South Essex Partnership University NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Basildon Mental Health Unit Rochford Hospital	RWN40 RWN10
Community-based mental health services for adults of working age	Trust Headquarters	RWN20
Mental health crisis services and health-based places of safety	Trust Headquarters	RWN20
Specialist community mental health services for children and young	Trust Headquarters	RWN20
Child and adolescent mental health wards	Rochford Hospital	RWN10
Community-based mental health services for older people	Trust Headquarters	RWN20
Wards for older people with mental health problems	Basildon Mental Health Unit Clifton Lodge Mountnessing Court Rawreth Court Rochford Hospital	RWN40 RWNJ3 RWN65 RWNJ2 RWN10

Summary of findings

	Thurrock Hospital	RWN50
Community mental health services for people with learning disabilities	Trust Headquarters	RWN20
Wards for people with learning disabilities	Heath Close	RWNB2
Forensic In Patient/Secure	Brockfield House Robin Pinto Unit Wood Lea Clinic	RWNK9 RWNM2 RWNL7
Community Health Services End of Life Care	Trust Headquarters	RWN20
Community Health Inpatient Services	Bedford Health Village Archer Unit Cumberlege Intermediate Care Centre Saffron Walden Community Hospital St Margaret's Community Hospital	RWNX2 RWNY6 RWNX7 RWNZ1
Community health services for children, young people and families	Trust Headquarters Child Development Centre	RWN20 RWNY2
Community dental services	Trust Headquarters Knightswick Clinic Warrior House Saffron Walden St Margaret's	RWN20 RWNY8 RWNY9 RWNX7 RWNZ1
Community adults	Trust Headquarters Saffron Waldon St Margaret's	RWN20 RWNX7 RWNZ1

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

Summary of findings

Ratings

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

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

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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Summary of findings

Overall summary

We rated South Essex Partnership University NHS Foundation Trust as good overall because:

- Services were effective, responsive and caring. Where concerns had arisen the board had taken urgent action to address areas of improvement.
- The board and senior management had a vision with strategic objectives in place and staff felt engaged in the improvement agenda of the trust. Performance improvement tools and governance structures were in place and had brought about improvement to practices.
- Morale was found to be good in most areas and most staff felt supported by local and senior management. There was effective team working and staff felt supported by this.
- Staff treated people who used the service with respect, listened to them and were compassionate. They showed a good understanding of people's individual needs.
- Admission assessment processes and care plans, including for physical healthcare, were good.
- A good range of information was available for people and the trust was meeting the cultural, spiritual and individual needs of patients.
- The inpatient environments were conducive for mental health care and recovery and the bed management system within inpatient services was effective.
- Services were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) guidelines.
- The trust had an increasingly good track record on safety in the previous 12 months. Effective incident, safeguarding and whistleblowing procedures were in place. Staff felt confident to report issues of concern. Learning from events was noted across the trust.
- A formal complaints process was in place and well implemented. However, some informal complaints were not routinely captured and recorded.
- There was a commitment to quality improvement and innovation.

However:

- The trust had undertaken significant work required under the Department of Health's 'Positive and Proactive Care: reducing the need for restrictive interventions' agenda. However, we had concerns about restrictive practice and seclusion across the trust.
- Clinical risk assessment was variable in some services.
- On the majority of wards there were clear arrangements for ensuring that there was single sex accommodation. However, there was a breach of the eliminating mixed sex accommodation guidance during our inspection. This was addressed immediately by the trust.
- Generally medicines management was effective and pharmacy was embedded into ward practice. However, some teams in the community adult mental health and crisis services did not have appropriate arrangements for the storage and transportation of medications.
- Not all patients had timely access to psychological therapies.
- Improvement was needed to procedures for consent to treatment.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement 

We rated South Essex Partnership University NHS Foundation Trust as requires improvement for safe because:

- We found ligature points that had not been noted in the forensic service. These were however addressed during the course of our inspection.
- Clinical risk assessments were of variable quality in some services and they did not always reflect the needs and risks of patients.
- On the majority of wards there were clear arrangements for ensuring that there was single sex accommodation. However, there was a breach of the eliminating mixed sex accommodation guidance during our inspection. This was however addressed immediately by the trust.
- Staffing was usually sufficient. However, there were a large number of vacancies and heavy reliance on bank and agency staff.
- The trust had undertaken significant work required under the Department of Health's 'Positive and Proactive Care: reducing the need for restrictive interventions' agenda. However, Seclusion and segregation was not always recognised by staff and so the safeguards required under the Mental Health Act code of practice were not in place. We also had concerns about restrictive practice across the trust.
- The health based place of safety at Basildon mental health unit did not meet the guidelines set by the Royal College of Psychiatrists.
- Generally medicines management was effective and pharmacy was embedded into ward practice. However, some teams in the community adult mental health and crisis services did not have appropriate arrangements for the storage and transportation of medications.

However:

- The trust had an increasingly good track record on safety over the previous 12 months and effective plans in place to address existing risks.
- Ward environments were clean and well maintained.
- Effective incident, safeguarding and whistleblowing procedures were in place. Staff felt confident to report issues of concern. Learning from events was noted across the trust.

Summary of findings

- Staff were aware of their responsibilities under the duty of candour requirements.
- Staffing training was in place and there was a good level of compliance with mandatory training.

Are services effective?

Good

We rated South Essex Partnership University NHS Foundation trust as Good for Effective because:

- Services were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) guidelines.
- Outcome measures were used across services.
- The trust had participated in a number of quality improvement programmes, research and quality audit.
- We found a strong commitment to multidisciplinary team working across all services and staff were qualified, skilled and supported to perform their roles.

However:

- Admission assessment processes and care plans, including for physical healthcare, were generally good. However, there were some gaps in acute and forensic services and some work was needed to develop these in the learning disability services.
- Not all patients had timely access to psychological therapies.
- Arrangements were in place to ensure effective use of the Mental Health Act and Mental Capacity Act. However, we found a number of practices that did not meet the MHA code of practice including the authorisation of medication and inconsistency in rights being read under the MHA.
- Improvement was needed to procedures for consent to treatment.

Are services caring?

Good

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

- Staff treated people who used the service with respect, listened to them and were compassionate. They showed a good understanding of people's individual needs.
- People were involved in their care and treatment and were aware of their care plans.
- Staff encouraged people to involve relatives and friends in care planning if they wished and visiting arrangements were in place.

Summary of findings

- Information about services was available to patients and staff supported people to understand their treatment.
- We were told that staff respected peoples' personal, cultural and religious needs.
- Information on how to access advocacy was available for people who used the service.
- The trust had a detailed programme of work to involve people in the planning and delivery of services.

Are services responsive to people's needs?

Good

We rated South Essex partnership University NHS Foundation trust as good for Responsive because:

- The inpatient environments were clean and maintained and most were conducive for mental health care and recovery.
- The bed management system within inpatient services was effective, ensuring that patients received timely access to services when they required it.
- In most community services target times for assessment were set and met. Referrals were usually seen quickly by skilled professionals.
- A good range of information was available for people in appropriate languages.
- The trust was meeting the cultural, spiritual and individual needs of patients.

However:

- Complaint information was available for patients and staff had a good knowledge of the complaints process. However, not all informal complaints were recorded.
- Food was not always at the standard required by patients.

Are services well-led?

Good

We rated South Essex Partnership NHS Foundation Trust as good for Well Led because:

- The trust board had developed a vision statement and values for the trust and most staff were aware of this.
- Leaders were visible and most staff felt supported.
- Good governance arrangements were in place, which supported the quality, performance and risk management of the services.
- The trust had undertaken positive engagement action with service users and carers.
- There was effective team working and staff felt supported by this.

Summary of findings

- Staff knew how to use the whistleblowing, safeguarding and incident reporting processes and could submit items to the risk register.
- There was a commitment to quality improvement and innovation.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Karen Dowman, Chief Executive, Black Country Partnership NHS Foundation Trust

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

Inspection Manager: Lyn Critchley, mental health hospitals, CQC

The team included CQC managers, four inspection managers, 15 inspectors, eight Mental Health Act reviewers, support staff and a variety of specialists and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

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

Why we carried out this inspection

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

How we carried out this inspection

When we inspect, we always ask the following five questions of every service and provider:

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

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

We carried out an announced visit between 29 June to 03 July 2015. Unannounced inspections were also carried out on the 6 to 9 July 2015.

Prior to and during the visit the team:

- Held service user focus groups and met with local user forums.
- Met with local stakeholders and user groups.
- Held focus groups with 35 different staff groups.
- Talked with over 300 patients and 50 carers and family members.
- Collected feedback using comment cards.
- Observed how staff were caring for people.
- Attended community treatment appointments.
- Attended multi-disciplinary team meetings.
- Looked at the personal care or treatment records of over 350 patients and service users.
- Looked at patients' legal documentation including the records of people subject to community treatment.
- Interviewed almost 200 staff members.
- Interviewed senior and middle managers.
- Attended an executive team meeting.
- Met with the MHA Hospital Managers
- Reviewed information we had asked the trust to provide.

We inspected all mental health inpatient services across the trust including adult acute services, the psychiatric intensive care unit (PICU), secure wards, older people's wards, and specialist wards for people with learning disabilities and children and adolescents. We looked at the trust's places of safety under section 136 of the Mental Health Act. We inspected a sample of community mental health services including the trust's crisis services, children and adolescents services, learning disability services, older people's and adult community teams.

Summary of findings

We visited four locations where community inpatient services were delivered. We also visited a large number of facilities where community outpatients, young people's and dental services were delivered from.

Information about the provider

The trust was created in 2000 to provide mental health, learning disability and substance misuse health and social care services. It became a foundation trust on 1 May 2006. Since 2013 it had also provided physical health community services across Bedfordshire, Essex and Suffolk.

The trust operated in two geographical based divisions: Bedfordshire and Essex & Suffolk. The Bedfordshire directorate delivered community healthcare services. The Essex & Suffolk directorate delivered mental health and learning disability services (Essex only) as well as community healthcare services.

At April 2015 the trust served a population of almost 2.5 million and employed almost 4,600 staff including nursing, medical, psychology, occupational therapy, social care, administrative and management staff. It had a revenue income of £324.5 million for the period of April 2013 to March 2014.

South Essex Partnership University NHS Foundation Trust had a total of 25 locations registered with CQC and had been inspected 22 times since registration in April 2010.

At the time of this inspection, there were two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, from January 2014, at the Basildon Mental Health Unit. These were in relation to staffing and records. During this inspection we reviewed this area of previous breach and found the trust had addressed these concerns.

What people who use the provider's services say

The Care Quality Commission community mental health survey 2014 was sent to people who received community mental health services from the trust to find out about their experiences of care and treatment. Those who were eligible for the survey were people receiving community care or treatment between September and November 2013. There were a total of 260 responses, which was a response rate of 31%. The trust was performing about the same as other trusts across all areas. Where comparable it was noted that trust had improved against previous results in some areas.

A review of people's comments placed on the 'patient opinion' and 'NHS choices' websites to March 2015 was conducted ahead of the inspection. 17 comments were noted of which nine were partly of wholly positive. Positive comments included that that staff were kind, compassionate and listened, that the hospital was clean, and there was good advice and information. Negative comments included issues with complaints handling, recordkeeping and access to appointments.

The trust had used the Friends and Families Test (FFT) since 2012. In the 12 months prior to our visit there had been over 25,000 responses to this survey. At June 2015 the results indicated that 85% of patient respondents were likely or extremely likely to recommend the trust services. The trust demonstrated an improving picture of satisfaction during the 12 months before our inspection.

Prior to the inspection we spoke with services users and their carers across the trust. This included conversations with independent user led local organisations and advocacy groups and attendance at user and carer groups linked to the trust. Generally people stated that staff were caring and responsive. A number commented on positive relationships with the trust.

During our inspection we received comment cards completed by service users or carers. We also received a large number of phone calls and emails directly to CQC from service users, carers and voluntary agencies supporting service users. Throughout the inspection we

Summary of findings

spoke with over 300 people who had used inpatient services or were in receipt of community treatment. We also spoke with over 50 relatives of people who used the service.

People who use inpatient services generally felt safe and supported. Almost all of the patients and relatives we spoke with told us that staff were kind and supportive, and that they or their loved one were treated with respect. We heard some very good examples of where staff had effectively supported patients. We received particularly positive comments in older people's mental health services and children's services. We did, however, hear some negative comments about staff attitudes in the acute services and a large number of patients, particularly in forensic and acute services, told us that the food was not of a good quality.

Most people who used community and crisis services told us that staff were good, supportive and respectful. A number of people told us they were very happy with the care and service received. They said they were usually kept informed and involved in planning care. They said staff had provided good care and had responded quickly to changing need. In outpatients and end of life services patients were particularly positive about the proactive approach of staff towards pain control and spoke highly of individual staff who felt that they went beyond the call of duty.

Most people we spoke with across the trust knew how to raise concerns and make a complaint. They felt they would be able to raise a concern should they have one and believed that staff would listen to them and act upon the issues.

Good practice

- A training programme called "pressure ulcer food first initiative" had been established by the trust in Bedfordshire. The programme offered on-going training and support to work based champions in 47 participating care homes. This programme had proved effective in reducing the incidents of avoidable care home acquired pressure ulcers. Due to its success, this innovative training programme had been adapted for trained nurses, published and rolled out to another major hospital trust.
- In children's community services outcomes of treatment were measured through education and health care plans which were recognised as best practice, and audits were undertaken against the continuing healthcare framework and the healthy child programme.
- Patients with specialised dental needs due to physical, mental, social and medical impairment could access these services when required to meet their needs and the needs of family and carers. The trust's oral health promotion team was working proactively within the local community to improve oral health and encourage active and effective teeth brushing. We noted some very positive evaluation of this team's work.
- The 'partnership for excellence in palliative support' was a good example of innovation used to improve care and treatment for patients and their relatives.
- The community team for adults in Southend was the Royal College of Psychiatrists' Psychiatric team of the year in 2014 for working age adults, for their work in medicines adherence - maintaining adherence programme. The Basildon teams had appointed staff with particular expertise in drug and alcohol misuse services, who were providing training and support to other staff and liaising with drug and alcohol services. The Rayleigh team ran carer groups which offered additional support and information which was well received by carers. Teams were able to contact the British transport police if someone who used the service was missing and they would alert train drivers in the area to slow down if there was a risk of self-harm.
- In older people's mental health services the clinical integration and shared office base between the older people mental health services and social services assisted with the speed of new referrals and joint assessment for capacity decisions and provided a shared pathway for safeguarding. This was despite the lack of joined up communication between the different electronic care record systems. There was an active post diagnostic service which included cognitive stimulation, carer education and support.

Summary of findings

- There was evidence of partnership working within the memory service which included representation from the Alzheimer's Society both at the monthly business meeting and also to support carers.
- In older people's mental health wards staff routinely completed person centred "this is me" documents for patients with dementia. Patients, families and carers were routinely involved in completing these documents to give them added relevance and meaning. Staff were innovative in their approach and open to change activities based on good practice, such as increasing the frequency of singing groups for patients with complex behaviours.
- RAID and street triage staff were providing Mental Health Act and Mental Capacity Act training for other external agencies, such as the police and acute hospital staff.
- In forensic services the cultivating recovery and opportunities (CROP) programme encouraged and enabled patients to grow fruit and vegetables to consume in the unit at Brockfield House. Brockfield House also provided support to access employment and further education for patients moving on from secure services. Ex-patients were used in the recruitment process of all staff.
- In learning disability services the teams took an active part in the community to promote and make people aware of their services. This included leading roles in 'big health days' with the next being planned for September 2015 in conjunction with Public Health England. In inpatient services there was a variety of alternative therapies available to patients including therapy dogs and ponies. This increased the choice of interventions available to support people in their recovery.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust must ensure that practices amounting to seclusion or segregation are recognised and managed within the requirements of the Mental Health Act Code of Practice.
- The trust must take action to reduce restrictive interventions particularly on Fuji ward where the numbers of prone restraints were high.
- The trust must review arrangements for food provision at acute mental health and forensic inpatient services to ensure that patients have sufficient choice and receive food of good quality.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure robust clinical risk assessment and that this is updated in line with peoples' changing needs.
- The trust should ensure that all potential ligature points are mangaged and the risk from these mitigated.
- The trust should ensure that arrangements for single sex accommodation are always adhered to ensure the safety and privacy of patients.
- The trust should ensure that the environment allocated to the place of safety suites is safe and fit for purpose and meets guidance.
- The trust should review their process within the crisis teams for safe transport of medication, safe storage of medication and safe dispensing of medication.
- The trust should ensure there are sufficient, experienced, staff on duty at all times to provide care to meet patients' needs.
- The trust should involve people in the care planning process to ensure that the goals in care plans reflect the wishes of the people who use the service.
- The trust should ensure that all relevant patients have easy access to psychological therapies.
- The trust should ensure that locally resolved complaints are recorded and monitored with outcomes identified.
- The trust should ensure the electronic care records systems and processes are sufficient to ensure that peoples' care is managed safely.

South Essex Partnership University NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

The Mental Health Act and safeguarding committee had overall responsibility for the application of the Mental Health Act (MHA) and the Mental Capacity Act (MCA) within the trust. Quality assurance was provided through monthly audits which involved a quarter of all detentions being examined in detail at ward level. The audit information was reported to the Mental Health Act and safeguarding committee as well as to the compliance and senior management teams.

We met with the hospital managers who told us that they receive a comprehensive induction which included training on the MHA and MCA as well as shadowing opportunities. The trust provided ongoing training which included updates to case law and other relevant guidelines or policies such as the revised code of practice.

The Mental Health Act and safeguarding committee provided a two way process for issues to be passed on to hospital managers and also for feedback from the hospital managers to influence changes to practice. It provided a direct link between MHA governance and staff across the trust to ensure actions were implemented. The Mental Health Act and safeguarding committee produced a monthly assurance report based on the audit which was presented to the board.

MHA and MCA training was part of the induction training provided to trust staff which was refreshed annually. An E-learning training programme regarding the revised MHA code of practice had recently been purchased and was currently being rolled out to staff.

All MHA documentation was sent to the Mental Health Act administration team to be scrutinised. MHA documentation relating to the patients' detention on the wards was generally available for review and appeared to be in order. However, in older people's wards the scanning of important legal documents into the electronic records system was inconsistent, some were clear to read but others were illegible.

Generally treatment was being given in line with the Code of Practice on the majority of the wards.

Seclusion was being used at a number of the services we visited. We found that in some areas people were being secluded in their bedrooms. Seclusion paperwork was often not fully completed and observation guidelines were not being followed in accordance within the Mental Health Act code of practice.

We also found that long-term segregation practices did not always follow the code of practice or trust policy. We discovered an example of this on one ward where we found a patient was being nursed in an intensive care suite on constant observations. The patient was prevented from leaving. However, the long-term segregation safeguards, such as regular reviews, were not taking place.

Detailed findings

Patients were generally being provided with information about their legal status and rights under section 132, at the time of their detention or soon afterwards. Most of the wards displayed posters about the independent mental health advocate (IMHA) service.

We discovered that one of the acute admission wards was non complaint with mixed-sex accommodation guidelines. However, this concern was addressed immediately by the trust.

We found that some wards had blanket interventions particularly around patients not being able to access their bedrooms during the day.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust has a policy in place on the application of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). Reporting to the board the Mental Health Act and safeguarding committee had overall responsibility for the application of the MCA. A monthly report was presented to the board, to inform the executive of performance and required actions across this area.

The trust told us that training rates for staff in the MCA were good with over 91% of staff trained at May 2015. Staff confirmed that they had received this training and updates were provided. Generally most staff had an awareness of the MCA and the DoLS. However, in the crisis and community adult teams not all staff could demonstrate their understanding of the MCA. Deprivation of Liberty safeguards applications had usually been made when required.

Generally at inpatient units people's capacity had been assessed and details were recorded. However, in the acute and older people's services we found that this was not always recorded or recorded in sufficient detail. In acute services we saw one example were the mental capacity assessment had been concluded and summarised incorrectly. In older people's services there were inconsistencies in referring patients to an independent mental capacity advocate (IMCA) when they lacked the capacity and a lasting power of attorney document was missing from two of the records we checked.

In most community services staff had a clear understanding of their responsibilities in relation to the MCA. Most were able to differentiate between ensuring decisions were made in the best interests of people who lacked capacity for a particular decision and the right of a person with capacity to make an unwise decision. However, in the crisis and community adult teams not all staff could demonstrate a full understanding of the MCA.

Requires improvement

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

Detailed findings

Summary of findings

We rated South Essex Partnership University NHS Foundation Trust as requires improvement for safe because:

- We found ligature points that had not been noted in the forensic service. These were however addressed during the course of our inspection.
- Clinical risk assessments were of variable quality in some services and they did not always reflect the needs and risks of patients.
- On the majority of wards there were clear arrangements for ensuring that there was single sex accommodation. However, there was a breach of the eliminating mixed sex accommodation guidance during our inspection. This was however addressed immediately by the trust.
- Staffing was usually sufficient. However, there were a large number of vacancies and heavy reliance on bank and agency staff.
- The trust had undertaken significant work required under the Department of Health's 'Positive and Proactive Care: reducing the need for restrictive interventions' agenda. However, Seclusion and segregation was not always recognised by staff and so the safeguards required under the Mental Health Act code of practice were not in place. We also had concerns about restrictive practice across the trust.
- The health based place of safety at Basildon mental health unit did not meet the guidelines set by the Royal College of Psychiatrists.
- Generally medicines management was effective and pharmacy was embedded into ward practice. However, some teams in the community adult mental health and crisis services did not have appropriate arrangements for the storage and transportation of medications.

However:

- The trust had an increasingly good track record on safety over the previous 12 months and effective plans in place to address existing risks.
- Ward environments were clean and well maintained.
- Effective incident, safeguarding and whistleblowing procedures were in place. Staff felt confident to report issues of concern. Learning from events was noted across the trust.
- Staff were aware of their responsibilities under the duty of candour requirements.
- Staffing training was in place and there was a good level of compliance with mandatory training.

Our findings

Track record on safety

We reviewed all information available to us about the trust including information regarding incidents prior to the inspection. A serious incident known as a 'never event' is where it is so serious that it should never happen. The trust had reported no 'never events' between April 2013 and October 2013 through STEIS (Strategic Executive Information System). When we received other information from the trust ahead of our inspection we noted that the trust had reported one never event in relation to wrong site surgery in Podiatric services in October 2014. We did not find any other incidents that should have been classified as never events during our inspection.

Since 2004, trusts have been encouraged to report all patient safety incidents to the National Reporting and Learning System (NRLS). Since 2010, it has been mandatory for trusts to report all death or severe harm incidents to the CQC via the NRLS. Between May 2014 and April 2015 the Trust had reported 7978 incidents to the NRLS (this includes from services no longer provider by the trust at the time of inspection). There were 39 incidents categorised as death during the period (13 of which were unexpected deaths in current registered services) and a further 46 had resulted in severe harm.

There were 574 serious incidents which required further investigation reported by the trust between January 2014 and December 2014. Four of these reports related to serious self-harm. Unexpected deaths accounted for 2%. Slips, trips and falls were 3.5% equating to 20 incidents. The largest category was grade 3 pressure ulcers at 89.4% equating to 513 incidents.

This was within the expected range of incidents for a trust of this type and size. Overall, the trust had improved its

reporting rates and had been a good reporter of incidents during 2014/15 when compared to trusts of a similar size. It was noted that the overall rate of severe, moderate and no harm incidents decreased during the reporting period. Overall incidents reported had also decreased throughout the period.

The National Safety Thermometer is a national prevalence audit which allows the trust to establish a baseline against which they can track improvement. During the 12 months to April 2015 it was noted that there were 228 new pressure ulcers and 14 new cases of catheter and urinary tract infections. There had been 113 falls resulting in harm since April 2014. It was noted that the levels of all three measures had fluctuated throughout the period with some improvement in the final quarter.

The Ministry of Justice publishes all Schedule 5 recommendations which had been made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths. One concern had been raised about the trust between March 2014 and March 2015. This related to the death of a community patient in Bedfordshire in July 2014. The trust was no longer responsible for the relevant service. Following the inspection, the death of a patient from self-ligation which occurred in May 2015, was reported to the coroner. This resulted in a Schedule 5 recommendation.

Learning from incidents

The staff survey 2014 had indicated that incident reporting was good at the trust. It also indicated that staff felt they would always be supported following a report or thought that procedures were fair and effective.

Arrangements for reporting safety incidents and allegations of abuse were in place. Staff had access to an online electronic system to report and record safety incidents and near misses. Staff had received mandatory training which included incident reporting and were able to describe their role in the reporting process. Staff told us that they were encouraged to report incidents and near misses and felt supported by their manager following any incidents or near misses. Staff told us that the trust encouraged openness. All staff felt that there was clear guidance on incident reporting.

The trust told us that a head of serious incidents had been appointed who was leading a review of the current reporting and learning system. As a result a new learning lessons oversight subcommittee had been set up chaired by the medical director to provide an overview of incidents across the trust. This reported to the clinical governance and quality committee. Meeting minutes confirmed that the board also received monthly updates about actions undertaken as a result of serious incidents via the quality report.

Where serious incidents had happened we saw that investigations were carried out. The trust had a group of trained staff to undertake serious incident investigations. The majority of investigations were carried out within the timescales required. We found the investigatory process was robust and followed the National Patient Safety Agency guidelines for incident investigation.

Ward and team managers confirmed clinical and other incidents were reviewed and monitored through trust-wide and local governance meetings and shared with front line staff through team meetings. Managers were able to describe learning as a result of past incidents and how this had informed improvements or service provision. We saw some particularly good examples of positive change following incidents within the community services and older people's wards.

Staff received alerts following learning from incidents in other parts of the trust. Almost all staff knew of relevant incidents and were able to describe learning as a result of these. Almost all staff felt that they got feedback following incidents they had reported.

The trust had developed an improvement plan as part of the sign up to safety campaign to reduce harm, including harm from falls by 50% over the following three years. They told us that they were recruiting to a therapy post to promote falls prevention across inpatient areas. The role will support the multi-disciplinary teams in the early detection of service users who are at risk of falls and work with staff to prevent falls. Data relating to falls was monitored both by analysis of the weekly data in relation to patients who repeatedly fell and a detailed analysis provided to the falls committee.

The trust was also working to reduce the number of avoidable pressure ulcers. Work had involved discussion and shared learning with other providers and the NRLS. As a result the trust had found differences in the grading of pressure ulcers across the trust and compared to partner organisations. Further work had begun to better

understand the prevalence of pressure ulcers and to promote consistency of reporting. Skin matters groups were in place in each locality to review any local issues of concern and share learning.

Duty of candour

In November 2014 a CQC regulation was introduced requiring NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong. The trust had placed compliance with this regulation on its risk register in August 2014. Since, a number of actions had been undertaken. These included training for the executive and managers, information for staff and a review of all relevant policies and procedures. Duty of candour considerations had been incorporated into the serious investigation framework, tools and report, and complaints procedures. Further training had been developed to be rolled out to staff. Staff were aware of the duty of candour requirements in relation to their role.

We examined case records where patients had experienced a notifiable event to check that staff had been open and honest in their dealings with patients and carers. We found that the trust was meeting its duty of candour responsibilities.

Safeguarding

The trust had clear policies in place relating to safeguarding and whistleblowing procedures. Additional guidance was available to staff via the trust's intranet. We were told that the trust's internal and the local authorities' safeguarding teams were also accessible and available to staff for additional advice.

Managers and staff told us of occasions where they had raised urgent issues of concern. We heard about a number of positive actions as a result of this.

Safeguarding training requirements were set out in line with the specific role undertaken by staff. We found that all but a few staff had received their mandatory safeguarding training and knew about the relevant trust-wide policies relating to safeguarding. Most staff were able to describe situations that would constitute abuse and could demonstrate how to report concerns.

A governance process was in place that looked at safeguarding issues at both a trust and at directorate levels on a regular basis.

Assessing and monitoring safety and risk

The trust had an integrated assurance framework and risk register. The risk register identified the responsible owner and the timescales for completion of identified actions.

Board meeting and assurance committee minutes confirmed that corporate and high level or emerging risks were discussed on an ongoing basis. Risk registers were also in place at service and directorate level. These were monitored through the directorate and locality assurance groups.

We looked at the quality of individual risk assessments across all the services we inspected. These addressed risks in most inpatient and community mental health services. However, in the acute services we found that the quality of risk assessments varied and not all been updated to address patients' current needs. Some risk assessments had not been updated since the person's previous admission. In one crisis team we also found that not all crisis plans had been completed and that risk assessments within the place of safety were not robust. Within forensic services the trust risk assessment document was used although the historical clinical risk management-20 tool (HCR-20) was rarely completed with patients in the first six months of admission as required by best practice guidance.

In community health services we found risk assessments in place that were reviewed as required. Where appropriate, these addressed personal care, pain management, pressure ulcers, nutritional safeguards, falls management, and prevention of venous thrombosis and embolism. In the end of life services, Macmillan nurses had developed a distress tool to assess the level of psychological intervention required.

The trust had an observation policy in place. Generally staff were aware of the procedures for observing patients. Ward managers indicated that they were able to request additional staff to undertake observations.

Safe and clean environments and equipment

The trust undertook an annual programme of environmental health and safety checks.

Ligature risk assessments were reviewed as part of this programme. The trust told us that this work was carried out by a specialist team consisting of a member of the risk management team and the estates department, with the

ward manager. The programme was overseen by the ligature audit task and finish group. All ligature related issues were also reported via the clinical incident report to the clinical quality and governance committee on a regular basis. There had been one inpatient death resulting from self-ligature in May 2015 which had occurred at Basildon Hospital.

We found that there were minimal ligature points on most wards and where necessary measures were in place to minimise the risk to patients, including the use of nursing observations and alterations to furnishings. Generally staff were aware of the risks to patients' safety caused by the environment and had assessed patients' individual risks and increased their observation level as needed. However, in secure services there were some ligature risks which we highlighted on the visit that had not been previously noted. At the time the trust took the appropriate action and added these to the risk register. In learning disability services ligature risks were mitigated by staff observation, risk assessment and care planning. However, staff told us that there were times when staffing levels affected observations which meant that staff observation could not always be relied upon as a mitigating factor.

We found that the layout of the wards generally allowed clear lines of sight for staff to observe patients. Where this was not the case we found the trust had installed observation mirrors or CCTV to mitigate this risk.

On the majority of wards there were clear arrangements for ensuring that there was single sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice. However, within acute services we were concerned that Grangewaters ward did not have clearly delineated single gender areas and that there was no female only lounge on the Assessment unit. We immediately raised our concerns with the trust. Before the end of the day, the chief executive confirmed that risk management arrangements had been put in place and a side room had been re-designated as a female only area.

At the learning disability service at Heath Close we were concerned male patients were able to see into a female bedroom window which meant that the patient's privacy and dignity was not maintained. This was also addressed immediately by the trust.

The health-based places of safety at the Basildon Mental Health Unit and Rochford Hospital did not meet all of the environmental requirements of the Royal College of Psychiatrists' national standards.

Fire procedures and equipment were in place at all services. Staff had received fire safety training, and were aware of what to do in an emergency.

The trust had an infection control committee that oversaw a programme of audit for this work. Hand hygiene and infection control audits were regularly undertaken across services and showed that staff demonstrated good hand hygiene. Staff received infection control practice as part of mandatory training. We found good levels of completion for this training. Regular trust-wide cleanliness audits were undertaken. There had been no cases of hospital acquired infection since 2012.

Infection control procedures were being followed by staff. Hand gels and other equipment was readily available and in use. There was information available to patients and families around good practice and advice to prevent the spread of infection. Most inpatient services were found to have hand-washing facilities readily available and we observed staff adhering to the trust's 'bare below the elbow' policy where appropriate. However, we had concerns about the lack of hand-washing facilities in the sluice at Cumberlege. Staff washed their hands at the nurses' station. The issue had been identified in an infection control review. The matron said the sluice room was too small to install another sink but said she had put arrangements in place to audit staff hand washing when they exited the sluice area.

In community health services we found that necessary clinical infection control guidelines were in place. For example, in dental services there was a central sterilising and decontamination unit which met HTM 01 05 (guidelines for decontamination and infection control in primary dental care).

Services were clean and most were well maintained. Patients were happy with the standards of cleanliness. The trust had performed better than the national average with regard to its overall score for cleanliness (99.5%) and condition, appearance and maintenance of the environment (96.3%) in the patient-led assessment of the care environment (PLACE) programme.

Detailed findings

All clinic rooms we visited appeared clean and most were fit for purpose. However, the clinic of the recovery and wellbeing and assertive outreach teams at Southend did not have suitable sink taps and the sharps box was on the floor. Crisis teams did not have designated clinic rooms (apart from the East CRHT where the room was not in use), instead medication and equipment was stored in offices.

Inpatient services had systems in place to ensure equipment was serviced and electrically tested. Equipment was labelled with testing dates which were current. Staff told us about the procedure in place to clean equipment between patients. Generally we found necessary equipment to carry out physical examinations, except at the west crisis team where the bag had gone missing twice and was on order.

At the place of safety at Rochford Hospital a bag with equipment was available for physical health emergencies. However, there was no checklist for staff to identify equipment that should be in the bag. A reservoir for the resuscitator was lacking and not all checks had been completed. Staff took action to resolve this during the inspection. Otherwise emergency resuscitation equipment was available and regularly checked across services. Staff could describe how they would use the emergency equipment and what the local procedures were for calling for assistance in medical emergencies. Other equipment, including resuscitators, were well-maintained, clean and checked regularly.

Community services staff had been trained in basic life support, and informed us that if a patient deteriorated or had a cardiac arrest at the community hospital, they would start resuscitation and call the emergency services through 999.

Potential risks

Systems were in place to maintain staff safety in the community. The trust had lone working policies and arrangements. Staff in community teams told us that they felt safe in the delivery of their role.

The trust had necessary emergency and service continuity plans in place and most staff we spoke with were aware of the trust's emergency and contingency procedures. Staff told us that they knew what to do in an emergency within their specific service. For example, this inspection was undertaken during extremely hot weather conditions. Staff told us about arrangements to deal with this heatwave.

Restrictive practice, seclusion and restraint

The executive director of clinical governance and quality was executive lead for restrictive practice. He was supported in this agenda by a local security management specialist and a clinical lead for restrictive practice.

Policies and procedures were in place covering the management of aggression, physical intervention, seclusion and segregation. These policies had been reviewed to reflect latest guidance regarding the safe management of patients in a prone position and addressed the specialist needs of children or people with a learning disability, autism or a physical condition. The seclusion and segregation policies had been reviewed to reflect the updated Mental Health Act Code of Practice.

The trust confirmed that initial work had been undertaken to meet the guidance set out in the Department of Health's 'Positive and Proactive Care: reducing the need for restrictive interventions'. This programme had included a review of all relevant policies and training delivery, development of audit procedures, amendments to reporting structure and involvement in the sign up to safety initiative. The lead for physical intervention confirmed that this work programme continues to ensure that restrictive practice is minimised.

The use of restraint and seclusion were defined as reportable incidents at the trust and arrangements were in place to monitor such incidents. Incidents were recorded on a database and would be discussed and monitored at the health, safety and security committee and the clinical governance group meetings. An annual report on restrictive practice was presented to the board in April 2015. Physical restraint incident figures were collated and sent out to managers on a weekly basis.

Prior to the visit we asked the trust for restraint and seclusion figures. Restraint was used on 610 occasions in the six months to April 2015. Of these face down (prone) restraint was used on 137 occasions. This equated to almost 22% of all restraints. It was noted that 90 of these (65%) had resulted in rapid tranquilisation. The majority of all restraints had occurred at Fuji ward, a female ward in secure services at 234 incidents equating to 68%. This ward also had the majority of prone restraints at 64 incidents equating to 47%.

We observed a number of examples of staff managing patients' aggressive behaviour effectively with an emphasis

on de-escalation techniques. Additional data supplied by the trust indicated that levels of restraint had been static since 2013 but levels of prone restraints had decreased. In 2013/14 there had been 406 episodes of prone restraint, in 2014/15 this had reduced to 312. It was noted that in the latter half of this period it had reduced to 137 episodes equalling 44% of all prone restraints during the year.

The trust reported that seclusion was used on 30 occasions during the period. The trust stated that there had been 65 uses of long term segregation. The majority of both had occurred on Hadleigh ward, the PICU, and Fuji ward, a female ward in secure services.

We reviewed seclusion and segregation practice across the trust and we had a number of concerns. These included:

- On Hadleigh ward, the PICU, the seclusion room had a 'blind spot' because the mirror in the room had been damaged by a patient five weeks previously and removed. We also found the seclusion room toilet area had sharp edges on facilities and exposed wires.
- At the acute wards we were told there was no seclusion or segregation. However, information provided by the trust stated there had been 7 episodes of seclusion in the 6 months to April 2015.
- When we reviewed patients' care records in the learning disability service we found that a patient was being secluded in a bedroom for periods of up to 24 hours as part of a behavioural management plan. This had not been recorded or safeguarded as required by the Mental Health Act code of practice.
- In the CAMH services there was no seclusion room on Poplar ward and records indicated that no seclusions had taken place. However, we found that some young people had been secluded in their bedrooms. The seclusions were not reported, recorded or reviewed as per the code of practice or trust policy.
- We also reviewed one record of a young person. We found that the decision was made to use long term segregation based on risk and the young person was allowed access to other areas of the ward and took part in activities with staff. However, there were no care plans, records or reviews for the use of long term segregation as per the code of practice or trust policy.
- In forensic serves at Brockfield House, we had a number of concerns. There was only one operational seclusion room. This was located on a male admission ward. Seclusion facilities on a female admission ward were being commissioned. However, were not ready for use. If a female required seclusion it would require them being taken onto a male ward. Seclusion was not recorded appropriately. The patient, whilst in segregation, was not allowed to have free access to leave the room, essentially secluding the patient. This practice was not recorded as seclusion or medically reviewed as such. The practice of segregating a patient was used before considering seclusion. All disciplines and management within Brockfield House expressed the view that patients could only be secluded in a designated room hence this practice occurring anywhere else was not considered as seclusion.
- At Robin Pinto seclusion facilities did not have a means for two way communication, toilet facilities had a sink that was vulnerable to vandalism and moved when tested and a tissue dispenser was a potential ligature risk.

Generally we found that staff did not restrict patients' freedom and that informal patients understood their status and knew how, and were assisted, to leave the wards. However, at Poplar ward, young people who were informal were not allowed to leave the ward for fresh air without staff permission and were not permitted leave for the first five days of their admission. This was supported by care records reviewed.

Generally patients were not subject to blanket restrictions. However, in acute and older people's services there was a restriction regarding access to the bedrooms which was only permitted at certain points in the day. In learning disability services we were told that patients have to request access to outside areas. On Fuji ward blanket restrictions were evident in relation to patients gaining access to bedrooms and the garden.

Safe staffing

In 2014 the trust reviewed and set staffing levels for all inpatient services. The trust's target shift fill rate was set at 90%. Since April 2014 the trust had published actual staffing levels as a percentage of planned staffing on their website.

Figures provided indicated that during May 2015 overall inpatient staffing had generally met the trust's target with an average of 98% of planned registered nurses and 101% of unregistered staff shifts filled across inpatient services throughout the month. However, there were particular

services were staffing had not met the trust's target. These included levels of registered staff shifts filled in Clifton Lodge, Gloucester Ward, Westley Ward, Grangewaters and Causeway Ward. It was noted that in most cases these vacant shifts had been filled by unregistered staff.

At the time of our inspection in June 2015 we found that staffing was generally sufficient on the wards. However, we found that some wards, particularly in acute services and community inpatients, were using very high levels of bank and agency staff to meet their staffing targets. At Saffron Walden Hospital we found shifts that were regularly dependent on 60% agency or bank staff.

Within crisis teams there were high vacancies that were impacting on caseloads. Caseloads within these teams were above the Royal College of Psychiatrists' recommended levels. At the time of our visit the vacancy rate stood at 28%. Despite recent action taken by the trust at the time of our visit to east team there were insufficient staff to cover appointments and telephone duty. Other community teams were better staffed through the use of bank and agency staff.

In some services we heard that regular bank and agency staff were used to minimise the risk to patients. However, in the children and young people's healthcare service and acute services we heard about issues with local induction for agency staff.

The trust confirmed that they have an overall vacancy rate of 11.8%. For registered nurses this stood at 16.6%. Staff turnover stood at 17% in March 2015.

The trust acknowledged challenges regarding recruitment and retention and maintaining safe staffing levels and told us that they are working hard to address this issue. We saw detailed action plans and positive information about recruitment initiatives. We found that staffing levels were improving for a number of teams.

In relevant services the trust used specific dependency tools to evaluate the number of staff required to ensure the service was safely staffed. Ward and team managers confirmed that processes were in place to request additional staff where required.

Medical cover was generally acceptable across all inpatient and community services.

The trust required staff to attend a variety of mandatory training courses. These included courses in basic life support, medical emergency response, observation of service users, fire safety, safeguarding, Mental Capacity Act, physical intervention and people moving and handling. Training records showed that 91% of staff had attended their mandatory training. It was noted that the trust did not offer mandatory training in the MHA.

The trust required staff to attend a variety of mandatory training courses. The trust supplied details of their set mandatory training requirements and uptake. These included courses in basic life support, medical emergency response, observation of service users, fire safety, safeguarding, Mental Capacity Act, physical intervention and people moving and handling. At May 2015 this indicated that that the trust was on target at 91% of staff compliant with core mandatory training. Most staff told us that they do have access to mandatory training.

Medicines management

The medicines management policy had been reviewed in January 2015 and was supported by procedures which were all in date. The trust used an electronic prescribing and medication administration record system which facilitated the safe administration of medicines.

Pharmacy teams worked throughout the trust and were a regular presence on the wards and at most community teams. We found that the pharmacy team was actively involved in all aspects of a person's individual medicine requirements at the point of admission through to discharge. Nursing staff told us that the pharmacy teams were a good support and if they had any medicine queries they always had access to pharmacist advice.

Medicines, including those requiring cool storage, were usually stored appropriately and controlled drugs were stored and managed appropriately. However, medication in some community adult mental health teams and in the crisis service was not always safely stored, recorded or monitored and that there was no clear record of medication being logged in or out. These issues were addressed by the trust by the end of our inspection. In addition there was a delay in scanning pharmacy medication charts at the older people's community teams which impacted on accessibility for pharmacy staff.

Emergency medicines were available where appropriate and there was evidence that these were regularly checked.

Detailed findings

Safety syringes and needles were available on the wards in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

Arrangements were in place to ensure that medicine incidents were documented and investigated. Medicine errors were reported directly to the medicine management committee and the patient safety committee.

The lead pharmacist told us that the trust had made the elimination of medicines errors part of the quality strategy and the 'harm free care' agenda. In 2014 a trust wide audit had been undertaken which had found that during the audit period 3.7% of doses had been missed or not signed for. Since, the trust had recorded and analysed all drug errors and could demonstrate steady improvement since the audit. The trust confirmed that missed doses had reduced from 240 per month to 40 per month.

Within inpatient services we found that most patients were receiving their medicines when they needed them and that these were correctly recorded. However, in Grangewaters ward, in the acute service, this was not the case. In addition we found recording errors with community adult mental health and crisis services.

Good

Are services effective?

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

Summary of findings

We rated South Essex Partnership University NHS Foundation trust as Good for Effective because:

- Services were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) guidelines.
- Outcome measures were used across services.
- The trust had participated in a number of quality improvement programmes, research and quality audit.
- We found a strong commitment to multidisciplinary team working across all services and staff were qualified, skilled and supported to perform their roles.

However:

- Admission assessment processes and care plans, including for physical healthcare, were generally good. However, there were some gaps in acute and forensic services and some work was needed to develop these in the learning disability services.
- Not all patients had timely access to psychological therapies.
- Arrangements were in place to ensure effective use of the Mental Health Act and Mental Capacity Act. However, we found a number of practices that did not meet the MHA code of practice including the authorisation of medication and inconsistency in rights being read under the MHA.
- Improvement was needed to procedures for consent to treatment.

Our findings

Assessment of needs and planning of care

The Care Quality Commission community mental health survey 2014 found that overall the trust was performing about the same as other trusts in all areas. On average, the trust was scored as 7.3 (out of 10) for the questions about how involved respondents were in planning their care (on a scale of 0 to 10, where 10 out of 10 is the most positive). On average, the trust was scored as 7.6 (out of 10) for holding formal meetings with respondents to discuss how their care was working in the last 12 months. On average, the trust was scored as 7.0 (out of 10) for information about who to contact out of hours if they have a crisis.

In all services we found that people were appropriately assessed at admission and that relevant treatment had been put in place.

Generally we found the care plans were detailed, individualised to the patients' needs and showed the patients' involvement in the care planning process. In the majority of mental health services people's care needs and risks were assessed and care plans had been put in place. However, this was not the case at all of the acute services and crisis services where we found gaps in care plans. In addition, at these services we found that the quality of care plans varied and some lacked sufficient detail. In the majority of services care plans had been reviewed following changes to people's needs, and risk assessments had been updated. Most care plans reviewed indicated the involvement of the patient. This was not the case within learning disability services. However, we did find that patients were knowledgeable about their care.

In community healthcare services we found that people were appropriately assessed and that relevant treatment and care plans had been put in place. For example, the variety of assessments in place for patients included moving and handling, skin integrity, nutrition, falls, and bed rails. These assessments were used as the basis for planning care for people and ensuring that people were safe. We found that nutrition and hydration assessments were completed on all appropriate patients. These assessments were detailed and we saw that appropriate follow up actions were taken when a risk was identified to ensure patients received sufficient nutrition and fluid to promote their recovery. We looked at food and fluid records and found these were complete, accurate and current.

Good

Are services effective?

Within services patients' physical health needs were identified. Patients had a physical healthcare check completed by the doctor on admission and their physical healthcare needs were being met. Physical health examinations and assessments were usually documented by medical staff following the patients' admission to the ward. Ongoing monitoring of physical health problems was taking place. However, there were some issues regarding access to blood test results in adult community mental health services. The majority of records we saw included a care plan which provided staff with clear details of how to meet patients' physical needs.

We found a large number of concerns about information sharing systems at the trust. A number of electronic record systems were in operation as well as paper records. Some teams used just the electronic system, others used partial electronic and partial paper notes, while others used only paper based systems. The electronic system was very new and was being rolled out to further services later in 2015. In the acute, forensic, older people's services and adult community mental health services we found that delays in scanning notes in to the system meant that current information was not always available. The trust initiated a system to improve this during the inspection. Some community hospitals had electronic systems. However, this was not universal meaning that discharge and transfer plans could be difficult to share.

Best practice in treatment and care

Services were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) or other relevant guidelines.

Generally people in mental health services received care based on a comprehensive assessment of individual need and usually outcome measures were considered using the Health of the Nation Outcome Scales (HoNOS) or other relevant measures. In older people's services healthcare assessments were routinely carried out using recognised tools such as the malnutrition universal screening tool and the modified early warning system. However, in forensic services we found that HoNOS secure and HCR-20 (the historical clinical risk management tool) were not always completed.

In community healthcare services pathways of care were based on national guidelines. For example, the care of patients who had suffered a stroke was based on NICE guidelines. Staff at Saffron Walden hospital provided care for people at the end of life and were able to describe how the trust had developed a new pathway based on 'priorities for care of the dying' which had replaced the Liverpool Care Pathway. The Archer unit used a nationally recognised assessment tool, the Barthel scale, for identifying patient need and to assess if they would be able to manage independently at home. In children's services we saw the use of the family nurse partnership outcomes, breastfeeding figures and immunisation statistics to monitor outcomes.

In most community and inpatient mental health services we found good access to psychological therapies. However, we found that a shortage of psychology staff in inpatient learning disability services, older people's wards, crisis services and at the Assessment unit meant that they were not all able to offer psychological therapies in line with NICE guidance.

The trust had participated in a number of applicable Royal College of Psychiatrists' (RCPsych) quality improvement programmes or alternative accreditation schemes. Acute wards either had or were working towards accreditation from the accreditation for inpatient mental health services (AIMS) programme. The learning disability services at Wood Lea held RCPsych accreditation. The forensic services were part of the quality network for forensic mental health services. The crisis teams held the home treatment accreditation scheme (HTAS) accreditation. However, the ECT suite at Basildon Hospital the PICU had not yet been accredited by the RCPsych. We found that facilities in the health-based place of safety did not meet all guidance issued by the RCPsych.

The trust had a research strategy in place and had participated in a wide range of clinical research. There was a dedicated research function in place and through its website provided detailed information on research projects. The trust also undertook a wide range of clinical effectiveness and quality audits. These included safeguarding practice, medicines management, prescribing, compliance with NICE guidance, hand hygiene, infection control, suicide prevention, clinical outcomes, physical healthcare, care planning, record keeping, pressure ulcer management, consent and capacity, Mental Health Act administration and patient satisfaction. We also found a large number of localised audits looking at practice within services.

Good

Are services effective?

During 2014 the trust participated in the national audit of schizophrenia (NAS), national audit of psychological therapies, national confidential inquiry into suicide and homicide by people with mental illness, the national audit of intermediate care, epilepsy 12 (childhood epilepsy), and the national Parkinson's audit. The Archer Unit and St Margaret's Hospital had contributed to the national audit of sentinel stroke. The trust also participated in POMH audits in prescribing for people with a personality disorder. The learning disabilities services contributed to the POMH (Prescribing Observatory for Mental Health) anti psychotics in learning disabilities audit.

The trust had undertaken a trust-wide audit using the Green Light Toolkit in 2014. This audit aims to assess whether services are appropriate for people with a learning disability. The trust provided us with an action plan indicating they were now compliant in all areas. The trust also delivered a health facilitation service which supported GP practices to ensure all people with a learning disability could access an annual health check.

Skilled staff to deliver care

In the 2014 NHS Staff Survey, the trust scored better than average for 11 key measures. These included staff receiving relevant training and development and a meaningful appraisal. Overall the trust had improved its position across relevant indicators against the 2013 survey results.

New permanent staff underwent a formal induction period. This involved attending a corporate induction, learning about the service and trust policies and a period of shadowing existing staff before working alone. In most services bank and agency staff received a local induction and where appropriate mandatory training. However, we had concerns about the quality of local induction for agency staff in children and young people's healthcare service and acute services.

Some specialist training to meet the needs of the client group was available such as dementia training and training to become a nurse prescriber or advanced practitioner. We spoke with a number of staff who had been supported to undertake nurse training.

Most teams were fully compliant with their annual appraisal programme. Most staff told us that clinical and management supervision was available and was used to manage performance issues and development.

Multi-disciplinary and inter-agency team work

At most mental health units we saw input from doctors, occupational therapists, psychologists, and pharmacy. Where required there was also input from physiotherapists, speech and language therapists and nutritionists. In community services we also saw input from social workers and social care staff. However, we found a shortage of psychology staff in some learning disability, older people's, crisis and acute services. This had some impact on the multidisciplinary process.

There was a strong commitment to multidisciplinary team working across all services. On the wards we visited we usually saw good multidisciplinary working, including ward meetings and regular multidisciplinary meetings to discuss patient care and treatment.

We saw documentary evidence of a multidisciplinary approach to discharge planning. Community teams usually attended discharge planning meetings making the process of leaving the wards more effective. Generally we saw that the community teams worked well with inpatient teams to meet people's individual needs.

Community mental health teams had effective inter-agency working in assessing and supporting those people subject to detention. There were effective links between the approved mental health professionals (AMHPs), the acute services, the police and the trust nursing team.

At most wards there were effective handovers with the ward team at the beginning of each shift. These helped to ensure that people's care and treatment was co-ordinated and the expected outcomes were achieved.

Adherence to the MHA and MHA Code of Practice

The Mental Health Act and safeguarding committee had overall responsibility for the application of the Mental Health Act (MHA) and the Mental Capacity Act (MCA) within the trust. Quality assurance was provided through monthly audits which involved a quarter of all detentions being examined in detail at ward level. The audit information was reported to the Mental Health Act and safeguarding committee as well as to the compliance and senior management teams.

We met with the hospital managers who told us that they receive a comprehensive induction which included training

on the MHA and MCA as well as shadowing opportunities. The trust provided ongoing training which included updates to case law and other relevant guidelines or policies such as the revised code of practice.

The Mental Health Act and safeguarding committee provided a two way process for issues to be passed on to hospital managers and also for feedback from the hospital managers to influence changes to practice. It provided a direct link between MHA governance and staff across the trust to ensure actions were implemented. The Mental Health Act and safeguarding committee produced a monthly assurance report based on the audit which was presented to the board.

MHA and MCA training was part of the induction training provided to trust staff which was refreshed annually. An E-learning training programme regarding the revised MHA code of practice had recently been purchased and was currently being rolled out to staff.

All MHA documentation was sent to the Mental Health Act administration team to be scrutinised. MHA documentation relating to the patients' detention on the wards was generally available for review and appeared to be in order. However, in older people's wards the scanning of important legal documents into the electronic records system was inconsistent, some were clear to read but others were illegible.

Generally treatment was being given in line with the Code of Practice on the majority of the wards.

Seclusion was being used at a number of the services we visited. We found that in some areas people were being secluded in their bedrooms. Seclusion paperwork was often not fully completed and observation guidelines were not being followed in accordance within the Mental Health Act code of practice.

We also found that long-term segregation practices did not always follow the code of practice or trust policy. We discovered an example of this on one ward where we found a patient was being nursed in an intensive care suite on constant observations. The patient was prevented from leaving. However, the long-term segregation safeguards, such as regular reviews, were not taking place.

Patients were generally being provided with information about their legal status and rights under section 132, at the time of their detention or soon afterwards. Most of the wards displayed posters about the independent mental health advocate (IMHA) service.

We discovered that one of the acute admission wards was non complaint with mixed-sex accommodation guidelines. However, this concern was addressed immediately by the trust.

We found that some wards had blanket interventions particularly around patients not being able to access their bedrooms during the day.

Good practice in applying the MCA

The trust has a policy in place on the application of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). Reporting to the board the Mental Health Act and safeguarding committee had overall responsibility for the application of the MCA. A monthly report was presented to the board, to inform the executive of performance and required actions across this area.

The trust told us that training rates for staff in the MCA were good with over 91% of staff trained at May 2015. Staff confirmed that they had received this training and updates were provided. Generally most staff had an awareness of the MCA and the DoLS. However, in the crisis and community adult teams not all staff could demonstrate their understanding of the MCA. Deprivation of Liberty safeguards applications had usually been made when required.

Generally at inpatient units people's capacity had been assessed and details were recorded. However, in the acute and older people's services we found that this was not always recorded or recorded in sufficient detail. In acute services we saw one example were the mental capacity assessment had been concluded and summarised incorrectly. In older people's services there were inconsistencies in referring patients to an independent mental capacity advocate (IMCA) when they lacked the capacity and a lasting power of attorney document was missing from two of the records we checked.

In most community services staff had a clear understanding of their responsibilities in relation to the MCA. Most were able to differentiate between ensuring decisions were made in the best interests of people who

Good

Are services effective?

lacked capacity for a particular decision and the right of a person with capacity to make an unwise decision. However, in the crisis and community adult teams not all staff could demonstrate a full understanding of the MCA.

Good

Are services caring?

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

Summary of findings

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

- Staff treated people who used the service with respect, listened to them and were compassionate. They showed a good understanding of people's individual needs.
- People were involved in their care and treatment and were aware of their care plans.
- Staff encouraged people to involve relatives and friends in care planning if they wished and visiting arrangements were in place.
- Information about services was available to patients and staff supported people to understand their treatment.
- We were told that staff respected peoples' personal, cultural and religious needs.
- Information on how to access advocacy was available for people who used the service.
- The trust had a detailed programme of work to involve people in the planning and delivery of services.

Our findings

Kindness, dignity, respect and support

Assessments undertaken under the patient-led assessment of the care environment (PLACE) reviews in 2014 identified that the trust scored worse than average at 85% for the privacy, dignity and well-being element of the assessment against an England average of 90%. However, a number of inpatient services at Saffron Walden Hospital, Basildon Hospital, Brockfield and the Robin Pinto unit scored above the average. Mountnessing Court, the Cumberledge Centre and Clifton Lodge scored significantly below the average at below 78%.

We observed positive examples of staff providing emotional support to people across all services visited. We saw that staff were kind, caring and responsive to people and were skilled in the delivery of care. We observed many instances of staff treating patients with respect and communicating effectively with them. Staff demonstrated that they wanted to provide high quality care and were knowledgeable about the history, possible risks and support needs of the people they cared for.

Almost all of the patients and relatives we spoke with told us that staff were kind and supportive, and that they or their loved one were treated with respect. We received particularly positive comments in older people's mental health services and children's services. We heard some negative comments about staff attitudes in the acute services.

We were told that staff respected people's personal, cultural and religious needs. We saw some very good examples of the trust attempting to deliver services in line with peoples' cultural needs.

The involvement of people in the care they receive

Inpatient services oriented people to the ward on admission. At most services we found welcome packs that included detailed information about the ward and a range of information leaflets about the service. However, information was found to be out of date at Mountnessing Court. Notice boards on the wards held a variety of information for patients and carers as well as staff picture boards. Almost all patients we spoke with told us that they were given good information when they were admitted to the wards. Some patients told us that staff had taken time to clearly explain ward procedures when they had been unclear or confused. Most detained patients told us that staff had explained their rights under the Mental Health Act.

Patients had access to advocacy including an independent mental health advocate (IMHA). There was information on the notice boards at most wards on how to access these services. Arrangements were also in place to access independent mental capacity advocates (IMCA) and we saw examples of where this was actively promoted.

Across most services we found good patient involvement of patients in their care. Almost all care plans and records

Good

Are services caring?

reviewed demonstrated the person's involvement. However, this was not the case in the learning disability inpatient service. In all services we found that there was an opportunity for patients to attend care planning meetings.

We found a number of examples of relatives being involved in care planning where this was appropriate. We observed that where a patient was unable to be actively involved in the planning of their care, or where they wanted additional support, staff involved family members with the patients' consent. At most services staff had a good awareness of carer's assessments. However, we found that while carers were involved in their loved one's care at end of life services further work was required regarding a formal care's assessment.

Patients told us that they had opportunities and were encouraged to keep in contact with their family where appropriate. Visiting hours were in operation within inpatient services. We found at most services there was a sufficient amount of dedicated space for patients to see their visitors. At most services there were specific children's visiting areas, However, this was not available at the Wood Lea Clinic.

The trust had a service user engagement strategy and customer service strategy that together set out arrangements for engagement with service users, carers and wider stakeholders. The trust was in the process of updating this work into a single strategy. Underpinning this was a detailed user and carer engagement implementation plan and customer service action plan. This work was overseen by a trust wide patient and carer experience steering group. All localities had patient experience groups with wide membership. The trust had a dedicated patient experience team. Work undertaken on this agenda had included increased partnerships with voluntary and community groups and service user involvement in training, recruitment, research and audit. Other initiatives developed included a 'buddying' scheme were service users worked alongside student nurses, a mystery shopper project and 'take it to the top' were the public could meet with the senior team.

Prior to the inspection we spoke with a large number of user groups, community support organisations and advocacy services. Generally we heard of positive relationships with the trust and of opportunities to be involved in providing feedback on how services are run or planned.

The trust had a number of carers' forums and inpatient services had community meetings to engage patients in the planning of the service and to capture feedback. In most services this meeting was chaired by patients and was attended by relevant ward staff. Minutes were usually taken and we saw evidence of actions that were raised being completed. Patients told us they felt able to raise concerns in the community meetings and that they usually felt listened to.

We saw that there was information available throughout the trust and via its website about how to provide feedback on the specific services received by people. The trust had employed latest technology to capture individual patient views. This included a brief survey for completion by all inpatients via the use of tablets.

The trust had used the Friends and Families Test (FFT) since 2012. At June 2015 the results indicated that 85% of patient respondents were likely or extremely likely to recommend the trust services. The trust demonstrated an improving picture of satisfaction during the 12 months before our inspection.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated South Essex partnership University NHS Foundation trust as good for Responsive because:

- The inpatient environments were clean and maintained and most were conducive for mental health care and recovery.
- The bed management system within inpatient services was effective, ensuring that patients received timely access to services when they required it.
- In most community services target times for assessment were set and met. Referrals were usually seen quickly by skilled professionals.
- A good range of information was available for people in appropriate languages.
- The trust was meeting the cultural, spiritual and individual needs of patients.

However:

- Complaint information was available for patients and staff had a good knowledge of the complaints process. However, not all informal complaints were recorded.
- Food was not always at the standard required by patients.

Our findings

Access, discharge and bed management

We found that community adult, older people, learning disability and CAMH services where meeting their targets for assessment.

There was a single point of contact (SPOC) for people who need mental health services available in an emergency. This acted as a single point of referral and triage for the trust. In crisis, referrals were initially triaged by SPOC and promptly referred through to the crisis teams. The crisis teams were meeting their set target of assessment within 24 hours from referral. Most people in urgent need were assessed within four hours from referral. 91% of admissions to acute wards were gate-kept by crisis teams at May 2015, but this was below the national target of 95%. The street triage team had led to a decrease in patients being taken to a place of safety for assessment under section 136. However, there could be delays in patients having mental health assessments at the place of safety.

In community healthcare services we found that good systems were in place to manage referrals via the trust's single point of access service. Close links were in place with other community care services and this assisted with the referral and assessment process.

Community hospitals had clearly defined criteria for admitting patients. Discharge facilitators assessed all new referrals to ensure they were appropriate for admission. Social care staff contributed to the work of the referral centre at Bedford hospital. There had been delays in social care assessments due to social worker capacity but another post had recently been put in place to reduce the number of delayed transfers. Two beds at Saffron Walden hospital were allocated to referrals assessed through the trust's single point of access service based at St Margaret's Hospital. Referrals to the wards at St Margaret's hospital were made through this service and accepted referrals from district nurses, GPs and referring hospitals. Discharge co-ordinators were employed at three of the four hospitals. Staff confirmed that this role had contributed to reducing people's length of stay.

The trust monitors both bed occupancy rates and delayed transfers of care. Between October 2014 and March 2015 there had been 64 delayed transfers of care across 15 wards. The average bed occupancy rate for the trust was 84%. There were five wards with bed occupancy over 95% experienced in wards in learning disability, forensic and community inpatient services.

During this inspection we found that there was not a shortage of beds within adult, older people, forensic or learning disability services. However, we heard that there were occasions when an acute bed was not available for a patients returning from leave. We were told that occasionally there could be delays in accessing a PICU bed but this was not evident during our inspection.

Good

Are services responsive to people's needs?

In all services patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient for example, if a patient needed to be admitted to general hospital, or became unwell and needed a more acute setting. Patients were not moved around in order to juggle beds.

At the time of our inspection the trust had met their target for percentage of patients on CPA followed up within 7 days of discharge at 95%.

The mental health ward teams told us that they worked closely with both crisis services and community teams to ensure continuity of care when patients were discharged from hospital. We observed that at all inpatient services' staff worked with other services to make arrangements to transfer or discharge patients. We found that generally there was evidence of different groups working together effectively to ensure that patients' needs continued to be met when they moved between services.

The service environment optimises recovery, comfort and dignity

Since 2013 patient-led assessments of the care environment (PLACE) visits had taken place to a number of inpatient services. This is a self-assessment process undertaken by teams including service users and representatives of Healthwatch. The trust had performed better than the national average with regard to its overall score for cleanliness (99.5%) and condition, appearance and maintenance of the environment (96.3%).

Generally we found that inpatient services were clean, well maintained and had environments that promoted recovery. Patients were happy with the standards of cleanliness. Most had room for activities, space for quiet and a place to meet visitors. However, we visited Grangewaters ward on an extremely hot day, over 30 degrees. The temperature in the ward was very hot which was compounded by the policy to keep many of the windows shut, particularly in the dormitory areas. We found Grangewaters ward to be an extremely busy ward which was not conducive for mental health recovery. We also found that Maple ward in older people's services was noisy and appeared chaotic and did not have a dementia friendly design

We found that most services had access to grounds or outside spaces. Wards we visited had a telephone available for patients' private use. Most inpatient services had lockable storage available to patients. In all longer stay services we found that people were able to personalise their bedroom space.

Overall the trust was performing worse than other trusts for the food score in the PLACE 2014 survey with 10 out of 17 wards scoring below the England average of 90%. Brockfield House had scored particularly badly at 70%. At acute and forensic services many patients were not happy with the choice and quality of food available to them. Most wards had facilities for drinks and snacks outside of meal times. In the majority of cases these were open to patients as appropriate.

Meeting the needs of all people who use the service

Inpatient and community services were mainly provided from facilities that were equipped for disability access. In environments where this was not possible arrangements were in place to ensure alternative access to the service.

We found a wide range of information available for service users regarding their care and treatment both within services and via the trust website. Many of the leaflets viewed were available in other languages and formats.

Staff told us that interpreters were available via local interpreting service and language line and were used to assist in assessing patients' needs and explaining their care and treatment.

At most inpatient services we saw that multi-faith rooms were available for patients to use and that spiritual care and chaplaincy was provided. We saw that generally there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.

Listening to and learning from concerns and complaints

The trust provided details of all complaints received during 2014 / 2015. There had been 377 formal complaints. Over half of these related to nursing, midwifery and health visiting. The largest number of complaints related to 'all aspects of clinical treatment'. Staff attitudes, communication and issues with appointments were the next highest categories. The trust informed us that during the period 66% of complaints had been upheld or partially upheld.

Good

Are services responsive to people's needs?

During the period 11 complaints had been referred to the Parliamentary and Health Service Ombudsman (PHSO): one had been upheld and one had been partially upheld, five were still being investigated. The trust also provided information about the complaint issues and the actions they had taken as a result of the findings. We reviewed this information and saw some good examples of learning from complaints.

The trust also provided information regarding compliments received. This indicated there had been over 5000 in the previous 12 months.

The trust provided details of their formal complaints process. This set out arrangements for response, investigation and ensuring lessons are learned and shared. We found that complaints were logged on the trust's incident management system and were notified to the trust complaints team. Complaints information was discussed at local governance meetings and was reviewed by the lessons learnt oversight committee and the quality and strategy group. The board also received details of complaints received and any relevant actions.

Staff received training about the complaints process during their induction and an ongoing basis. Staff were generally aware of the complaints process. Staff told us they that were aware of complaints raised in the service and usually heard of the outcome and any learning this raised. We saw that staff discussed the learning from complaints at a number of team meetings we observed.

At the inpatient services most patients told us that they were given information about how to complain about the service. This was usually contained within the ward information pack and included information about how to contact the patients advice and liaison service (PALS). Information about the complaints process was usually displayed at the wards. All patients knew how to complain and most felt they would be listened to. At most community teams we found that complaints information was displayed and that additional information was available. Most community patients knew how to complain.

Complaints information was also looked at some of the services we visited. Reports usually detailed the nature of complaints and a summary of actions taken in response. Generally complaints had been appropriately investigated and included recommendations for learning. We saw examples of where the outcome of the complaint had included duty of candour considerations. At some units we saw actions that had occurred as the result of complaints.

The trust told us that they were actively trying to manage complaints on an informal basis. In a number of community and inpatient services verbal complaints were managed at service level and the findings were usually acted upon. In CAMH and crisis services we found that most complaints were resolved at a local level. However, these were not recorded and therefore we could not ascertain how many had been made or what the outcome was. This impeded staff learning lessons from these complaints. We were told that the trust was looking in to logging all local complaints in order to share learning and outcomes.

Good

Are services well-led?

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

Summary of findings

We rated South Essex Partnership NHS Foundation Trust as good for Well Led because:

- The trust board had developed a vision statement and values for the trust and most staff were aware of this.
- Leaders were visible and most staff felt supported.
- Good governance arrangements were in place, which supported the quality, performance and risk management of the services.
- The trust had undertaken positive engagement action with service users and carers.
- There was effective team working and staff felt supported by this.
- Staff knew how to use the whistleblowing, safeguarding and incident reporting processes and could submit items to the risk register.
- There was a commitment to quality improvement and innovation.

Our findings

Vision, values and strategy

The trust board and senior management team had a clear vision with strategic objectives and values. We were told that the trust developed their vision and values during 2012 following detailed engagement with service users, staff and commissioners. The vision was: 'Providing services that are in tune with you'. The values underpinning this were stated as: Positive, Welcoming, Respectful, Involving, Kind and Accountable.

The trust gave us a copy of their strategy for 2014 to 2019. This set out the trust's overarching objectives. The operational plan from 2014 to 2016 also set out more detailed objectives to meet this strategy, as well as arrangements to monitor progress.

Additional annual objectives were also set out in the annual quality account. For 2014/15 the objectives included the promotion of safer care, more positive experience of care, more effective care, and well organised and responsive care. Work to meet the objectives had included initiatives to reduce harm through falls, pressure ulcers and self-harm, work on reducing restrictive practice, increased audit, staff recruitment and improving end of life care.

The trust board, executive team and the quality and safety committee review performance against the strategy on a monthly basis via a business performance report and dashboard approach. Performance against annual objectives was also published within the quality account.

Most staff we spoke with said they were aware of the trust's vision and values, and strategic objectives. Staff were generally familiar with the trust mission statement. We found evidence of the vision and values on display within the services and this was also available to staff on the trust intranet. Staff told us that they received regular information and newsletters setting out progress against objectives.

The trust board members we spoke with were clear about the vision and strategy and were able to articulate their specific areas for improvement. Senior management were aware of the strengths and improvement needs of the trust and the specific objectives of their own service areas.

We found that staff were committed to ensuring that they provided a good and effective service for patients and most felt able to influence change within their service. Most staff were aware of the trust's management structure and who their locality managers were. Most staff had an understanding of the trust vision, values and strategy. Staff demonstrated that they usually had a good understanding of directorate and service level objectives.

Good governance

The trust has a board of directors who were accountable for the delivery of services and assurance through its governance structure for the quality and safety of the trust. Reporting to this were committees for audit and assurance, quality assurance, mental health & safeguarding, finance

and performance, and remuneration. The trust managed all quality governance through the quality and safety committee. Reporting to this were sub-committees for clinical governance, information governance, audit and research, patient experience, health and safety, lessons learnt, infection control, safeguarding and capital projects. These committees had terms of reference, defined membership and decision making powers.

The trust had an integrated board assurance framework and risk register which is reviewed monthly by the board. Risk registers were also in place held at different levels of the organisation which were reviewed at directorate meetings. We saw that there was a clear connection between the risks identified at grass roots level and those recognised by the board.

At inspection we found that the board members had a good grip on issues the trust faced in delivering services. We found that the board held staff to account in an appropriate way whilst enabling executives to manage the delivery of services.

The quality performance dashboard acted as a performance report against key indicators and an early warning system for identifying risks to the quality of services. This includes measures of organisational delivery, workforce effectiveness and quality and safety. These include: complaints, serious incidents, access and waiting time targets, delayed transfers of care, bed occupancy, average length of stay, as well as staffing measures such as vacancies, sickness, turnover and training rates.

The mental health and safeguarding committee had overall responsibility for the application of the Mental Health Act and the Mental Capacity Act. We met with the hospital managers and found that they provided a regular annual report to the board, to inform of performance in this area. The board also received further information and assurance regarding the Mental Health Act through the board committee structure.

Staff demonstrated they were aware of their responsibilities in relation to governance. Most staff told us that they were aware of the governance structure and had access to performance information and meeting minutes. Most staff told they would escalate risks they were aware of.

Team managers confirmed that they were involved in governance groups and that they were able to raise issues through the risk register and operational groups. We reviewed the risk registers for the trust and directorates and noted that the concerns we found had been highlighted and were part of risk registers.

The trust had taken actions to address previous breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 at Basildon Mental Health Unit. However, at the CAMH service actions arising from previous Mental Health Act reviewer visits had not been fully addressed.

Leadership and culture

Morale was found to be good in most areas. Generally staff felt engaged by the trust. Staff told us that the chief executive and senior managers were visible. However, some staff in the forensic, community mental health, children's healthcare and crisis services, were less positive about morale and senior leadership.

At the time of our inspection in June 2015 we found that staffing was generally sufficient on the wards. The trust confirmed that they had a vacancy rate of 11.8% and that overall staff turnover stood at 17.1% in May 2015. For registered nurses the vacancy rate was higher at 16.6%. Nevertheless, figures provided indicated that during May 2015 overall staffing had generally met the trust's target with an average of 98% of planned registered nurses and 101% of unregistered staff shifts filled across inpatient services throughout the month.

In the 2014 NHS Staff Survey, the trust scored better than average for 11 key measures. These included motivation and job satisfaction, effective teamwork, opportunities for promotion, ability to engage in improvement. Overall the trust had improved its position across relevant indicators against the 2013 survey results.

The trust told that they had undertaken a range of initiatives to engage staff. These included more visible leadership, executive team service visits, developing staff champions, the take it to the top initiative, and a promotion of the speak-up charter.

The trust used the Friends and Family Test on a quarterly basis to consider staff's views. Since April 2014 this had shown a steadily increasing improvement in staff's level of satisfaction. At March 2015 the results indicated that 96% of staff respondents were likely or extremely likely to recommend the trust services.

Good

Are services well-led?

Most staff told us they knew their immediate management team well and most felt they had a good working relationship with them. Most staff were aware of, and felt supported by, the trust's directorate management structures. Most staff were aware of who the senior management team were at the trust. Some staff stated that they had met with or seen senior managers at their service and felt supported by this. Some staff reported that the senior team had worked within their service and this was welcomed. However, some staff in forensic and community health services stated they had not seen senior managers and that the trust senior team felt remote. In community children's services some staff felt that the executive board did not understand their role and there was a lack of strategic direction.

Staff were aware of their role in monitoring concerns and assessing risks. They knew how to report concerns to their line manager and felt they would be supported if they did. We found some good examples of staff feeling that learning from past incidents was informing planning of services or service provision.

The trust had a year-long leadership programme. The feedback was positive from staff that had attended. This was being modified for charge nurses to support them in the development of their role.

In November 2014 a CQC regulation was introduced requiring NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong. The trust had placed compliance with this regulation on its risk register in August 2014. Since, a number of actions had been undertaken. These included training for the executive and managers, information for staff and a review of all relevant policies and procedures. Duty of candour considerations had been incorporated into the serious investigation framework, tools and report, and complaints procedures. Further training had been developed to be rolled out to staff. Staff were aware of the duty of candour requirements in relation to their role.

In November 2014 a CQC regulation was introduced requiring NHS trusts to ensure that all directors were fit and proper persons. As a consequence of this the trust had checked that all senior staff met the necessary requirements. The trust had set up policies and procedures to ensure that all future senior staff have had the relevant checks.

Engagement with the public and with people who use services

The trust had a service user engagement strategy and customer service strategy that together set out arrangements for engagement with service users, carers and wider stakeholders. The trust was in the process of updating this work into a single strategy. Underpinning this was a detailed user and carer engagement implementation plan and customer service action plan. This work was overseen by a trust wide patient and carer experience steering group. All localities had patient experience groups with wide membership. The trust had a dedicated patient experience team. Work undertaken on this agenda had included increased partnerships with voluntary and community groups and service user involvement in training, recruitment, research and audit. Other initiatives developed included a 'buddying' scheme were service users worked alongside student nurses, a mystery shopper project and 'take it to the top' were the public could meet with the senior team.

The trust had used the Friends and Families Test (FFT) since 2012. In the 12 months prior to our visit there had been almost 7000 responses to this survey. At March 2015 the results indicated that 85% of patient and 96% of staff respondents were likely or extremely likely to recommend the trust services. The trust demonstrated an improving picture of satisfaction during the 12 months before our inspection.

Since 2013 'Patient-Led Assessments of the Care Environment' (PLACE) visits had taken place to a number of inpatient services. This is a self-assessment process undertaken by teams including service users and representatives of Healthwatch.

The trust had a number of carers' forums and inpatient services had community meetings to engage patients in the planning of the service and to capture feedback. In most services this meeting was chaired by patients and was attended by relevant ward staff. Minutes were usually taken and we saw evidence of actions that were raised being completed. Patients told us they felt able to raise concerns in the community meetings and that they usually felt listened to.

Good

Are services well-led?

Patients and their families or carers were engaged by staff in community services using a variety of methods. We saw that there was information available throughout the trust and via its website about how to provide feedback on the specific services received by people.

Many patients told us that they felt listened to and their requests were usually acted upon. Generally we found good patient involvement of patients in their care. Almost all care plans and records reviewed demonstrated the person's involvement. In all services we found that there was an opportunity for patients to attend care planning meetings. In learning disability services we found that care plans were not all written in an appropriate format to be accessible to the patients. We found a number of examples of relatives being involved in care planning where this was appropriate.

Prior to the inspection we spoke with a large number of user groups, community support organisations and advocacy services. Generally we heard of positive relationships with the trust and of opportunities to be involved in providing feedback on how services are run or planned.

Quality improvement, innovation and sustainability

The trust had participated in a number of applicable Royal College of Psychiatrists' (RCPsych) quality improvement programmes or alternative accreditation schemes. Acute wards either had or were working towards accreditation from the accreditation for inpatient mental health services (AIMS) programme. The learning disability services at Wood Lea held RCPsych accreditation. The forensic services were part of the quality network for forensic mental health services. The crisis teams held the home treatment accreditation scheme (HTAS) accreditation. However, the ECT suite at Basildon Hospital the PICU had not yet been accredited by the RCPsych. We found that facilities in the health-based place of safety did not meet all guidance issued by the RCPsych.

The trust had a research strategy in place and had participated in a wide range of clinical research. There was a dedicated research function in place and through its website provided detailed information on research projects. The trust also undertook a wide range of clinical effectiveness and quality audits. These included safeguarding practice, medicines management, prescribing, compliance with NICE guidance, hand hygiene, infection control, suicide prevention, clinical outcomes, physical healthcare, care planning, record keeping, pressure ulcer management, consent and capacity, Mental Health Act administration and patient satisfaction. We also found a large number of localised audits looking at practice within services.

During 2014 the trust participated in the national audit of schizophrenia (NAS), national audit of psychological therapies, national confidential inquiry into suicide and homicide by people with mental illness, the national audit of intermediate care, epilepsy 12 (childhood epilepsy), and the national Parkinson's audit. The Archer Unit and St Margaret's Hospital had contributed to the national audit of sentinel stroke. The trust also participated in POMH audits in prescribing for people with a personality disorder. The learning disabilities services contributed to the POMH (Prescribing Observatory for Mental Health) anti psychotics in learning disabilities audit.

We found a large number of innovative improvement projects including:

- Mayfield and Meadowview wards had built a safe space garden between the units and won a "highly commended" award from the Building Better Healthcare Awards 2014.
- Due to the high incidence of care home acquired pressure ulcers staff had devised a training programme called "pressure ulcer food first initiative". The programme offered on-going training and support to work based champions in 47 participating care homes. This programme had proved effective in reducing the incidents of avoidable care home acquired pressure ulcers.
- Staff in the PEPS service told us about the 'virtual ward' initiative in the West Essex service. Daily meetings were held to discuss all patients within the virtual ward to establish any changes to their care needs. Care needs were re-assessed due to these meetings.
- In acute services we saw patients views were gathered through feedback upon discharge via comments cards. We saw how these results were analysed by the individual ward managers to provide an overview of the service.
- Staff at Saffron Walden and St Margaret's hospitals were working with GPs on a project to support the care of the

Good

Are services well-led?

frail elderly, to prevent admissions to acute hospitals particularly during the winter. This meant GPs could refer patients to community hospitals as an alternative to being admitted to acute hospitals.

- The oral health promotion team was working proactively within the local community to improve oral health and encourage active and effective teeth brushing. We noted some very positive evaluation of this team's work

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The trust must ensure that all practices amounting to seclusion or segregation are recognised, recorded and safeguarded in line with requirements set out in the Mental Health Act Code of Practice. • The trust must take action to reduce restrictive interventions particularly on Fuji ward where the numbers of prone restraints were high. Regulation 13(4)(b).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs · The trust must review arrangements for food provision at acute mental health and forensic inpatient services to ensure that patients have sufficient choice and receive food of good quality.