inspection.

Psychiatric intensive care units

Basildon Mental Health Unit

- The Hadleigh unit is a 15 bedded, mixed sex psychiatric intensive care unit

Broomfield Hospital Mental Health Wards

- The Christopher unit is a 10 bedded, mixed sex psychiatric intensive care unit

Summary of the last CQC inspections of these wards:

A focused inspection took place in September 2016 for North Essex Partnership University NHS Foundation Trust. The CQC issued a section 29A warning notice to the trust to make significant improvements and issued requirement notices.The inspection report can be found on our website: http://www.cqc.org.uk/sites/default/files/new_reports/AAAF7969.pdf

A comprehensive inspection took place in August 2015 of North Essex Partnership University NHS Foundation Trust and this core service was rated overall as 'inadequate'. The CQC issued a section 29A warning notice to the trust to make significant improvements with a date for making them by 30 November 2015. Additionally requirement notices were issued.The inspection report can be found on our website: http://www.cqc.org.uk/sites/default/files/new_reports/AAAE1334.pdf

A comprehensive inspection took place in June 2015 of South Essex Partnership University NHS Foundation Trust and this core service was rated overall as 'good'.The inspection report can be found on our website: http://www.cqc.org.uk/provider/RWN/inspectionsummary#mhpsychintensive

Essex Partnership University NHS Foundation Trust was formed on 1 April 2017 following the merger of North Essex Partnership University NHS Foundation Trust and South Essex Partnership University NHS Foundation Trust.

Our inspection team

Our inspection team was led by:

- Team Leader: Julie Meikle, head of hospital inspection, mental health CQC
- Lead Inspector: Victoria Green, inspection manager, mental health CQC

The team that inspected this location included an inspection manager, four inspectors, two mental health act reviewers and a pharmacist inspector. There was also an expert by experience, someone who has experience of using or caring for someone using mental health services and two specialist advisors with nursing and social work backgrounds.

Summary of findings

Why we carried out this inspection

This was an unannounced inspection of this core service. Our monitoring highlighted concerns and we decided to carry out a focused inspection to examine these. These included concerns about the ward environment, the care and treatment given to patients and staff response to incidents.

How we carried out this inspection

We have reported in each of the five domains safe, effective, caring, responsive and well led. As this was a focused inspection, we focused on specific key lines of enquiry in line with concerns raised with us. Therefore, our report does not include all the headings and information usually found in a comprehensive inspection report. We have not given ratings for this core service, as this trust has not yet had a comprehensive inspection. However, we have detailed areas for improvement in the report.

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

We carried out an unannounced visit from 6 to 9 November 2017.During the visit we:

- visited ten wards
- spoke with 31 patients using the service
- spoke with 29 staff members; including nurses, healthcare assistants, doctors, occupational therapy staff and community staff
- spoke with nine ward managers
- spoke with three senior managers
- spoke with an advocate
- reviewed care and treatment records relating to 34 patients
- reviewed patient prescription charts
- observed how staff were caring for people
- reviewed information we had asked the trust to provide
- reviewed a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

- Twenty four patients were complimentary about the care and support given by ward staff.
- Patients told us staff involved them in their care and treatment and they had opportunities to give feedback on the service staff given.
- Twenty six patients said the food was good and 21 patients were satisfied with the amount of activities offered.

However:

- Ten patients (four across Thorpe and Grangewaters) said there should be more activities, including at weekend.
- Seven patients did not know who their keyworker was on the ward (mostly Broomfield Hospital Mental Health Wards).
- Five patients across Thorpe and Grangewater wards gave negative feedback about night staff.
- Five patients said they could not recall receiving a copy of their care plan.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that Basildon Mental Health Unit staff gives adequate treatment and care of patients with diabetes.
- The trust must review their governance systems for sharing information with staff on wards for learning from serious incidents.

Summary of findings

- The trust must ensure that staff have easy access to accurate ward ligature risk assessments.
- The trust must take action to reduce the number of ligature points on wards.
- The trust must review their staff processes to reduce the number of unfilled staffing shifts.
- The trust must ensure that records and checks of patients in seclusion meet the requirements of the Mental Health Act 1983/2007 code of practice.
- The trust must review restrictive staff practices.
- The trust must ensure that it meets all requirements in the Department of Health guidance and Mental Health Act 1983 code of practice in relation to the arrangements for eliminating mixed sex accommodation.
- The trust must review their bed management systems for patient admission and discharges.
- The trust must ensure consistent searching processes of patients and management of items that might pose a risk to patients across wards.
- The trust must review their process for checking that care plans and risk assessments are completed.
- The trust must review their process for informing patients detained under Mental Health Act 1983/2007 of their legal rights.

Action the provider SHOULD take to improve

- The trust should review the provision of activities.
- The trust should take action to remove dormitories at Basildon Mental Health Unit by 2020.
- The trust should ensure that staff do not plan or intentionally restrain patients in a prone/face down position.
- The trust should review how they manage staff sickness.
- The trust should review their process for ensuring nursing observation charts are completed.

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
The Hadleigh unit MH assessment unit Thorpe ward Grangewater ward	Basildon Mental Health Unit
The Christopher unit Finchingfield ward Galleywood ward	Broomfield Hospital Mental Health Wards
Chelmer ward Stort ward	Chelmer and Stort Mental Health Wards
Cedar ward	Rochford Hospital

Mental Health Act responsibilities

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

- Trust information for 16 November 2017, showed all wards had achieved the trust target of 90% compliance for staff completing the Mental Health Act 1983/2007 training.
- The trust had mental health administration offices to check mental health documentation papers and oversee patient's legal detention.
- The trust had systems for informing informal patients of their rights.

However:

Detailed findings

- Staff notes for an informal patient on Galleywood ward and the assessment unit indicated their community leave was restricted.
- Staff had not regularly informed five patients detained under Mental Health Act 1983/2007 of their legal rights.
- Staff's completion of seclusion records and reviews of patients did not always meet the recommendations of the Mental Health Act code of practice 2015. For example, five patients' records were on copies of carbonated forms and we were unable to read some of the entries, which included staff names. We identified issues including, three occasions when the doctor did not attend during the first hour to review the patient; nursing review times did not detail if secure bedding was available for one patient. Staff had not detailed the patient's care plan; information about what the patient took into the room and whether the carer was informed or the patient's wishes. Staff had not documented individualised patient information in a care plan and medical reviews did not take place four hourly for a patient until the first multi-disciplinary review. One record showed a patient requested breakfast at 07:00 hours but did not receive it until two hours later and staff had not recorded the reason.

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

- The trust's oversight and management of risks from potential ligature points was not robust. We had told North Essex Partnership University NHS Foundation Trust to make significant improvements ensure adequate management of ligature risks following our inspection in 2016. A ligature point is a fixed item to which a person could tie something for the purpose of self-strangulation. Finchingfield and Chelmer ward's last ligature risk assessment was not available for staff's reference. Trust assessments available on wards did not always capture risks. For example, Finchingfield ward's assessment 05 May 2017 did not include toilet seats. Thorpe ward's manager had raised issues with the trust regarding the accuracy of ligature assessments since May 2017 and was still awaiting the updated version. Staff did not have access to the latest assessment on Cedar ward from 4 August 2016 following changes to door hinges. The trust sent us one dated 19 September 2017, which had updated this risk. The ligature risk assessment dated 18 October 2017 for the assessment unit did not include window screws. The Chelmer ward manager did not have access to ligature assessment to show us on site.
- The trust's new ligature risk assessment did not assess individual rooms. The template grouped rooms by type. Staff had access to photographic lists identifying ligature 'hotspot' areas for greater observation but these did not include all risk areas. Chelmer and Stort ward's list was more detailed than others. Staff on Finchingfield and Chelmer wards had kept out of date policies relating to ligature cutters and management. There was a risk that staff would not be aware of the actions they should take to keep patients safe.
- Wards had a variety of ligature points including mid-level hand driers and low-level toilet seats across all wards in washrooms where patients would be alone. Washrooms had wall fixed soap, paper and towel dispensers. Managers said the fitting collapsed if patients tried to use them to self-harm. However, the trust had not ensured that not all ward ligature risk assessments specified this.
- The trust had a plan in place to further reduce ligature risks in high risk areas in acute wards. This included the replacement of toilets, wardrobes and shower doors. All ward communal areas contained high and mid-level ligature points. The trust ligature assessment referred to staff mitigating risk in these areas through observation. However, we observed occasions where patients were in communal areas without staff.
- Staff reported from April to October 2017, 14 incidents of a patient using a ligature on a fixed point to self-harm (six for toilet seats). The majority of these were on Galleywood and Chelmer women's wards with patients using clothing to tie to a ligature point.
- The trust had some systems to manage ligature risks, such as wards in the north had top door sensors. Wards had designated areas for staff to keep ligature cutters. The trust was replacing all toilets with an anti- ligature point design. The trust had reassessed wards for ligature risks and identified an inconsistency in approach to reducing potential risk in the past e.g. some door handles in a corridor or windows on a ward replaced with anti-ligature design, but not others.
- Wards had environmental risks that still posed risks to patients or others. Ward layouts did not easily allow staff to observe all parts of the ward. For example, the newly built Chelmer ward had blind spots in corridors due to closed doors, which the ward manager said was due to an error in design. The trust had learned from this and reduced doors on Stort ward to give staff easier observation. However, some staff still raised concerns about poor visibility of the ward. Chelmer and Stort ward's garden had overgrown bushes and whilst there was CCTV, it would prove difficult for staff to observe patients. Staff said that men and women had separate times to use the garden. Thorpe ward had a blind spot near the multidisciplinary room, which managers acknowledged and said they would take action to address this.
- The trust had not fully complied with the Department of Health and Mental Health Act 1983 code of practice in relation to the arrangements for eliminating mixed sex

accommodation across all wards. The trust had mixed sex wards on Thorpe, Grangewater, the assessment unit and Cedar wards. The trust had reported a breach of same sex accommodation for the assessment unit in September 2017 when they were not able to keep men and women's sleeping areas separate. Staff's monitoring on Cedar ward was not robust because we found two men asleep in a female lounge. Staff took action to address this once they became aware of it.

- Wards did not have seclusion rooms. Cedar ward had an extra care area for unsettled patients to spend time in a lower stimulus environment. Staff said they would transfer patients to the nearest psychiatric intensive care unit if seclusion was required.
- Wards had fully equipped clinic rooms with accessible resuscitation equipment and emergency medication that staff checked regularly. Staff were not confident that oxygen cylinders were full. On checking a gauge showed the tank as empty. Staff addressed this immediately. Information provided by the trust following the inspection showed that staff were expected to lock the valve after testing the fill rate. This meant the gauge showed as empty. Staff did not explain or demonstrate this at the time of the inspection.
- Most ward areas were clean, had good furnishings and were well-maintained. Patients were satisfied with the standard of cleaning on wards and we saw audits took place. However, we found some cleaning required on Finchingfield, Galleywood and Cedar wards, which staff addressed during our visit. The assessment unit had a room with an offensive odour that staff were trying to resolve. Galleywood's garden had cigarette butts in it despite being a designated no smoking area.
- The trust had not ensured that systems for checking, reporting and addressing ward maintenance issues were robust. We found risks on ward including, Chelmer ward staff had to supervised all patients using the bathroom because the door had not been replaced with an anti-barricade one. The trust stated that the maintenance team were not aware of the current risks and they had now logged the issue. However, staff had identified this on their ligature risk assessment 16 May 2017 and the latest trust risk register 20 October 2017. Finchingfield ward manager said they had reported access to ceiling tiles (and cables) because it was a risk for patients. The trust advised they had taken action after a report in November 2016. They stated the ward had not identified the ongoing risk and the trust had now logged this for maintenance staff to action. However, staff had identified this as a risk on their ligature risk assessment May 2017. Grangewater and Thorpe wards had high-level windows in bedrooms that staff or patients could not easily open or close and staff had to ask maintenance staff to do so. Thorpe ward had identified this as a risk and had a system for checking if windows were open. However, staff were not consistently monitoring this because five out of six records showed checks were not taking place as per the standard set. Chelmer ward had damaged safety glass in a communal room that staff had reported for repair August 2017. The trust said due to being a specialist item they had needed to contact the manufacturer for replacement and had contacted them again for feedback on the timeframe for replacement.
- The trust had made some changes to the environment since the last inspection. Some work was underway at the time of this inspection. This included replacement of Finchingfield ward kitchen and toilets during our visit. Staff across wards said the trust was replacing all toilets with anti ligature ones. The trust was replacing washroom flooring on Thorpe wards washrooms. The trust had arranged maintenance staff to repair a hole in Cedar ward celling reported two weeks before.
- The trust had ensured that staff had access to personal alarms. Some staff at Chelmer and Stort and Broomfield Hospital Mental Health Wards said alarms did not work in all the garden area and took actions to reduce the risk of this, such as ensuring staff knew where the risk areas were, notifying other staff of when the garden was being used. Patients had access to alarms in bedrooms in order to summon help.
- Closed circuit television was present in some communal areas such as Chelmer and Stort ward's garden and ward reception areas.

Safe staffing

- The trust had not always ensured staffing for wards met the standards they had identified. This posed risk that there was not enough staff available to deliver patients' care and treatment and keep them safe. We had told North Essex Partnership University NHS Foundation Trust to take action to ensure sufficient staffing following our inspection in 2016.
- The trust's identified staffing establishment for these wards was 96 whole time equivalent nurses (wte) and 91 wte nursing assistants.

Are services safe?

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

- The trust had not ensured that all wards had sufficient staffing to ensure patient and staff safety. Three wards Thorpe, Grangewater and Cedar had more than 18 beds; this was above the nationally recommended number for acute wards to ensure safety and privacy. There is no national guidance for staffing levels on wards, because staffing should depend on the patents needs. However, the ward managers on Grangewater arranged five staff per shift for 28 patients. (1:5.6).The trust had used two tools: the Keith Hurst and Midlands Tool (in partnership with Health Education England) to assist in determining ward staffing levels and the ratio of staff on acute wards. The trust were reviewing this further.
- The trust had 46 wte staffing vacancies. Trust information for September 2017 showed Grangewater ward had the highest amount with 10 vacancies and Chelmer ward was the lowest with one wte vacancy. All wards except Cedar ward had a 'red' risk rating for staffing vacancies. Grangewater ward had the highest with 41%. Acute wards had 32 nurse wte vacancies. Stort ward had the highest amount with seven vacancies and Chelmer ward was the lowest with one. The trust had 14 wte nursing assistant vacancies. Galleywood had the highest amount with three vacancies and Stort ward had the lowest with two vacancies.
- The trust had two different data recording systems for the north and south wards but as from November, the same system of collecting and reporting staffing was in place. The trust provided information from May to October 2017 for south wards and information from April to August 2017 for north wards. This showed 4,606 hours when the trust had not arranged for nursing staff and 1,769 hours when they had not arranged for nursing assistant staff cover.
- Trust information for September 2017, showed four wards as having over 40% bank staff usage. The highest use was on was Thorpe ward (50%) and the lowest use was Stort ward (14%). Seven wards had over 10% agency staff usage (trust limit). The highest was Stort ward (36%) and the lowest was Finchingfield ward (4%).
- Wards did not have a full complement of staff across the service. Staff told us that whilst the trust gave authorisation to get bank or agency staff, they had difficulty getting cover at short notice, such as when a patient needed increased observation. North staff said this had deteriorated since the change in the bank booking system. Staff could not contact them in the evenings and weekend. Staff on Finchingfield, Galleywood, Chelmer and Stort wards said their workload had increased since they had changed their search policy. Teams required extra staff to supervise patients in the garden. We saw that wards could request additional staff for this.
- Trust data from April to October 2017 showed staff had reported 13 staffing incidents when they did not have sufficient staffing. Cedar and Thorpe wards had the highest with three. Two incidents, related to insufficient acute ward staff to cover the health based place of safety.
- Eighteen staff and ten patients told us that staff shortages affected the service delivered. Staff across wards said there could be problems getting authorisation for bank or agency staff cover for shifts and covering escorted leave. Ward managers said they sometimes covered nursing shifts (which we observed during our visit). Patients said this affected their opportunities for leave, activities, and staff availability to talk to them.
- Thorpe ward had the highest staff turnover rate for the last 12 months with 16% with Finchingfield having the lowest with 0%.
- Managers' logged safer staffing data daily and took part in 'sit rep' calls to discuss staffing and risk issues. Managers made requests to move staff across wards to cover and to ensure appropriate gender mix in these calls. Nursing staff shift patterns differed across locations, south staff completed 12-hour shifts. The trust was consulting north staff about introducing this.
- Trust information showed they were working towards dependency monitoring on a shift-by-shift basis and implementation of the 'safe care' module within e-Rostering.
- The trust had ensured that ward staff had achieved over 75% compliance with mandatory training. Six wards were below the trust target of 90% compliance for mandatory training. The lowest compliance was Chelmer ward with 76%.

Assessing and managing risk to patients and staff

- Twenty two of thirty patients risk assessments seen were comprehensive and regularly updated by staff after incidents. However, we found eight examples where staff's records for the risk assessment of patients were not fully completed. On Galleywood ward a doctor's assessment and decision making for an informal patient who had a history of self-harm and

wanted to self-discharge from hospital was not available. Staff had not updated another patient's risk assessment after the patient had fallen. On Finchingfield ward, staff had not updated a patient's risk assessment following a self-harm incident. Staff had not documented their risk assessment for all Cedar patients prior to them going on community leave. On the assessment unit, a doctor had detailed that staff should place a patient on level two observations (four to six checks an hour) but staff had not updated other documentation. A patient's risk assessment stated a patient was not at risk of suicide risk despite previous records stating they had suicidal thoughts. On Grangewater, staff did not document the outcome of a patient attending A&E following an incident. Staff had not fully completed a Galleywood patient's community leave form, for example detailing what they were wearing.

- Staff had information in care plans about how to support patients when they relapsed or when they were in crisis. However, these were not in two Cedar ward patient records.
- Thorpe and Galleywood staff told us of actions taken to reduce blanket restrictions such as ensuring room access and supervised access to headphones with cords to listen to music therapeutically. The trust was monitoring restrictive practices because Thorpe ward manager had an email showing they had reduced them. Managers had requested ward staff feedback on how they had achieved this to share learning with others.
- Staff restricted patients on some wards. Staff on Cedar ward and the assessment unit prevented patients having access cards to bedrooms, unless individual risk assessment allowed. Patients on the assessment unit were restricted from bedrooms from 09:30-12:30 hours. Staff did not allow patients out on community leave until after 09:30 hours. This included informal patients not detained under the Mental Health Act 1983/2007.
- Seven wards had good medicines management practice (transport, storage, dispensing, and medicines reconciliation). However, nurses did not manage and support patients with diabetes appropriately at Basildon Mental Health Unit. Staff had not given a patient two doses of insulin and staff had delayed taking action to manage a patient with diabetes and high blood glucose monitoring results who was receiving insulin. This had posed a risk to the patients' health. We raised this with the trust for their urgent attention and they informed us of the actions they had taken to address the concerns and reduce the risk of reoccurrence.
- Pharmacy staff completed weekly missed dose audits and results were fed back to the management team. We found Galleywood staff records of administration of medicine for patients had some gaps for this, which the ward managers said they would take action to investigate. Thorpe ward staff had not completed the medicines charts to indicate if a patient was detained under the Mental Health Act 1983/2007 or if they had consented or not to treatment. Galleywood clinic cupboard had some loose medication in the bottom, which staff removed. There was no pharmacy bin for staff to use.
- The ward manager on Galleywood and Cedar ward were not aware of a patient safety alert around the use of sodium valproate in pregnancy. However, the trust had developed an action plan and other staff were aware of this via a medicines management newsletter sent to all staff in May 2017.
- Ward staff had restricted certain items such as plastic bags on wards to reduce the risks of patients harming themselves or others. Staff allowed some items on the ward and they restricted patient access subject to risk assessment and staff supervision.
- Staff told us they did not want to issue blanket bans regarding these items for all patients. They said the majority of self-harming incidents by patients was using their clothing but not tying a ligature to a fixed point. Where staff had assessed a patient as being at risk of self-harm they would place them under increased staff observation. Two Thorpe patients told us of an incident where another patient had used an item of clothing as a ligature. We checked and staff had reported this as an incident for investigation (staff reported that the patient had not tied the ligature to a fixed point).
- The trust had not ensured that staff nursing shift handover documentation was fully completed records. For example for five patients on Finchingfield, ward handover notes had gaps and missing information such as who their keyworker was and treatment status.
- Staff were recording their individual notes of patients using the the nationally recognised approach 'situation, background, assessment, recommendation' structure to assist in communicating information.

Are services safe?

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

- The trust's search policy was not consistent across all wards. For example, Finchingfield, Galleywood, Chelmer and Stort ward staff had a process for searching patients on return from leave, for restricted items with their consent and recording this, whereas other ward staff did not us the same forms. Staff in wards in the north said since the no smoking policy started in October 2017 and patients were using leave more frequently in the day to smoke outside the hospital grounds; this work had significantly increased and had affected their other duties. The trust had increased staffing, for example on Finchingfield ward to help cover this.
- Staff said they had received safeguarding adults and children training and could contact safeguarding leads for wards to report incidents or gain advice. The trust took action to investigate an issue raised by a patient when we brought it to their attention. Ward managers had differing systems for monitoring and tracking incidents reported for their wards. For example, Chelmer ward manager had a folder with safeguarding incidents whereas other wards managers had to request information on this from the centralised safeguarding team.
- Trust data from April to August 2017 showed that staff had restrained patients on 227 occasions. The highest amount for August 2017 was Thorpe ward with 61 incidents and the lowest was Chelmer ward with three. Staff reported six occasions when patients were held in prone position (face down). On five occasions, this was for staff to administer medication by injection. The trust had a policy and procedure in place to guide staff to safely manage disturbed behaviour, which states planned prone restraint should not be used other than in exceptional circumstances. During inspection, staff were not able to tell inspectors prone restraint would happen in exceptional circumstances.
- Trust data showed one occasion when staff had placed a patient in seclusion on Cedar ward. Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour, which is likely to cause harm to others. Staff on Finchingfield and Galleywood wards said they might nurse a patient in seclusion in their room as a temporary measure if required but that would be subject to necessary to checks taking place.

Track record on safety

- Because this was a focused inspection, we did not request specific data about the number of serious incidents for this core service since April 2017.
- Since our inspection in 2016, the trust had received in two regulation 28, prevention of future deaths reports relating to North Essex Partnership University NHS Foundation Trust from Essex coroner for this core service. One was regarding a patient who had died whilst on community leave in 2017. The other related to a patient who died on the ward in 2015 from an incident where they tied a ligature. Both related to the Broomfield Hospital Mental Health Wards.
- Essex police had informed the trust they were reviewing historical inpatient and community patients deaths, whilst under the care of North Essex Partnership University Foundation Trust, to consider if further action should be taken.

Reporting incidents and learning from when things go wrong

- The trust governance systems for sharing information with staff after serious incidents and for checking systems were not fully effective. There was a risk that the staff had not received information and learning following incidents to reduce the risk of reoccurrence. Ward team meeting minutes did not always detail how managers were sharing information and learning from serious incidents with ward staff. This was despite, the trust developing prompt headings on meeting agendas.
- A prevention of future deaths report had identified learning and actions for the trust, which included staff risk assessment, observation and search of patients. The trust had not ensured that staff were aware of this and were consistently searching patients and restricting access to items that posed a risk to themselves or others. On Thorpe ward, patients in a shared bedroom dormitory had easy access to shoelaces and decorative ribbons. This was despite two reported incidents (one for Thorpe ward) involving patients tying shoelaces as a ligature to a fixed point. Thorpe staff said patients were risk assessed for their suitability to stay in dormitories and there were single bedrooms for patients at higher risk of self-harm. However, a staff member said that patients at high risk of self-harming occasionally had slept in the dormitories. Staff had identified razors and aerosols as restricted items to be kept in locked

drawers, but a Finchingfield patient had these in an unlocked area. Staff immediately safely stored them for the patient. Galleywood staff had not recorded the search of a patient's possessions on admission where they had risk of hiding items to harm themselves. On Finchingfield ward, we had conflicting information from staff and records as to if a patient required regular enhanced, level two searches due to an assessed risk of posing harm to others.

- Staff did not consistently manage and record the observation of patients in line with trust policy. We had identified this as a risk also in our recent focused inspection of acute wards in Colchester. We found examples where staff had not fully completed observation records such as for Grangewater, Thorpe and Finchingfield wards. This included no rationale given by staff for the level of observation of a patient, incorrect recording of the times of observation and gaps in recording of observations for an hour making it unclear if staff had observed the patient.
- Trust staffing capacity affected the reporting of incidents. This posed a risk that staff would not take action to reduce the risk of reoccurrence. We found gaps in records where Grangewater staff had not reported all incidents for a patient. A staff member staff told us staff did not always report incidents, due to the pressure of work. Cedar ward had 64 reported incidents dating back to July 2017 showing as 'open' and not reviewed by a manager.
- The trust had not ensured that all wards used incident data to identify themes for their ward and take actions to reduce the reoccurrence. Ward managers could request incident information from central trust departments of the number and type of incidents per ward. Stort ward and Finchingfield ward staff showed they had systems for this. Thorpe ward manager had trust feedback that they had reduced incidents involving ligatures. Other wards had limited details of how they using this information to reduce risks.
- Staff said they got some feedback from serious incident investigations via team meetings and trust safety alert emails. Staff gave some examples of learning from incidents including removing most collapsible shower curtain rails following an incident on Galleywood ward. North site wards had replaced waste bins in rooms to reduce the risk of patients using them to self-harm with (although south wards had not). Chelmer staff said they were mindful to regularly review patients' observations levels and increase as required if they had concerns about patients' risks. Finchingfield staff talked of changes to how they assessed and managed risk for patients on community leave with family or friends. Other examples included searching 'pom poms' for hidden restricted items.
- Staff said they had regular opportunities for reflective practice to discuss complex cases or incidents. Managers held debriefs following incidents to review actions and offer staff support and learning. Thorpe and Grangewater staff said they used using time centred 'safety huddles' to discuss patient's risks during the day as part of the 'safe wards' model of care.
- Two staff said they had recently completed revised root cause analysis training organised by the trust to equip them for investigating serious incidents, which they had found useful.

Psychiatric intensive care units

Safe and clean environment

- The trust's oversight and management of ligature point risks was not robust. We had told North Essex Partnership University NHS Foundation Trust to make significant improvements to ensure adequate management of ligature risks following our inspection in 2016.
- The Christopher unit's ligature risk assessment 12 May 2017 did not capture all risks such as the gym. The manager said they had been awaiting replacement wardrobes for two years because they posed a risk of patients self-harming. The trust stated they had agreed funding for this. The trust's new ligature risk assessment had grouped rather than individualised rooms risks. The Christopher Unit staff had out of date policies relating to ligature cutters. Staff had access to photographic lists identifying ligature 'hotpot' areas for greater observation. The trust had not ensured that the Christopher unit staff had access to an updated version as the trust had made environmental changes since the last one dated December 2016. Therefore we were not assured that staff would aware of the actions they should take to reduce risks to patients.
- Units had a variety of ligature points including Hadleigh unit's low-level toilet, and high-level air vent, which the trust had identified for removal. Staff had reported one

incident of a patient using a ligature on a fixed point to self-harm. Units had designated areas for staff to keep ligature cutters. Unit layouts allowed staff to more easily observe patients.

- Unit seclusion rooms had two-way communication, toilet facilities and a clock. At our last inspection we had identified the Christopher unit seclusion room did not meet the standards required. The trust had taken action to make significant improvements to the room. However, a small blind spot area remained meaning staff could still not fully observe a patient in all room areas. In addition, the underside of the door had been damaged and had a potentially a sharp edge. Staff said if required they would use the seclusion facilities in the health-based place of safety or low secure unit Edward House if required. During our visit, Edward House staff used the Christopher Unit's seclusion room to manage one of their patients because an incident prevented the safe use of theirs. The Christopher unit also had a de-escalation area, lower stimulus environment for staff to use with unsettled patients.
- The trust had not fully complied with the Department of Health and Mental Health Act 1983 code of practice in relation to the arrangements for eliminating mixed sex accommodation. For example, both psychiatric intensive care units were mixed sex. Hadleigh unit did not have an identified female patient's lounge, which would affect patients' dignity, privacy and safety. The trust had ensured there were designated bedrooms areas for men and women.
- The trust had ensured that most unit areas were clean, had good furnishings and were well-maintained. Patients were satisfied with the standard of cleaning on units and we saw audits took place. The Christopher unit garden had cigarette butts in it despite being a designated no smoking area.
- Units had fully equipped clinic rooms with accessible resuscitation equipment and emergency medication that staff checked regularly.
- The trust had ensured that staff had access to personal alarms and patients had access to alarms to summon assistance in their rooms. Staff did not offer CQC staff alarms during our first visit, which the service manager said should have occurred.

Safe staffing

- The trust had not always ensured staffing for units met the standards they had identified. This posed risk that there was not staff available to deliver patients' care and treatment and keep them safe. We had told North Essex Partnership University NHS Foundation Trust to take action to ensure sufficient staffing following our inspection in 2016.
- Not all units were staffed sufficiently to ensure patient and staff safety. The trust's identified staffing establishment for these units was 24 whole time equivalent nurses (wte) and 30 wte nursing assistants.
- The Christopher unit had a 32% staff vacancy rate with two band five nurse and one band three nursing assistant vacancies. The Hadleigh unit had 22% of vacancies with one band three nursing assistant vacancy. A manager said they had challenges getting adverts out to recruit new staff.
- Trust information for September 2017, showed the Hadleigh unit had 53% bank staff usage and the Christopher unit had 46%. Both units were identified a risk area by the trust and given a 'red' risk rating. Both units used less agency staff, the Hadleigh unit had 1% agency and the Christopher unit had 2%.
- The trust had two different data recording systems for the north and south wards but as from November, the same system of collecting and reporting staffing was in place. Trust information from May to October 2017 for the Hadleigh unit and April to August 2017 for the Christopher Unit staffing showed 464 hours when the trust had not arranged for nursing staff and 530 hours when they had not arranged for nursing assistant staff cover.
- The Hadleigh unit had the highest staff turnover for the last 12 months with 12% and the Christopher unit had six percent.
- Trust data from April to October 2017 showed four staffing incidents logged by staff (two for each unit). We saw examples on staff rotas of not being able to have a full complement of staff across units. For example, the Hadleigh unit's showed unfilled shifts for a nurse and nursing assistant the week commencing 30 October 2017.

Are services safe?

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

- Managers referred to logging 'safer staffing' data daily and senior staff and unit managers having 'sit rep' telephone conference calls to discuss staffing and risk issues for the units and requests could be made to move staff across units for cover (to also ensure gender a mix). Nursing staff shift patterns differed across locations, south staff had 12 hour shifts. The trust was consulting north staff about introducing this.
- Trust information showed they were working towards dependency monitoring on a shift-by-shift basis and implementation of the 'safe care' module within e-Rostering.
- Trust data training data for September 2017 showed both wards were just below the trust target of 90% for staff mandatory training. The Christopher unit had achieved 87% compliance and the Hadleigh unit 86%.

Assessing and managing risk to patients and staff

- The trust had not ensured that the Christopher unit staff's completion of seclusion records and review of patients met the recommendations of the Mental Health Act code of practice 2015. Five patients' records were on copies of carbonated forms and some of the entries were unreadable, such as staff names. Issues included, three occasions when the doctor did not attend during the first hour to review the patient; nursing review times did not detail if safe bedding was available for one patient. Staff had not detailed the patient's care plan; information about what the patient took into the room and whether the carer was informed or the patient's wishes. Staff could not show us the segregation policy. The trust later sent this to us.
- The trust had ensured Hadleigh unit staff had completed records more fully. However, we identified that staff had not recorded for a patient what they took into the seclusion room. Staff had not documented individualised patient information in a care plan and medical reviews did not take place four hourly for a patient until the first multi-disciplinary review. One record showed a patient requested breakfast at 07:00 hours but did not receive it until two hours later and no rationale was given.
- Trust data from April to August 2017 showed ten occasions when staff had placed a patient in seclusion: two occasions on the Christopher unit and eight occasions on the Hadleigh unit.
- Trust information for the same period, showed that staff had restrained patients on 65 occasions on the Christopher unit and 20 occasions on the Hadleigh unit. In August 2017, staff reported three occasions when the patient was held in prone position (face down) for staff to administer medication by injection. This is not in line with the Department of Health's 2014 guidance 'Positive and Proactive Care'.
- The trust had not ensured that staff always followed policies and procedures for the observation of patients, which could pose a risk to patients or others safety. We checked a sample of observation records and staff had not signed several on the Christopher Unit with no comment on how the patient presented. Several entries referred to the patient sleeping without reference to staff checks if they were breathing. We raised this with the manager who said they would take action address this.
- Units had good medicines management practice (transport, storage, dispensing, and medicines reconciliation). However, staff had recorded that the Christopher unit's clinic room temperature had exceeded recommended limits and did not detail what action staff had taken. There was no evidence that medication was affected.
- The trust had made improvements in their risk assessment of patients since our last inspection in 2016.
- Staff used the nationally recognised approach 'situation, background, assessment, recommendation' structure in nursing notes to communicate important information.
- Staff said they had safeguarding training and leads for units. They knew how to report incidents or gain advice. The Christopher unit manager stated there was an issue with centralised trust data systems not updating so they kept their own log of training, which showed 100% compliance for safeguarding adults and children training.

Track record on safety

- Because this was a focused inspection, we did not request specific data about the number of serious incidents for this core service since April 2017.

Are services safe?

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

Reporting incidents and learning from when things go wrong

- The trust had systems for staff to report incidents and kept a central record of the number and type of incidents per unit.
- Staff said they got some feedback from serious incident investigations via team meetings and trust safety alert emails. Examples of learning from incidents included, the Christopher Unit staff provided unbreakable pencils to patients following incidents of patients self-harming using broken pencils. The Hadleigh unit were using regular agency staff at night to ensure consistency of care to patients. This had reduced night-time incidents. The trust was reviewing window safety following an incident where a patient absconded from the unit.
- Staff said they had regular opportunities for reflective practice to discuss complex cases or incidents. In addition, managers held debriefs following incidents to review actions and offer staff support and learning. Staff on the Hadleigh unit said the chaplain also gave support in these.

Are services effective?

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

Our findings

Acute wards

Assessment of needs and planning of care

- The trust had ensured that staff's assessment of twenty-four patients and care plans were comprehensive and completed soon after admission. Staff offered most patients a physical examination and had ongoing monitoring of physical health problems.
- The trust had not ensured that staff had updated records for eight patients, which could pose a risk to patients' care and treatment. Staff had not updated a Broomfield Hospital Mental Health Wards patient's care plan with information about the assessment for a blood borne virus. We found information elsewhere in notes. Staff had not recorded for a Galleywood patient that they were reviewing their physical health. Staff had not fully completed another patient's ward review notes 1 November 2017. Staff had not updated a Cedar patient's care plan regarding smoking cessation. Staff had not fully completed another patient's preadmission assessment and physical health assessment. Staff had not fully completed an assessment unit patient's care plan instead stating that their family history was 'previously noted' on the records without other details. Staff on Galleywood ward had not updated two patients care plans regarding safeguarding children issues, despite reference in other documents about risks.
- The trust was working to develop an inpatients record system. Staff in the north and south of the trust were using different patient record systems. Staff said they could not access electronic records if transferring patients across wards. Staff on Cedar ward said that agency staff did not have access to electronic records.The trust informed us after the inspection that they have systems in place to give bank and agency staff access to the electronic records system using guest logins.

Adherence to the MHA and the MHA Code of Practice

- The trust had ensured that all wards had achieved the trust target of 90% compliance for staff completing the Mental Health Act 1983/2007 training.
- The trust had mental health administration offices and systems to check mental health documentation papers and oversee patient's legal detention. Staff knew who their MHA administrators were. The trust audited Mental Health Act 1983/2007 processes.
- Staff regularly reviewed patient's capacity and consent to their treatment at ward reviews.
- The trust had systems for informing informal patients of their rights. However, staff notes for an informal patient on Galleywood ward and the assessment unit indicated their community leave was restricted. Trust staff said they would investigate this.
- The trust displayed information for patients who were detained under the Mental Health Act 1983 on how to contact the CQC.

Psychiatric intensive care units

Assessment of needs and planning of care

- The trust had ensured that staff's assessment of patients and care plans were comprehensive and completed by staff soon after admission.
- Staff offered patients a physical examination and ongoing monitoring of their physical health problems.
- The trust was working to develop an inpatients record system. Staff in the north and south of the trust were using different patient record systems. Staff said they could not access electronic records if transferring patients across wards.

Adherence to the MHA and the MHA Code of Practice

- The trust had not ensured that staff were regularly informing patients detained under Mental Health Act 1983/2007 of their legal rights. This was identified as an issue at a mental health reviewer visit in October and the trust stated they now had a system to check this happened. However, five patient's records on the Christopher unit showed gaps in staff completing this.
- The trust had ensured that units had achieved the trust target of 90% compliance for staff completing the Mental Health Act 1983/2007 training.

Are services effective?

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

- The trust had mental health administration offices and systems to check mental health documentation papers and oversee patient's legal detention. Staff knew who their administrators were. The trust audited Mental Health Act 1983/2007 processes.
- Staff regularly reviewed patients' capacity and consent to their treatment at reviews.
- The trust displayed information for patients who are detained under the Mental Health Act 1983 on how to contact the CQC.

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

- Twenty-three patients were complimentary about the care given by ward staff. Patients who were discharged had sent cards thanking staff for their help.
- We observed staff interacting with patients in a caring manner treating them with, respect and dignity and giving them time to talk. Staff had a good understanding of patients' individual needs.
- Thorpe ward manager in post since May 2017 told us they had made changes to ward culture by ensuring staff put patients first. Staff and patients also gave some positive feedback about this work.
- We received some negative feedback from five patients across Thorpe and Grangewater wards about night staff. Comments included staff being rude, disrespectful and disinterested. A manager said they had regular bank staff covering mostly at night. However, that they also tried to rotate day and night staff to ensure consistency of care. Thorpe ward patients had recently raised some concerns in a community meeting. We raised this with the trust and they said they would investigate the concerns further.

The involvement of people in the care they receive

- Patients told us staff involved them in their care and treatment.
- The trust had ensured that ward staff across the trust were using a booklet 'my care my recovery' to gain feedback from patients about their needs and this was mostly reflected in care plans. Staff encouraged patients to sign their care plans and raise issues in ward reviews.
- Ward staff had displayed information about advocacy services. An advocate said staff encouraged use of the service. However, staff usually preferred to refer when they visited rather than referring by email.
- The trust had systems to involve patients' families and carers in care and treatment. Wards displayed local carers support details. Thorpe ward manager gave examples of having meetings with carers.
- The trust had admission processes to inform and orientate patients to the ward and the service. However, the trust had not ensured there were consistent systems in place for staff to give patients and carer's information, because seven patients did not know who their keyworker was they were (mostly Broomfield Hospital Mental Health Wards). Five patients said they could not recall receiving a copy of their care plan. Three patients said staff had not spoken to them about the side effects of medication. A mental capacity assessment on Galleywood did not detail the involvement of a patient's relatives.

Psychiatric intensive care units

Kindness, dignity, respect and support

- Due to the psychiatric intensive care units being unsettled when we visited, we did not speak to many patients.
- We observed staff interacting with patients in a caring manner treating them with, respect and dignity and giving them time to talk. Staff had a good understanding of patients' individual needs.

The involvement of people in the care they receive

- Staff had admission processes to inform and orientate patients to the unit and the service.
- Unit staff were using a booklet 'my care my recovery' to gain feedback from patients about their needs and this was mostly reflected in care plans. Staff encouraged patients to sign their care plans and raise issues in reviews.
- Unit staff had displayed information about advocacy services.
- We saw examples where staff involved patient's families and carers in care and treatment.

Are services responsive to people's needs?

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

Our findings

Acute wards

Access and discharge

- The trust oversight and management of patient admission and discharges needed improvement. This meant that patients may return to a bed on a different ward if they returned from community leave and we saw examples of this during our visit. Trust information for September 2017 showed all wards except the assessment unit had bed occupancy of more than 85%. This is above the national identified average recommended for an adult in-patient mental healthcare ward. Grangewater ward had 35 patients (seven patients who were on leave) when we visited and staff said at times that they had 38. Cedar ward had three empty beds and Chelmer had one. Ward managers said they had 'capped' beds, which meant commissioners paid for a set amount of beds on the ward, even though wards might have more. Staff said that the patients had more complex needs than in previous years.
- Clinical commissioning groups had needed to fund 142 patients out of trust /area placements during April to August 2017. The trust had funded one placement. One hundred and six patients were in placements over 30 miles away from family and friend support networks and we considered this was not conducive to their recovery. The trust stated following the inspection that they had developed systems to reduce out of area placements. During the CQC visit in November, these were significantly reduced with a trajectory of 0 by December 2017. They stated they had a centralised bed management team.
- The average length of stay for patients ranged from the lowest, seven days for the assessment unit to 143 days on Finchingfield ward. The assessment unit was for short-term admissions of patients up to a week. Staff reported there could be delays moving patients to other wards. Sixteen patients had been on the ward over a week when we visited.
- The trust had difficulties discharging patients from wards; there were five patients with delayed discharges for these wards. Staff said there would be difficulties finding appropriate accommodation. We saw examples of discharge plans developed for patients.
- The trust informed the CQC they were reviewing their bed capacity and function. Staff reported good links and good gatekeeping by home treatment teams (or equivalent). These staff and discharge facilitators attended the ward for meetings to check when patients were ready for discharge or to go on leave.
- After staff had discharged a patient, the trust had a system in place to contact patients to assess their welfare. The ward staff telephoned the patient 48 hours after discharge, and then, either the home treatment team or community teams would visit within seven days of discharge from the ward. However, following a serious incident investigation, the trust had identified some learning for the assessment unit but staff did not reference this.

The facilities promote recovery, comfort, dignity and confidentiality

- The trust had ensured that wards had a range of rooms and equipment to support treatment and care such as a clinic room to examine patients, and activity rooms. They had designated areas where patients could meet visitors. The trust had changed the use of the 'hub' at Chelmer and Stort mental health wards following our last inspection. Staff said patients had choices to attend and now ate their meals on the wards. The trust had ensured that male and female patients at Broomfield Hospital Mental Health Wards now had separate mealtimes in the communal dining room.
- Patients could access a phone to make private calls, although many patients had access to their own mobile phone.
- Most patients had not personalised their bedroom areas. The trust had arranged lockers for patients to lock valuables in their rooms.
- Thorpe ward staff and patients had developed as part of the 'safe wards' scheme 'discharge trees'. Ward staff had displayed numerous patient developed aspirational comments with the aim of giving hope to patients for their recovery. Wards had a range of leaflets and posters giving patient's information about services.
- Twenty-six patients said the food was good. The trust was refurbishing Finchingfield ward's kitchen to include a new beverage station for patients.
- Twenty-one patients said activities were available on the wards including evenings and weekends. Staff and patients gave examples of activities they had provided, such as Finchingfield staff had arranged football, movie

Are services responsive to people's needs?

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

night, X factor events with patients. Grangewater staff had arranged a Halloween party and a 'pamper' event. Thorpe and Finchingfield staff had donated books and DVDS for patient's use. However, ten patients (four across Thorpe and Grangewaters) said there should be more activities.

- Patients on Cedar, Chelmer and Stort wards had ensuite washrooms. On other wards, patients shared washing facilities. Staff had arranged toiletries for patients to use if they had none when they arrived.
- The trust had not ensured patients' dignity and privacy on Thorpe and Grangewater wards. Dormitories cannot always guarantee patients' dignity. There were four dormitory rooms with five patients sharing each room (total 20). Patient's beds were in a partitioned cubicle with a curtain door. One cubicle contained two washbasins separated also by curtains. Curtains were open when we visited so people could see directly into the cubicles. A patient told us a person came in and woke them up. Another patient said people kept pulling the curtain down. A trust CQC preparation visit of Thorpe ward on 3 July 2017 had identified that patient bed areas were small and cluttered. In addition, patients were concerned about not having their own rooms. The ward had not identified an action plan to respond to this.
- We observed that most vision panels in bedroom doors were open. Patients were unable to close the panels on Thorpe and Cedar wards. Galleywood ward had no privacy screening on bedroom windows overlooking a communal area.
- Thorpe ward staff had not fully ensured that they maintained women's dignity because we saw several women had gathered at the entrance to the female corridor in nightwear, and men could easily see them.

Listening to and learning from concerns and complaints

- The trust had ensured that patients could give feedback on the service using ward suggestion boxes, discharge surveys and the 'family and friend' test. Ward staff had displayed information for patients on the trust's process for making a complaint. Thorpe ward manager said they had reduced the level of formal complaints by more actively trying to resolve issues informally with patients.
- The trust had not ensured that wards held regular community meetings. Minutes from meetings held mostly gave limited information and did not detail how staff gave fedback on actions taken following issues raised. Staff said they would give feedback on the 'you said we did' boards.
- The trust had not ensured that they shared outcome of investigation of complaints and actions with staff because team meetings minutes held limited information.

Psychiatric intensive care units

Access and discharge

- The trust oversight and management of patient admission and discharges was more effective for psychiatric intensive care units. Latest trust information for September 2017 showed the average bed occupancy was 87% for the Christopher unit and 81% for Hadleigh unit. There was less risk on the units that patients would not have a bed to come back to if they returned from community leave.
- The clinical commissioning groups had placed fewer patients in out of area/trust psychiatric intensive care unit beds. Trust information for August 2017 showed three patients' were out of area for the Christopher Unit; two were in independent healthcare locations.
- The average length of stay for patients was 101 days at the Hadleigh unit and 94 days at the Christopher unit.
- Staff said they would assess patients prior to admission to identify if the patient needed the higher level of care and treatment. There were no patients with a delayed discharge when we visited.
- Potentially the trust transferred patients to other wards or discharged them into the community. Following discharge there was a system in place to contact patients to assess their welfare. The ward staff telephoned the patient 48 hours after discharge, and then, either the home treatment team or community teams would visit within seven days of discharge from the ward. However, a patient discharged from the Christopher unit in August 2017 needed readmission October 2017 to an acute ward. Notes referenced gaps in them seeing their community care coordinator.
- Staff said there could be issues with getting community care coordinators to attend meetings, because due to

Are services responsive to people's needs?

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

the wider catchment area some patients were further away from home. The trust was investigating a complaint regarding the Hadleigh unit and staff's transfer of a patient to another trust.

- Staff told us the psychiatric intensive care unit and health based place of safety was closed at Chelmer and Stort Mental Health Wards with plans to reopen in 2018, depending on building work.

The facilities promote recovery, comfort, dignity and confidentiality

- The trust had ensured units had a range of rooms and equipment to support treatment and care such as a clinic room to examine patients, and activity rooms. They had designated areas where patients could meet visitors.
- Patients had bedrooms with ensuite washrooms. Units had areas for patients to lock valuables in.
- Patients could access a phone to make private calls.
- Units had activity timetables. Patients had access to a gym, subject to risk assessment.

Listening to and learning from concerns and complaints

- The trust had ensured that patients could give feedback on the service using unit suggestion boxes, discharge surveys and the 'family and friend' test. Unit staff had displayed information for patients on the trust's process for making a complaint.
- Staff displayed actions taken in response to patient's feedback via 'you said we did' boards.
- The Hadleigh unit staff gave an example of receiving feedback and learning from a previous complaint. They said the trust gave staff customer care training to improve communication with patients and others.

Are services well-led?

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

Our findings

Acute wards

Good governance

- The trust's governance systems for oversight and management of ligature point risks needed improvement. We had told North Essex Partnership University NHS Foundation Trust to make significant improvements following our inspection in 2016. The trust stated they had a system for reviewing all ward ligature risk assessments. However, they had not ensured that staff had easy access to the latest one and that assessments held all the information required for staff to manage risks. They had not checked that ward had removed outdated policies and procedures. Therefore, not all staff had updated information for their work to keep patients safe. The trust had not removed all ligature points from Finchingfield and Galleywood wards. The trust had completed some work in relation to the removal of high risk ligature points across a variety of wards. A plan remained in place to continue to address this issue and was prioritised by risk. The trust acknowledged that further work was required to strengthen the ligature assessment process to ensure staff identified and mitigated all issues that posed a risk to patients.
- There were delays in responding to maintenance requests, despite ward managers reporting risks, for example on Chelmer and Finchingfield wards.
- The trust had not ensured that a sufficient number of staff of the right grades and experience covered all staffing shifts and to meet patient's needs. For example staff said they had difficulties booking bank and agency staff such as to observe patients when their risk of harm to themselves or others increased. Several managers said the trust had difficulty recruiting staff due to competition from other trusts due to a national shortage of nurses. In addition, wards close to London had difficulty attracting staff due to either the cost of living or applicants preferred to apply for jobs with London weighted salaries. Other examples included staff preferred to work for an agency and have more flexibility with choosing shifts.
- The trust had not ensured that all managers had easy access to key performance indicators and data to gauge the performance of their team and wards and highlight operational risks. The trust had identified challenges getting accurate data for staff training and supervision compliance.
- Managers on Chelmer and Stort Mental Health Wards, had more developed systems than others, but only had data available until September 2017. Ward managers told us they had started to attend 'quality and safety' meetings and told us of an 'observation and engagement project' starting. Some staff gave feedback that wards were reliant on senior managers giving feedback on issues but were hopeful that changes in trust governance systems would give staff easier access to information.
- The trust had identified £211,000 to complete further improvement works at Broomfield Hospital Mental Health Wards location.
- The trust staffing recruitment plans including, liaising with local universities to attract new staff and 'growing their own' by supporting nursing assistants to complete advance practitioners course and then go onto nursing training. The trust informed us that the merger had affected the recruitment process, as likely some staff would be redeployed following changes to posts.
- The trust had introduced the matron assurance tool, a process for assessing and monitoring the quality of the service in north, across wards. The trust were reviewing and harmoninising all previous trust policies to ensure there was one across the trust. They had ensured staff had access to their intranet to refer to these.
- The trust had developed their systems to ensure for these wards that staff received mandatory training and were appraised and supervised. Trust data showed most staff had received appraisals of their work. Grangewater, Chelmer and Stort wards had the lowest compliance rates below the trust a target of 90%, the lowest being Chelmer ward with 76%. The trust was developing their systems to monitor staff supervision compliance. Data showed most wards had met the trust targets of 90% (every eight weeks). However, Cedar ward was just below and Chelmer ward was the lowest with 69%. Wards managers for wards in the north said the target was every four to six weeks.
- The trust had introduced ward CQC preparation visits with feedback for improvements. Wards had developed action plans in response.

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- The trust had received 'accreditation for inpatient mental health services' from the Royal College of Psychiatrists for the mental health assessment unit (until 2018) and Grangewater ward (until 2019).

Leadership, morale and staff engagement

- Thirty-nine staff told us their morale was good and that they were proud of their work with patients. They said there was effective team working and support. Some wards had planned team away days.
- Twenty-seven staff said the trust had engaged with them effectively about the merger. They said they had opportunities to give feedback on services and give input into service development. Staff told us they had opportunities to meet the chief executive and deputy chief executive, and that they had opportunities to ask them questions. The trust had recruited a director and associate director for adult mental health services.
- The trust had ensured that staff knew how to use whistle-blowing process. The majority of staff said they would feel comfortable to talk to their line manager about any issues they had, who would do their best to try and resolve things. They were aware how to contact their 'freedom to speak up guardian'.
- Managers said there were opportunities for leadership and development. Two staff said they had accessed the Mary Seacole programme for first time leaders.
- Managers gave examples of how they supported staff's diverse needs. For example, Thorpe ward staff told us how managers supported staff to report incidents of racist abuse by patients to them. Chelmer ward manager said the trust had involved them in the 'workforce race equality standards' group.
- Ward managers gave example of actions they took regarding staff competency and capability.
- Staff at Broomfield Hospital Mental Health Wards talked about the pressure staff had faced following media reports. Managers said they gave support and staff had access to the employee assistance.
- Six of eight wards had staff sickness rates above the national average and the trust target of 4.5%. Stort ward had the highest staff sickness with 9% and Galleywood ward had the lowest with 2%. Managers said the trust used the nationally recognised Bradford score system for monitoring this and gave examples of supporting staff to return to work.

Psychiatric intensive care units

Good governance

- The trust's governance systems for oversight and management of ligature point risks needed improvement. We had told North Essex Partnership University NHS Foundation Trust to make significant improvements following our inspection in 2016. The trust stated they had a system for reviewing all ward ligature risk assessments they had not ensured that staff had easy access to the latest one. They had not checked that ward had removed outdated policies and procedures. Therefore, not all staff had updated information for their work to keep patients safe.
- The trust had delayed in taking action address some other environmental risks highlighted by ward staff, for example, regarding the replacement of wardrobes on the Christopher unit.
- The trust had not ensured that a sufficient number of staff of the right grades and experience covered all staffing shifts and to meet patient's needs. The trust had challenges managing staffing sickness. Both the Hadleigh and Christopher units' average sickness rates for staff over the last 12 months were above the national average (7% and 6%). Manager said the trust used the nationally recognised Bradford score system for monitoring this and gave examples of supporting staff to return to work.
- The trust had sent the CQC their plans for transitional arrangements for the merger. This included making changes to staffing, executive team, governance structures, policies and procedures. The trust had reviewed North Essex Partnership University trust's action plan and had identified improvements.
- Managers told us that there were reviewing south and north Essex policies to ensure there was one policy. They had ensured staff access to an intranet to refer to new policies.
- Managers told us they had started to attend 'quality and safety' meetings and told us of an 'observation and engagement project' starting.
- The trust had developed their systems to ensure staff received mandatory training and were appraised and supervised for these units. Trust data showed most staff had received appraisals of their work. The Hadleigh unit had 87% compliance and the Christopher Unit had 88% compliance just below a trust target of 90%. The trust was developing their systems to monitor staff

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supervision compliance. Data was available only for the Hadleigh Unit, which showed 100% (every eight weeks). The trust had identified challenges getting accurate data for staff training and supervision compliance.
- Staff had the ability to submit items to the trust risk register.

Leadership, morale and staff engagement

- Most staff told us their morale was good and that they were proud of their work with patients. They said there was effective team working and support.
- Most staff said the trust had engaged with them effectively about the merger. They said the trust had given the opportunity to give feedback on services and input into service development. Staff told us they had opportunities to meet the chief executive and deputy chief executive, and that they had opportunities to ask them questions. The trust had recruited a director and associate director for adult mental health services.
- The trust had ensured that staff knew how to use whistle-blowing process. The majority said they would feel comfortable to talk to their line manager about any issues they had who would do their best to try and resolve things. They were aware how to contact their 'freedom to speak up guardian'. Staff gave us some feedback that they were unsure who to contact in human resources due to changes and the merger had affected trust communication.
- Managers said there were opportunities for leadership and development.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • The trust had not ensured that all wards met the Department of Health guidance and Mental Health Act 1983 code of practice in relation to the arrangements for eliminating mixed sex accommodation.

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 had not ensured that Basildon Mental Health Unit staff gave adequate treatment and care of patients with diabetes. • The trust had not ensured that records and checks of patients in seclusion met the requirements of the Mental Health Act 1983/2007 code of practice. • The trust did not have consistent search processes of patients and management of items that might pose a risk to patients across wards. • The trust did not ensure that staff had easy access to accurate ward ligature risk assessments. • The trust had not taken sufficient actions to reduce the number of ligature points on wards. • The trust process for checking that care plans and risk assessments were completed was not vigorous.

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 • Trust bed management systems for patient admission and discharges were not robust.

This section is primarily information for the provider

Requirement notices

- The trust had not ensured that staff were regularly informing patients detained under Mental Health Act 1983/2007 of their legal rights.
- The trust had not sufficiently reduced staff restrictive practices.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The trust had not ensured all staffing shifts were covered on wards.