Essex Partnership University NHS Foundation Trust

Evidence appendix

The Lodge
Lodge approach
Runwell
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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

The trust had 22 locations registered with the CQC (on 3 April 2018).

Registered location	Code	Local authority
439 Ipswich Road	R1LY8	Essex
Basildon Mental Health Unit	R1LY9	Essex
Brian Roycroft Ward	R1LX8	Essex
Brockfield House	R1LX6	Essex
Broomfield Hospital Mental Health Wards	R1LX7	Essex
Chelmer & Stort Mental Health Wards	R1LX9	Essex
Clifton Lodge	R1LJ3	Southend-on-Sea
Colchester Hospital Mental Health Wards	R1LY2	Essex
Cumberlege Intermediate Care Centre	R1LZ2	Southend-on-Sea
Heath Close	R1LY3	Essex
HMP Chelmsford	R1LMP	Essex
Landemere Centre Mental Health Wards	R1LY4	Essex
Mountnessing Court	R1L65	Essex
Rawreth Court	R1LJ2	Essex
Robin Pinto Unit	R1LY7	Luton
Rochford Hospital	R1LZ9	Essex
Saffron Walden Community Hospital	R1LTH	Essex

St Margaret's Community Hospital	R1LX4	Essex
The St Aubyn Centre	R1LX1	Essex
Thurrock Hospital	R1LX2	Thurrock
Trust Head Office	R1LZ8	Essex
Wood Lea Clinic	R1LX3	Bedford

The trust had 772 inpatient beds across 47 wards, 37 of which were children's mental health beds. The trust also had no outpatient clinics a week and 983 community clinics a week.

Total number of inpatient beds	772*
Total number of inpatient wards	47
Total number of day care beds	0
Total number of children's beds (MH setting)	37
Total number of children's beds (CHS setting)	0
Total number of outpatient clinics a week	N/A
Total number of community clinics a week	983

*excluding nursing homes and 8 ESC beds

Is this organisation well-led?

Leadership

The trust board had the appropriate range of skills, knowledge and experience to perform its role. Board members modelled leadership behaviours and demonstrated the values of the organisation. The board engaged in continuous learning opportunities using board development sessions. An example included sessions on risk appetite. The trust provided learning and development opportunities to staff, of all grades, through a leadership and development programme. The trust used this programme as a form of succession planning to develop and grow their own staff. The trust had made a financial commitment to staff development and allocated this training to all newly promoted managers. At the time of inspection, 22 staff completed the management development programme, with 308 enrolled on the programme. Eighty-six staff completed the leadership development programme, level one, with 41 having completed level 2.

Fit and proper person checks were in place for all board members and non-executive directors. The trust secretary had ensured all members applied for enhanced disclosure and barring checks and was waiting for the applications to be returned. All files contained standard disclosure and barring checks.

The senior leadership team worked cohesively and efficiently together. All senior managers were equipped with the necessary experience, knowledge and skills to perform their role. The trust allocated leaders to speciality services, such as child and adolescent mental health and learning disabilities. Leaders for these services were passionate about their area of expertise and demonstrated a drive to provide high quality care to patients and carers.

The trust leadership team were acutely aware of the challenges faced by the organisation and had allocated appropriate resources to overcome them. Recent examples included a programme of work undertaken, across a variety of locations, to remove ligature anchor points and improve ligature risk assessment. This followed the last CQC inspection in November 2017.

The leadership team were visible across services. Senior leaders had completed over 250 service visits since April 2017. Many staff referred to visits from the team to their wards and services. This

included at evenings and weekends. The leadership team varied the visit times to ensure inclusivity and to capture the views of as many staff as possible. Staff across the organisation reported leaders were visible and approachable at all levels.

	BME %	Women %
Executive	14.3%	28.6%
Non-executive	12.5%	75.0%
Total	13.3%	46.7%

Vision and strategy

The board and senior leadership team had consulted with staff to create, agree and launch values that reflected the work within the organisation. All staff, at every level, knew the values of the organisation and demonstrated this in their day-to-day work. The board and non-executive directors reviewed the organisations performance against the values at the end of each board meeting. Staff readily gave examples where they felt their teams reflected the values of the organisation in their work with patients and carers. Managers and staff discussed vision and values during the appraisal process and at interviews to ensure the right people, with the same values, worked for the organisation. The trust embedded vision and values across the organisation; managers displayed values information in all the services we visited.

The trust had a robust and realistic strategy for delivering high quality care and achieving its priorities. Senior leaders spoke of service frameworks which outlined the vision and strategy for their service. We heard how non-executive directors challenged executive members in a positive way to consider options and issues.

The trust vision of improving lives was seen in all staff groups who could tell us how their job helped to achieve this and how they could contribute to people leading better lives. Staff told us how the values of the organisation supported the vision. Staff we spoke to throughout the trust knew their role in supporting people to improve their lives.

The trust quality strategy (2017-2020) outlined the role of the quality academy, as one of the initiatives, for achieving the trust priorities to develop good quality, sustainable care. Staff signed up as quality champions to drive forward changes to improve the quality of care across the organisation. The trust set future targets to train 50 staff from clinical services, 10 quality ambassadors from the senior leadership team and 20 patients or carers per year over the next three years. Training opportunities will include quality improvement techniques. The strategy refers to the ‘Always event’ toolkit that centres around patient experience. The trust quality committee reviewed and had oversight of quality improvement across the organisation.

Culture

Leaders had prioritised culture following the merger of the north and south mental health trusts in April 2017. Leaders talked openly about taking the positives from both previous organisations to embed in the new organisation. Senior leaders discussed referred to the value of being open as a priority for the approach of the new organisation. Leaders encouraged inclusive and supportive relationships between all staff grades.

In the 2017 NHS Staff Survey the trust had better results than other similar trusts in one key area:

Key finding	Trust score	Similar trusts average

KF14. Staff satisfaction with resourcing and support	3.38	3.33

In the 2017 NHS Staff Survey: the trust had worse results than other similar trusts in four key areas

Key finding	Trust score	Similar trusts average
KF1. Staff recommendation of the trust as a place to work or receive treatment	3.61	3.68
KF27. % reporting most recent experience of harassment, bullying or abuse	55%	57%
KF29. % reporting errors, near misses or incidents witnessed in the last month	90%	92%
KF32. Effective use of patient / service user feedback	3.59	3.69

Staff felt positive about the merger of the organisations and felt proud to work for the trust. They told us that the focus was patients and high-quality care was the priority.

The trust recognised staff contributions through staff awards and encouraged staff to explore areas of interest and specialities. We saw this in examples of staff attending national conferences and leading on work for the workforce race and equality standards.

Managers addressed poor staff performance when needed and adhered to their policies during the process.

The trust had appointed a Freedom to Speak Up Guardian following nominations and staff elections. The guardian had been appointed in December 2017 and worked two flexible days per week in that role. The trust had increased the capacity of the guardian following discussion and a review of capacity. Not all staff were aware of the guardian or the role they performed and it was recognised by senior leaders that work remained in promoting the role. The Freedom to Speak Up Guardian reported to an executive director monthly and planned to meet with the chief executive four time per year. There were 10-15 local speak up guardians in post at the time of inspection, the majority of which came from the south of the area. Following a recruitment drive, 4-5 staff expressed an interest in the local role, from the north. The Freedom to Speak Up Guardian reported 10-15 examples of staff reporting concerns since being in post. All staff were aware of the whistleblowing policy and referred to other ways in which they could raise concerns. This included an ‘I am concerned about’ intranet facility that meant staff could report concerns anonymously. The trust addressed staff concerns in a way that supported staff and was transparent. Staff felt able to raise concerns, without fear of retribution.

The trust applied the Duty of Candour appropriately. A dedicated serious incident team investigated deaths and there were specific mortality governance groups in place. The trust reported deaths in line with national expectations. The serious incident team allocated staff to specifically to liaise with families and carers of people who died, who kept them informed of investigation progress and to discuss their views. The serious incident team formed positive working relationships with family liaison officers from the Police and planned to work with the Police to train more staff to support families.

The trust had an appraisal system which aligned with the values of the organisation and gave staff an opportunity to discuss career development. Staff received annual appraisals where managers discussed the learning and development opportunities available. New staff accessed robust

induction that was in three parts; face to face induction to the trust, mandatory e-learning and local service based induction activities. Inductions took place over six weeks.

Staff had access to occupational health services and the trust held a variety of wellbeing events for staff throughout 2017/8. These included gardening competitions, Wimbledon competitions and table tennis competitions. The trust held wellbeing events throughout September 2017. Local leaders provided regular opportunities for staff to discuss wellbeing. We were given examples where board members gave significant support to local teams after significant events.

The trust lacked pace regarding equality and diversity initiatives. Whilst there was an established BAME (black and minority ethnic) group, there was a lack of formal networks and groups that supported people with protected characteristics, other than race. We spoke with equality and diversity leads and staff working in services and the picture was unclear as to what other networks staff could seek support from. The trust identified 200 equality champions, however the engagement of the champions was inconsistent and we heard that some champions did not have any communication with the equality leads. The equality and diversity leads provided bi-monthly assurance reports to the board and sought assurance through the equality and inclusion committee.

Teams across the organisation had strong, positive working relationships. Staff addressed issues openly with each other or used their managers as support.

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 83% and 94%, higher than the England average for patients recommending it as a place to receive care for three of the six months in the period (August 2017 to January 2018). August 2017 saw the highest percentage of patients who would recommend the trust as a place to receive care with 94%, and each month in the period scored above 83%.

The trust was similar to the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care for two months.

	Trust wide responses				England averages	
	Total eligible	Total responses	% that would recommend	% that would not recommend	England average recommend	England average not recommend
January 2018	22,146	177	83%	7%	88%	4%
December 2017	20,910	155	90%	5%	88%	4%
November 2017	7,891	217	86%	5%	87%	5%
October 2017	22,456	274	89%	4%	86%	6%
September 2017	20,856	250	90%	3%	89%	4%
August 2017	21,883	223	94%	1%	94%	1%

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures	Trust target

Total number of substantive staff	31 January 2018	5009.87	N/A
Total number of substantive staff leavers	1 April 2017 and 31 January	253	N/A
Average WTE* leavers over 12 months (%)	1 April 2017 and 31 January	7%	10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	31 January 2018	719.26	N/A
Total vacancies overall (%)	31 January 2018	14%	10%
Total permanent staff sickness overall (%)	Most recent month (31 January 2018)	4%	<4.5%
	1 April 2017 and 31 January	4%	<4.5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	31 January 2018	1585.55	N/A
Establishment levels nursing assistants (WTE*)	31 January 2018	1207.08	N/A
Number of vacancies, qualified nurses (WTE*)	31 January 2018	250.46	N/A
Number of vacancies nursing assistants (WTE*)	31 January 2018	147.04	N/A
Qualified nurse vacancy rate	31 January 2018	16%	10%
Nursing assistant vacancy rate	31 January 2018	12%	10%

Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 April 2017 and 31 January	31,709 (31%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 April 2017 and 31 January	12,577 (12%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 April 2017 and 31 January	795 (<1%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 April 2017 and 31 January	60,464 (42%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 April 2017 and 31 January	5,916 (4%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	Date-Date	804 (<1%)	N/A

*WholeTime Equivalent

The trust identified staffing as a current challenge and the senior leadership team communicated this openly. The executive team received weekly safer staffing reports from inpatient services, which informed them of planned staffing levels against actual levels achieved. Community teams reported staffing monthly. Senior leaders reviewed 49 staffing establishments following the merger to review staffing levels and ensure numbers met the needs of the patients.

Staffing remained a hotspot identified by the finance and performance committee reporting to the board. The trust worked hard to ensure that bank and agency staff worked to fill vacancies. Where possible, manager used regular bank and agency staff who were familiar with the services. The

deployment of temporary workers policy supported managers using bank and agency staff to ensure that the skills met the needs of the patients. The trust had a recruitment and retention strategy which outlined intended ways to recruit and retain staff. Managers gave examples of recruitment initiatives including career fayres and financial incentives for 'referring a friend'.

Managers took part in twice daily situational report (SITREP) calls to discuss staffing levels with senior leaders. Senior leaders increased the SITREP to three times daily if required. Managers displayed staffing levels on wards to inform patients of who was on shift and staffing levels were good across the services.

As at December 2017, the training compliance for trust wide services was 82% against the trust target of 85%. Of the training courses listed 30 failed to achieve the trust target and of those, 10 failed to score above 75% which included Infection Prevention, Control & Hand Hygiene with 74%, MERT (Enhanced Emergency Skills) with 73%, Manual Handling – People with 69%, Medicines Management (MH) with 67%, Mental Capacity Act Level 2 with 64%, Personal Safety Breakaway - Level 1 with 63%, Fire Safety 2 years with 59%, Fire Safety 3 years with 40%, Basic Back Care (Face to Face) with 39% and Basic Back Care (E-Learning) with 27%.

The trust reported difficulties in harmonising training data following the merger in April 2017. Staff reported discrepancies in training records; for example, courses completed showing as incomplete. Managers kept local training matrix's as assurance staff completed training. During the inspection, local records checked for Essex services did not demonstrate concerns regarding training. Staff compliance in Luton and Bedford required improvement. Staff reported the recent closure of local training facilities effected their ability to undertake face to face training, due to length of time, and distance to travel to Essex facilities. Managers were arranging for some local sessions to take place to increase compliance.

The trust's target rate for appraisal compliance is 90%. As at 31 January 2018, the overall appraisal rates for non-medical staff was 82%. Four of the 21 core services (18%) achieved the trust's appraisal rate.

Core Service	Total number of permanent non-medical staff who required an appraisal within the last 12 months	Total number of permanent non-medical staff who have had an appraisal in the last 12 months	% appraisals
CHS - Children, Young People and Families	184	178	97%
Other - ASC service	59	57	97%
MH - Community mental health services for people with a learning disability or autism	50	48	96%
MH - Secure wards	164	146	89%
CHS - Adults Community	655	573	87%
MH - Mental health crisis services and health-based places of safety	54	47	87%
Other	1352	1151	85%
MH - Community-based mental health services for older people	219	182	83%
MH - Wards for older people with mental health problems	186	155	83%
CHS - Urgent Care	17	14	82%
MH - Child and adolescent mental health wards	83	67	81%
MH - Wards for people with learning disabilities or autism	21	17	81%
CHS - End of Life Care	5	4	80%

Core Service	Total number of permanent non-medical staff who required an appraisal within the last 12 months	Total number of permanent non-medical staff who have had an appraisal in the last 12 months	% appraisals
CHS - Community Inpatients	146	113	77%
MH - Long stay/rehabilitation mental health wards for working age adults	22	17	77%
MH - Other Specialist Services	74	56	76%
CHS - Sexual Health	32	23	72%
MH - Community-based mental health services for adults of working age.	476	332	70%
MH - Acute wards for adults of working age and psychiatric intensive care units	260	173	67%
MH - substance misuse	55	30	55%
MH - Specialist community mental health services for children and young people.	7	3	43%
Total	**4121**	**3386**	82%

The trust supervision policy combined clinical and management supervision. Staff reported feeling supported by managers in their role and described examples where they received informal supervision. Many staff told us their managers had 'open door' policies where they could be approached for discussions about patient care and treatment.

Local managers gave rationales for supervision rates that did not meet target, this included staff on long terms absence from work and female staff who were on maternity leave.

The trust's target rate for clinical supervision is 90%. As at 31 January 2018, the overall clinical supervision compliance was 86%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Seven of the 18 services (39%) achieved the trust's clinical supervision target. Twelve core services failed to achieve the trusts target.

Core Service	Formal supervision sessions each identified member of staff had in the period	Formal supervision sessions should each identified member of staff have received	Clinical supervision rate (%)
MH - Long stay/rehabilitation mental health wards for working age adults	177	180	98%
CHS - Children, Young People and Families	1,423	1,462	97%
MH - Community mental health services for people with a learning disability or autism	320	332	96%
MH - Secure wards	1,675	1,744	96%
Other - ASC service	571	615	93%
CHS - Adults Community	4,347	4,714	92%
CHS - Community Inpatients	1,514	1,658	91%
MH - Wards for people with learning disabilities or autism	127	145	88%

Core Service	Formal supervision sessions each identified member of staff had in the period	Formal supervision sessions should each identified member of staff have received	Clinical supervision rate (%)
Other	723	845	88%
MH - Community-based mental health services for older people	1,432	1,638	87%
MH - Other Specialist Services	764	876	87%
MH - Acute wards for adults of working age and psychiatric intensive care units	2,293	2,681	86%
MH - Mental health crisis services and health-based places of safety	602	713	84%
MH - Child and adolescent mental health wards	514	632	81%
MH - Wards for older people with mental health problems	1,664	2,072	80%
CHS - Sexual Health	142	180	79%
MH - Community-based mental health services for adults of working age.	2,552	3,399	75%
MH - substance misuse	221	500	44%
TOTAL	**21,061**	**24,386**	**86%**

The trust had a robust approach to investigating and responding to complaints. A dedicated complaints team provided weekly reports to the executive team and to service directors. Staff that investigated complaints received training in how to do so effectively. The complaints team provided a rolling programme of training to local teams to empower staff to resolve issues at a local level and to record this appropriately. The head of complaints provided quarterly complaint thematic reports which identified trends and themes from complaints received by the organisation. From October 2017 – December 2018 themes included patient possessions going missing on wards and the communication to relatives about patient discharge.

Managers discussed lessons learnt from complaints as a standard agenda item in team meetings. The trust displayed ‘you said, we did’ information on their website. The chief executive had final sight and sign off for all complaints to ensure quality and to ensure the trust upheld the principles of duty of candour. Non-executive directors completed an anonymous review of four complaints per month to ensure quality, duty of candour and that responses reflected the values of the organisation. We reviewed 9 examples of complaints which demonstrated staff followed the correct process.

At the time of the inspection there were 51 open complaints in process. The complaints tracker showed 26 overdue, 15 of which received an agreed extension to ensure investigators addressed the complaint in full. The system for allocating investigators did not account for the sharing of workload. This could affect the trust’s ability to meet complaint deadlines.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

	In Days	Current Performance
What is your internal target for responding to* complaints?	Acknowledged within 3 working days	100%

	In Days	Current Performance
What is your target for completing a complaint?	We agree a timescale with complainant	97%
If you have a slightly longer target for complex complaints please indicate what that is here	We agree a timescale with the complainant for all complaints	97%

* Responding to defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken

	Total	Date range
Number of complaints resolved without formal process*** in the last 12 months	289	01 April 2017 - 21 February 2018
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	12	01 April 2017 - 21 February 2018

**Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example, PALS resolved or via mediation/meetings/other actions

This trust received 661 compliments during the last 9 months from 1 April to 31 December 2017. 'Community health services for adults' had the highest proportion of compliments with 38%, followed by 'wards for older people with mental health problems' with 15% and 'acute wards for adults of working age and psychiatric intensive care units' with 10%.

Governance

The trust provided its board assurance framework. The trust outlined four strategic objectives:

1 – Patient – safety, experience and outcomes
2 – Attract, develop and enable high performing individuals and teams
3 – Enable service improvement plans with system partners
4 – Top 25% performance for operational, financial and productivity measures

The trust had a clear and robust governance structure to oversee performance, quality and risk. Eight governance committees reported directly to the board, with several sub-committees reporting below. Governance spanned the entire organisation, with local managers discussing issues at service level in team meetings. We saw a variety of minutes and papers from meetings during the inspection which demonstrated staff reviewed risk, quality and performance.

Executives, non-executives and senior leaders knew their responsibilities and chaired appropriate governance committees. They took ownership of their areas and knew key areas of risk and good practise. Local managers knew the reporting structure for sharing information and escalating concerns and could describe the ward to board governance structure.

We identified some problems within substance misuse services and end of life care. The issues related to leadership and oversight of the service. This was not identified as an issue by senior leaders. The services did not feel connected to the trust. We were concerned by the lack of oversight and the potential impact on client safety and quality. There were problems with

substance misuse patients not receiving timely reviews of medication and managers could not demonstrate how they monitored unexpected deaths in the service. Managers could not provide performance information about training and supervision. In end of life services, staff did not provide patients with suitable information about the service and there were no opportunities for patients, families and carers to provide feedback.

There was a Mental Health Act (MHA) and safeguarding committee and a pre-operational sub-committee that were responsible for oversight of the monitoring of the Mental Health Act. The MHA and Safeguarding committee provided a report to the board of directors. The Mental Health Pre-operational sub-committee met every two months and the executive lead chaired the meeting. The senior MHA manager developed trust policies relating to the MHA. They were sent to the relevant governance committee for sign-off.

The learning lessons sub-committee brought together leads from complaints, serious incident and safeguarding teams to assess and review themes and trends. The group produced monthly reports for the executive team. Senior leaders shared learning across the organisation via learning portfolios and 'five key learning points'. Local managers displayed 'five key learning points' in most of the services visited. There were minimal locations where staff were not aware of this initiative.

The trust had rapid assessment, interface and discharge (RAID) services to provide the liaison mental health services to both Southend and Basildon General Hospitals, this replaced the service provided by the crisis teams. The trust had plans to transform the approach across both crisis teams in the south as part of the wider transformation programme. There was a street triage team working in the Chelmsford, alongside Police, which had successfully reduced the use of the health based places of safety and was able to direct a patient to the most appropriate service.

The trust provided a document detailing its highest profile risks. Each of these had a current risk score of eight or more.

The table below shows the highest risks in the board assurance framework:

Key:

Extreme (20-25)	High (10-16)	Medium (4-9)	Low (1-3)

ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.	Last review date
BAF17041901	If services fall short of the standards required to remain compliant with the Health and Social Care Act there is the potential for CQC enforcement action or in extreme cases closure of services.	20	20	12	1	Feb 2018
BAF1904315.	If EPUT fails to provide high quality services from premises that are safe and with minimised risk	12	20	12	1	Feb 2018

ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.	Last review date
	related to ligatures this will impact upon the safety of inpatient services					
BAF 17061924	If fire systems and processes are not suitable and sufficient there is a potential risk to patient and staff safety and that enforcement action could be taken by the Fire Service.	15	20	12	1	February 2018
BAF 17041923	If action being taken is not having an impact on the number of restraints (particularly prone restraint) the Trust will need to consider whether there are gaps in plans in place	16	16	3	1	
BAF17041911	If the assumed reduction in agency spend is only partially be achieved this may impact on the financial position of the Trust	16	16	3	4	

The trust has provided a document detailing their highest profile risks. Each of these have a current risk score of nine or higher.

Key:

Extreme (20-25)	High (10-16)	Medium (4-9)	Low (1-3)

Opened	ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.	Last review date
January 2018		If recommendations from fire risk assessments are not actioned there is the potential for serious harm to patients, staff and visitors as well as action by the Fire Authority in the form of restrictions, forced closure of premises, fines or prosecution/custodial sentencing of responsible persons	20	20	15	1	February 2018
		Potential risk of injury or death to patients, staff and visitors, and that enforcement action could be taken by the Fire Authority in the form of restrictions, forced closure of premises,	20	20	-		February 2018

Opened	ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.	Last review date
		fines or prosecutions/custodial sentencing for Responsible Persons.					
May 2017	Legacy SEPT Risk agreed as post merger risk May 2017	Due to shortages of nursing and custody staff, prisoner care in the healthcare in-patient unit is compromised by reduced therapeutic input The CQC identified this as an area for improvement in May 17	20	20	8		01/02/2018
Jan 18	Fire Risk Assessment (Jan 18) CICC (Cumberlege)	If recommendations from fire risk assessments are not actioned there is the potential for serious harm to patients, staff and visitors as well as action by the Fire Authority in the form of restrictions, forced closure of premises, fines or prosecution/custodial sentencing of responsible persons	20	20	15		Feb 2018
Oct 16	Legacy NEP Risk post merger risk Oct 16	Currently we do not have a sufficient number of fire marshal's trained within the Trust and subsequently our fire evacuation plans need further work. There is also a risk currently that we haven't been able to hold evacuations drills for our staff. The final area for compliance is the outstanding actions for management and estates regarding fire risk assessments.	20	20	15		Feb 2018
	Directorate objective	If the Finance Department are unable to provide dedicated support for the CIP then there is a risk that Operational Team plans may be unrealistic and unfocussed due to operational pressures, resulting in slippage from timescales and cost reduction schedules.	20	20	5		January 2018

Essex Partnership University NHS Foundation Trust has submitted details of three external reviews commenced or published in the last 12 months.

- Royal College of Psychiatrists Quality Review: Forensic Mental Health Services Brockfield House (January 2018). Broadly positive outcome reported with good practice highlighted in respect of the Recovery College, patient activities, links with prison, criminal justice and immigration services, use of mobile phones policy and carer support. 5 recommendations were made for action in respect of reflective practice, security procedures, carer engagement, line of sight and advocacy arrangements.
- HSE Investigation (Incident of assault by patient on a taxi driver and staff escort occurred in NEP pre-merger and HSE commenced investigation. Outcome of investigation was received by EPUT (Aug-17). Outcome of investigation by the HSE did not result in prosecution and/ or further action by HSE. The HSE required the trust to act in respect of ensuring appropriate risk assessments are in place and communicated to the transport provider, staff being suitably trained and monitoring compliance. An action plan was developed and taken forward.
- HSE Investigation (The HSE has advised that it is investigating patient deaths that occurred pre-merger in NEP. No details have been shared with EPUT but it is understood the investigation is taking place in parallel with a Police investigation which is also in progress)

Management of risk, issues and performance

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts to make improvements. The executive team established a deceased patient review group in April 2017 to review incidents where patients have died. The group reviewed all serious incidents to ensure the appropriate action was taken and lessons identified and shared. The group also initiated case note reviews of incidents that do not meet serious incident criteria as a further measure to identify learning.

The trust employed a mortality project manager to co-ordinate mortality review work. This role involved reviewing national guidance, attending the mortality review subcommittee and providing bi-monthly assurance to the board about the trusts mortality work. The mortality group was chaired by an executive lead and supported by the compliance team. The 2017/8 thematic review of deaths identified learning around processes, tools and data dashboards and physical health monitoring. Senior leaders shared the outcomes of the review to the physical health workstream to make changes to practise.

All senior leaders communicated the risks to the organisation contained on the risk register. Staff working within services could escalate concerns to senior managers. Local risk registers matched the board assurance framework for the organisation. The quality committee reviewed directorate risk registers and reported to the board.

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of identifying an incident.

Between 1 April 2017 and 31 January 2018, the trust reported 125 STEIS incidents. The most common type of incident was apparent/actual/suspected self-inflicted harm meeting SI criteria with 76. Fifty of these incidents occurred in Community based mental health services for adults of working age.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level,

and should have been implemented by all healthcare providers. Essex Partnership University NHS Foundation Trust reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the same period on their incident reporting system. The number of the most severe incidents was broadly not comparable with the number the trust reported to STEIS. The differences occurred due to different date periods and some grade 3 and 4 pressure ulcers were missing from the submission. From the trust's serious incident information, two of the four of the unexpected deaths were instances of apparent/actual/suspected self-inflicted harm meeting SI criteria and both of these occurred in acute wards for adults of working age and psychiatric intensive care units.

Type of incident reported on SIRI	CHS - Adults Community	CHS - Community Inpatients	MH - Acute wards for adults of working age and psychiatric intensive care units	MH - Child and adolescent mental health wards	MH - Community-based mental health services for adults of working age.	MH - Community-based mental health services for older people	MH - Mental health crisis services and health-based places of safety	MH - Secure wards	MH - Wards for older people with mental health problems	Other	Other - ASC service	Total
Abuse/alleged abuse of adult patient by third party									1			**1**
Abuse/alleged abuse of child patient by staff				1								**1**
Apparent/actual/suspected homicide meeting SI criteria					2		1					**3**
Apparent/actual/suspected self-inflicted harm meeting SI criteria			8	3	45	1	14		2	3		**76**
Disruptive/ aggressive/ violent behaviour meeting SI criteria				1			1	1				**3**
Other									1			**1**
Pending review (a category must be selected before incident is closed)			1		2							**3**

Type of incident reported on SIRI	CHS - Adults Community	CHS - Community Inpatients	MH - Acute wards for adults of working age and psychiatric intensive care units	MH - Child and adolescent mental health wards	MH - Community-based mental health services for adults of working age.	MH - Community-based mental health services for older people	MH - Mental health crisis services and health-based places of safety	MH - Secure wards	MH - Wards for older people with mental health problems	Other	Other - ASC service	Total
Pressure Ulcer meeting SI Criteria	1								4			**5**
Slips/trips/falls meeting SI criteria	1	1			1				13		2	**18**
Unauthorised absence meeting SI criteria								14				**14**
Total	2	1	9	5	50	1	16	15	21	3	2	125

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. They do not report staff incidents, health and safety incidents or security incidents to NRLS.

The highest reporting categories of incidents reported to the NRLS for this trust for the period 1 April 2017 to 31 January 2018 were patient accident, self-harming behaviour and implementation of care and ongoing monitoring / review. These three categories accounted for 47% of the 9103 incidents reported. Self-harming behaviour accounted for 35 of the 69 deaths reported.

Ninety five percent of the total incidents reported were classed as no harm (70%) or low harm (25%).

Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Patient accident	1115	368	30	3		1516
Self-harming behaviour	947	402	28	1	35	1413

Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Implementation of care and ongoing monitoring / review	88	935	324		1	1348
Treatment, procedure	993	59	3			1055
Medication	930	84	1			1015
Disruptive, aggressive behaviour (includes patient-to-patient)	820	120		1	1	942
Access, admission, transfer, discharge (including missing patient)	505	76	8			589
Documentation (including electronic & paper records, identification and drug charts)	411	31				442
Other	148	79	17	1	32	277
Consent, communication, confidentiality	169	20				189
Infrastructure (including staffing, facilities, environment)	142	31	1			174
Patient abuse (by staff / third party)	51	27	3			81
Clinical assessment (including diagnosis, scans, tests, assessments)	22	5	1			28
Medical device / equipment	21	3				24
Infection Control Incident	5	5				10
Total	6367	2245	416	6	69	9103

We are unable to provide data from the latest six-monthly National Patient Safety Agency Organisational Report for the trust as data is unavailable.

The trust had an audit committee responsible for monitoring and analysing internal and external audit activity. A non-executive director chaired the committee. The group had oversight of the audit programme and challenged the board with areas of the trust that required improvement. Leaders encouraged external audits and acted to address results. There were recent examples of clinical audits of medical equipment, staffing, modified early warning scoring system (MEWS) and restrictive practise. MEWS audits actions included embedding physical health leads to each ward, physical health training for staff at band 1-4; in line with the care certificate and registered staff undertaking advanced physical health skills programmes. Senior leaders reported clinical audit results to the clinical governance quality committees.

The trust had a policy for major incidents and a continuity plan in place for emergencies. For example, to deal with adverse weather, a flu outbreak, or disruption to business continuity. The trust was affected by a national cyber-attack but the disruption was minimal due to proactive actions taken to protect itself. The trust introduced a cyber team as a response to this and they worked with NHS digital to test their security and procedures. NHS digital failed the Trust in December 2017, a result expected from internal audit and were due to be visited again on at the end of May 2018.

Where cost improvements were taking place, there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability.

Leaders challenged business development proposals if the impact on the trust was less than positive. Where cost improvements were taking place, the focus was on not compromising patient care.

Information management

The board received holistic information on quality and sustainability. Leaders used meeting agendas to address quality and sustainability at all levels across the trust. Staff said they had access to all necessary information and were encouraged to challenge its reliability.

The team who had oversight of information risk and rights had processes in place to identify and respond to risk in this area. There was information governance training in place to help staff. We saw a consistent flow of information escalated to board and shared with all staff via the intranet. Systems were in place including confidentiality of patient records. The trust learned from data security breaches and followed a robust process for investigating such incidents.

Leaders used key performance indicators to monitor performance. This fed into a board assurance framework and to the quality committee. Executives had access to a performance dashboard that was interactive and mirrored the trust quality and performance report. Local managers had access to a variety of performance information via ‘dashboards’ that supported their management roles. Information included fill rates, incidents and supervision and appraisal compliance. Local managers also provided staff with performance stations which highlighted the key items and areas to address.

Staff had access to information technology equipment and systems needed to do their work. Most staff reported issues with connectivity and felt this affected their time to compete administration tasks. The trust invested in iPads for surveys, lone working trackers to maintain staff safety and virtual training packages to support carers of patients with dementia.

The trust identified problems with reporting training compliance due to the harmonisation of two systems, following the merger. Local manager had mitigated this issue using local training matrix’s. The trust was working on fixing the problem at the time of the inspection. We were assured staff received training and managers were aware of reasons for under performance and were actively addressing the gaps.

The trust was prepared and ready for new changes to the data protection act (the Genera Data Protection Regulation).

Engagement

The trust employed a dedicated patient experience and engagement team to encourage people who use their services, their representatives and people close to them to provide feedback on services. The trust website had a dedicated page for patient experience that provided information on ways to feedback, engagement groups and other ways for people to have their say about services. This included Essex mental health forums and pages dedicated to information about being a carer. Staff gave patients regular opportunities to feedback through weekly community meetings.

The trust engaged patients in service developments. We saw one example of staff involving young people in the creation and development of an e-safety leaflet to be used in services. The leaflet explained issues such as cyber bullying and ways young people could seek help.

Results from the March 2018 friends and family test showed the following results of how many people would recommend trust services to friends and family:

Specialist Services	100%
Essex Mental Health	83%
South East Essex Community Health	98%
West Essex Community Health	97%

Senior leaders provided an opportunity for staff to give feedback during 'Your voice' sessions however the sessions attendance was low.

The trust provided training and support to Governors. This included structured inductions and the selection of a mentor/buddy. Governors actively attended board meetings, conducted monthly visits to services and attended stakeholder meetings. Governors also met with Governors from different mental health trusts to share learning and good practise.

The trust engaged with external stakeholders. Feedback from stakeholders was positive about the way the trust managed the merger and they commented on the stable leadership throughout the process. The trust invited stakeholders to comment on reports and commissioners made regular quality visits to services.

Learning, continuous improvement and innovation

The trust encouraged staff to identify ways to improve services. Staff had lead roles in reducing restrictive interventions and identified this as an important agenda across inpatient services. The work identified the need to reduce restraints, long term segregation, seclusions and blanket restrictions. Staff referred to the positive and proactive agenda to change the culture and practise across the trust. The trust had a reducing restrictive intervention steering group with an identified executive sponsor. Leads provided wards with 'GABE' tables that told the story of their ward in a monthly report. Information included the number of verbal de-escalations used to validate the positive work of staff on the wards. The multi-disciplinary team used the monthly GABE table to identify themes and trends. Restrictive practise leads looked at high restraint wards in more detail and provided staff from wards with away days to explore the reasons for this. Staff set actions from away days that included specific training and changes to practise to continuously work towards reducing restraint.

Staff in Forensic services provided increased opportunities for patients to integrate in the community and to prepare for life outside hospital. The trust provided self-contained flat accommodation for patients nearing discharge. This encouraged patients to live independently and develop skills that transferred to living in the community. Staff also provided patients with many opportunities to engage with the local community through running marathons, attending vocational training to increase employability and supporting patients to obtain part time employment. Due to the robust support available for patients leading up to hospital discharge only one patient, in over 5 years, was re-admitted to the ward following discharge.

The trust was committed to working innovatively to improve the quality of services and the experience of people using them. A community car, manned by a paramedic, supported inpatient and acute health services. The paramedic assessed patient referrals in the community and determined where best to place patients requiring care. This scheme hoped to reduce the number of patient's receiving care in an inappropriate setting. Community inpatient services were part of a 50-day challenge initiative. The initiative supported collaborative working between the community inpatient wards and the older people's mental health wards at St Margaret's Community Hospital.

Patients on the mental health ward who required acute care, such as a cannula change, now attended the inpatient ward to receive their care, reducing the strain on the local acute hospital.

	Historical data		Projections	
Financial Metrics	Previous financial year (2 years ago)	Last financial year (2016/2017)	This financial year	Next financial year (2018/2019)
Income	N/A	N/A	£340,471	£293,040
Surplus	N/A	N/A	-£5,633	-£2,730
Full costs	N/A	N/A	£346,104	£295,770
Budget	N/A	N/A	-£6,636	-£2,730

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed.

The table below shows services across the trust awarded an accreditation (trust-wide only) and the relevant dates.

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
Quality Network for Perinatal Mental Health Services (QNPMH)	N/A	Rainbow Unit	(October 2015)
ECT Accreditation Scheme (ECTAS)	N/A	ECT Accreditation (Basildon)	(September 2016)

Community health services

Community health services for adults

Facts and data about this service

Location site name	Team/ward/satellite name	Address for location	Patient group	Number of clinics per month	Geographical area served
Trust Head Office	Cancer support & Information Service	Addison House, Hamstel Road, Harlow, Essex	Mixed	N/A	East Herts, Epping Forest area, Uttlesford
Trust Head Office	MSK Physiotherapy	Addison House, Hamstel Road, Harlow, Essex	Mixed	20	Harlow, Nazeing, Hoddesdon, Epping, Bishop Stortford, Dunmow and Sawbridgeworth, West Essex
Trust Head Office	Patient Appliances	Addison House, Hamstel Road, Harlow, Essex	Mixed	6	Harlow, Sawbridgeworth
Trust Head Office	Podiatry West Essex	Addison House, Hamstel Road, Harlow, Essex	Mixed	20	Harlow
Trust Head Office	TB Nursing Service	Basildon Hospital, Nethermayne, Basildon, Essex	Mixed	8	Thurrock, Wickford, Billericay, Basildon
Trust Head Office	Care Coordination (Castle Point & Rochford)	Benfleet Clinic, 513 High Road, Benfleet, Essex	Mixed	N/A	Castle Point, Rayleigh Rochford
Trust Head Office	Continence Service	Benfleet Clinic, 513 High Road, Benfleet, Essex	Mixed	3	
Trust Head Office	Podiatry	Benfleet Clinic, 513 High Road, Benfleet, Essex	Mixed	6	South East Essex
Trust Head Office	Podiatric Surgery	Billericay Health Centre, Stock Road, Billericay, Essex	Mixed	14	Basildon, Brentwood Thurrock
Trust Head Office	Podiatry	Billericay Health Centre, Stock Road, Billericay, Essex	Mixed	16	South West Essex
Trust Head Office	Podiatric Surgery	BMI Southend Private Hospital, 15-17 Fairfax Avenue, Westcliff on Sea, Essex	Mixed	3	Basildon, Brentwood/ Thurrock
Trust Head Office	Continence Service	Brentwood Community Hospital, Crescent Drive,	Mixed	3	Not stated

Location site name	Team/ward/satellite name	Address for location	Patient group	Number of clinics per month	Geographical area served
		Brentwood, Essex			
Trust Head Office	Podiatry	Brentwood Community Hospital, Crescent Drive, Brentwood, Essex	Mixed	16	South West Essex
Trust Head Office	TB Nursing Service	Broomfield Hospital Court Road Chelmsford CM1 7ET	Mixed	8	Braintree, Halstead, Chelmsford, Maldon, Burnham, Sth Woodam-Ferriers
Trust Head Office	Integrated Team (Epping)	Buckhurst Way Clinic, 51 Buckhurst Way, Buckhurst hill Essex	Mixed	N/A	Epping
Trust Head Office	Podiatry West Essex	Buckhurst Way Clinic, 51 Buckhurst Way, Buckhurst hill Essex	Mixed	8	Buckhurst Hill
Trust Head Office	Home Oxygen Service (LTOT)	Canvey Satellite Clinic (Old Council Offices), Long Road, Canvey Island	Mixed	N/A	Southend & CPR CCQ
Trust Head Office	Continence Service	Central Canvey Island Primary Care Centre Long Road Canvey Island	Mixed	3	Not stated
Trust Head Office	Diabetes (Adult)	Central Canvey Island Primary Care Centre Long Road Canvey Island	Mixed	7	Not stated
Trust Head Office	Leg Ulcer Team	Central Canvey Island Primary Care Centre Long Road Canvey Island	Mixed	23	Clinic open to anyone who specifically wishes to attend this location but generally those living in the vicinity
Trust Head Office	Podiatry	Central Canvey Island Primary Care Centre Long Road Canvey Island	Mixed	20	South East Essex
Trust Head Office	Integrated Team (Castle Point & Rochford)	Central Canvey Island Primary Care Centre Long Road Canvey Island	Mixed	N/A	Castle Point & Rochford
Trust Head Office	Podiatric Surgery	Chelmsford Medical Centre, Fenton House, 85-89 New	Mixed	6	Basildon, Brentwood/ Thurrock

Location site name	Team/ward/satellite name	Address for location	Patient group	Number of clinics per month	Geographical area served
		London Road, Chelmsford, Essex,			
Trust Head Office	Single Point of Referral (SPOR)	Southend Civic Centre, Civic Centre (Southend Borough Council), Victoria Avenue	Mixed	N/A	South East Essex
Trust Head Office	Podiatry	Corringham Health Centre, Giffords Cross Rd, Corringham, Essex	Mixed	8	South West Essex
Trust Head Office	Home Oxygen Service (LTOT)	Pantile Avenue Southend On Sea Essex	Mixed	N/A	Southend & CPR CCQ
Trust Head Office	Southend Therapy and Recovery Team (START)	Pantile Avenue Southend On Sea Essex	Mixed	N/A	South East Essex
Trust Head Office	Stroke Team / ESD	Pantile Avenue Southend On Sea Essex	Mixed	12	Southend Rochford Rayleigh Castlepoint
Trust Head Office	Integrated Team (Uttlesford)	Dunmow Clinic, 58 High Street, Dunmow, Essex	Mixed	N/A	Uttlesford
Trust Head Office	MSK Physiotherapy	Dunmow Clinic, 58 High Street, Dunmow, Essex	Mixed	20	Dunmow and South Uttlesford, West Essex
Trust Head Office	Podiatry West Essex	Dunmow Clinic, 58 High Street, Dunmow, Essex	Mixed	8	Dunmow
Trust Head Office	Dietetics	St. Margaret's, Community Hospital, The Plain, Epping, Essex	Mixed	4	West Essex
Trust Head Office	Podiatry	Grays Hall, Orsett Road, Grays, Essex	Mixed	20	South West Essex
Trust Head Office	Continence Service	Hadleigh Clinic, 49 London Road, Hadleigh, Essex	Mixed	3	Not stated
Trust Head Office	Podiatry	Hadleigh Clinic, 49 London Road, Hadleigh, Essex	Mixed	20	South East Essex
Trust Head Office	Speech & Language Therapy (Adult)	Hadleigh Clinic, 49 London Road,	Mixed	12	South East Essex

Location site name	Team/ward/satellite name	Address for location	Patient group	Number of clinics per month	Geographical area served
		Hadleigh, Essex			
Trust Head Office	Speech & Language Therapy (Adult)	The Hamilton Practice, Keats House, Bush Fair, Harlow, Essex	Mixed		West Essex
Trust Head Office	Complex Care Coordination (Southend)	Harcourt House, Harcourt Avenue, Southend on Sea, Essex	Mixed	N/A	Southend
Trust Head Office	District Nurse Liaison Service	Harcourt House, Harcourt Avenue, Southend on Sea, Essex	Mixed	N/A	South East Essex
Trust Head Office	Home Oxygen Service (LTOT)	Harcourt House, Harcourt Avenue, Southend on Sea, Essex	Mixed	N/A	Southend & CPR CCQ
Trust Head Office	Integrated Team (Southend)	Harcourt House, Harcourt Avenue, Southend on Sea, Essex	Mixed	N/A	Southend
Trust Head Office	Night Service (Community Nursing	Harcourt House, Harcourt Avenue, Southend on Sea, Essex	Mixed	N/A	Not stated
Trust Head Office	Single Point of Referral	Harcourt House, Harcourt Avenue, Southend on Sea, Essex	Mixed	N/A	South East Essex
Trust Head Office	Continence Service	Herts and Essex Hospital, Haymeads Lane, Bishops Stortford, Hertfordshire	Mixed	3	Not stated
Trust Head Office	MSK Physiotherapy	Herts and Essex Hospital, Haymeads Lane, Bishops Stortford, Hertfordshire	Mixed	20	East and North Herts and West Essex
Trust Head Office	Patient Appliances	Herts and Essex Hospital, Haymeads Lane, Bishops Stortford, Hertfordshire	Mixed	2	Bishops Stortford and Stanstead

Location site name	Team/ward/satellite name	Address for location	Patient group	Number of clinics per month	Geographical area served
Trust Head Office	Podiatric Surgery	Herts and Essex Hospital, Haymeads Lane, Bishops Stortford, Hertfordshire	Mixed	8	Harlow, Hertfordshire, Epping, Bishops Stortford, Loughton
Trust Head Office	Podiatry West Essex	Herts and Essex Hospital, Haymeads Lane, Bishops Stortford, Hertfordshire	Mixed	20	Bishops Stortford and Stanstead
Trust Head Office	Integrated Team (Castle Point & Rochford)	Hockley Clinic, 53 Spa Rd, Hockley	Mixed	N/A	Castle Point & Rochford
Trust Head Office	Podiatry	Hockley Clinic, 53 Spa Rd, Hockley	Mixed	12	South East Essex
Trust Head Office	Community Equipment Service	Independent Living Centre, Unit 3 Stortford Hall Ind Pk, Dunmow Rd, Bishop's Stortford	Mixed	N/A	West Essex
Trust Head Office	Continence Service	Independent Living Centre, Unit 3 Stortford Hall Ind Pk, Dunmow Rd, Bishop's Stortford	Mixed	20	Not stated
Trust Head Office	Continence Service	Thurrock Community Hospital, Long Lane, Grays, Essex	Mixed	3	Not stated
Trust Head Office	Continence Service	Keats House Clinic, The Fairway Bush Fair, Harlow	Mixed	16	Not stated
Trust Head Office	Heart Failure	Keats House Clinic, The Fairway Bush Fair, Harlow	Mixed		Not stated
Trust Head Office	Integrated Care Team (Adult - Harlow)	Keats House Clinic, The Fairway Bush Fair, Harlow	Mixed	N/A	Not stated
Trust Head Office	Podiatry	Laindon Health Centre, High Road, Laindon, Essex	Mixed	20	South West Essex
Trust Head Office	Community Respiratory Specialist Team	Latton Bush, Southern Way, Harlow,	Mixed	20	Not stated
Trust Head Office	Falls Prevention Service	Latton Bush, Southern Way, Harlow,	Mixed	N/A	Not stated

Location site name	Team/ward/satellite name	Address for location	Patient group	Number of clinics per month	Geographical area served
Trust Head Office	Integrated Team (Harlow)	Latton Bush, Southern Way, Harlow,	Mixed	N/A	Harlow
Trust Head Office	Multiple Sclerosis Nurse Specialist Service	Latton Bush, Southern Way, Harlow,	Mixed	10	West Essex
Trust Head Office	Parkinson's Specialist Nurse (Harlow)	Latton Bush, Southern Way, Harlow,	Mixed	5	Not stated
Trust Head Office	Pulmonary Rehabilitation Service	Latton Bush, Southern Way, Harlow,	Mixed	N/A	West Essex
Trust Head Office	Specialist Community Diabetes Service (SCDS)	Latton Bush, Southern Way, Harlow,	Mixed	3	Not stated
Trust Head Office	Tissue Viability Nurse Specialist Team	Latton Bush, Southern Way, Harlow,	Mixed	N/A	Harlow
Trust Head Office	Leg Ulcer Club	Salvation Army Hall, Frobisher Way, Shoeburyness	Mixed	4	Leg Club Drop In service open to anyone within South East may attend
Trust Head Office	Diabetes (Adult)	Leigh Primary Care Centre, 918 London Road, Leigh on Sea, Essex	Mixed	7	Not stated
Trust Head Office	Heart Failure	Leigh Primary Care Centre, 918 London Road, Leigh on Sea, Essex	Mixed	48	Not stated
Trust Head Office	Home Oxygen Service (LTOT)	Leigh Primary Care Centre, 918 London Road, Leigh on Sea, Essex	Mixed	N/A	Southend & CPR CCQ
Trust Head Office	Integrated Team (Southend)	Leigh Primary Care Centre, 918 London Road, Leigh on Sea, Essex	Mixed	N/A	Leigh-on-Sea
Trust Head Office	Leg Ulcer Team	Leigh Primary Care Centre, 918 London Road, Leigh on Sea, Essex	Mixed	23	Clinic open to anyone who specifically wishes to attend this location but generally those living in the vicinity
Trust Head Office	Podiatry	Leigh Primary Care Centre, 918 London Road, Leigh on Sea, Essex	Mixed	20	South East Essex
Trust Head Office	MSK Physiotherapy	Lister Medical Centre, Lister House, Staple Tye, Harlow, Essex	Mixed	4	Harlow, West Essex

Location site name	Team/ward/satellite name	Address for location	Patient group	Number of clinics per month	Geographical area served
Trust Head Office	Continence Service	St. Margaret's, Community Hospital, The Plain, Epping, Essex	Mixed	16	Not stated
Trust Head Office	Continence Service	Saffron Walden Community Hospital, Radwinter Road, Saffron Walden	Mixed	16	Not stated
Trust Head Office	Continence Service	Mayflower Community Hospital, First Floor, Blunts Wall Road, Billericay	Mixed	3	Not stated
Trust Head Office	Mountnessing Court OT	240 Mountnessing Road Billericay Essex	Mixed	N/A	Not stated
Trust Head Office	Mountnessing Court Physiotherapy Service	240 Mountnessing Road Billericay Essex	Mixed	20	Basildon, Billericay, Wickford and Brentwood
Trust Head Office	Continence Service	North Road Primary Care Centre, 183-195 North Road, Westcliff on Sea	Mixed	3	Not stated
Trust Head Office	Diabetes (Adult)	North Road Primary Care Centre, 183-195 North Road, Westcliff on Sea	Mixed	7	Not stated
Trust Head Office	Leg Ulcer Team	North Road Primary Care Centre, 183-195 North Road, Westcliff on Sea	Mixed	23	Clinic open to anyone who specifically wishes to attend this location but generally those living in the vicinity
Trust Head Office	Integrated Team (Harlow)	Nuffield House Community Clinic, Nuffield House Health Centre, The Stow, Harlow	Mixed	N/A	Harlow
Trust Head Office	MSK Physiotherapy	Nuffield House Community Clinic, Nuffield House Health Centre, The Stow, Harlow	Mixed	4	Harlow, West Essex
Trust Head Office	Podiatric Surgery	Orsett Hospital, Rowley Road, Orsett, Essex	Mixed	8	Whole of Essex

Location site name	Team/ward/satellite name	Address for location	Patient group	Number of clinics per month	Geographical area served
Trust Head Office	Podiatry	Orsett Hospital, Rowley Road, Orsett, Essex	Mixed	4	South West Essex
Trust Head Office	Continence Service	Pitsea Clinic, High Road, Pitsea	Mixed	3	Not stated
Trust Head Office	Cancer support & Information Service	Princess Alexandra Hospital, Hamstel Road, Harlow, Essex	Mixed	N/A	East Herts, Epping Forest area, Uttlesford
Trust Head Office	Community Assessment & Rehabilitation Service (CARS)	Princess Alexandra Hospital, Hamstel Road, Harlow, Essex	Mixed	N/A	Herts & West Essex
Trust Head Office	Community Assessment and Referral Service	Princess Alexandra Hospital, Hamstel Road, Harlow, Essex	Mixed	N/A	Not stated
Trust Head Office	Patient Appliances	Saffron Walden Community Hospital, Radwinter Road, Saffron Walden	Mixed	2	Saffron Walden
Trust Head Office	TB Nursing Service	Princess Alexandra Hospital, Hamstel Road, Harlow, Essex	Mixed	16	Harlow
Trust Head Office	Continence Service	Raphael House, Old Ship Lane, Rochford	Mixed	3	Not stated
Trust Head Office	Diabetes (Adult)	Raphael House, Old Ship Lane, Rochford	Mixed	7	Not stated
Trust Head Office	Speech & Language Therapy (Adult)	Raphael House, Old Ship Lane, Rochford	Mixed	8	Not stated
Trust Head Office	Collaborative Care Team	Rayleigh Clinic, Eastwood Road, Rayleigh, Essex	Mixed	N/A	Castle Point Rochford and Rayleigh
Trust Head Office	Continence Service	Rayleigh Clinic, Eastwood Road, Rayleigh, Essex	Mixed	3	Not stated
Trust Head Office	Diabetes (Adult)	Rayleigh Clinic, Eastwood Road, Rayleigh, Essex	Mixed	7	Not stated
Trust Head Office	Leg Ulcer Team	Rayleigh Clinic, Eastwood Road, Rayleigh, Essex	Mixed	23	Clinic open to anyone who specifically wishes to attend this location but generally those

Location site name	Team/ward/satellite name	Address for location	Patient group	Number of clinics per month	Geographical area served
					living in the vicinity
Trust Head Office	Podiatry	Rayleigh Clinic, Eastwood Road, Rayleigh, Essex	Mixed	16	South East Essex
Trust Head Office	Integrated Team (Epping)	Rectory Lane Community Clinic, Rectory lane, Loughton, Essex	Mixed	N/A	Epping
Trust Head Office	MSK Physiotherapy	Rectory Lane Community Clinic, Rectory lane, Loughton, Essex	Mixed	6	Loughton, Buckhurst Hill, Chigwell, West Essex
Trust Head Office	Parkinson's Specialist Nurse (Harlow)	Rectory Lane Community Clinic, Rectory lane, Loughton, Essex	Mixed	5	Not stated
Trust Head Office	Podiatry West Essex	Rectory Lane Community Clinic, Rectory lane, Loughton, Essex	Mixed	8	Loughton, Chigwell
Trust Head Office	Care Coordination (Castle Point & Rochford)	Union Lane Rochford Essex	Mixed	N/A	Castle Point, Rayleigh Rochford
Trust Head Office	Physiotherapy	Union Lane Rochford Essex	Mixed	N/A	South Essex
Trust Head Office	Care Home Service	Union Lane Rochford Essex	Mixed	N/A	Southend
Trust Head Office	Continence Service	Union Lane Rochford Essex	Mixed	3	Not stated
Trust Head Office	Diabetes (Adult)	Union Lane Rochford Essex	Mixed	7	Not stated
Trust Head Office	Leg Ulcer Team	Union Lane Rochford Essex	Mixed	23	Clinic open to anyone who specifically wishes to attend this location but generally those living in the vicinity
Trust Head Office	TB Nursing Service	Union Lane Rochford Essex	Mixed	N/A	N/A
Trust Head Office	Tissue Viability inc. Pressure Relieving Equipment Service	Union Lane Rochford Essex	Mixed	N/A	West Essex
Trust Head Office	Community Integrated Care Teams (Adult)	Radwinter Road	Mixed	N/A	Not stated

Location site name	Team/ward/satellite name	Address for location	Patient group	Number of clinics per month	Geographical area served
		Saffron Walden Essex			
Trust Head Office	Falls Prevention Service	Radwinter Road Saffron Walden Essex	Mixed	N/A	Not stated
Trust Head Office	MSK Physiotherapy	Radwinter Road Saffron Walden Essex	Mixed	20	Loughton, Buckhurst Hill, Chigwell, West Essex
Trust Head Office	Parkinson's Specialist Nurse (Harlow)	Radwinter Road Saffron Walden Essex	Mixed	5	Not stated
Trust Head Office	Podiatry West Essex	Radwinter Road Saffron Walden Essex	Mixed	8	Saffron Waldon
Trust Head Office	Respiratory Team	Radwinter Road Saffron Walden Essex	Mixed	7	Not stated
Trust Head Office	Saffron Walden Outpatients	Radwinter Road Saffron Walden Essex	Mixed		Not stated
Trust Head Office	Specialist Community Diabetes Service (SCDS)	Radwinter Road Saffron Walden Essex	Mixed	3	Not stated
Trust Head Office	Tissue Viability Nurse Specialist Team	Radwinter Road Saffron Walden Essex	Mixed	N/A	Saffron Walden, Dunmow, Uttersford
Trust Head Office	Podiatry	South Ockenden Health Centre, Darenth Lane, South Ockenden, Essex	Mixed	12	South West Essex
Trust Head Office	Diabetes (Adult)	Southend Hospital, Prittlewell Chase, Westcliff-on-Sea, Essex	Mixed	7	Not stated
Trust Head Office	TB Nursing Service	Southend Hospital, Prittlewell Chase, Westcliff-on-Sea, Essex	Mixed	8	Southend, Castlepoint, Rochford
Trust Head Office	Occupational Therapy (SE)	Southend Integrated Resource Centre, Unit 8, The Forum, Templefarm Industrial Estate,	Mixed	N/A	South East Essex

Location site name	Team/ward/satellite name	Address for location	Patient group	Number of clinics per month	Geographical area served
		Southend-on-Sea, Essex			
Trust Head Office	Wheelchair Service	Southend Integrated Resource Centre, Unit 8, The Forum, Templefarm Industrial Estate, Southend-on-Sea, Essex	Mixed	9	Southend
Trust Head Office	Adult Learning Disability	Latton Bush, Latton Bush, Southern Way, Harlow,	Mixed	N/A	Mid-West (Braintree, Colchester, Chelmsford etc.) West Essex (Harlow, Waltham Abbey, Loughton etc.)
Trust Head Office	Early Supported Discharge	The Plain Epping Essex	Mixed	N/A	Not stated
Trust Head Office	Falls Prevention Service	The Plain Epping Essex	Mixed	N/A	Not stated
Trust Head Office	Integrated Team (Epping)	The Plain Epping Essex	Mixed	N/A	Epping
Trust Head Office	Integrated Team (Harlow)	The Plain Epping Essex	Mixed	N/A	Harlow
Trust Head Office	MSK Physiotherapy	The Plain Epping Essex	Mixed	20	Epping Forest District and Harlow District, West Essex
Trust Head Office	Multiple Sclerosis Nurse Specialist Service	The Plain Epping Essex	Mixed	10	West Essex
Trust Head Office	Patient Appliances	The Plain Epping Essex	Mixed	4	Epping, Ongar, Buckhurst Hill, Waltham Abbey
Trust Head Office	Podiatry West Essex	The Plain Epping Essex	Mixed	20	Epping and Ongar
Trust Head Office	Prostate Cancer Specialist	The Plain Epping Essex	Mixed	N/A	West Essex
Trust Head Office	Rapid Access Clinic	The Plain Epping Essex	Mixed	N/A	West Essex
Trust Head Office	Respiratory Team	The Plain Epping Essex	Mixed	7	Not stated
Trust Head Office	Single Point of Access	The Plain Epping Essex	Mixed	N/A	West Essex
Trust Head Office	Specialist Community Diabetes Service (SCDS)	The Plain Epping Essex	Mixed	3	Not stated

Location site name	Team/ward/satellite name	Address for location	Patient group	Number of clinics per month	Geographical area served
Trust Head Office	Speech & Language Therapy (Adult)	The Plain Epping Essex	Mixed		Not stated
Trust Head Office	Tissue Viability Nurse Specialist Team	The Plain Epping Essex	Mixed	N/A	Epping, Loughton Buckhurst Hill, Waltham Abbey
Trust Head Office	Continence Service	Stanford Clinic, Wharf Road, Stanford Le Hope, Essex	Mixed	3	Not stated
Trust Head Office	Podiatry	Stanford Clinic, Wharf Road, Stanford Le Hope, Essex	Mixed	4	South West Essex
Trust Head Office	Podiatry	Stifford Clays Health Centre, Crammavill Street, Stifford Clays, Essex	Mixed	4	South West Essex
Trust Head Office	MSK Physiotherapy	Thaxted Clinic, The Surgery, Margaret Street, Thaxted, Essex	Mixed	4	Not stated
Trust Head Office	Continence Service	Thorpedene Clinic, Delaware Road, Shoeburyness	Mixed	3	Not stated
Trust Head Office	Diabetes (Adult)	Thorpedene Clinic, Delaware Road, Shoeburyness	Mixed	7	Not stated
Trust Head Office	Integrated Team (Castle Point & Rochford)	Thundersley Clinic, 8 Kenneth Road, Thundersley, Essex	Mixed	N/A	Castle Point & Rochford
Trust Head Office	Continence Service	Tibury Health Centre, London Road, Tilbury, Essex	Mixed	3	Not stated
Trust Head Office	Podiatry	Tibury Health Centre, London Road, Tilbury, Essex	Mixed	4	South West Essex
Trust Head Office	Diabetes (Adult)	The Tyrells, 39 Seamore Avenue, Benfleet	Mixed	7	Not stated
Trust Head Office	Home Oxygen Service (LTOT)	The Tyrells, 39 Seamore Avenue, Benfleet	Mixed	N/A	Southend & CPR CCQ
Trust Head Office	Leg Ulcer Team	The Tyrells, 39 Seamore Avenue, Benfleet	Mixed	23	Clinic open to anyone who specifically wishes to attend this location but generally those

Location site name	Team/ward/satellite name	Address for location	Patient group	Number of clinics per month	Geographical area served
					living in the vicinity
Trust Head Office	Diabetes (Adult)	Valkyrie Road, Westcliff-on-Sea	Mixed	7	Not stated
Trust Head Office	Podiatric Surgery	Valkyrie Road, Westcliff-on-Sea	Mixed	60	Southend, Castlepoint & Rochford
Trust Head Office	Podiatry	Valkyrie Road, Westcliff-on-Sea	Mixed	20	South East Essex
Trust Head Office	Podiatry	Vange Health Centre, Southview Road, Basildon	Mixed	20	South West Essex
Trust Head Office	Integrated Team (Epping)	Waltham Abbey Clinic, 13 Sewardstone Road, Waltham Abbey	Mixed	N/A	Epping
Trust Head Office	MSK Physiotherapy	Waltham Abbey Clinic, 13 Sewardstone Road, Waltham Abbey	Mixed	20	Waltham Abbey, West Essex
Trust Head Office	Podiatry West Essex	Waltham Abbey Clinic, 13 Sewardstone Road, Waltham Abbey	Mixed	8	Waltham Abbey
Trust Head Office	Respiratory Team	Waltham Abbey Clinic, 13 Sewardstone Road, Waltham Abbey	Mixed	7	Not stated
Trust Head Office	Continence Service	Warrior House, 42-82 Southchurch Road, Southend-on-Sea, Essex	Mixed	3	Not stated
Trust Head Office	Podiatry	Warrior House, 42-82 Southchurch Road, Southend-on-Sea, Essex	Mixed	20	South East Essex
Trust Head Office	Podiatry	Wickford Health Centre, Market Road, Wickford, Essex	Mixed	18	South East Essex
Trust Head Office	Continence Service	Wickford Health Centre, Market Road, Wickford, Essex	Mixed	3	Not stated

Is the service safe?

Mandatory training

The trust generally had systems and processes in place to ensure that staff received effective training in safety systems, processes, and practices. The service had gaps in mandatory completion in particular safeguarding training.

The trust set a target of 85% for completion of mandatory training, with the exception of 90% for safeguarding adults (level two) and the service's overall training compliance was 83%. The trust has a rolling month on month compliance rate for mandatory training.

A breakdown of compliance for mandatory courses –at 31 December 2017 for medical/dental and nursing staff in community health services for adults is shown below:

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Core Service	Grand Total %
Clinical Record Keeping	100%
Dual Diagnosis	100%
LAC e-learning	100%
LAC face to face	100%
Safeguarding Children (Level 3)	100%
Security Training (eLearning)	100%
Venous Thromboembolism	100%
Safeguarding Adults (Level 1)	97%
Corporate Induction	96%
Equality and Diversity	96%
Harassment & Bullying	95%
Dementia Awareness (inc Privacy & Dignity standards)	94%
Duty of Candour (Overview Version)	94%
Induction E-Learning	94%
Cascade Fire Trainer	93%
Conflict Resolution	93%
Consent	93%
Diabetes Training	93%
Personal Safety - MVA	91%
Complaints Handling	90%
Food Hygiene	89%
Medicines Management (community)	87%
Safeguarding Adults (Level 2)	87%
Mental Capacity Act Level 2	85%
Personal Safety Breakaway - Level 1	84%
Safeguarding Adults (Level 3)	84%
Duty of Candour (Detailed Version)	83%
Mental Capacity Act Level 1	83%
Fit for Work	82%
Care Certificate	81%
Information Governance	81%
Anaphylaxis	80%

Infection Prevention, Control & Hand Hygiene	80%
Transfusion Process training	80%
Basic Life Support & AED	79%
Hoisting e-learning	75%
Health and Safety (Slips, Trips and Falls)	65%
Hoisting	65%
Manual Handling - People	65%
Fire In-patient	63%
Fire Safety 2 years	60%
Mental Health Act	57%
PREVENT (WRAP) Training	56%
First Aid Trained	50%
Observation of Service User	50%
Clinical Risk Assessment	44%
Basic Back Care (Face to Face)	42%
Fire Safety 3 years	42%
Basic Back Care (E-Learning)	18%
MERT (Enhanced Emergency Skills)	0%
TASI Trained	0%
Total	83%

Team leads and modern matrons we spoke with told us that staff completed a mandatory training matrix according to their role. This meant that staff were not expected to complete every module of mandatory training delivered by the trust. The training matrix we reviewed confirmed this.

The trust had a policy for induction and mandatory training. The policy was up-to-date with version control with the next review of the policy due in April 2020. The policy set out the responsibilities of all staff grades in relation to mandatory training and induction training.

The mandatory training modules that the trust required nursing staff to complete were corporate induction, induction e-learning, fit for work, fire e-learning, fire face to face, basic life support, anaphylaxis, conflict resolution, infection prevention and control, consent, manual handling, safeguarding level two, customer service, equality and diversity, harassment and bullying, information governance, be open duty of candour, and diabetes. With additional training for qualified nurses, these included medicines management mentorship and safeguarding adults level three.

Team leads and modern matrons we spoke with explained that staff had encountered issues with logging into e-learning, to complete their mandatory training'. However, this issue was resolved prior to our inspection with additional help from the IT department.

Staff we spoke with told us that they have difficulty booking popular mandatory training courses such as basic life support due to the number of spaces available in the face-to-face training. This meant that some staff had to wait for this training. Managers reminded staff to book face to face training in a timely way to ensure a timely completion of this training. One of the managers told us that basic life support training was always booked very quickly.

In each of the nursing teams we visited each team lead and modern matron had processes in place to track the completion of mandatory training for their staff.

Team meeting minutes we reviewed demonstrated that staff discussed mandatory training and the need to book face-to-face training in a timely way to remain up-to-date.

Team leaders and modern matrons we spoke with told us that staff on maternity leave or long-term sickness were still included in the mandatory training figures.

Safeguarding

The trust generally had systems, processes and practices in place to protect people from abuse, neglect, harassment, and breaches to their dignity and respect.

People were protected from discrimination, which might amount to abuse or cause of psychological harm. This included harassment and discrimination in relation to protected characteristics under the Equality Act, 2010.

The trust had policies for safeguarding in place for staff to follow, one for adults and one for children. Both policies were up to date referencing legislation and best practice. The policies set out the responsibilities of all staff including the board and gave detailed information about the types of abuse and local pathways for raising concerns.

Staff we spoke with understood their responsibility in relation to raising safeguarding concerns. Staff gave examples of the types of abuse they would escalate. Staff knew how to raise safeguarding concerns and had access and support from the trust's named safeguarding lead.

The trust promoted safety in their recruitment practice, staff support arrangements, disciplinary procedures and ongoing checks, for example Disclosure and Barring Service (DBS) checks.

All staff had to complete a DBS before their employment with the trust. The trust managed the oversight of the DBS checks centrally in human resources and sent email alerts to team leads when a staff member was required to renew the DBS check.

Staff mostly received effective training in safety systems, processes, and practices in relation to safeguarding.

The safeguarding training rates were below the trust's target of 90% for safeguarding level two and 85% for safeguarding adult's level three. However, all staff we spoke with told us they had completed the relevant safeguarding training for their role. The trust had arrangements in place to safeguard adults and children from abuse and neglect in line with legislation and local requirements. Staff understood their responsibilities and adhered to safeguarding policies and procedures. Staff worked in partnership with other agencies.

All staff were expected to complete safeguarding training to level two via e-learning. The module covered children and adults. The training covered all types of abuse including female genital mutilation (FGM). The staff employed within the community adult services did not treat children under the age of 16 years. However, the service did see young people over the age of 16 years during their transition from child services to adult services. The staff completion rate for safeguarding children level three training was 100%.

Safeguarding adults level three training was face-to-face for grades band six and above (district nurses). The training covered all types of abuse including female genital mutilation (FGM). One of the modern matrons we spoke with told us that staff had fed back that they found the training good and understood what the signs of FGM were.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority had their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to children's services, adult services or the police should take place.

The trust have provided details of the total number of safeguarding referrals made from 1 April 2017 to 31 December 2017 with 802 referrals made for adults and 180 for children. However, this is for the whole trust and has not been broken down to core service level.

Cleanliness, infection control and hygiene

The trust mostly had systems and processes in places to maintain standards of cleanliness and hygiene and reduce the risk of health care associated infections.

The bases we visited were mostly visibly clean, tidy, and free from clutter. However, items of equipment and consumable items were stored directly on the floor of storage rooms. This meant we were not assured that these areas had been adequately cleaned.

The trust had an up-to-date infection prevention and control policy, which set out the responsibilities of all staff in relation to the prevention and control of healthcare associated infections. Staff were expected to complete infection prevention and control training via e-learning on a yearly basis to remain up-to-date with policy and national guidance.

The trust undertook regular audits for hand hygiene and uniforms. We reviewed the results of the hand hygiene audits from April 2017 to March 2018, which demonstrated 97.5% compliance in South East Essex. West Essex achieved 96.9% overall compliance with hand hygiene. The trust internal target for hand hygiene audits was 95%. However, West Essex did not achieve the trust's target of 95% in quarter two (July to September 2017) with compliance of 94.7% and quarter four (January to March 2018) with compliance of 94.5%.

The trust had an up-to-date uniform policy for staff to follow which set out the responsibilities of all staff in relation to maintaining their uniform. Staff had visibly clean uniforms with short sleeves and staff were bare below the elbows when providing care and treatment to their patients.

We observed staff on visits to their patients, we saw that staff washed their hands appropriately and used personal protective equipment such as gloves and aprons, which they disposed of following care and treatment. Staff demonstrated good practice in relation to aseptic technique during our observations.

Environment and equipment

The design, maintenance, and the use of equipment, facilities, and premises mostly kept people safe.

The arrangements for managing waste and clinical specimens kept people safe.

Equipment used for patient care was up-to-date with the safety testing. We reviewed 15 items of equipment stored at the bases we visited such as suction machines and syringe drivers, of these 14 items were up to date with safety testing. This meant that one item had not had safety testing within the required period.

Equipment was not always safe for the use in patient care. We reviewed six syringe drivers in the Canvey Island nursing base and found five without lockable covers. We spoke with staff about this who reported that additional covers were on order. We were not assured that patients who required the use of a syringe driver would receive one in a timely way.

The trust had a dressing's formulary for staff to order and use appropriate dressings in the care of their patients. Nursing staff took dressings from the nursing base to their patients on each visit.

Staff kept storage cupboards in all nursing bases tidy and well stocked. We sampled 94 dated items single-use equipment and found that of these items 87 were within their expiry date. We found that seven items were outside their expiry date, we escalated this to a senior manager. The manager removed the items immediately and disposed of them.

Staff used special carrying boxes for transporting specimens such as blood samples, from patient's homes to the laboratory or GP surgery. This meant that the service reduced the risk of contamination from these samples and the spread of healthcare associated infections.

The trust had arrangements with the local authority to collect large amounts of contaminated waste where there was a risk of healthcare associated infections. Nurses disposed of small amounts of waste for example soiled dressings within the patient's own domestic waste in line with the trust's policy.

Staff disposed of contaminated used sharps such as needles appropriately. Staff kept sharps containers in patient's own homes. Staff sealed and removed these containers once they had become full and took them to the nursing base ready for collection. Full sharps containers were collected on a weekly basis from the nursing bases.

Assessing and responding to patient risk

The service had processes in place to ensure that staff assessed patients in a timely manner. A senior nurse triaged all new referrals that the single point of contact received. The senior nurses within the single point of contact electronically tasked the referral to the appropriate team and assessed the urgency of the referral.

Each patient admitted to adult community services received a holistic assessment upon their first appointment. Staff assessed patients and undertook appropriate risk assessments during this appointment. We reviewed 11 sets of electronic patient records and found that 10 of the records demonstrated a holistic assessment took place on the first appointment.

The service had various electronic risk assessment tools for example the malnutrition universal screening tool and the Waterlow pressure ulcer risk assessment tool. However, we reviewed 11 sets of patient records and found four records we reviewed in one of the bases did not have up-to-date risk assessments. We raised our concerns with the modern matron responsible for the base where we found the out of date risk assessments. This meant that we were not assured that the service always complete patient risk assessments and take preventative measures in a timely way in that location.

The service undertook individual risk assessments for individual patient circumstances where staff identified concerns about the care environment or staff safety. One of the team leads we spoke with told us that the service undertook these individual risk assessments, as it was difficult to identify all risks associated to community care in a standardised risk assessment. This meant risk managers identified and assessed on an individual basis for unique patient circumstances. One of the team leads gave us an example of a patient living on a boat, which required an individual risk due to environmental factors.

In South East Essex, community teams had undertaken training to identify sepsis. Staff used national early warning score to help identify a deteriorating patient. We saw that sepsis training was included within the training timetable for new staff. One of the modern matrons we spoke with told us that this training was new to help detect patients with sepsis in a timely way.

Data provided by the trust showed that 392 (83.9%) staff out of 467 in South Essex had completed sepsis training.

The community nursing teams used a patient dependency tool to assess patients most in need of care. Staff we spoke with told us that the assessment of patient acuity was important in times when their business continuity plan was actioned. Staff gave an example of bad weather prior to our inspection where they had to prioritise patient care in accordance with acuity scoring.

The service had pathways in place for the management of patients such as managing a patient with a suspected deep tissue injury and the diabetic foot care pathway. These pathways set out standardised care and treatment to reduce risks of patient deterioration.

Staffing

Staffing formed one of the risks on the corporate, divisional, and local level risk registers for the service due to the high vacancy rate. Senior managers we spoke reported that recruitment was challenging due to their proximity to London. The trust was developing strategies to attract staff and retain their existing workforce by offering developments and educational opportunities for staff.

The teams within South East Essex configured their teams in a different way to West Essex due to the way commissioners had commissioned services. Modern matrons led integrated teams in South East Essex with district nursing teams, long-term conditions matrons and end of life care specialists working together. In West Essex, staff worked together in neighbourhood teams, which

comprised of district nursing teams, therapists, specialist nurses including end of life care and matrons.

Band six district nurses led a small team, supported by band five registered nurses and healthcare assistants. The expected skill mix for the Southend base consisted of six band six district nurses supported by 28 band five registered nurses and 10 band three healthcare assistants. The team numbers were dependent of the number and the dependency of the patients on the team caseload.

The staff rotas demonstrated that managers ensured all shifts were appropriately filled. Managers completed staff rotas electronically and staff had access to the rotas for their off duty. We reviewed the electronic rotas from February to April 2018, which demonstrated appropriate staff numbers and skill mix within the district nursing teams.

Teams had processes in place to handover information about their patients. We saw examples of electronic tasks used to handover important information about patients. In Epping, we observed the daily face-to-face handover where staff discussed the management of complex patients with the wider team for support and advice.

In January 2018, the trust reported an overall vacancy rate of 14% in community health services for adults.

Staff group	Total % vacancies overall (excluding seconded staff)
NHS infrastructure support	16%
Qualified Allied Health Professionals (Qualified AHPs)	16%
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	50%
Support to doctors and nursing staff	8%
Qualified nursing & health visiting staff (Qualified nurses)	16%
Support to ST&T staff	0%
Core service total	**14%**

In each of the bases we visited, we saw that vacancies varied between three and five whole time equivalent band five registered nurses. None of the bases had vacancies for band three healthcare assistants.

Team leads and modern matrons knew and understood their vacancies for example the team lead in Epping had five vacancies for band five registered nurses. The team lead told us that bank or agency nurses filled vacant shifts on the rota left by the vacancies. The trust was actively advertising the vacant posts and they had decreased the time from interview to new starter dates.

The divisional director spoke about the challenges in recruiting specialist nurses and allied health professional staff such as physiotherapists. The director told us that the trust had plans to offer training posts to nurses wishing to specialise and understood the temporary skill gap during the training period.

From April 2017 to January 2018, the trust reported an overall turnover rate of 8% in community health services for adults.

Staff group Team	Total number of substantive staff	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
364 E7TBD Tissue Viability	1.99	1.00	50%

Staff group Team	Total number of substantive staff	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
364 E5ADS Diabetes Wechs	3.46	1.60	46%
364 E7PBL Complex Cases Care Co-Ord	5.11	1.80	35%
364 E5AFP Falls Prevention - Wechs	9.32	2.60	28%
364 E5FDV Tissue Viability Wechs	3.72	1.00	27%
364 E7PBH Care Co-Ordination Service Cpr	12.62	3.00	24%
364 E5AHA Msk Physio Wechs	30.03	7.30	24%
364 E7OAB Ot Seechs	8.90	1.93	22%
364 E7NAA Int Team Leigh	34.06	6.10	18%
364 E7TBJ Adult Slt Seechs	3.82	0.60	16%
364 E7NAD Start	4.90	0.80	16%
364 E7RCB Collaborative Care	14.87	2.27	15%
364 E5FF1 Podiatry Wechs	9.73	1.39	14%
364 E7SPR Spor	8.01	1.00	12%
364 E5ACA Epping Icct	67.75	6.80	10%
364 E7PBD Esd - Stroke	10.39	1.00	10%
364 E5ACD Harlow Icct	49.33	5.17	10%
364 E7RAA Int Team Hockley	34.65	3.00	9%
364 E5ASB Esd - Stroke + Neuro	13.17	1.00	8%
364 E5ADD Dietetics Wechs	10.22	0.80	8%
364 E5ACF Uttlesford Icct	75.75	5.28	7%
364 E7NAG Int Team Central Southend	112.14	1.80	2%
364 E7PCA Int Team Canvey + Thundersley	43.07	1.00	2%
364 E7TCA Podiatry Seechs	24.29	0.20	1%
300 Physiotherapy East	1.00	0.00	0%
300 CDAT Harlow	1.00	0.00	0%
364 E7RAE Respiratory Team	6.76	0.00	0%
364 E7RCA Therapy	2.64	0.00	0%
364 E7NAJ Leg Ulcer	5.40	0.00	0%
364 E7RAB Southend Care Homes Project	3.50	0.00	0%
364 E7TBA Diabetes Adults	7.96	0.00	0%
364 E7TBB Se Continence Service Adults	5.67	0.00	0%
364 E7TBF Tb Nurse Specialist	4.00	0.00	0%
364 E7TCC Podiatric Surgery South East	4.61	0.00	0%
364 E7TCD Podiatric Surgery South West	2.18	0.00	0%
364 E7UAB Equipment Service Cpr Seechs	1.00	0.00	0%
364 E7TBE Heart Failure Nurse Specia	6.12	0.00	0%
364 E5CCR Cars Team	5.00	0.00	0%

Staff group Team	Total number of substantive staff	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
364 E7PBC Community Stroke Team	5.72	0.00	0%
364 E5ACJ Adult Slt Wechs	6.24	0.00	0%
364 E7LGD Mgmt - Integrated Adults - We	15.56	0.00	0%
364 E5CSP Single Point Of Access	8.83	0.00	0%
364 E5ALD Adult Ld Wechs	5.72	0.00	0%
364 E5ASP Podiatry Surgery Wechs	1.80	0.00	0%
364 E5ACR Heart Failure & Cardiac Rehab	3.62	0.00	0%
364 E5ARW Respiratory Wechs	7.60	0.00	0%
364 E5CRS Crs Wechs	1.61	0.00	0%
364 E5F00 Patient Appliances	3.31	0.00	0%
364 E5HC2 Prostate Specialist Nurse	1.60	0.00	0%
364 E5ANN Neuro Nursing - Ms/ Parkinsons	3.35	0.00	0%
364 E5ALU Leg Ulcer Svs Wechs	0.94	0.00	0%
364 E5S0P Swch Outpatients	2.94	0.00	0%
364 E5FC2 Continence Services - Wechs	2.37	0.00	0%
364 E5FL1 Equipment Service Wechs	3.90	0.00	0%
364 E5FWC Wheelchair Service Wechs	4.73	0.00	0%
364 E7OAA Wheelchair Service Seechs	6.36	0.00	0%
364 E7OAF Wheelchairs - Esd	0.48	0.00	0%
364 E7OFA Falls OT EIV Pilot	1.00	0.00	0%
Core service total	735.79	58	8%

The trust was located close to London where staff could travel a short distance for an increased salary due to London weighting. Senior managers we spoke with understood that staff were drawn to London due to the salary difference and told us that the trust was developing initiatives to attract and retain staff.

Managers and team leads we spoke with told us that staff had left for other jobs and returned to their teams after a short period. We spoke with two members of staff who had returned to the team in Epping, they both told us they returned due to feeling supported by the team lead and the wider team.

From April 2017 to January 2018, the trust reported an overall sickness rate of 5% in community health services for adults.

Staff group	Total % permanent staff sickness overall
364 E7RCB Collaborative Care	17%
364 E7NAD Start	16%

Staff group	Total % permanent staff sickness overall
364 E5CRS Crs Wechs	15%
364 E5ANN Neuro Nursing - Ms/ Parkinsons	14%
364 E5FC2 Continence Services - Wechs	14%
364 E5AFP Falls Prevention - Wechs	12%
364 E5FDV Tissue Viability Wechs	11%
364 E5ACD Harlow Icct	8%
364 E5ASB Esd - Stroke + Neuro	7%
364 E5ACR Heart Failure & Cardiac Rehab	7%
364 E5ALU Leg Ulcer Svs Wechs	7%
364 E5FF1 Podiatry Wechs	6%
364 E7LGD Mgmt - Integrated Adults - We	6%
364 E7NAA Int Team Leigh	5%
364 E7NAG Int Team Central Southend	5%
364 E7RAA Int Team Hockley	5%
364 E7RAE Respiratory Team	5%
364 E5ACA Epping Icct	5%
364 E7PBD Esd - Stroke	5%
364 E7PBC Community Stroke Team	5%
364 E7SPR Spor	5%
364 E5ADD Dietetics Wechs	5%
364 E5CSP Single Point of Access	5%
364 E7PBL Complex Cases Care Co-Ord	4%
364 E7TCA Podiatry Seechs	4%
364 E7TBB Se Continence Service Adults	4%
364 E5HC1 Cancer Information Service	4%
364 E5ACF Uttlesford Icct	3%
364 E7NAJ Leg Ulcer	3%
364 E5AHA Msk Physio Wechs	3%
364 E7TBD Tissue Viability	2%
364 E7PCA Int Team Canvey + Thundersley	2%
364 E7RAB Southend Care Homes Project	2%
364 E7PBH Care Co-Ordination Service Cpr	2%
364 E7RCA Therapy	2%
364 E5CCR Cars Team	2%
364 E5ASP Podiatry Surgery Wechs	2%
364 E7OAA Wheelchair Service Seechs	2%
364 E7OAB Ot Seechs	2%
364 E7LGC Mgmt - Integrated Adults - Se	1%
364 E7TBA Diabetes Adults	1%
364 E7TCC Podiatric Surgery South East	1%
364 E7TBE Heart Failure Nurse Specia	1%
364 E5FMS Medical Staffing	1%
364 E5ACJ Adult Slt Wechs	1%
364 E5ADS Diabetes Wechs	1%
364 E5F00 Patient Appliances	1%
364 E7UAB Equipment Service Cpr Seechs	1%
364 E7TBS Abs - Speech Therapy	0%
364 E5AE5 End of Life Wechs	0%
364 E7TBF Tb Nurse Specialist	0%

Staff group	Total % permanent staff sickness overall
364 E7TCD Podiatric Surgery South West	0%
364 EF895 Stroke Team / ESD	0%
364 E7TBJ Adult Slt Seechs	0%
364 E5ARW Respiratory Wechs	0%
364 E5HC2 Prostate Specialist Nurse	0%
364 E5ALD Adult Ld Wechs	0%
364 E5S0P Swch Outpatients	0%
364 E5FL1 Equipment Service Wechs	0%
364 E5FWC Wheelchair Service Wechs	0%
364 E7OAF Wheelchairs - Esd	0%
300 Dietetics East	0%
Core service total	**5%**

Team leads and modern matrons actively monitored staff sickness within their teams. We reviewed eight staff records, which demonstrated sickness surveillance with appropriate action taken for persisting sickness episodes. The records showed that team leads and modern matrons conducted sickness return interviews with their staff on return to work.

Staff we spoke with told us that their workload increased when a member of the team was sick however, they supported each other to ensure their patients received care and treatment.

From April 2017 to January 2018, this core service reported an overall bank and agency usage of 7302 shifts for qualified nursing staff.

Total Number of Shifts available	Total Shifts Filled by Bank Staff	Total shifts Filled by Agency Staff	Total shifts NOT filled by Bank Staff
7,302	6,077	1,225	0

From April 2017 to January 2018, this core service reported an overall bank and agency usage of 1556 shifts for healthcare assistants.

Caveat: The total number of shifts filled and the shifts unfilled does not add up to the total number of shifts available.

Total Number of Shifts available	Total Shifts Filled by Bank Staff	Total shifts Filled by Agency Staff	Total shifts NOT filled by Bank Staff
1,558	1,391	165	0

The service used bank and agency to fill vacant shifts on the electronic rotas. One of the team leads we spoke with told us that the trust was limiting the use of agency nurses.

Bank and agency nurses received an induction to the local team on their first shift. We reviewed the induction records for bank and agency staff, which demonstrated that inductions took place.

Quality of records

Individual care records, including clinical data were managed in a way that kept people safe. The trust used electronic patient records with two-point security access to maintain patient confidentiality. Staff only had access to the electronic records of patients cared for in their locality.

All the information needed to deliver safe care and treatment was available to relevant staff in a timely and accessible way.

Staff accessed and updated electronic patient records remotely. Staff who worked in areas with poor connectivity utilised a download system for patient records. The laptop devices uploaded the new records to the server once staff moved to an area with connectivity.

We reviewed 11 sets of patient records, all of which were legible and dated with an electronic staff signature. This meant staff did not need to decipher hand written records and they could easily identify the clinician and the date for each entry.

All the 11 records we reviewed demonstrated the plan of care and treatment. However, we found that staff had not completed timely risk assessments such as the malnutrition universal screening tool and Waterlow assessments in four of the records. The service conducted monthly records audits to monitor the accurate and timely completion of patient records including risk assessments.

The service met the key performance indicator (KPI) target of 95% of data entries within one day. However, the multiple sclerosis team, early stroke discharge team and wheelchair services in West Essex had consistently not met the target from April 2017 to March 2018. The management team were investigating the issues surrounding the delay in data entries for these teams to facilitate a solution.

Medicines

The service had a Medicines Management policy, which was last reviewed on 27th May 2017. The policy set out the responsibilities of staff, for clinicians prescribing and administering medicines. Staff we spoke with knew how to access the trust's policy and they had completed training in administering medicines. Staff had awareness of the policies regarding the administration of medications and controlled drugs set out by the Nursing and Midwifery Council, Standards for Medicine Management.

The service had processes in place for the safe administration medicines. Staff reviewed the medicines administration directive to ensure that the prescriber had fully completed the prescription with a signature. We reviewed 11 medicines administration directives and all of these were completed appropriately.

Managers had oversight of medicines transported by staff. The only medicines staff transported were vaccines and anaphylaxis boxes. Managers kept records of staff that carried anaphylaxis boxes and the expiry date on the box. Vaccines had a temperature indicator for the period of transit; staff discarded any vaccines when the temperature indicated that the vaccines were not safe for use. Staff collected the vaccines from the pharmacy and returned any unused vaccines to the pharmacy.

The majority of specialist nurses and district nurses prescribed medicines within the scope of their practice and had completed a specialist university course to do so. The medicines management team and the local clinical commissioning group had oversight of all prescriptions generated by staff to identify any issues with the prescriptions. We requested medicines prescribing audits but the trust did not supply these.

The medicine management team conducted antimicrobial stewardship audits monthly. The audits gave the team oversight of the antibiotics staff prescribed and challenged prescriptions for antibiotics associated with the increased risk of clostridium difficile.

The service had measures in place to prevent the miss-use of prescription pads. Staff kept prescription pads in a locked cupboard within the nursing bases when not in use. Staff had to return all prescription pads for destruction when leaving the organisation.

Safety performance

The service completed the safety thermometer monthly.

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

The safety thermometer data showed that 98.9% of patients received harm free care in South East Essex from April 2017 to March 2018. Patients in West Essex received 98.5% harm free care for the same period.

The service did not display the safety thermometer in the nursing bases we visited. One of the team leads we spoke with told us that the locality team were exploring ways to use the information to improve patient care. They also told us that the pressure ulcer figures stay about the same due to the time pressure ulcers take to heal. This meant that staff counted the same pressure ulcers each month until they healed.

The service completed a root-cause analysis for each service acquired harm (pressure ulcers, catheter acquired urinary tract infections, falls and venous thromboembolisms). We reviewed a root cause analysis investigation report and we found that the investigation was thorough and identified the root cause.

Incident reporting, learning and improvement

Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses and to report them internally and externally where appropriate.

The trust had an Incident reporting policy version one, which was last reviewed in April 2017. Staff could easily access the policy and knew their responsibilities in raising an incident report including how to categorise the incidents. Staff completed e-learning induction training which, included incident reporting. Staff compliance for induction training was 96%, which was above the trust target of 85%. All clinical staff received training in relation to duty of candour during their induction training. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Staff reported incidents using an electronic system. Once reported, managers reviewed the incidents and, where necessary investigated. All the staff we spoke to, who held responsibility for investigating incidents, told us they had received root cause analysis (RCA) training.

Staff knew how to report incidents and gave example of the types of incidents they reported such as equipment issues and when patients developed pressure ulcers. Staff felt able to report incidents without fear of punitive action from their managers.

Community services for adults reported 4,855 incidents from April 2017 to March 2018. We requested detailed information from the trust regarding the type and severity of the incidents reported by staff and this information was not supplied.

The trust had forums for staff learning such as the skin matters monthly meetings. Staff from all disciplines met to present pressure ulcer root cause analysis investigations. The meetings also gave staff the opportunity to gain support from the tissue viability team. One of the managers we spoke with told us that they wanted to replicate the learning opportunities from the skin matters in other specialist areas. Staff we spoke with told us that they found the skin matters meetings a good learning resource.

Team meeting minutes and the minutes from the senior management meetings demonstrated that staff discussed incidents and learning from investigations. We reviewed a variety of meeting minutes, which showed that incidents formed part of a rolling agenda. Teams learned from local and wider incidents across the trust. Staff we spoke with confirmed that they received learning about incidents during team meetings.

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS), these include never events. A never event is a type of serious incident that is wholly preventable where guidance or safety recommendations that provide strong systematic protective barriers are available at a national level and should have been implemented by all healthcare providers. In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in Community health services for adults, which met the reporting criteria, set by NHS England between, April 2018 and January 2018. Of these, one was related to 'slips/trips/falls meeting SI criteria' and one to 'pressure ulcer meeting SI criteria'.

The number of the most severe incidents recorded by the trust incident reporting system is comparable with that reported to Strategic Executive Information System (STEIS). This gives us more confidence in the validity of the data.

Incident Type	Number of Incidents
Pressure Ulcer meeting SI Criteria	1
Slips/trips/falls meeting SI criteria	1
Core Service Total	**2**

Community services for adults had two incidents that met the serious incident threshold from April 2017 to January 2018. One was due to a patient fall, sustained a serious injury, and seconded related to an avoidable pressure injury. We reviewed the investigation reports for the serious incidents and we found them to be thorough. They identified the root cause and identified learning for the wider team. The documentation included duty of candour conducted by staff throughout the investigation process.

Is the service effective?

Evidence-based care and treatment

The service generally assessed people's physical, mental health and social needs holistically in line with best practice, national guidance and legislation. Staff generally delivered support in line with legislation, standards and evidence based guidance including National Institute for Health and Care Excellence (NICE) and other expert professional bodies to achieve effective outcomes.

The trust had various clinical policies and guidelines such as the pressure ulcer prevention and management clinical guideline and the safeguarding adult's policy. The policy and guidance documents were up to date and referenced national guidance, legislation, and best practice.

Staff could easily find policy and pathway information on the trust's intranet. Staff showed us how they found policies, standard operating procedures, and guidance.

Staff assessed the needs of patients and provided treatment in line with current legislation, standards and evidence based guidance. Senior managers and clinical leads reviewed and disseminated new recommendations or guidance. For example, they provided assurance that for NICE or other relevant guidance was reflected through policy documents and clinical pathways. The diabetic foot care pathway followed NICE guidance for staging diabetic foot complications. The pathway clearly identified each stage of diabetic foot complications and gave guidance on the management of these wounds.

The service conducted regular audits to monitor the compliance of policies with staff for example the trust monitored hand hygiene in relation to the infection prevention and control policy. The trust completed a regular documentation audit to monitor compliance with the record keeping policy.

Nutrition and hydration (only include if specific evidence)

Staff completed a malnutrition universal screening tool for all new patients during their first assessment. Clinical staff gave advice about nutrition and hydration where appropriate. We observed staff providing advice about nutrition following a pressure ulcer dressing change.

Staff did not always re-evaluate malnutrition universal screening tool assessments in a timely way. The pressure ulcer prevention and management guideline stipulates that staff should complete the assessment monthly.

Staff could refer patients to the dietetics service if a patient required further advice and support with their nutritional needs.

Staff could refer patients to the speech and language therapy teams for those patients who had swallowing difficulties.

Pain relief

All patient records we reviewed demonstrated that staff undertook pain assessments with their patients.

Patient records demonstrated that nurses had completed pain assessments for these patients on each visit. The nursing teams prioritised the visit requests for pain relief, and for palliative care patients.

Staff had access to clinicians such as district nurses to prescribe specific pain relief for visits. One of the team leads we spoke with told us that they had completed the prescribing qualification and they could assess patients and prescribe pain-relieving medicines in the event of a district nurse not being available.

Patient outcomes

The trust routinely collected and monitored information about the outcome of people's care and treatment.

The services in South East Essex had different key performance indicators (KPIs) from the teams in West Essex due to the different clinical commissioning groups. The local commissioners set out a number of KPIs for quality measurement of the services.

The trust set out 23 community health service KPIs internally such as complaints resolution and reduction in grade one and two pressure ulcers. The data provided by the trust showed that the services met 14 of the internal KPIs.

Data provided by the trust showed that the West Essex service had 69 KPI measure in place such as 95% of leg ulcer patients assessed within 20 days and 95% of urgently referred to cardiac specialist nursing to be seen within two working days. We saw that the service had met 40 of the KPIs and not met 17 of the targets to meet the KPIs. The data showed that 12 KPIs had no percentage attached.

The South Essex service had 41 KPIs and of these met 39. The KPI included 92% of service users on incomplete pathways (yet to start treatment) wait no longer than 18 weeks.

The KPI dashboard showed that managers had implemented investigations regarding when the service failed to meet their KPIs. The dashboard showed that the trust was in the process of negotiation with their commissioners regarding continence service annual reviews due to the high patient demand.

The trust had a service delivery and oversight group who had oversight of improvements and improved patient outcomes. The group had a comprehensive action plan in place to improve services and outcomes for patients. The action plan recorded regular updates and each action had a named manager with oversight responsibility. One of the actions on the service delivery and oversight group was an improved podiatry service model to make better use of clinical and administrative resources to improve the patient journey.

The service participated in local and national audit programmes. One of the managers we spoke with told us that the trust was in the process of collating basic benchmark data to review how the service had developed in the first year of the organisation.

The trust participated in three clinical audits in relation to this core service as part of their Clinical Audit Programme.

Audit name / title	Key Successes	Key concerns	Key actions following the audit
Audit Record keeping		Actions locally to address issues in Record keeping in community ict areas	re-audit planned Q4
National Benchmarking Intermediate care	Intermediate care teams West Essex-Benchmarking	Wait times for Therapies outside of national	Feedback to teams for review

The trust had completed the intermediate care national survey. The results of the audit gave managers insight into the performance of the trust nationally. The trust's performance was satisfactory against all the measures; however, the trust had identified areas for improvement such a reduction of agency staff usage. The trust had strategy in place to reduce the use of agency staff.

Competent staff

People had their needs assessed, preferences and choices met by staff with the right skills and knowledge.

Staff had appropriate training to meet their learning needs to cover the scope of their work and they had protected time for training.

Band six district nurses working within the bases we visited had completed a specialist district nursing qualification. All the district nurses we spoke with could prescribe medicines and medical devices for their patients following the completion of the qualification.

The service had a preceptorship programme to ensure that newly qualified staff are supported by senior staff.

All new staff had a period of induction, which included an educational programme followed by a competency portfolio. New staff reported they felt well supported by senior staff during their induction period.

Staff held their own competency documents during and after completion. Managers kept a staff competency spreadsheet which they updated when staff were signed off.

The trust supported staff with the process of professional revalidation. Staff felt supported by managers during professional revalidation.

The service supported healthcare assistants with the completion of the care certificate, which prepared them with increased knowledge, and skills to provide high quality care.

The service had processes in place to monitor staff performance. We reviewed staff records, which demonstrated that managers supported staff to improve their performance. Where performance was below the expected level, staff developed an improvement action plan with their manager in specified period. All the documents we reviewed were completed in a timely way.

The trust offered development to staff. One of the managers we spoke with told us that the trust offered specialist training to staff who wished to specialise or develop further in their role. Managers identified staff members who wished to develop during the appraisal process.

Band six district nurses completed appraisals with the junior staff within their teams and they held responsibility for the management of their team.

We reviewed 10 sets of staff records, which demonstrated that each member of staff had received clinical supervision and completed the appraisal process in the last 12 months. All the staff we spoke with told us that they had completed the appraisal process within the last 12 months. Staff told us that appraisals were ‘meaningful and personal’ and that goals were set that were achievable and supported, such as mentorship training, non-medical prescribing and district nursing courses.

From 1 April 2017 to 31 January 2018 the average clinical supervision rate for the core service was 92% against the trust’s target of 90%.

Team	Clinical supervision sessions required	Clinical Supervision Delivered	Clinical supervision rate (%)
Community Stroke Team	40	40	100%
Int Team Canvey + Thundersley	464	464	100%
Int Team Central Southend	602	602	100%
Int Team Hockley	375	374	100%
Int Team Leigh	237	236	100%

Team	Clinical supervision sessions required	Clinical Supervision Delivered	Clinical supervision rate (%)
Specialist therapies (West Essex)	20	20	100%
Spor	12	12	100%
Tissue Viability	14	14	100%
Wheelchair Service SEECHS	20	20	100%
Care Co-ordination Service CPR	92	91	99%
Physiotherapy	71	70	99%
Ot Seechs	40	39	98%
Saffron Waldon Outpatients	37	36	97%
Leg Ulcer	50	48	96%
Tissue Viability Wechs	23	22	96%
Single Point of Access	40	38	95%
Complex Cases Care Co-Ord	33	31	94%
Diabetes Adults	80	75	94%
Esd - Stroke	50	47	94%
Msk Physio Wechs	40	37	93%
START	60	55	92%
Respiratory Wechs	80	73	91%
Cancer Information Service	20	18	90%
Se Continence Service Adults	50	45	90%
Uttlesford Icct	557	502	90%
Abs - Speech Therapy	18	16	89%
Collaborative Care	170	151	89%
Epping Icct	509	454	89%
Integrated Teams (West Essex)	70	62	89%
Multiple Sclerosis Nurse Specialist Service / Parkinsons Specialist Nurse	40	35	88%
Respiratory Team	30	26	87%
Esd - Stroke + Neuro	60	51	85%
Adult Slt Seechs	19	16	84%
Heart Failure Nurse Specia	60	50	83%
Leg Ulcer Svs Wechs	12	10	83%
Adult Slt Wechs	10	8	80%
Southend Care Homes Project	41	33	80%
Harlow Icct	410	313	76%
CARS Team	40	30	75%
Continence Services - WECHS	20	15	75%
TB Nurse Specialist	40	29	73%
Patient Appliances	10	7	70%
Prostate Specialist Nurse	10	7	70%
Heart Failure & Cardiac Rehab	38	25	66%
Core Service Total	**4,714**	**4,347**	**92%**

From April 2017 to January 2018, 87% of permanent non-medical staff within the community health services for adult's core service had received an appraisal compared to the trust target of 90%.

No appraisal data was submitted by the trust for medical staff in this core service during this period.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Abs - Speech Therapy	3	3	100%
Adult Slt Seechs	6	6	100%
Adult Slt Wechs	7	7	100%
Asthma	1	1	100%
CARS Team	4	4	100%
Chronic Fatigue Service	3	3	100%
Community Stroke Team	9	9	100%
Complex Cases Care Co-Ord	1	1	100%
Continence Services - WECHS	2	2	100%
Crs Wechs	1	1	100%
Equipment Service - WECHS	5	5	100%
Equipment Service CPR SEECHS	1	1	100%
Esd - Stroke	11	11	100%
Heart Failure Nurse Specia	4	4	100%
Leg Ulcer	6	6	100%
Leg Ulcer Svs Wechs	1	1	100%
Ot Seechs	12	12	100%
Out of Hospital Asthma Service	1	1	100%
Patient Appliances	4	4	100%
Podiatry SEECHS	29	29	100%
Podiatry Surgery WECHS	2	2	100%
Podiatry WECHS	9	9	100%
Prostate Specialist Nurse	2	2	100%
Respiratory Team	3	3	100%
Se Continence Service Adults	7	7	100%
Single Point of Access	10	10	100%
START	6	6	100%
SWCH Admin	6	6	100%
Swch Outpatients	2	2	100%
TB Nurse Specialist	5	5	100%
Therapy	2	2	100%
Tissue Viability	2	2	100%
Wheelchair Service SEECHS	8	8	100%
Wheelchair Service WECHS	2	2	100%
Harlow Icct	51	49	96%
Collaborative Care	15	14	93%
Int Team Canvey + Thundersley	42	39	93%
Int Team Hockley	34	31	91%
Msk Physio Wechs	28	25	89%
Care Co-ordination Service CPR	8	7	88%
Dietetics Wechs	14	12	86%
Falls Prevention - Wechs	7	6	86%
Int Team Central Southend	70	60	86%

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Int Team Leigh	22	19	86%
Podiatry Admin	7	6	86%
Respiratory Wechs	7	6	86%
Uttlesford Icct	66	55	83%
Diabetes Adults	9	7	78%
Podiatric Surgery South East	9	7	78%
Neuro Nursing - Ms/ Parkinsons	4	3	75%
Diabetes Wechs	3	2	67%
Southend Care Homes Project	3	2	67%
Tissue Viability Wechs	3	2	67%
Esd - Stroke + Neuro	11	7	64%
Epping Icct	57	34	60%
Heart Failure & Cardiac Rehab	4	2	50%
Spor	2	1	50%
Dietetics East	1	0	0%
Stroke Project	1	0	0%
Core service total	**655**	**573**	**87%**
Trust wide	4121	3386	82%

Multidisciplinary working and coordinated care pathways

We observed effective multidisciplinary working across the service with good examples of communication across speciality teams. There was a positive working relationship between staff groups, GPs, and local hospitals.

Staff networked and developed close working relationships with staff from external services and agencies. Speciality teams such as diabetes and heart failure had close working relationships with hospital consultant and specialist nursing teams. This meant that staff had access to consultant support.

The service held weekly locality multidisciplinary team meetings where staff discussed the holistic needs of adult patients on the caseload. The service had processes in place to ensure that all the relevant specialities attended the meetings. Staff assessed, planned, and implemented the co-ordinated care delivery for patients.

The trust had a daily dashboard shared with local hospitals and clinical commissioning groups. The dashboard contained information such as patient dependency and staffing. One of the managers we spoke with told us that the trust helped one of the local NHS hospitals by sending staff to work in the hospital when the hospital had severe staffing pressures.

Staff in adult services worked in multidisciplinary teams, in West Essex staff worked in neighbourhood teams. The neighbourhood teams had nurses and therapists such as physiotherapists working together. Staff we spoke with told us that the team composition improved communication and found it easier to discuss their shared patients. One of the team leads we spoke with told us that the neighbourhood teams had improved relationships between the service and local GP services.

District nurses worked closely with the tissue viability specialists to gain support in managing complex wounds. Staff we spoke with told us that they carried out joint visits with the tissue viability specialists to gain addition knowledge and skills in wound care.

The service worked closely with the local NHS ambulance trust to provide the care to patients after a fall to prevent hospital admissions. Physiotherapists and paramedics on board an ambulance responded to patients that had fallen in their homes.

Health promotion

The service actively supported patients to lead healthier lives and provided advice and support to patients about self-management of their condition. We observed one member of staff providing information about the self-management of their wound and advised when the patient should contact the nursing team.

The diabetes team worked closely with dieticians to provide support to patients with type two diabetes. One of the diabetes nurse specialists we spoke with told us that many of these patients had a high body mass index and required additional support to manage their lifestyle.

Staff provided advice and support to patients such as healthy eating and smoking cessation to their patients. Staff could sign post patients to other internal and external services where patients required additional support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were aware of their responsibilities to seek patient consent in line with current legislation regarding consent and mental capacity. Staff we spoke with told us they supported patients to make decisions about their care and treatment, if patients did not have capacity to consent staff made best interest decisions.

Staff received training in consent, which formed part of the mandatory training programme for staff. The completion rate for consent training was 93%.

The Mental Capacity Act is designed to protect patients who may lack capacity to make certain decisions about their care and treatment. Staff received training about the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS), which formed part of the mandatory training programme for all clinical staff. The completion rate for mental capacity act training was 85%.

We observed care given in patients' own homes and we saw that staff consistently gained verbal consent from their patients before providing care and treatment.

Is the service caring?

Compassionate care

We observed staff delivering care in patient's homes. Their interactions were professional, friendly, and kind. Staff demonstrated an understanding of the importance of treating patients and those who were important to them in a caring and sensitive manner.

We observed casual discussions between staff members and their patients about family members, staff knew about home circumstances and concerns. This all helped to put patients at ease.

All the staff we spoke with took great pride in their work and were committed to providing the best care they could.

Staff treated patients with privacy, respect, and dignity and we saw this when they protected patients from cold and exposure, using blankets to cover exposed parts of the body whilst administering physical and or intimate care whilst in their own homes.

Staff took the time to explain and interact with patients and relatives, they were sensitive to patients needs offering explanations and being supportive when patients expressed concerns. We observed the one member of staff showing compassion to a patient as they had removed bandages two days before the visit. The nurse sensitively advised the patient that removing the bandages could cause deterioration or delayed healing of their wound and reassured the patient that they could contact the nursing team if the dressings became uncomfortable.

The staff respected the confidentiality of patients and did not discuss or display confidential information in the hearing of others. Staff shared information appropriately with each other either during handover or within the secure electronic records systems.

Staff addressed personal, cultural, social, and religious needs. Staff we spoke with were aware of their patients' specific needs such as those with strong religious feelings and some staff had developed links with local clergy to help support patients.

One patient that had received care told us that "The nurses are great" and "they are most responsive and attend to my needs".

The friends and family test for community services for adults showed that 99.4% of patients would recommend the service to the friends and family in January 2018, 96.8% for February 2018 and 98% for March 2018.

The service results for the "How did we do?" patient survey were favourable for staff demonstrating kindness and caring for their patients. The service scored 9.9 for in South Essex and 9.8 in West Essex out of 10 for staff being kind and caring in March 2018.

Emotional support

Staff presented a caring and emotionally supportive manner. We observed a member of staff supporting a patient and their relatives after a sudden death of a family member. The staff member showed empathy for the whole family.

Many staff had worked in the same area for many years and some of the patients were well known to the staff. One of the patients we spoke with told us that the nurses had visited them for over six years.

Staff could signpost patients or their relatives to other service such as bereavement counselling and patient support groups when they required additional support emotional with their condition or situation.

Understanding and involvement of patients and those close to them

All staff interactions we observed demonstrated good communication with patients and their relatives and carers.

We saw that staff involved patients and their families in planning care and treatment. Staff explained procedures in a manner that was easily understood so that patients knew what they were consenting to. We observed staff involving patients in treatment decisions by explaining the treatment options available.

Staff we spoke with understood the importance of involving patients and those close to them in their care and treatment. One member of staff told us that patients involved in their care seem to have better outcomes.

Is the service responsive?

Planning and delivering services which meet people's needs

The design of buildings met the needs of people using the service. The design of the building we visited, which held patient clinics met the needs of patients. For example, all buildings could be accessed by patients using mobility aids.

The trust worked together with commissioners and other organisations across Essex to plan and meet the needs of the local population. The service planned and provided services, delivered by district nursing teams, specialist nursing teams, therapists, and social workers.

Managers for the service met with their commissioners regularly. The service had action plans in place extend or improve the provision of care and treatment. Managers worked in collaboration with their stakeholders and commissioners to extend the service provision where the service did not meet the needs of local people. One of the team leads we spoke with told us about catheter clinics for patients that worked and had difficulties receiving care at home during their working hours. The service had plans to develop a clinic to manage these patients. One of the team leads told us that clinicians working within other services such as GP surgeries did not always have the skills to manage these patients outside of their working day.

The service development and improvement group had oversight and managed all new service developments and improvements to existing services. The group had an action plan in place with a named owner responsible for coordination and updates of these actions. We reviewed the action plan, which demonstrated that named owners updated the action plan on a regular basis.

The service had engaged with local people to plan and design services. The trust held "Have your say" events, which enable local people to provide feedback about services and services gaps. The trust used this information to plan and improve services. The director for the service told us that they supported these events and they provided insight into gaps in provision.

Meeting the needs of people in vulnerable circumstances

Dementia awareness formed part of mandatory training for clinical staff. Information provided by the trust showed that 94% of staff had completed this training. All the staff we spoke with told us that they had completed dementia training.

The trust had dementia champions to support patients and staff in providing care to people living with dementia. The service had 14 dementia champions in West Essex. However, the service had no dementia champions in South East Essex at the time of our inspection.

Staff had access to interpreters when their patient's first language was not English. Staff we spoke with knew how to access this service. Managers understood the population of their locality and the nationalities of their patients for example Harlow had a large Polish community.

The community matrons and district nurses worked closely with the wider multidisciplinary team for example social workers and GPs to ensure patients in vulnerable circumstances had support to remain independent or stay in their own homes.

The community service for adults supported patients with frailty in their own homes. Physiotherapists and occupational therapists provided care and treatment in patients their own homes in falls prevention and aid rehabilitation. The service also had an initiative with the local ambulance trust for paramedic and a therapist to assess patients following a fall in their own home. This meant that patients did not automatically attend an ED and they could stay in their own homes if appropriate.

The trust had a wheelchair service to either assess the needs of wheelchair users with specialist modifications or supply additional equipment such as pressure relieving cushions.

The design of the building we visited, which held patient clinics met the needs of patients with mobility aids such as walking frame and wheelchairs.

Access to the right care at the right time

The trust had arrangements in place for a single point of contact for each of the two locality areas. Staff could refer patients internally through the single point of contact to specialties such as speech and language therapists and dietetics. Senior nurses triaged all incoming referrals within the single point of contact to allocate patients to the right service and prioritised patients with the greatest need.

All referral to the services went to the single point of access. The service received patient referrals, electronically, by telephone or by fax. Senior nurses triaged all referrals and allocated to the appropriated team. Staff prioritised the patients with the greatest need within each team within the service.

Patients we spoke with told us that they found it easy to contact the service in the event of changes to their condition.

The teams in South East Essex provided a 24-hour service. The service provided urgent care at night for example patients at patients with blocked urinary catheters.

The information submitted showed that the service had met all the national targets for 18 weeks and commissioners' local targets for referral to treatment times. The national target was set to prevent treatment delays from initial referral to the first appointment.

The trust identified the services in the table below as measured on 'referral to initial assessment' and 'assessment to treatment'. The trust met the referral to assessment target in all 38 of the targets listed.

The trust has stated N/A for days from assessment to treatment and comments regarding this can be found in the table below.

Name of hospital site or location	Name of in-patient ward or unit	Service Type	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
			National Target	Actual (mean)	National Target	Actual (mean)	
St Margaret's Community Hospital	EPUT WEX Adult Speech and Language	Community	12wks	4	N/A		we do not monitor initial assessment to onset of treatment as following implementation of access policy treatme
Independent living center	EPUT WEX Continence Advisory Service	Community	8wks	3	N/A		
St Margaret's Community Hospital	EPUT WEX Dietetics	Community	8wks	4	N/A		
St Margaret's Community Hospital	EPUT WEX Early Stroke Discharge Unit	Community	N/A	1	N/A		
West Essex	EPUT WEX Falls Prevention Service	Community	N/A	1	N/A		
Harlow	EPUT WEX MS Specialist Nurse	Community	18wks	0	N/A		

Name of hospital site or location	Name of in-patient ward or unit	Service Type	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
			National Target	Actual (mean)	National Target	Actual (mean)	
Harlow	EPUT WEX PD Specialist Nurse	Community	18wks	0	N/A		nt is usually started at first appointment
Herts & Essex Hospital	EPUT WEX Podiatric Surgery	Community	18wks	10	N/A		
St Margaret's Community Hospital	EPUT WEX Prostate Service	Community	N/A	4	N/A		
St Margaret's Community Hospital	EPUT WEX Tissue Viability Service	Community	N/A	4	N/A		
Independent living center	EPUT WEX Wheelchair Service	Community	18wks	6	N/A		
Epping	EPUT WEX Epping - Urgent and Scheduled Care - Case Managers	Community	N/A	1	N/A		
Epping	EPUT WEX Epping - Urgent and Scheduled Care - Nursing	Community	N/A	1	N/A		
Epping	EPUT WEX Epping - Urgent and Scheduled Care - OT	Community	18wks	2	N/A		
Epping	EPUT WEX Epping - Urgent and Scheduled Care - Physio	Community	18wks	1	N/A		
Harlow	EPUT WEX Harlow - Urgent and Scheduled Care - Case Managers	Community	N/A	0	N/A		
Harlow	EPUT WEX Harlow - Urgent and Scheduled Care - Nursing	Community	N/A	2	N/A		
Harlow	EPUT WEX Harlow - Urgent and Scheduled Care - OT	Community	18wks	1	N/A		
Harlow	EPUT WEX Harlow - Urgent and Scheduled Care - Physio	Community	18wks	8	N/A		
Uttlesford	EPUT WEX Uttlesford - Urgent and Scheduled Care - Case Managers	Community	N/A	0	N/A		
Uttlesford	EPUT WEX Uttlesford - Urgent and Scheduled Care - Nursing	Community	N/A	1	N/A		
Uttlesford	EPUT WEX Uttlesford - Urgent and Scheduled Care - OT	Community	18wks	1	N/A		
Uttlesford	EPUT WEX Uttlesford - Urgent and	Community	18wks	4	N/A		

Name of hospital site or location	Name of in-patient ward or unit	Service Type	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
			National Target	Actual (mean)	National Target	Actual (mean)	
	Scheduled Care - Physio						
Herts and Essex Community Hospital	EPUT WEX Podiatry - Biomechanics	Community	8wks	10	N/A		
Herts and Essex Community Hospital	EPUT WEX Podiatry - Podiatry	Community	8wks	5	N/A		
Latton Bush	EPUT WEX Respiratory Service - CReST Pulmonary Rehabilitation	Community	8wks	5	N/A		
Latton Bush	EPUT WEX Respiratory Service - Respiratory CReST Service	Community	8wks	0	N/A		
Latton Bush	EPUT WEX Specialist Nursing - Cardiac - Cardiac Rehabilitation	Community	8wks	5.5	N/A		
Latton Bush	EPUT WEX Specialist Nursing - Cardiac - Heart Failure	Community	N/A	1	N/A		
Herts and Essex Community Hospital	EPUT WEX Patient Appliance - Herts and Essex	Community	18wks	16	N/A		
Addison House	EPUT WEX Patient Appliance - Addison House	Community	18wks	13	N/A		
St Margaret's Community Hospital	EPUT WEX Patient Appliance - St Margaret's Community Hospital	Community	18wks	9	N/A		
West Essex	EPUT WEX MSK Physio	Community	8wks	27	N/A		
South Essex - Range	Continence Adults	Community health services for adults	18wks	29	N/A		
South Essex - Range	Respiratory	Community health services for adults	18wks	36	N/A		
South Essex - Range	Diabetes Adults	Community health services for adults	18wks	43	N/A		
South Essex - Range	Heart Failure	Community health	18wks	29	N/A		

Name of hospital site or location	Name of in-patient ward or unit	Service Type	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
			National Target	Actual (mean)	National Target	Actual (mean)	
		services for adults					
South Essex - Range	Long Term Conditions	Community health services for adults	18wks	4	N/A		
South Essex - Range	Tuberculosis	Community health services for adults	18wks	13	N/A		
South Essex - Range	Podiatry	Community health services for adults	18wks	35	N/A		
South Essex - Range	Podiatric Surgery	Community health services for adults	18wks	51	N/A		
South Essex - Range	Podiatry - Biomechanics	Community health services for adults	18wks	46	N/A		
South Essex - Range	Occupation Therapy	Community health services for adults	18wks	12	N/A		
South Essex - Range	SLT Adults	Community health services for adults	18wks	40	N/A		
South Essex - Range	Tissue Viability	Community health services for adults	18wks	13	N/A		
South Essex - Range	Stroke	Community health services for adults	18wks	4	N/A		
Bedfordshire - Range	Beds Podiatric Surgery	Community health services for adults	18wks	75	N/A		Podiatric Surgery is provided by way of a sub-contract to Circle Health. Circle Health perform a telephon

Name of hospital site or location	Name of in-patient ward or unit	Service Type	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
			National Target	Actual (mean)	National Target	Actual (mean)	
							e triage prior to forwarding on the referral to our service, this process incurs delays caused by the referral processing at Circle Health.
South Essex - Range	Crisis intervention (Community Integrated Nursing Team)	Community health services for adults	2 hours	0	N/A		KPI States: % of appropriate referrals for crisis intervention or admission avoidance seen within 2 hours of referral
South Essex - Range	Integrated community Teams - Referral Response	Community health services for adults	2 hours	0	N/A		KPI States: Number of patients referred as urgent contacted within two hours

Percentage of patients that are children

Less than 1% (2236) of patients attending community health adult services within the last 12 months were identified as being a child aged 17 years or under.

Community adult services supported the transition from children and young people (CYP) services in to adult services with complex cases. We saw examples where the transition was individualised to consider the circumstances for everyone. An example of transition from CYP to adult services was the adult diabetes service reviewed and treated patients from the age of 14 years.

Learning from complaints and concerns

The trust had processes in place to manage, investigate, and respond to complaints effectively.

The service had an up to date complaints policy, which was last reviewed in April 2017. Staff followed the complaints policy, which provided guidance on how to manage complaints efficiently. Staff managed all complaints and concerns on the electronic reporting system. Team leads managed complaints who resolved concerns at the earliest opportunity. An appointed named member of staff dealt with a complaint where the service was not able to resolve the concern. This member of staff was the lead investigator for the complaint response. The director responsible for the oversight of the service reviewed all complaints responses for quality. The director told us that this process gave assurance that the response answered all the concerns raised.

The service received 48 complaints from April 2017 to March 2018. Records supplied by the trust demonstrated that managers investigated complaints and resolved these in line with the trust's complaints policy. The records showed that the trust upheld or partially upheld 36 of the complaints.

We reviewed six complaint responses and all the responses answered the concerns raised and provided information about what to do if the response was unsatisfactory.

Complaints posters and leaflets describing the complaints procedure were on display and available at all clinics we visited. The service provided patients with information on how to progress a complaint by the ombudsman if they were not satisfied with the trusts internal complaints process.

Community adult services received 27 complaints between 1 April and 31 December 2017. The main theme of complaints were relating to clinical practice with 15 complaints

Team	Clinical Practice	Communication	Systems & Procedures	Staff Attitude	Environment	Total
Podiatry	2		2		1	5
Recovery and Wellbeing Brentwood	1		1	1		3
Continence	2					2
Plane Ward (SMH)	2					2
Harlow Integrated Care Team	1			1		2
Epping Integrated Care Team	2					2
Uttlesford Integrated Care Team		2				2
District Nursing Team	1	1				2
Heart Failure Care		1				1
Recovery and Wellbeing Southend	1					1
Tissue Viability Service	1					1

Team	Clinical Practice	Communication	Systems & Procedures	Staff Attitude	Environment	Total
Acquired Brain Injury Service			1			1
Podiatric Surgery			1			1
MS & Parkinsons Nursing Team	1					1
Musculoskeletal Physiotherapy (MSK)	1					1
Total	**15**	**4**	**5**	**2**	**1**	**27**

Is the service well-led?

Leadership

The trust had clearly identified lines of accountability for adult community health services at board level. The director of integrated community services stated they held the board level executive position with responsibility for the service. Associate directors and their deputies supported the director of integrated community services. Staff at all levels understood their responsibilities within their roles.

The trust made appointments for all non-executive and director roles following the fit and proper person requirement, which ensured they were suitably skilled, qualified, and experienced for the roles, which they undertook.

Locally, staff told us their managers were routinely visible and approachable. We observed strong leadership at a local level with staff praising their local managers regarding their support and communication. Staff felt they could raise concerns without the fear of reprimand and they were confident action would be taken as result.

A team of dedicated and proactive managers supported the services who received a high amount of praise from the staff they managed. Each manager was fully versed in the challenges and areas of good practice in their individual areas and committed to making positive change. Staff stated that they felt valued and supported in their role.

Vision and strategy

The trust had an overarching mission, vision and set of values known by staff and reflected the local objectives within the service. The trust had worked with staff to develop the local organisational values and staff worked to those values. The values included ‘compassionate, empowering, and open’ with the vision ‘working to improve lives’.

We saw the trust vision, values, and strategy displayed in the trust buildings and as a screensaver. The values were also included in the recruitment interviews for staff to confirm what open, compassionate and empowering meant to them.

The service aligned to the trust’s strategic objectives; continuous improved safety, experiences, and outcomes, by attracting, developing, enabling, and retaining high performers. Staff confirmed they were aware and informed of the strategy, which fed into the overall trust strategy.

The service had a set of strategic objectives for example the reduction of service acquired pressure ulcers. The service had a strategy in place to pressure ulcers and had monthly skin matters forums for staff learning in relation to pressure ulcers. Staff discussed learning following root cause analysis investigations and had access to advice and support from the tissue viability team.

Culture

The trust encouraged staff to demonstrate candour, openness and honesty at all levels. The trust had a policy in relation to duty of candour and this was readily available to staff via the trust intranet.

Staff reported an open and honest culture and said they felt able to raise any concerns with their managers. All the staff we spoke with confirmed that the needs and experience for their patients was the centre of the service.

Staff morale was good and staff spoken with during the inspection confirmed that they felt valued and well supported by colleagues and managers within their roles.

Several staff members described how they had started as a band five and had achieved promotion within the service.

The trust held staff recognition awards in recognition of staff contributions to the service. We saw that staff members had received awards in recognition of their work.

Governance

The service had an effective governance framework to support good quality care. The service held senior leadership team and team leads meetings, which monitored progress on achieving strategic aims, and reported to the trust Board.

There was a range of policies, which underpinned the governance structure. The trust reviewed policies in line with expected review dates. These included the incident reporting and the safeguarding policies.

The service set out clear roles, responsibilities, and systems of accountability to support good governance and management of the service. Staff we spoke with described the service's management structure and specific roles and responsibilities.

The service had monthly senior management team meetings for the division. The meetings had a standardised agenda to discuss performance and quality measures such as emerging risks and incidents. The service produced a monthly quality and safety report, reviewed locally and at trust board level.

Managers disseminated the meeting minutes to the appropriate staff members to update staff in local team meetings and communications.

Board papers demonstrated that the board had oversight of adult community services quality and performance measures. The March 2018 board papers identified areas of performance improvement. One area identified by the trust was appraisal rates for community health services in West Essex where the appraisal rate was lower than the trust's target.

Management of risk, issues and performance

The service had clear and effective processes for managing risks issues and performance. The trust had an electronic risk register. The trust used risk registers based on the potential consequence of the risk and the likelihood of the risk happening again. All risks had a review date, a named owner, and an action plan.

The service had local risk registers and a divisional risk register. We saw that staffing was included on each of the local risk registers and on the divisional risk register. All the managers we spoke with identified staffing as their largest concern.

The service completed risk assessments for activities such as phlebotomy. Managers conducted risk assessments on an individual basis for issues such as a patient's home environment to ensure patients and staff remained safe.

Performance and risk formed the rolling agenda from divisional meetings to local team meetings. We saw that performance and risk formed part of the agenda for the divisional senior management team meeting and for local team meetings. The meeting minutes we reviewed demonstrated the rolling agenda and recorded the actions and updates to risk. For example, in March 2018 the senior management team minutes showed that issues with fire risk assessments were resolved and to be reviewed by the health and safety team.

The services used performance clinical dashboards, which provided assurance that service delivery was in line with national guidelines. The service conducted clinical audits across the service for assurance for all staff of the safety of the service.

Information management

Staff across the trust could access information from the intranet, including policies and national guidance. Staff knew how to access information through the intranet and through paper documentation available at main sites across the trust.

Staff used electronic patient records and they utilised downloaded case records in areas with poor connectivity. The service used the electronic records system to compile reports as evidence to their commissioners and for internal and external KPI monitoring.

The service utilised a dashboard for oversight of KPIs and other quality and performance indicators such as service acquired pressure ulcer reduction.

Staff accessed all electronic records via a two-point security log in process to prevent inappropriate access to sensitive information.

The service development and improvement group reviewed and managed all initiatives to make service improvements and the development of new services identified by the division.

Engagement

The senior management team and team leads had regular engagement with their commissioners and other stakeholders such as local NHS hospitals. The engagement took the form of regular meetings and a shared dashboard.

The service actively sought feedback from service users by means of the friends and family test and the "How did we do?" patient survey. The division monitored the feedback in the performance dashboard. The trust held regular events chaired by one of the directors to gain feedback from patients using the services provided across the trust.

Specialist nurses attended local patient forums to provide support and advice.

The service held team meetings monthly and staff confirmed that there was good teamwork and engagement.

Learning, continuous improvement and innovation

The service continuously aspired to improve the experience of their patients by reviewing opportunities to adapt aspects of the service to meet the needs of groups of patients. An example of this was the planned catheter clinics for working patients. The service planned to hold the clinics in the evenings to reduce the need for patients to take time off work to wait for a home visit

The service had a service development and improvement group to implement or make changes to the way staff provided care and treatment.

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

None of the services within community health services for adults have been awarded an accreditation.

Community health services for children, young people and families

Facts and data about this service

Location site name	Team/ward/satellite name	Patient group	Number of clinics per month	Geographical area served
Trust Head Office	Immunisation	Mixed	N/A	Essex
Trust Head Office	Speech & Language Therapy (Children)	Mixed	27	Essex
Trust Head Office	Speech & Language Therapy (Children)	Mixed	27	Not stated
Trust Head Office	Immunisations	Mixed	N/A	Not stated
Trust Head Office	Immunisation	Mixed	N/A	Not stated
Trust Head Office	Speech & Language Therapy (Children)	Mixed	27	Not stated
Trust Head Office	Family Nurse Partnership	Mixed	N/A	South Essex
Trust Head Office	Health Visiting	Mixed	22	Not stated
Trust Head Office	Short Break Service	Mixed	N/A	South Essex
Trust Head Office	Specialist School Nursing	Mixed	N/A	South Essex
Trust Head Office	Speech & Language Therapy (Children)	Mixed	27	Not stated
Trust Head Office	Health Visiting with Learning Disabilities	Mixed	N/A	South Essex
Trust Head Office	Jigsaws	Mixed	N/A	South Essex
Trust Head Office	Speech & Language Therapy (Children)	Mixed	27	Not stated
Trust Head Office	Immunisations	Mixed	N/A	Not stated
Trust Head Office	Speech & Language Therapy (Children)	Mixed	27	Not stated
Trust Head Office	Paediatric Liaison	Mixed	N/A	Essex
Trust Head Office	Children's Continence Service	Mixed	N/A	South East/South West
Trust Head Office	Paediatric Asthma and Allergy Service	Mixed	16	Essex
Trust Head Office	Paediatric Continence	Mixed	24	South East/South West
Trust Head Office	Paediatric Community Nursing (PCN)	Mixed	N/A	Essex
Trust Head Office	Paediatric Diabetes Specialist Nursing Team (PDSN)	Mixed	12	Essex
Trust Head Office	Speech & Language Therapy (Children)	Mixed	27	Not stated
Trust Head Office	Health Visiting	Mixed	34	Essex

Location site name	Team/ward/satellite name	Patient group	Number of clinics per month	Geographical area served
Trust Head Office	Immunisations	Mixed	N/A	Not stated
Trust Head Office	Speech & Language Therapy (Children)	Mixed	27	Not stated
Trust Head Office	Speech & Language Therapy (Children)	Mixed	27	Not stated
Trust Head Office	Immunisations	Mixed	N/A	Not stated

Is the service safe?

Mandatory training

The service had a clear, up-to-date mandatory training policy that all staff could easily access.

All staff had completed the mandatory training for their grade, which included basic life support.

Mandatory training included modules for the safe care and treatment of children and young people in the service as below.

All staff completed a full induction when they started work for Essex Partnership University NHS Foundation Trust.

Managers monitored training and made sure staff knew when to update their training.

The trust set a target of 85% for completion of mandatory training and their overall training compliance was 95% against this target.

The trust provided a breakdown of compliance for mandatory courses at December 2017 for staff in community services for children, young people and families is shown below:

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	Compliance %
Dementia Awareness (inc Privacy & Dignity standards)	100%
Mental Capacity Act Level 1	100%
Personal Safety - MVA	100%
Safeguarding Children (Level 4)	100%
Cascade Fire Trainer	100%
Diabetes Training	100%
Duty of Candour (Detailed Version)	100%
First Aid Trained	100%
Hoisting	100%
Corporate Induction	99%
Equality and Diversity	97%
Harassment & Bullying	97%
Duty of Candour (Overview Version)	97%

Training course	Compliance %
Safeguarding Children (Level 3)	97%
Induction E-Learning	96%
Medicines Management (community)	96%
Safeguarding Adults (Level 1)	95%
Complaints Handling	95%
Consent	95%
Conflict Resolution	94%
Safeguarding Children (Level 2)	93%
LAC e-learning	92%
Information Governance	92%
Basic Life Support & AED	92%
Fit for Work	91%
Anaphylaxis	90%
PREVENT (WRAP) Training	90%
Infection Prevention, Control & Hand Hygiene	87%
LAC face to face	87%
Manual Handling - People	86%
Care Certificate	78%
Fire Safety 2 years	58%
Mental Capacity Act Level 2	50%
Fire Safety 3 years	46%
Total	95%

Mandatory training included basic life support, fire safety, dementia awareness, information governance and Prevent. Prevent training is a government-led training programme designed to identify and prevent the threat of terrorism. All staff we spoke with confirmed they had completed this training.

Training was delivered through E-learning and face to face training. Sepsis management was included in the infection prevention control training and the deteriorating sick child training.

Staff received training on sepsis management as part of the infection prevention and control training and included the use of sepsis screening tools and use of the sepsis care bundle.

Staff were told three months before their training renewal date and team leads could see any

outstanding training flagged. Team leads had the responsibility of supporting staff to attend mandatory training. There was a practice development nurse employed within the service who supported staff training and all staff spoken with were positive about the support they had received.

Clinical leads provided cover or covered for staff themselves so staff could attend training opportunities.

Staff told us they received effective, appropriate training.

The service held alternate monthly professional development days where topics discussed were

Identified by staff and relevant to the service.

The manual handling training data submitted showed 0% of staff had completed this training; however, this topic was included as part of the e learning induction training which showed 96% compliance.

Safeguarding

The service had effective processes in place to keep children and young people and families safe and protected from harm. The service had safeguarding policies for children and young people based on statutory guidance within the Children Act 1989 (2014). The Safeguarding Children policy version one was reviewed in April 2017. Staff knew how to access the policy easily. Staff were knowledgeable about what the term safeguarding meant and how to recognise signs of abuse. Staff knew how to identify and report abuse and neglect and confirmed how they escalated concerns which followed trust policy.

The service ensured that staff were trained to the appropriate level set out in the intercollegiate document Safeguarding Children and Young People: Roles and competencies for Health Care Staff published in March 2014 and were familiar with Government guidance 'Working Together to Safeguard Children'. Clinical staff who worked directly with children had received level three safeguarding training with 92% attendance reported for April 2018.

The service had clear guidelines on the investigation and progress for safeguarding concerns. When a safeguarding was raised regarding a child or vulnerable young person, the organisation worked to ensure the safety of the individual, with an assessment of the concerns to determine whether a referral to a local authority or external organisation should take place. The safeguarding team were informed about all local authority referrals and worked with the local teams to support the child or young person.

The trust had provided details of the total number of safeguarding referrals made from 1 April 2017 to 31 December 2017 with 1600 referrals made for adults and 375 for children. However, this is for the whole trust and has not been broken down to core service level. The data reviewed during inspection collaborated these safeguarding referrals for children and young people and that the number of safeguarding referrals had increased from April 2017. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

The trust had a named executive director responsible for safeguarding with a lead for safeguarding for children and young people. The lead for safeguarding shared information with other stakeholders such as the police, local authority and specialist schools. Each service across the trust had a safeguarding champion who was an identifiable champion responsible for co-ordinating communication for children at risk of safeguarding issues within the service.

The safeguarding and Mental Health Act committee met monthly and provided reports to the board. The training strategy for safeguarding ensured that all staff received the appropriate training.

All safeguarding activities were logged on the trusts electronic system and followed through by the safeguarding team to ensure processes are followed and staff are supported.

On reviewing the annual safeguarding report for Essex Partnership University NHS Foundation Trust (EPUT) dated 2017-18 it showed that safeguarding was a key priority for the trust and was included within the trust corporate objectives.

There was safeguarding supervision in place for all staff with compliance submitted to the trust board which was in line with the trust target of 90%. Staff described how they could discuss the specific cases within their area of responsibility.

The service ensured staff training and competencies reflected government guidance including how to recognise signs of child sexual exploitation and female genital mutilation (FGM). FGM is an illegal procedure where the female genitals are deliberately changed when there is no medical requirement. Although staff had not seen any individual with FGM they described photographs shared from the trust training and were confident when they described actions they would take to escalate any concerns.

All children, children's social care, police and health teams had access to a paediatrician external to the organisation with child protection skills 24 hours a day in line with the recommendations in the "Facing the Future" report published by The Royal College of Paediatrics and Child Health (RCPCH, 2015).

The trust overall reported there had been a slight increase in serious case reviews in 2017. There were nine serious case reviews that EPUT had been involved in. Although, there were no specific recommendations for EPUT the learning from other organisations involved in the reviews was discussed.

The manager described how all reviews were shared and discussions held with staff to ensure lessons were learned across all organisations.

Health visitors discussed serious case reviews and outlined the recommendations implemented. Good practices were observed in child health clinics and home visits ensured that fathers were included in shaping the care plans for their children. There was a clear system in place for linking fathers and significant others within the clinical record system. We reviewed the action plan and saw the completed progress recorded.

We observed multi agency partnership working between health visitors, police, education and children social care who used evidence based tools called "Signs of Safety" and the "Voice of the child" to formulate safeguarding plans.

The trust safeguarding team attended the local multi-agency safeguarding hub (MASH) meetings to improve information sharing and partnership development with other agencies. The service contacted the multi- agency referral and assessment team (MARAT) which accepted referrals for children and young people that are identified as requiring additional support and undertake child protection enquiries where appropriate. We asked to see the evidence of these referrals and the impact on children and young people service's but this has not yet been received.

Senior staff described the risk of abduction included as part of the safeguarding policy and was included in safeguarding training for staff. We have requested the policy from the service but it has not yet been received.

Cleanliness, infection control and hygiene

The service had an updated infection prevention and control policy which was reviewed on 30th June 2017. Staff who had completed training for infection prevention and control showed 86% compliance which was within the trusts target. Staff knew how to report infection control incidents and how to escalate to the infection prevention and control team.

The clinic and hospital locations visited were visibly clean and clutter free. All clinical areas had vinyl flooring, in line with best practice guidelines from the Department of Health.

Staff followed best infection prevention and control practices and adhered to 'arms bare below the elbows'. We saw that staff had access to appropriate protective equipment such as gloves and aprons to carry out procedures and personal care activities. Staff told us of a uniform policy change and the only staff that wore clinical uniforms were the nursing staff from the children's

continence and diabetic teams. This was implemented following a consultation with patients, parents and the infection control team.

Signed cleaning schedules were completed daily following staff cleaning clinical areas. Staff cleaned toys appropriately after each use followed by a deep clean of all toys monthly or more frequently if there was an identified risk. Equipment was seen to be cleaned between each patient use.

The service had identified trust wide IPC link workers and hand hygiene champions. The service had regular hand hygiene audits with January 2018 report showing 98% compliance achieved which assured managers that staff were compliant with hand hygiene policies and procedures.

We saw appropriate facilities for the disposal of clinical waste and sharps in clinical areas. There were different coloured bags to identify categories of waste in line with current waste management.

Staff were seen providing education to children and their parents/carers on infection control practices at clinic appointments and home visits with written information which gave contact numbers for further support if needed.

However, we reviewed the standard operating procedure for vaccine management during immunisation session dated 2016 and found that there was no reference to infection prevention and control practices (IPC). This meant that managers would not be assured that all IPC practices had been maintained by staff prior to or following immunisation.

The service had several hand operated waste bins in place instead of foot pedal bins which was escalated to the nurse in charge as this was a risk when dealing with nappies or clinical waste.

Environment and equipment

The service had suitable premises which were well maintained and were observed as safe for children. Access was through secured doors accessed by identity cards held by authorised staff. Clinics were held in several locations across Essex in properties which were owned by other organisations. Staff ensured that the facilities met the needs of the service users and their families as far as practical. All locations had service level agreements with the appropriate organisation and risk assessments completed. Locations that provided services visited during the inspection were based in Benfleet, Canvey, Southend and included a specialist school. In addition, inspectors visited service users within their home environment. Staff knew what to do if a child or young person's condition deteriorated and had access to first aid equipment and resuscitation trolleys within the acute hospital. Staff could access the up-to-date Resuscitation Council (UK) guidance.

Staff told us how children and young people were offered the opportunity to attend the location before the appointment date to familiarise themselves with the environment. The facilities were generally fit for purpose and staff had access to quiet room and assessment areas.

Staff told us that when the child with diabetes reached 14 years of age they were considered as being in the diabetes transition phase. This is when the young person then attended the adult diabetic clinic supported by the children and young people's diabetic team. Staff from the two teams would see the child or young person until the individual was confident in attending the adult diabetic clinics. There was a suitable separate room available for children and young people away from the rooms used by adults.

The children's equipment store room was kept in a secure room within the community hospital. All equipment seen had up to date electrical safety test labels in place with an identified equipment maintenance programme which included the planned service dates. Equipment reviewed included nine syringe pumps, ten apnoea monitors and two oxygen cylinders with asthma bags. The two asthma support bags had fully completed daily checklists and contained anaphylactic support and appropriate, within date medication. Staff told us that all stored equipment that did not require daily checks had safety tests before sending for patient use. The children's store cupboard temperature was recorded daily with all documentation reviewed for April 2018.

The service showed good practices were in place with the equipment database, which included a note for all staff to remind them that in 2020 all syringe drivers would need a spring replacement as per the recall alert of 2017.

Raphael House lacked child friendly adaptations with no child sized chairs or table. This was discussed with the senior manager who confirmed the service had already reviewed another more suitable alternative location. This was not on the risk register and we requested the risk assessment but had not yet received it at the time of writing this report.

Assessing and responding to patient risk

Staff had undertaken training and had knowledge of how to complete the paediatric early warning sign tool. This is a national tool and used by staff to quickly determine if a patient's illness has declined. The service had a deteriorating patient policy which described the process for escalation to the acute hospital and included the management of sepsis. Staff confirmed they had a good understanding of the signs and symptoms of sepsis and knew when to escalate. If a child or young person's condition rapidly deteriorated staff knew to contact the emergency services for an immediate referral to the nearest acute hospital.

All children and young people had completed risk assessments which were continually reviewed and updated with changes found during any clinic or professional attendance.

Health risks to children and young people and their families were assessed and monitored and managed appropriately. The service used the healthy child programme to assess and monitor the welfare and development of children and young people and families. This is an early intervention and prevention public health programme which allows staff to screen immunise and review the development of children. This also allows staff to identify risk of harm disorder, ill health, or when additional support is required. The service provided this additional support through the universal partnership plus service.

The total number of children seen within the service from 1 April 2017 to 31January 2018 were 135,395 which is 56% of the overall trust attendance figures.
Health visitors and specialist school nurses assessed risks and gave advice to families and to specialist schools. School nurses were no longer employed within this service but staff confirmed they continued to share information to ensure any child or young people was at the centre of the care they delivered.

Health visiting records reviewed showed patient risk assessments were completed appropriately and updated. The health visitors recorded the observations of infant development indicators such as height and motor skills in the red baby record book.

The paediatric community nursing team provided care to children and young people with a wide range of health conditions.

Staff were observed supporting children including those with Autism spectrum disorder (ASD) and Attention deficit hyperactivity disorder (ADHD). Autism spectrum disorder is the name for a range of similar conditions, that affect a person's social interaction, communication, interests and behaviour. *ADHD* is a group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness.

The arrangements for chaperones included staff attendance during consultations with the young person's consent.

The children in care team or looked after children had provided health assessment on all children and young people in care in line with statutory guidance. Staff were aware of lessons learned and we saw evidence of case studies reviewed and actions taken, an example was staff ensured that identified risks are clearly outlined in care plans.

Staffing

Managers planned and reviewed staffing levels and caseloads to make sure the correct number of staff delivered care to the children and young people and their families.
The clinical leads had overall responsibility for staffing levels and caseloads.
From April 2017 to January 2018, the trust reported an overall vacancy rate of 10% in community services for children, young people and families.

Staff group	Total % vacancies overall (excluding seconded staff)
Qualified nursing & health visiting staff (Qualified nurses)	10%
Support to doctors and nursing staff	9%
Qualified Allied Health Professionals (Qualified AHPs)	25%
Support to ST&T staff	6%
NHS infrastructure support	-62%
Core service total	**10%**

From April 2017 to January 2018, the trust reported an overall turnover rate of 6% in community services for children, young people and families.

Staff group	Total number of substantive staff	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Speech Therapy Children	16.94	4.17	25%
Fnp Essex	2.84	0.60	21%
Essex Wide Imms Service	48.76	3.94	8%
Continence Service – Children's	1.82	0.13	7%
Health Visiting Southend	47.02	2.97	6%
Imms & Vacs Bchs	16.95	0.86	5%
Family Nurse Partnership Bchs	6.00	0.00	0%
Abs - Speech Therapy	12.18	0.00	0%
Paediatric Comm Nursing	15.64	0.00	0%

Staff group	Total number of substantive staff	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Mgmt - Children's Servs – Echs	6.60	0.00	0%
Looked After Children	1.00	0.00	0%
Specialist School Nursing Se	5.16	0.00	0%
Se Continence Service Adults	0.67	0.00	0%
Asthma	1.80	0.00	0%
Diabetes - Children Se	5.06	0.00	0%
FNP - ABS	1.00	0.00	0%
FNP - ABS	2.00	0.00	0%
Student Health Visitors Se	4.73	0.00	0%
CCG Specialist Paed Roles Se	6.33	0.00	0%
Core service total	205.32	13	6%

From April 2017 to January 2018, the trust reported an overall sickness rate of 4% in community services for children, young people and families.

Staff group	Total number of substantive staff	Total % permanent staff sickness overall
NHS infrastructure support	1,492.56	2%
Qualified Allied Health Professionals (Qualified AHPs)	2,720.11	1%
Qualified nursing & health visiting staff (Qualified nurses)	18,433.78	4%
Support to doctors and nursing staff	39,970.21	5%
Support to ST&T staff	1,455.82	1%
Core service total	64,072.47	4%

From April 2017 to January 2018, site reported an overall bank and agency of 366 shifts for qualified nursing staff.

Total Number of Shifts available	Total Shifts Filled by Bank Staff	Total shifts Filled by Agency Staff	Total shifts NOT filled by Bank Staff
366	366	0	0

From April 2017 to January 2018, this core service reported a total of eight shifts filled by bank and agency for healthcare assistants.

Total Number of Shifts available	Total Shifts Filled by Bank Staff	Total shifts Filled by Agency Staff	Total shifts NOT filled by Bank Staff
8	8	0	0

This service ensured that the paediatric community nurses establishment and working patterns provided 24-hour End of Life Care, seven days a week as recommended by the Royal College of nursing. The clinical leads gave examples of when staff had provided 24-hour end of life care support for individuals at home. Staff told us they were supported and allowed time to reflect on each experience.

Although there is no nationally agreed caseload, the Community Practitioners and Health Visitors association (CPHVA) recommend an optimum caseload size of 250 children per health visitor for safe and effective care and had included levels of deprivation. Health visiting service leads and health visitors reported a caseload of 1:200 for babies and children aged between 0 to two years. The Health Visitors told us their service model is aligned with the national 4,5,6 approach evidenced by the Healthy Child Programme (HCP). On reviewing the March 2018 health visitor clinical dashboard, they had delivered against the national key performance indicators for the five mandates which are set as new birth visits 96%, 12 month reviews 50%,12 to15 month reviews 50%, two year to two and a half year review or 30 month reviews 50%.

Quality of records

Staff followed the trust's records management policy which provided guidance about confidentiality and right to access records. Patient records were stored on the trust electronic patient record system which was password protected and accessible to staff working within the service. Staff had been provided with mobile phones and laptops. Staff told us that they currently had no connectivity issues and we observed health visitors and specialist nurses update the electronic record.

Staff showed us they used the system which was user friendly with tabs to easily identify where information was stored. We reviewed twelve sets of records which were completed comprehensively, clearly and contemporaneously. The records focused on the needs of the child and included documentation which related to communication across the multidisciplinary team. Risk assessments had been completed which highlighted potential patient safety risks. Detailed individualised care plans were in place for staff to use to improve their documentation and communicate between teams.

Personal Child Health Records (PCHR) were used by staff, known as red books they were seen in use and fully completed by health visitors and other staff at every opportunity to ensure they had an accurate development and growth record.

Staff requested the young persons or parental consent before gaining access to general practitioner's records. This was demonstrated that staff were respectful of the right to access patient records.

Children and young people were supported with their individual needs and their views were documented by staff through the "voice of the child" electronic record. The voice of the child is an electronic documentation of discussions between the individual and staff which used the child or young person's own words.

Systems were in place to identify and monitor all vulnerable children and families on the electronic record system. Staff included details on the patient documentation database about how vulnerable children and young people were supported.

Record audits were completed monthly on at least ten sets of records and compliance showed that staff were aware of and delivered the required record keeping standard.

The service had reviewed and confirmed they met the General Data Protection Regulation (GDPR) for the last 12 months prior to the new data protection law introduced from 25 May 2018.

Medicines

The service had a Medicines Management policy which was last reviewed on 27th May 2017 but we saw no specific reference to children and young people. The submitted attendance figures for April 2018 for Medicines Management training showed staff compliance at 84% which was just below the trust target of 85%.

Staff we spoke with were aware of policies on administration of medications and controlled drugs as per the Nursing and Midwifery Council – Standards for Medicine Management.

On reviewing the children and young people's medication charts, all had allergies clearly documented in the prescribing documents we reviewed.

Staff recorded the child's weight and all prescriptions seen were appropriate for the child's weight.

We observed medicines were stored safely and securely. Fridge temperatures were checked daily and completed fully to ensure medicines were stored at the correct temperature.

The immunisation service provided by EPUT was a vaccination service across Essex and Bedfordshire which included baby vaccinations and school age immunisation programme. The pharmacy service was responsible for dispensing of all medicines within the community. The service was available Monday to Friday 8.30am to 5.00pm.

Medication audits were carried out by the pharmacy team based at Rochford hospital and any errors were shared with staff to prevent reoccurrence.

Staff reported 21 medication errors from January 2017 to December 2017 with discussions held for shared learning and to prevent reoccurrence.

A Patient Group Direction (PGD) for Human Papillomavirus (HPV) vaccine was reviewed. This is an active immunisation against HPV for the prevention of cervical cancer, genital warts and precancerous lesions, given in accordance with the national Immunisation programme to females aged between 12 years and 13 years of age. The PGD was approved by the medicines management committee in June 2015 and was signed by the appropriate staff members. Information within the PGD included the drug details, storage requirements, administration route and dosage. Inclusion and exclusion criteria were fully completed and there were clear indications for cautions, side effects and further advice. The records and audit trial information was itemised. Patient records completed after vaccination matched the requirements of the PGD.

Safety performance

The children and young people service monitored safety and quality performance through clinical dashboards and produced a monthly report for the Quality and safety steering committee. This information included incidents, patient satisfaction and complaints.

Incident reporting, learning and improvement

We saw the trust wide Incident reporting policy version one which was last reviewed in April 2017. Staff knew how to access the policy and were knowledgeable about their responsibilities in raising an incident report including how to categorise the incidents. Staff received training about incidents

at the induction e-learning training and staff compliance showed 96% for this service which was above the trust target of 85%.

There were effective processes for staff to record and manage incidents through the electronic database where all incidents were reported. Staff reported 442 incidents from 1 January 2017 to 17 May 2018. The top three incident themes related to communication, child protection and information governance concerns.

The team leads and managers were notified when an incident was recorded onto the system. If a serious incident was identified this would be investigated and learning was disseminated amongst staff through team meetings or staff briefings. Managers shared learning from incidents after full investigations were completed. Incidents were an agenda item and discussed at management and team monthly meetings. Staff gave an example of a reported incident that included a safeguarding concern, the outcome and learning from the incident included a review of documentation. This was good as it showed embedded learning within the organisation.

From April 2017 to April 2018, there were no reported never events within this service. A never event is a type of serious incident that is wholly preventable where guidance or safety recommendations that provide strong systematic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community services for children and young people which met the reporting criteria, set by NHS England between, April 2017 and January 2018.

Staff understood the principles of duty of candour and could give examples of when they should use it. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Is the service effective?

Evidence-based care and treatment

Staff assessed the needs of children and young people within the service and provided treatment in line with current legislation, standards and evidence based guidance. All new recommendations or guidance was reviewed by senior managers and clinical leads evaluated their current practice and provided assurance that National Institute for Health and Care Excellence (NICE) or other relevant guidance had been followed.

Staff told us they could easily find corporate information on the trust's intranet. Staff showed us how they found policies, standard operating policies and guidance. Policies and procedures were developed based on the latest guidance from NICE. This included NICE guidelines and quality standards related to the care of children and young people with diabetes and epilepsy. Staff told us how new policies had been introduced or existing policies were updated. Managers informed them at team meetings, team minutes or by electronic information.

The service participated in UNICEF UK Baby Friendly, and You're Welcome (Department of Health) programme which supported the delivery of health services that are suitable for young people. The *UNICEF UK Baby Friendly* Initiative supported breastfeeding and parent infant relationships by working with public services to improve standards of care.

Staff proudly described changes implemented to support young people. This included the “Ready, Steady, Go” support for young people from the age of 14 years of age during transition into the adult services which was normally completed by the individuals nineteenth birthday.

The service followed the public health programme National Child Measurement Programme.

We observed clinical specialist staff who provided competent and evidence based care to children and their families in the clinical environment. We attended a diabetic and immunisation clinic and heard staff give the appropriate information to children and young people and their families/carers.

The speech and language team provided care and management for children and young people who had additional feeding and swallowing needs. Staff referred children and young people to the acute hospital dietician for support with maintaining the correct dietary requirements to promote growth and development.

All staff conducted full assessments and provided up-to-date evidence based advice. Children had appropriate health assessments and health care plans to meet their needs. We observed children being assessed thoroughly, with staff demonstrating a good understanding of the individual personal, culture, social and religious needs.

The health visitors delivered the Department of Health’s national programme called The Healthy Child Programme (HCP). The delivery of the HCP was vital as it was key in delivering Public Service Agreements for improving the health and wellbeing of children; made a crucial contribution to the Every Child Matters (HM Government 2004) and National Service Framework for Children, Young People and Maternity Services (DH 2004) outcomes; and fed directly into The Children’s Plan (Department for Children, Schools and Families, 2007) and locally driven Children’s Plans.

The HCP promotes regular contact with every family to include screening tests, developmental reviews and support. Health visitors we saw gave information to parents in line with the HCP. The health visitors confirmed they used the Ages and Stages Questionnaire 3 (ASQ3) an evidence based assessment tool that allowed parents to provide information about the development status of their child across the five developmental areas.

The trust provided the family nurse partnership (FNP) programme through the FNP team. The programme was an intensive evidence based preventative programme which offered specialist support to young people with first time pregnancies. Family nurses delivered the structured programme which was monitored to ensure compliance with the national FNP guidelines. This is good practice as the FNP team used learning from the national Accelerated Design and Programme Testing (ADAPT) programme to meet the needs of local families and changing demands. There was a good rag rated flagging system observed within the electronic supervision tracker.

Sepsis screening and management is completed effectively, in line with national guidance from NICE and UK Sepsis Trust. Staff confirmed their knowledge regarding recognising the sick child and actions they would take when a paediatric early warning score (PEWS) indicated a referral to hospital was required.

There was a local audit programme that fed into the trust wide audit programme and included infection prevention and control and record management audits. Senior staff informed us that the audit outcomes were discussed at team meetings and gave staff an opportunity to discuss changes within the documentation or any practice changes.

The children's specialist teams monitored outcomes and we saw key indicators in place to monitor initial assessment, triage and discharge.

Nutrition and hydration (only include if specific evidence)

Heath visitors and specialist school nurses educated families and carers about the importance of nutritional health. Health visitors gave clear information to mothers about breastfeeding and feeding regimes. We saw a training session where evidence based information was discussed with all staff and confirmed the importance of eating healthier and the benefits eating healthier and the benefits of breast feeding. Children and young people with eating concerns were supported in maintaining a diary to improve any habits that required resolving.

The service had an infant feeding lead that attended team meetings to discuss how staff could support the women and increase the level of engagement.

The service had achieved UNICEF UK Baby Friendly Accreditation Level 3 which is confirmation that staff met all the criteria relating to promoting and supporting breast feeding. Staff were commended for the efforts made to ensure pregnant women and new mothers received a very high standard of care.

Mothers were complimentary about the relationship that they had developed with their Health Visitor. The local initiative based on Family Nurse Partnership model worked with young parents and promoted healthy eating and drinking.

Pain relief

Patient records supported staff discussions with children and young people about pain relief. Staff used the paediatric early warning score (PEWS) to assess patient deterioration. The tool included a numerical scale to assess and record patient pain. For younger children, the service used age appropriate pain assessment tools, which included a face pain rating scale.

Patient outcomes

The service regularly reviewed the effectiveness of care and treatment through local and national audits. Patient care and treatment information was collected and monitored to provide managers with assurance and to drive improvements to the service. Senior staff sent key performance indicators data monthly to the local CCG. Senior staff told us that this review ensured quality standards were monitored in line with agreed targets.

The service delivered the Healthy Child Programme which assessed and monitored patient outcomes. The service reported that between January 2018 and March 2018 health visitors had achieved 96% for when they attended to babies within their first 10 days of life and 98% attendance for when they attended to the baby for the six to eight week visit. The health visitor's 12 month visit compliance was 94% and the two year visit achieved 96% which was about the same as the agreed trust target of 95% between January 2018 and March 2018.

Staff told us that all targets were met with evidence of flexible teamworking, support and prioritising those families who had the greatest need.

The service delivered the National Child Measurement Programme, a national public health programme. All children were measured by weight and height in reception year six to assess obesity levels. Overweight children were supported with their parents to ensure no health problems caused them to be overweight and referred to the appropriate team to support them with healthy eating. As part of the National Child Measurement Programme all children and young people were screened for obesity. The NCMP report showed 21% of reception class (4-5years)

and 32% of year six (10-11years) children were assessed as being in the overweight and obese category. Staff provided health advice to all children who were assessed as being overweight and their parents or carers. Staff supported them through an individualised weight management programme.

Staff described how they reviewed children and young people and ensured they were on the correct pathway and that the child or young person's interests were met while delivering the best patient outcomes.

Children's Speech and Language Therapy (SALT) was a community-based service that provided a service for children and young people aged up to 18 years who live within and are registered with a GP in South East Essex. The service provided was evidence-based, friendly and approachable. The service anticipated and responded to the needs of children and young people that had or were at risk of having speech, language and/or communication difficulties. The SALT had developed a website link to support children and young people and staff thinking about the best outcomes pre and post therapy.

There was a systematic programme of clinical audit across the service to assure senior staff of the safety of the service. We saw evidence that the team leads had used results to implement improvements in the service.

Family nurse partnership team (FNP) submitted data to the national database system which showed national results in May 2017 of 58% of FNP clients initiate breastfeeding, 81% of FNP babies meet the same developmental milestones as their peers at fourteen months and 92% of FNP babies are up to date with immunisations at six months. The overall children and young people immunisation compliance rate increased by 5% for 2017 with 85-90% CYP immunisations completed reported in September 2017. This demonstrated good patient outcomes.

The recently awarded funding from "The Big Lottery" had been invested in "A Better Start Southend" project which helped develop new and improved Children's Services for Southend. The initiative was part of a ten-year research and development programme working in partnership with parents, carers, and professionals to create and improve services focusing on families with children under four years-old.

"A Better Start Southend" project involved a partnership of organisations which included EPUT to give local children the best possible start in life and used new ways of thinking which provided preventative support at an early age. This project focuses on families in six local areas of Southend. The work completed has already made a difference in three areas of those children's lives and included communication and language, social and emotional development and diet and nutrition.

The Communication and Language Team consisted of Speech and Language Therapists, Speech and Language Therapy Assistants, and a Specialist Teacher who are developing and testing preventative programmes in the local community. The team ran free courses for families with children of various ages to support and encourage Speech and Language development, from 6 months of age.

SALT courses currently available included, Let's Talk with your Baby (6-9 months), Talking Tiddlers (12-18months), Talking Toddlers (18-24 months) Chatting Children Super Sounds and 23 months check by invite for children within the six a better start Southend areas. This showed a good support programme for younger children.

The trust had participated in five specific clinical audits in relation to this core service as part of their Clinical Audit Programme.

Audit name / title	Audit scope	Core service(s) that participated in the audit	Type of audit	Date completed	Key actions following the audit
Audit Of Seclusion practice	All Episodes of seclusion April - July 17	Provider wide	Clinical	Qtr2	Key actions will be noted and taken forward by the restrictive practices group.
Risk Assessments following episode of Self Harm	Across MH services	Provider wide	Clinical	Qtr4	
Care planning Following an episode of self-harm	Across Mental Health services	Provider wide	Clinical	Qtr4	
Estates Management (fire safety)		Provider wide	Environment	Qtr 3	Fire Safety Committee to be established with Terms of Reference. Standardised training programme to be presented to EOC and cascade trainers package in place to aid consistency across the Trust. All Trust sites have been prioritised and status of FRA reported to HSSC. All remedial actions being updated to Datix, and Task and Finish group established to monitor progress. Evacuation aids are being ordered and deployed to sites. Datix now includes all fire alarm activations.
Medical Records Management		Provider wide	Corporate	Qtr 2	A combined IM&T strategy has been produced. All records management policies have been reviewed. Trust will explore one data storage site in the future - former NEP contract expires October 2018. Terms of Reference for IG Steering Group have been approved.

Competent staff

Staff had the appropriate skills, knowledge and experience to deliver effective care and treatment. There was an up-to-date induction programme for all new staff working within the service.

Staff received bespoke training and all staff spoken with had completed revalidation within the last three years. Revalidation is the mandatory process where nursing staff provide evidence of their updated professional knowledge and working hours for registration with the Nursing and Midwifery Council.

There were competency assessments for all staff which were signed off by the team leaders. We saw that staff had completed competencies and further specialist training appropriate to their role. Staff told us they were supported in completing additional relevant training opportunities. An example given was two staff who are now completing the non-medical prescribing course.

The staff received supervision and appraisal with the service supporting staff in taking protected time to complete these activities. Staff identified their learning needs through the yearly appraisal. Clinical leads provided monthly supervision to their teams or more frequently when staff had complex cases on their caseloads. The clinical dashboard was presented at senior nurses meeting to review staff compliance.

The service had a preceptor programme to ensure that newly qualified staff are supported by senior staff.

Staff we spoke with who had just returned following long-term absence informed us that the service had “Keep in touch” update opportunities which supported the individual’s confidence when they returned to work as they were informed of all recent changes within the service.

There was a practice development nurse who supported staff development requirements, in addition to alternative monthly training sessions. The training days covered subjects identified by staff as a training requirement. Senior staff supported staff attendance at alternative monthly professional development days to support staff with succession planning and developing their own staff. We were informed of two members of staff who had commenced at EPUT as band five level staff and who were now in senior roles within the service.

All healthcare assistants were supported in completing the care certificate which gave them increased knowledge and skills to provide high quality care.

The service supported placements for medical, nursing and therapy staff.

The trust had a combined approach to management and clinical supervision as set out in policy. All staff are required to have supervision a minimum of every eight weeks (unless specific service or professional requirements apply it is more frequently e.g. forensics). Data is provided below for all non-medical staff which will include clinical and non-clinical staff.

From 1 April 2017 to 31 January 2018 the average clinical supervision rate for the core service was 97% against the trust’s target of 90%.

Team	Clinical Supervision Target	Clinical Supervision Delivered	Clinical supervision rate (%)
Essex Wide Imms Service	434	434	100%
FNP Essex	50	50	100%
Paediatric Asthma & Allergy Service	10	10	100%
Speech Therapy Children	55	54	98%
Continence Service – Children’s	30	29	97%
Health Visiting Southend	527	513	97%
Paediatric Comm Nursing	148	143	97%
Specialist School Nursing	68	66	97%

Team	Clinical Supervision Target	Clinical Supervision Delivered	Clinical supervision rate (%)
Children's Community Staff (Various Services)	60	57	95%
Children's Community Services Management (South East Essex)	10	9	90%
Paediatric Diabetes Specialist Nursing Team (PDSN)	50	43	86%
Professional Lead HV SE	20	15	75%
Core Service Total	**1,462**	**1,423**	**97%**

From April 2017 to January 2019, 97% of permanent non-medical staff within the community services for children, young people and families core service had received an appraisal compared to the trust target of 90%. All teams or services achieved an appraisal compliance rate above the trust target of 90% with the exception of Professional lead HV SE (67%), this is a small team of three.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
CCG Specialist Paed Roles SE	6	6	100%
Continence Service – Children	3	3	100%
Diabetes - Children Se	6	6	100%
FNP Essex	6	6	100%
Looked After Children	2	2	100%
Safeguarding Children	3	3	100%
Specialist School Nursing SE	6	6	100%
Essex Wide Imms Service	57	56	98%
Health Visiting Southend	57	56	98%
Paediatric Comm Nursing	14	13	93%
Speech Therapy Children	21	19	90%
Professional Lead HV SE	3	2	67%
Core service total	**184**	**178**	**97%**
Trust wide	**4121**	**3386**	**82%**

Multidisciplinary working and coordinated care pathways

We saw effective multidisciplinary working across the service with good examples of communication across all speciality teams. There was a positive working relationship between staff groups and the local hospital. The paediatric liaison staff told us how they had developed links with the local hospital with daily visits and to promote admission avoidance. Staff told us how they had accessed resources in the acute hospital when required.

The service held a weekly multidisciplinary team meeting where the holistic needs of the child or young person were discussed. Processes had been put in place to ensure that the appropriate specialties had been involved in the multidisciplinary team meeting. All appropriate staff assessed, planned and implemented the co-ordinated care delivery for the child or young person and their

immediate family. The speech and language therapy, specialist nursing, health visiting staff, paediatricians and social service staff all attended the multidisciplinary meeting.

Paediatric community nurses were supported by healthcare assistants who assisted with clinics.

Staff networked and developed close working relationships with staff from external services and agencies. For example, the paediatric liaison nurse worked closely with the acute hospital staff in the emergency department, special care baby unit and the children's ward to facilitate a seamless service and to avoid admission where possible.

Staff reported a strong professional working relationship with social care services, children's centres and midwives across the region.

There was a strong working relationship between specialist school nurses and external staff. We received positive feedback from a specialist school head teacher for the specialist school nursing team. They spoke highly of the service provided by EPUT. "The staff demonstrate and provide a caring, efficient service that is consistent and responsive".

The specialist school maintained a link with the SALT for staff to seek support and advice.

GP practices had a linked health visitor to ensure information was shared between services.

Children and young people requiring mental health treatment were referred to another organisations Child and Adolescent Mental Health Service(CAMHS). CAMHS provided outpatient assessments, support and treatment for emotional and behavioural difficulties in children up to the age of 16 and adolescents aged between 16 and 18. The service provided help to children and to the wider family.

There were transition arrangements for young people moving to other services or adult services.

Health promotion

We observed health visitors and PCN staff discussing a variety of ways to promote their child's health. Health promotion leaflets were available in the clinics we visited and in the hospital setting.

We saw staff present a training session with thirty-eight multidisciplinary staff in attendance. The presenting staff described different methods to support a child or young person who was sleep deprived, had limited nutrition or associated behaviour that disturbed that individual's growth and development.

Staff described recent training that they had completed called "Sleep Scotland" which is a sleep counselling service which helps families with children with additional support needs. This service supports children and young people and had been used across the teams.

Staff advised parents how to maintain their home environment to promote children and young people's safety and promote growth and development.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training in the Mental Capacity Act (MCA, 2005) and understood policy on patients giving informed consent to treatment. The Mental Capacity Act is designed to protect patients who may lack capacity to make certain decisions about their care and treatment. Information about the Mental Capacity Act and associated Deprivation of Liberty Safeguards (DoLS) was included as part of the mandatory training programmes. Data provided from the trust showed that 93% of staff had completed the Mental Capacity Act training as of April 2017, against a trust target of 85%. Staff were aware of their responsibilities to seek patient consent in line with current legislation. Staff told us they were aware of Gillick competence and applied this when obtaining consent from

young people. Gillick competence was used to describe when a child could consent to their own medical treatment.

Fraser guidance is used to meet the needs of young people under the age of 16 years, so they can receive contraceptive advice or treatment without parental knowledge or consent. While the school nursing service is no longer provided at EPUT. Staff provided us with an example when a young person requested contraceptive advice and staff demonstrated a good knowledge of Fraser guidance.

We observed staff obtaining consent from children and young people and parents or carers before delivering care.

Staff encouraged young people to involve their families in decisions about consent.

Is the service caring?

Compassionate care

We observed staff who provided compassionate care during interactions with children and young people. Staff had explained to the child or young person the care they would provide. Staff then checked with the child or young person that they understood and agreed prior to delivering any care. Staff were highly motivated and inspired to offer care that was kind and promoted dignity, an example given included how staff described care they delivered to a long term service user and their family. These relationships are highly valued by staff and promoted by leaders.

Language used was appropriate to the age of the child or young person and staff were observed maintaining the children and young people's dignity, respect and individual needs were met.

Assessment or treatment rooms had doors closed to maintain the privacy, dignity and confidentiality of any children and young people discussions. Staff were professional and extremely kind during interactions observed.

We observed that no child or young person was left unsupervised during care.

Staff described the different ways in which the service gained feedback through friends and family test (FFT) and the child's voice. There were three parents and five children and young people spoken with during this inspection. All spoke positively about staff and praised the staff for their professionalism, friendliness and support. We saw compliment cards and letters from parents and children and young people which contained praise and thanks to staff across this service. Comments included praise for staff from another service provider who confirmed staff went the extra mile and gave an example when staff exceeded a family's expectations.

Children and young people and their families provided feedback on the service using the FFT patient satisfaction survey. From January 2018 to March 2018, the overall satisfaction for this service was 95% the trust target of 87%.

There was a strong, visible children centred culture within this service. Staff were observed interacting with children with different individual needs and demonstrated a non-judgemental attitude when talking about children or young people who have specific phobia's, diagnoses or disabilities.

Staff allocated extra time to children or young people who were frightened, confused or had phobia's. An example was a child who had a needle phobia and refused immunisation. Staff provided extra support and time to discuss their options and what the risks were if they did not have the vaccination. The individual asked if they could make a telephone call to their parent and after further discussion they agreed to have the vaccination.

Emotional support

Staff described the importance of providing emotional support and told us how they supported children and young people and their families. They described how they provided the care required and how they supported the child to ensure that the individual's requests were identified and delivered. This included not only the child but also the requirements and support they were able to offer the parents. Children and young people are active partners in their care and staff described how they were fully committed to working in partnership with children and young people to make this a reality for every individual. Staff gave an example of when an individual presented at clinic and when they felt confident to, discussed their concerns with staff. Staff supported the individual throughout the management of the concern and referred the individual to the appropriate service. Children's emotional and social needs are highly valued by staff and are embedded in their care and treatment.

Staff accessed child psychologists through the acute hospital when required for children and young people. Staff recognised when children and young people required additional emotional support and agreed an extra time allowance for the child or young person.

The speech and language therapy team developed the "Chatty Bear" which was used to provide children and their families with advice. The "Chatty Bear" had made several intranet appearances which provided information about travelling, noise reduction and planning. This meant that the service promoted the available support and provided the child or young person with a better quality of life.

Staff informed us of the close network they have with external agencies to ensure that appropriate counselling or bereavement services were available for children and their families to receive the individualised support they needed when receiving bad news.

Staff recognised the religious or spiritual needs of the children and young people and their families and took into consideration any particular spiritual or religious commitments when scheduling visits or appointments.

Understanding and involvement of patients and those close to them

We observed staff who communicated appropriately with children and young people and their families. Staff respected the children and young people in their care which included cultural, social and religious needs. We saw easy read information available for children and young people.

Child friendly leaflets and information on the webpage was available to support children and young people in making decisions about their care and treatment. Staff told us about the introduction of teddy bears used with age appropriate children to support communication between the child and the professional. We saw information about the diabetic teddy bear and the "chatty" bear used by the speech and language therapists in health education videos. All children completed an assessment and then were issued by staff with a teddy bear kit to support them with long term conditions. The teddy was introduced as a withdrawal technique method used with the child to support with sleeping and took the child's attention away from the parent or carer and towards the teddy. This was a good technique used that allowed staff to support and involve the children and young people.

We saw Friends and family test cards suitable for children, the voice of the child assessment sheets recorded in language used by the child and the patient, advice and liaison service (PALS) information leaflets for any concerns children and young people wanted to raise.

When asked about care plans and their involvement in the care provided those parents and children we spoke to, confirmed the staff put the child at the centre of care and was informed before any change was made.

Staff had access to communication aids provided through the speech and language team.

Is the service responsive?

Planning and delivering services which meet people's needs

The trust worked together with commissioners and other organisations across Essex to plan and meet the needs of the local population. The service planned and provided services which were delivered by health visitors, specialist school nurses, immunisation teams, therapy teams, family nurse partnership team, paediatric community nurses, specialist nurses and the speech and language therapy team.

Staff ran clinics in several locations across Essex and included bases in GP surgeries and health and community centres. Clinics were also held in the dedicated child development centre in Southend. Appointment times were agreed with the patient to allow patients flexibility and choice which reduced "did not attends" appointments.

The trust's facilities and premises were appropriate for the service it delivered. Most areas had child friendly areas including a play area supplied with toys and games. Although one area was seen to not have child friendly adaptions or child information boards. Managers told us the service had plans to relocate this service to more appropriate facilities. Private rooms were available at clinics to maintain confidentiality and privacy.

The paediatric community nursing team provided on call support service 24 hours a day, seven days a week which included when a child or young person approached the end of life. School nurses and sexual health staff are now employed by an external company so those specialities are no longer provided within this service.

The service had an access policy to ensure patients are seen by staff who could meet the children and young people's needs.

The service had established robust relationships with external organisations and professionals to ensure that the children and young people could access the correct team.

Individualised care pathways were in place to provide the best treatment approach for the child and included individual therapy techniques that were used in the home with the child or young person. Advice offered included how the environment at home/school/nursery can be changed to support the child to reach their communication potential. Staff attended "Team Around the Child" and "One planning meetings" which provided written support of advice for the individual. This was monitored by managers and drove the service forward with shared learning presented across the team at alternate month team training days.

Meeting the needs of people in vulnerable circumstances

The service was delivered to meet the needs of children and young people, including those in vulnerable circumstances.

The service employed a team of six specialist clinical staff to support play and parenting advice for children and young people and their parents or carers who were homeless. We spoke with a play and parent advisor who described the complex needs they had recently organised to meet the needs of homeless families. There was no waiting time to see the team and hostels frequently contacted them directly. The team had access to nurseries with free spaces within the local

community and referred children and young people directly to the speech and language therapy team should the child present with additional needs. We met with the team and they described systems they had in place to be informed of homeless children and young people within their area. They had robust networks in place to meet needs of the local population and an example given was a homeless child had been in a nursery placement within several hours of the team being informed about the child.

The specialist school nurses offered support for children during their attendance schools. These schools were maintained by the local authority and provided education for children with specialist needs.

The service delivered individualised care for children and young people with complex needs. Multi-disciplinary team assessments were conducted which allowed staff to identify the patient's individual needs and family care and treatment in an individualised manner. Staff confirmed there was an electronic flagging system to record any individualised concerns. The Lighthouse child development centre held treatment programmes for children with development problems including learning difficulties and social communication. There was specialist equipment available for children and young people including mobility aids.

We observed clinics held at the local hospital and observe staff supporting children and providing reassurance to young people and their parents. Staff had access to specialist therapists who had received additional training and provide advice and support. Staff received training to make them aware of the potential needs of people with complex conditions such as learning disability and autism. Staff gave an example where they adapted their practice to meet the needs of the patient by assessing the individual out of the allocated area.

The service had access to the "Big word" language line and interpreters were booked as required for children and young people whose first language was not English.

Access to the right care at the right time

The parents or carers had a single point of contact to obtain support from correct team within the service. Teams described support offered with development diaries to ensure the individual obtained the right care. Staff described the diversity of the local community it serves. On reviewing the local ethnic minority distribution the representation is outlined as below.

	Ethnic minority group	Percentage of catchment population (if known)
First largest	White English/Welsh/Scottish	84.39%
Second largest	White Irish	1.06%
Third largest	Asian/Asian British Pakistani	1.63%
Fourth largest	Black/African/Caribbean/Black British: African	1.65%

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

The trust met the referral to assessment target in four of the targets listed.

The trust has stated N/A for days from assessment to treatment and provided clarification below.

Name of hospital site or location	Name of in-patient ward or unit	Service Type	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
			National Target	Actual (mean)	National Target	Actual (mean)	
South Essex - Range	Continence Childre n	Community health services for children, young people and families	18wks	74	N/A		we do not monitor initial assessment to onset of treatment as following implementation of access policy treatment is usually started at first appointment
South Essex - Range	Paediatric Asthma & Allergy	Community health services for children, young people and families	18wks	22	N/A		
South Essex - Range	Paediatric Community Nursing	Community health services for children, young people and families	18wks	2	N/A		
South Essex - Range	SLT Childre n	Community health services for children, young people and families	18wks	78	N/A		

The information submitted showed that the service had met all four national targets for 18 weeks. This national target was set to prevent treatment delays from initial referral to the first appointment. The service did not monitor initial assessment to onset of treatment as treatment was commenced at the first children and young people's appointment.

All parents and carers registered with an Essex general practitioner (GP) had access to the health visiting service. The health visitors provided home visits and drop in sessions across South Essex. Children and young people had access to therapy programmes in clinics through GP referrals, specialised school referrals or through the children and young people community teams. The children and young people community teams referred children and young people to the appropriate service when required. The speech and language therapy team provided regular sessions for patients.

The service monitored children and young people waiting times to identify services in high demand and manage appropriately to prevent any delays.

The health visiting team supported families with contact visits during the antenatal and perinatal (birthing) period, at six to eight weeks in addition to a 12 month and two-year review. From April 2017 to March 2018 health visitors had completed visits to 96% of babies within their first 10 days and again at six to eight weeks. Health visitors met the trust target of 95% for contact visits to children at 12 months and two years.

Staff ran a variety of clinics in different locations across the region, on different days of the week with morning and afternoon sessions to promote attendance. For example, the paediatric continence service held clinics between 9.30am and 4.30pm based in 15 different locations each month. Staff offered parents/carers opportunities to book appointments to meet the needs of the child or young person in addition to home visits.

Children and young people and families who did not attend appointments were contacted to schedule another agreed appointment. The service rescheduled any cancelled appointments and offered flexibility where possible. We received feedback from a parent after a delay occurred during the clinic appointment, the parent was spoken to by the nurse and accepted the reason given for the delay. There were no clear processes observed if clinics ran behind time.

All services were available Monday to Friday between 9.00am to 5.00 pm. Paediatric community nurses provided an out of hours on call service.

Assessments of the needs and risks to children and young people were documented in referrals made by health professionals. Guidance supported the referrals made to ensure that the correct children and young people information was available to the teams. We saw referral guidance for the speech and language therapy service which ensured information about the individual's referral was available before the service accepted the child or young person.

However, one concern raised was a possible delay for young people with autism spectrum disorder who could wait up to two-years for a multidisciplinary assessment. This trust was not responsible for providing this service.

Learning from complaints and concerns

The service had an up to date complaints policy which was last reviewed in April 2017. Staff followed the complaints policy which provided guidance on how to manage complaints efficiently. All complaints and concerns were logged by staff onto the electronic reporting system. Complaints were managed by the team leads who resolved concerns at the earliest opportunity. If a complaint was raised due to them not being able to resolve the concern, a named staff member was appointed as the lead for the investigation and response. All complaints and responses were reviewed by the senior team before they were sent out to the complainant from the chief executive.

Children and young people services received five complaints from 1 April 2017 and March 2018 with no referrals to the Parliamentary and Health Service Ombudsmen (PHSO).

Complaint themes included dissatisfaction of treatment from the service, staff attitude and communication.

The service acknowledged all complaints within three working days and provided resolution or complaint responses within 28 days.

A Lessons Learned Oversight Committee ensured that learning was taken forward and implemented within the service delivery. An example seen was where the service had sent a letter to the parent/carer which invited them to call if they had any questions but had not included a contact name or telephone number. The parents found a number on the website but on calling the telephone was unanswered. This complaint was addressed successfully, the website telephone numbers updated and all letters are checked to ensure they include a contact name and number.

Complaints were discussed in the management and team monthly meetings. An example documented was poor communication between a member of staff going on long term leave who did not inform a parent who waited for the staff member to return call regarding her child's appointment. The complaint was resolved and processes reviewed to prevent future reoccurrence.

The trust had developed a patient advice and liaison service information leaflet specifically for the children and young people service which meant children and young people could understand the complaints process.

Complaints leaflets describing the complaints procedure and complaints posters were available at clinics and at child health centres. Patient families told us they would feel confident to raise a complaint if necessary. The service provided patients with information on how to progress a complaint by the PHSO if they were not satisfied with the trust's internal complaints process.

The main complaints themes related to clinical practice, communication and systems and procedures.

Team	Clinical Practice	Communication	Systems & Procedures	Total
Paediatrician	1		1	2
Health Visitors		1		1
Community Doctor Services for Children	1			1
Community Physiotherapy for Children	1			1
Total	**3**	**1**	**1**	**5**

The trust received 661 compliments during the last nine months from 1 April to 31 December 2017. Fifty-four of these related to community services for children, young people and families, which accounted for 8% of all compliments received by the trust whole.

Is the service well-led?

Leadership

The service has a non-executive director named as the children's champion who provided links to the trust board. The designated children's lead was the executive director who reported to the board as the lead responsible for managing quality assurance. Staff reported there was low visibility at executive level although all staff praised the local senior team for their leadership. Staff stated that they felt valued and supported in their role.

Community health services for children and young people were overseen by the children and young people's associate director and deputy director. Each team had a clinical lead who reported to the associate deputy director.

Staff confirmed that they were supported with professional development opportunities and gave examples of recent training they had attended. Staff had attended leadership development and local and national conferences.

There was a specialist named nurse for safeguarding and although there was no named doctor employed within the trust for safeguarding, staff informed us that the service was supported by the trust wide medical director and medical staff at the acute hospital. We met with all the team leads available during the inspection and recognised that they were all experienced and passionate leaders who inspired and empowered their teams. The team leads were active role models for their teams. They were knowledgeable about current changes, guidance and delivered high quality care.

Vision and strategy

The trust had an overarching mission, vision and set of values known by staff and which reflected the local objectives within the service. The values included ensuring that everyone counts by putting the patient at the centre of care while treating all with individuals with compassion, respect and dignity. Their commitment to high quality care while working together with children and young people and their families to improve their lives.

The trust had worked with staff to develop the local organisational values and staff demonstrated that they worked to those values.

The overall trust strategy included four objectives which focused on continuously improving patient safety, experience and outcomes, attracting and developing high performing staff and co-designing and co-producing service improvement and quality plans. Staff confirmed they were aware and informed of the service's strategy which fed into the overall trust strategy.

The service's strategy reflected national recommendations and direction for care of children and young people, for example the immunisation programme.

The vision for the service was to be open, compassionate and empowering.

We saw the trust vision, values and strategy displayed in the trust buildings and used as a screensaver on trust computers. The values were also included in the recruitment interviews for staff to confirm what open, compassionate and empowering meant to them.

Culture

Staff reported an open and honest culture and said they felt able to raise any concerns with their managers. All staff confirmed that the needs and patient experience of the children and young people was central to the service.

Staff morale was positive and staff spoken with during the inspection confirmed that they felt valued and well supported by colleagues and managers within their roles. An example was one staff member who told us this was the best team she had worked in.

The service encouraged and supported staff to progress. Staff reported that equality and diversity was promoted and staff gave examples of succession planning and career progression. Several staff members described how they had started as a band five and had achieved promotion within the service.

Staff knew how to use the whistle-blowing process and how to contact the Freedom to Speak up Guardian.

The service had taken measures to improve the safety for staff working alone in the community and had issued team activation alarms. Staff described how they recorded their names and locations before going into children and young people's homes and if the alarm was activated this recorded message was accessed. The trust had a lone working policy reviewed in April 2017 and staff confirmed they were aware of their responsibilities and how to escalate concerns.

The trust ran staff recognition awards for staff contributions to the service. A staff member was successful in winning the trust wide customer care award for 2017.

Governance

There is an executive and non-executive director lead for the service. Staff confirmed that although at the last inspection that they had not had a recognised lead executive for the service this was immediately addressed after the last inspection and we saw the executive lead details displayed within the clinical leads office.

The board was presented with a quarterly and annual report for safeguarding children and young people. Evidence submitted from the trust included the annual safeguarding report for 2017/18.

There were clear roles and responsibilities and systems of accountability to support good governance and management of the service. Staff we spoke with described the service's management structure and specific roles and responsibilities. There were monthly team meetings and team leader meetings. The minutes for team meetings were circulated to all staff. The service produced a monthly quality and safety report which was reviewed locally and at trust board level.

There were clear lines of responsibility for safeguarding and supporting looked after children. Senior managers attended mortality and morbidity meetings held across the trust to ensure that learning was shared across the service.

Management of risk, issues and performance

There were clear and effective processes for managing risks issues and performance. The service had an electronic trust wide risk register. The trust risk register was based on the potential consequence of the risk and the likelihood of the risk happening again. All risks had a review date, a named responsible individual and an action plan. There were eight risks currently on the risk register. However, senior staff were not able to confirm the top three risks for this service, but when asked their concerns reflected the service risks. The senior manager confirmed that these were discussed at the last team meeting. We reviewed the team minutes which noted this was an agenda item.

The service participated in local and national audits. The national audits topics included diabetes and infant breast feeding.

The services used performance clinical dashboards which provided assurance that the service was being delivered in line with national guidelines. There was a clinical audit across the service for assurance for all staff of the safety of the service.

The major incident plan guidance version one was ratified on 15 June 2017 and staff knew how to access and could describe their roles and responsibilities. Staff gave examples of two major incidents which included the cyber-attack in 2017 and the snowfall of 2018. Both incidents required business continuity plans to be implemented to meet daily activity. Paper records were maintained until the electronic records were available. Telehealth and skype calls were used when visits were not able to be completed due to distance or the snowfall which caused roadblocks. The lack of impact on daily activity demonstrated that the team worked extremely well together to ensure patient needs had been prioritised.

Information management

We saw performance measures which assured managers and provided reports for the trust board. Clinical dashboard produced a service level monthly report which was presented at team meetings and the quality and safety meeting.

Staff told us they accessed the information they needed to ensure they provided safe and effective care to children and young people.

The trust had arrangements to ensure the availability of records was in line with Data Security standards. This included that confidential information would only be accessed on a need to know basis.

Engagement

Children and young people and their families spoken with confirmed they are engaged and involved in the service. Parents and carers worked alongside staff and shared their experiences to drive services forward with improvements.

Staff used a variety of ways to seek feedback from children and young people and their families which included child friendly feedback forms. Patient satisfaction feedback responses were mostly positive. The service took part in the friends and family test which indicated how likely a service user or their family would be to recommend the service to a friend or family member. Results of

the latest friends and family test showed positive outcomes. Children and young people would be either likely or extremely likely to recommend the service to others.

Staff were actively engaged in the planning and delivery of the service. Staff attended monthly team meetings to share ideas to discuss different ways of working and feedback any concerns. Staff confirmed that there was good teamwork and engagement.

The uniform policy had been changed so that all clinical staff wore their own clothes except for the children's continence and diabetic team. This was after consultation with patients, parents and the trust's infection and prevention team who felt that this would be less intimidating for children and young people. This was a good example when staff acted on feedback from children and parents.

Learning, continuous improvement and innovation

Staff confirmed there are systems in place for them to continuously develop, improve and which supports innovation. The trust ran staff recognition awards for outstanding contributions to the service.

Staff had started using alternative methods of communication to improve mother and baby interactions. The service had links with local universities and contributed to local and national research news. We saw that a member of staff had recently undertaken research and had their work published.

The speech and language therapy team had developed a website with guidance for parents or carers support. An example given during inspection was a request had been posted on social media from a concerned uncle requesting how to complete two Makaton signs. Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order. The speech and language team responded with a video link which demonstrated how to sign the words requested.

This service had achieved UNICEF UK Baby Friendly community accreditation level three.

NHS Trusts participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

Community health inpatient services

Facts and data about this service

Location site name	Team/ward/satellite name	Patient group	Number of beds	Geographical area served
Cumberlege Intermediate Care Centre	Cumberlege Intermediate Care Centre	Mixed	22	South East Essex
Mountnessing Court	Mountnessing Court	Mixed	22	South East Essex
Saffron Walden Community Hospital	Avocet Ward	Mixed	19	West Essex
St Margaret's Community Hospital	Beech Ward	Mixed	22	West Essex
St Margaret's Community Hospital	Plane Ward	Mixed	22	West Essex
St Margaret's Community Hospital	Poplar Ward	Mixed	22	West Essex

Is the service safe?

Mandatory training

Staff received effective training in safety systems, processes and practices. Staff completed a number of mandatory training modules as part of their induction and updated them in line with the training policy. Mandatory training included equality and diversity, information governance and conflict resolution. Training was delivered through a combination of online assessment and practical training days.

All healthcare assistants were completing the care certificate. The certificate aimed to prepare health and social care support workers with the knowledge and skills to provide safe and compassionate care.

Ward managers monitored training via an online tracker and would notify staff when their training was due for renewal. Staff were positive about the training they received and were supported to attend additional training, if relevant to their role.

The trust set a target of 85% for completion of mandatory training and their overall training compliance was 84% against this target. A breakdown of compliance for mandatory courses from April 2017 to December 2017 for medical and nursing staff is shown below. As evidenced by the table, 14 training courses were below the trust compliance target.

Key:

Below CQC target of 75%	Between 75% & trust target	**Trust target and above**

Training modules	Compliance
Mental Capacity Act Level 2	100%
Mental Health Act	100%

Training modules	Compliance
Personal Safety - MVA	100%
Personal Safety Breakaway - Level 1	100%
Safeguarding Adults (Level 3)	100%
Clinical Risk Assessment	95%
Health and Safety (Slips, Trips and Falls)	95%
Equality and Diversity	93%
Mental Capacity Act Level 1	93%
Dementia Awareness (inc Privacy & Dignity standards)	92%
Complaints Handling	90%
Conflict Resolution	88%
Consent	88%
Venous Thromboembolism	88%
Other (Please specify in next column)	87%
Safeguarding Children (Level 2)	87%
Manual Handling - People	86%
Information Governance	83%
Safeguarding Adults (Level 1)	83%
Fire Safety 2 years	50%
Fire Safety 3 years	0%
Safeguarding Children (Level 3)	0%
Grand Total	88%

Safeguarding

The service had effective processes in place to keep people safe and protected from harm. The trust had a named safeguarding lead and a safeguarding and serious incident team. The team met weekly to ensure a shared understanding and response to all incoming incidents and serious case reviews. The safeguarding team and trust board regularly reviewed trust policies and training programmes to ensure they were up to date with national safeguarding guidance.

Safeguarding training was part of the mandatory training programme and included information on female genital mutilation, child sexual exploitation and PREVENT. PREVENT is a government-led training programme, designed to identify and prevent the threat of terrorism.

Staff knew what the term safeguarding meant and how to recognise signs of abuse. They could explain the reporting process and knew how to seek support if needed. Staff could name the trust's safeguarding lead and several gave examples of when the trust's safeguarding team had supported them. The safeguarding team provided clinical safeguarding supervision and had regular meetings with community teams.

We saw dedicated information boards within ward areas, offering advice and guidance to staff and patients on how to recognise and report abuse. Staff knew how to access safeguarding policies and procedures on the trust intranet.

A safeguarding referral is a request made to the local authority or police to intervene, support or protect a child or vulnerable adult from abuse. From April 2017 to December 2017, there were 40 adult safeguarding referrals made within community health services. Patient experience was captured to improve the safeguarding service.

Cleanliness, infection control and hygiene

Staff followed best practice regarding infection prevention and control (IPC). All community areas, including patient bays, clinical areas, day rooms and therapy rooms, were visibly clean and tidy. Signed cleaning schedules were in place and housekeeping staff cleaned the departments daily. Staff labelled equipment with 'I am clean' stickers to indicate that it was ready for use.

Domestic and clinical waste was disposed of correctly. Staff segregated clinical waste using different coloured bins, in line with current legislation. We noted that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Sharp bins were clearly labelled and tagged to ensure the appropriate disposal of sharp items, such as needles. The trust had a named responsible officer who was responsible for ensuring that all requirements for safe water legislation were met.

Staff used effective hand hygiene techniques and their arms were 'bare below the elbow' when providing care. Hand sanitiser points were widely available to encourage good hand hygiene practice and we saw staff washing their hands before and after contact with patients. This was in line with National Institute for Health and Care Excellence (NICE) Quality Standard 61, which states that staff should decontaminate their hands immediately before and after every episode of direct contact care.

Personal protective equipment (PPE), such as gloves and aprons, was accessible for staff in all clinical areas to ensure their safety and reduce the risk of cross-infection when providing care. We saw staff using PPE appropriately.

The IPC team ran a yearly programme of audits trust-wide, which included an audit of hand hygiene and the ward environment. From April 2017 to March 2018 the audit data showed the trust's compliance with hand hygiene across community inpatients was an average of 98.5%. Within the same time period, community inpatient ward environments achieved an IPC compliance rating of 93.5%.

All patients were screened for infection on admission to a ward. Staff took steps to prevent transmission of infections and isolated patients when infection was suspected. In the IPC annual audit report, dated June 2017, 100% of patients were screened for methicillin-resistant staphylococcus aureus (a hospital acquired bacterial infection) on admission to a community inpatient ward.

Environment and equipment

The ward environments varied between sites. St Margaret's Community Hospital was purpose built and had three community inpatient wards spanning over two floors. Poplar Ward held 22 beds for patients admitted from the community and Plane Ward was a 22-bedded rehabilitation ward. Beech Ward also held 22 beds, 12 of which were designated to stroke patients.

Avocet Ward at Saffron Walden Community Hospital provided 19 beds for inpatient care and rehabilitation, with capacity for an additional two beds to be commissioned during the winter period. Mountnessing Court was a single-storey, 22-bedded rehabilitation unit. Cumberlege Intermediate Care Centre had originally been a care home and provided 22 beds for rehabilitation, six of which were allocated to stroke patients. However, at the time of our inspection, the centre was being prepared for renovation and the number of beds provided had reduced to 16. The renovation was due to start July 2018.

At Cumberlege Intermediate Care Centre, all patient rooms were based on the first floor. As the centre cared for patients who were frail and had limited mobility, we had concerns about the efficiency of the fire evacuation process. We raised the issue with the service lead who shared our concerns and had placed this risk on the risk register for escalation. We reviewed the trust's fire

policy and emergency fire plan for inpatients, which contained safety information for staff to follow in the event of a fire.

There was sufficient space for therapeutic activity. Each site had a well-equipped and spacious physiotherapy room, designed for group and one-to-one therapy sessions. Access to clinical rooms, including the sluice and medicine room, was secure and lockable.

There was enough equipment to meet the needs of patients. All sites had a resuscitation trolley or grab bag, for staff to use in the event of a cardiac arrest. Staff used tamper evident tags to alert staff if the resuscitation equipment had been used. Staff checked resuscitation equipment daily against an equipment checklist to ensure essential equipment was available and in working order. On each ward, we found satisfactory checks had been completed for the previous three months (March to May 2018).

We inspected the equipment storeroom on each ward and found equipment was stored in an orderly and safe way. There was a rolling testing programme for portable equipment overseen by the trust's estates department. We checked the expiry dates of 16 pieces of consumable equipment and found all items had expiry dates clearly marked on them and were within date. We checked 24 pieces of electrical equipment, including defibrillators and suction machines. We found all pieces of equipment had been electrical safety tested and were within the stated date for review, except for two nebulisers. The nebulisers were removed when raised with the ward manager. Staff told us they had enough equipment to deliver safe care and could order equipment when needed.

Assessing and responding to patient risk

Staff assessed, monitored and managed patient risk appropriately. Staff used the Modified Early Warning Score (MEWS) to assess patient deterioration. The MEWS is a tool, used by staff, to quickly determine the degree of patient illness, based upon six cardinal vital signs and patient observation.

The inpatient units did not provide acute care for patients. If a patient deteriorated, nursing staff would seek medical support or contact the out of hours service. If a patient rapidly deteriorated or went into cardiac arrest, the emergency services would always be the first point of contact. There was a resuscitation trolley or grab bag on each ward, in an easily accessible area. Staff had been trained so that they could respond to an emergency while awaiting the ambulance's arrival.

Staff we spoke with had a good understanding of the signs and symptoms of sepsis and knew how to respond if they identified concerns. Any patient with suspected or recognised sepsis, as identified using the MEWS, would be transferred via ambulance to a local acute hospital for management and review. Sepsis would not be managed on a community inpatient ward.

Community inpatient teams could request sepsis awareness training sessions on an ad hoc basis. The IPC team had circulated an adapted sepsis screening tool for staff reference and guidance.

Staff completed thorough risk assessments for all patients admitted onto the wards. Risk assessments included assessing the risk of falls and pressure ulcers. We reviewed 20 patient records and found all contained detailed risk assessments. Patients were also assessed by the therapy team within 24 hours of admission. Therapists used specific tests, designed to measure a patient's performance in the activities of daily living. This allowed the team to tailor treatment and care to individual needs.

Staff acted to reduce any risk to patients. For example, for patients at risk of falling, staff nursed patients close to the nurse's station, used low mattresses and bed rails. These preventative

measures were appropriately risk assessed and stored on the patients' electronic records. Staff also completed a 'comfort round' to check on patient needs and we saw this recorded in patient care records. Staff told us that making regular, proactive checks on patient needs reduced the risk of falls. Staff provided one-to-one care for patients who presented with challenging behaviour and required enhanced care if their risk assessment concluded that this level of care was required.

Staffing

Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment. The trust submitted a monthly safer staffing report and undertook a six-monthly safe staffing review to monitor staffing levels for patient safety. The trust also used a safer staffing intranet tool, allowing staff from each ward to input the fill rate for every shift. Staff fill rates compare the proportion of planned versus actual hours worked by staff.

The table below shows staff fill rates for community registered nurses and care staff during September, October, and November 2017. As evidenced by the table, all planned versus actual staffing levels were within range for this service, and no shifts had been under or over staffed.

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	Sep 17				Oct 17				Nov 17			
Mountnessing	95.8	98.7	100.0	96.7	96.7	98.8	96.8	97.8	93.3	98.7	93.3	101.9
Avocet	96.7	95.6	100.0	98.3	94.4	97.4	98.4	95.3	91.7	93.9	93.3	91.7
Poplar	100.0	99.6	98.3	100.0	100.0	99.7	95.0	100.0	99.2	99.0	93.2	100.0
Plane	100.0	100.0	100.0	100.0	100.0	99.4	100.0	100.0	100.0	100.0	100.0	98.9
Beech Ward	100.0	99.5	100.0	100.0	98.9	99.5	98.4	99.2	97.8	95.9	95.0	100.0
Cumberlege	99.2	98.6	100.0	100.0	97.6	99.2	100.0	98.4	97.5	100.0	100.0	101.7

On a shift by shift basis, staffing levels were adjusted depending on patient acuity. From what we observed during inspection, staffing levels met the needs of patients and the demands of the service. St Margaret's Community Hospital had recently changed to a 12-hour shift pattern and used twilight shifts to support handovers and shift changes. All other units had early, late and night shifts for nursing and support staff. The ward managers reviewed and adjusted staffing across the wards daily, to meet patient needs. Ward managers were allocated two office days per week but were available to provide clinical support to their staff, if required.

From April 2017 to January 2018, the trust reported an overall sickness rate of 7% in community inpatient services. If a nursing shortage was identified, staff could either resource a nurse from another community inpatient ward, or request a nurse from the bank/agency pool. Bank and agency staff received a local induction before working on a ward. Staff on all units told us that they tried to use the same bank and agency staff to promote continuity of care for patients. The table below shows the number of shifts filled by bank and agency staff from April 2017 to January 2018. As evidenced by the table, community inpatient services reported an overall bank and agency usage of 2863 shifts for qualified nursing staff and 4340 shifts for healthcare assistants.

Staff group	Total number of shifts available	Total shifts filled by bank staff	Total shifts filled by agency staff	Total shifts NOT filled by bank staff
Nursing staff	10,816	1,091	1,772	305
Healthcare assistants	21,250	2,695	1,645	403

Within the same time period, no medical shifts were filled by bank staff and 526 medical shifts were filled by agency staff. Thirty-four medical shifts were left unfilled.

Vacancy rates varied between sites. As of January 2018, there were 2.97 full time equivalent (FTE) nursing vacancies on Plane Ward and 0.03 FTE on Poplar Ward. Beech Ward had 5.53 FTE nursing vacancies for stroke beds and no vacancies for general beds. There were 2.47 FTE nursing vacancies on Avocet Ward, 2.79 at Cumberlege Intermediate Care Centre and 6.56 at Mountnessing Court. Across community inpatient services, medical vacancies accumulated to 1.04 FTE. Between April 2017 and January 2018, the trust reported an overall vacancy rate of 21% in community inpatient services.

The table below shows that from April 2017 to January 2018, the trust reported an overall staff turnover rate of 12% in community inpatient services.

Staff group	Total number of substantive staff	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Avocet Ward	21.34	6.88	32%
Plane Ward	24.61	4.92	20%
Poplar Ward	29.52	3.64	12%
Beech Ward - stroke rehab	30.83	3.00	10%
Beech Ward - general rehab	10.51	0.00	0%
Cumberlege Intermediate Care Centre	20.75	2.80	13%
Mountnessing Court	35.04	1.00	3%
Medical Staffing	6.76	0.40	6%

Service leads identified staffing as their biggest concern and were actively looking at ways to recruit and retain staff, while mitigating risk. For example, the service was looking to develop an app that showcased all staff benefits and discounts. The service had also introduced a new role, physician associate, to mitigate the medical staff vacancies. Physicians associates support doctors in the diagnosis and management of patients. The trust was also working to improve the HR process so that newly recruited staff started within four weeks of their appointment.

Staff had access to medical support in the event of patient deterioration. At St Margaret's Community Hospital, Saffron Walden Community Hospital and Mountnessing Court, doctors, employed by the trust, were on site Monday to Friday, 9am to 5pm. For medical cover at all other times, staff used the out of hours service.

At Cumberlege Intermediate Care Centre, medical support was provided by the local GPs. At the time of our inspection, the local GPs were trialling a reduction in their medical on-site support and attended the centre on a Monday, Wednesday and Friday. Out of hours, they were available on call. The service lead and ward manager told us that the centre would be returning to medical on-site support five days per week, as staff felt the additional support was needed.

Physiotherapists and occupational therapists worked on the wards Monday to Friday, 9am to 5pm, with support from generic workers. Patients did not have access to qualified therapists at weekends. To mitigate this, ward staff ensured patients received therapy interventions from nursing staff and healthcare assistants, in line with their rehabilitation plans, at weekends. Other members of the multidisciplinary team visited patients on the units upon referral, including a dietitian and a speech and language therapist.

Quality of records

Staff followed the trust's records management policy, which provided guidance about the creation, storage and disposal of records. It also detailed standards for confidentiality and rights to access records. Staff at St Margaret's Community Hospital, Saffron Walden Community Hospital and Mountnessing Court used a combination of paper records and an electronic patient records system. At Cumberlege Intermediate Care Centre, all records were paper based.

Paper records were stored securely in lockable trolleys. The electronic patient records system was password protected and accessible to all staff employed by the trust. Agency staff told us that they did not have access to the electronic patient records system. They were required to complete paper records which would then be scanned onto the system by a permanent member of staff. We raised concerns that this arrangement could lead to missing information in a patient record. The modern matron was aware of this issue and explained that the trust was working to address this.

As part of our inspection, we reviewed the records of 20 patients. We found them all to be clear, complete and up to date. All those reviewed included individualised care plans and thorough risk assessments. Therapy records were thorough, comprehensive and completed in line with professional standards. Observation and medication charts were kept in folders at the patient's bedside.

Staff had access to information needed to deliver safe care. Staff told us that the electronic patient records system was user-friendly and that it was easy to find information. Information available to staff included a patient's date of admission, planned date of discharge, medical history, therapy input and clinical risk assessment results.

Staff told us they completed audits of patient care records. We requested the audit results for patient care records, however the trust was unable to provide this information.

Medicines

The trust's pharmacy service was responsible for the procurement and dispensing of all medicines on community wards, Monday to Friday, 9am to 5.30pm. Outside of these hours, staff would contact an on-call pharmacist. A pharmacy technician or pharmacy support worker visited each ward once a week to ensure adequate levels of medicines were held in stock.

Staff followed an up-to-date medicine management policy. Medicines were prescribed by medical staff and visiting GPs. The modern matrons were also trained to prescribe certain medicines. We reviewed a sample of prescription charts and found the majority were completed appropriately, with any missed doses of medicine clearly documented.

Medicines were stored safely. On each ward, staff stored all medicines in a locked cupboard or fridge, in secure clinical rooms. Oxygen cylinders were also stored securely at each site. Fridge temperatures were checked daily and logged to ensure medicines were stored at the correct temperature. We saw evidence that when an irregular temperature was recorded, staff escalated this to the ward manager.

On each ward we undertook a random check of controlled drugs (CD). We reviewed the controlled drugs register and found staff followed their internal procedures for the storage and administration of CDs, which included two signatories following each administration. Staff completed daily checks to ensure that CD stock was monitored and accounted for. We checked the expiry dates of a sample of 21 medicines and found all were within their expiry date.

Arrangements were in place to ensure that medicine incidents were reported, recorded and investigated. The trust held monthly medicines management group meetings for community services, chaired by the director of infection prevention and control. We reviewed the minutes of the meetings held in November 2017, December 2017 and January 2018. The minutes showed that medicine incidents were discussed and any learning from an incident was disseminated to community teams.

Safety performance

Community inpatient services monitored safety performance using the NHS safety thermometer. The safety thermometer is a monthly snapshot audit, used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. The types of harm the trust monitored included falls, catheter and urinary tract infections (UTI) and pressure ulcers. Safety thermometer data was displayed on each ward, allowing patients, visitors and staff to view safety performance monthly.

England's average for harm free care is 95%. From February 2017 to February 2018, community hospitals achieved 93.5% harm free care in the safety thermometer audit results. The tables below show the trust's safety thermometer results, broken down by type of harm.

The trust reported 23 new pressure ulcers from February 2017 to February 2018.

	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Prevalence %	0	4.67	0	1.49	0.49	3.37	0.77	0	0.84	1.24	0	0.91	0
No	0	5	0	3	1	6	1	0	2	3	0	2	0

The trust reported 15 catheters and UTI from February 2017 to February 2018.

	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Prevalence %	1.96	0	0	0	0	0.56	1.54	1.28	0.84	2.07	0	0	0
No	2	0	0	0	0	1	2	3	2	5	0	0	0

The trust reported 22 falls with harm from February 2017 to February 2018.

	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
Prevalence %	0.98	0	0.75	0	0	0	0	2.14	3.36	1.24	0.46	0.45	0.43
No	1	0	2	0	0	0	0	5	8	3	1	1	1

Incident reporting, learning and improvement

There were effective processes to record and manage incidents. Incidents were reported using the trust's electronic recording system. Staff we spoke with knew how to report incidents and were aware of the types of incidents they needed to escalate.

From April 2017 to January 2018, there were no reported never events within this service. Never events are a type of serious incident that is wholly preventable, where guidance or safety

recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

Within the same time period, community staff reported one serious incident. Serious incidents are adverse events, where the consequences are so significant or the potential for learning is so great, that a heightened level of response is justified. The serious incident was categorised as a slip/trip/fall and occurred on Avocet Ward. Staff told us that they received regular email bulletins, ensuring learning from incidents was shared around the trust.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were aware of the principles of duty of candour and could give examples of when it should be triggered.

Staff gave examples of changes in practice following an incident. For example, a concern was raised that a patient had acquired a pressure ulcer before they were discharged from Poplar Ward. The ward had no documentation to record the patient's condition upon discharge, therefore staff could not identify at what time the patient had acquired the pressure ulcer. The ward now completes a body map on every patient before discharge.

Is the service effective?

Evidence-based care and treatment

Staff delivered care and treatment in line with evidence-based practice and national guidance. Staff had access to policies and guidance through the trust intranet and in paper format. The policies we saw were version controlled, ratified and included clear dates for review. For example, we reviewed the induction and mandatory training policy, dated January 2018, and found it was ratified, in date for review and referenced various national guidance such as the intercollegiate guidance in safeguarding adults, 2016 and National Institute for Health and Care Excellence (NICE) guidance.

The clinical governance and quality team reviewed trust policies to ensure they were in accordance with the latest NICE guidance and updated them when required. Service leads were alerted to any new policy changes and would disseminate changes to their team.

Patients receiving rehabilitation had clear, personalised care plans which were up to date, in line with relevant good-practice guidance, and set out clear outcome goals. We spoke with physiotherapists and occupational therapists who could all describe the recognised assessment tools used for patients during their rehabilitation. There were a number of evidence-based pathways for staff to follow for specific conditions, such as stroke and end of life care.

During our inspection, we saw evidence that the trust ran a programme of local clinical audits for community inpatient services. Post-inspection we requested the audit results for this service, however the trust was unable to provide this information.

Nutrition and hydration

Staff understood the importance of nutrition and hydration for effective care and treatment. Aids for drinking and eating were available and we observed patients using them. On each ward patient meal times were protected to ensure patients could have their meals without being interrupted. Staff told us they encouraged carers to support patients with eating and drinking where appropriate. Catering staff could accommodate special dietary needs, including food allergies and needs relating to religion and culture.

Nutritional risk was assessed using the Malnutrition Universal Screening Tool (MUST). The tool is a five-step process, used to identify adults who are malnourished, at risk of malnutrition (undernutrition), or obese. Staff used the GULP (gauge, urine, look, plan) dehydration risk screening tool to assess the dehydration risk of patients. Any patients found to be at risk of malnutrition or dehydration would have a specialised care plan in place.

Pain relief

Staff told us they regularly assessed and managed patient pain levels, and the patient records we reviewed supported this. Staff used the modified early warning score (MEWS) to assess patient deterioration. The tool included a numerical scale to assess and record patient pain. Patients told us their pain was well managed and that nursing staff administered pain relief in a timely manner.

Patient outcomes

Information about the outcomes of patient care and treatment was routinely collected and monitored. Service leads updated key performance indicators monthly onto the quality dashboard. Quality performance data was also displayed on wards, allowing patients, visitors and staff to see how the service was performing.

Staff told us that local audit programmes were used to measure outcomes for patients and drive improvements to the service. We requested evidence of local audit results but the trust was unable to provide this information.

The service participated in national audit programmes to measure and compare performance against similar services. For example, the trust participated in the Sentinel Stroke National Audit Programme (SSNAP). The purpose of this audit is to monitor the performance of stroke services in England. The audit identified where the trust was compliant with standards. For example, the percentage of days that speech and language therapy was conducted by was three times higher than the national score. Recommendations from the audit prompted a revision of South East Essex's pathway for stroke care.

Therapy staff used outcome measures to monitor patient progress with rehabilitation. Each patient had a personalised rehabilitation plan, which included a Barthel scale score on admission and discharge. The Barthel scale is an evidence-based measure, used to assess patient performance in activities of daily living. A high score indicates that the patient has a greater likelihood of being able to live at home with a degree of independence, following discharge. Staff working with stroke patients assessed their degree of independence using the modified Rankin Scale. The scale specifically measures the degree of dependence in the daily activities of people who have suffered a stroke.

Competent staff

Staff had the appropriate skills, knowledge and experience to deliver effective care and treatment. The trust had an up to date policy for all new staff starting work at the trust. New staff were required to attend a corporate induction and complete a local induction programme.

The trust had arrangements for staff supervision and appraisal. Staff identified their learning needs and development opportunities through their yearly appraisal. The table below shows that from April 2017 to January 2018, 77% of staff had received an appraisal against a trust target of 90%. Appraisal rates for staff on Beech Ward and Mountnessing Court were significantly below the trust target at 53%.

Team name	Total number of staff requiring an appraisal	Total number of staff who have had an appraisal	% appraisals
Plane Ward	23	23	100%
Avocet Ward	22	20	91%
Poplar Ward	27	24	89%
Cumberlege	21	18	86%
Beech Ward	34	18	53%
Mountnessing Court	19	10	53%
Core service total	146	113	77%
Trust wide			82%

Staff told us they had been supported with their revalidation through clinical supervision. Revalidation is the process where nurses renew their registration with the Nursing and Midwifery Council. The table below shows that from April 2017 to January 2018, the average clinical supervision rate for community staff was 92%.

Team	Clinical Supervision Target	Clinical Supervision Delivered	Clinical supervision rate (%)
Plane Ward	237	236	100%
Avocet Ward	251	235	94%
Beech Ward	364	336	92%
Cumberlege	157	145	92%
Mountnessing Court	317	275	87%
Poplar Ward	312	272	87%

There were competency assessments for new nursing and healthcare staff. There were also specific competency assessments for nursing staff caring for stroke patients. Core competencies included evaluating care, health promotion, resuscitation, pain management and end of life care. Competencies for nursing staff caring for stroke patients included assessing manual handling needs, recognising swallowing problems, nasogastric tubes and communication. All competencies required sign off by the ward manager.

The trust ensured staff had the necessary training to deliver effective care, support and treatment. Additional training opportunities were publicised at team meetings and on staff notice boards. Staff told us that they were supported to pursue additional training opportunities relevant to their role. On Cumberlege Intermediate Care Centre, healthcare assistants received regular training from the therapy team to improve their ability to support patients with their rehabilitation goals. Healthcare assistants could also request to do a one-month rotation with the therapy team. The trust supported medical, nursing and therapy students on placement.

Multidisciplinary working and coordinated care pathways

There was effective multidisciplinary working across the service. Each ward held a weekly multidisciplinary team (MDT) meeting to discuss, in detail, the needs of patients. All members of the MDT were involved with assessing, planning and implementing patient care. The MDT included medical, nursing, therapy, pharmacy and social care staff. Staff also held daily board meetings and handover meetings to discuss and plan patient care.

We attended an MDT meeting at St Margaret's Community Hospital, led by the matron. We observed staff discussing patient progress and discharge plans. Action plans and rehabilitation goals were also reviewed for each patient.

Staff could make patient referrals to the wider multi-disciplinary team, including the speech and language service and clinical psychology team. A GP referral was required for patients to be seen by a dietician. Patient care records contained evidence of referrals made to community services, including community nurses and hospital at home teams.

Staff at St Margaret's Community Hospital described having good working relationships with their mental health colleagues. In April 2018, community inpatient services won an award for collaborative working between staff on Poplar and Plane Ward and on the older people's mental health wards at St Margaret's Community Hospital. Patients on the mental health ward who required acute care, such as a cannula change, now attended the inpatient ward to receive their care, reducing the strain on the local acute hospital. Patients were accompanied by a staff member working on the mental health wards, which ensured safety and allowed for cross directorate learning.

Staff had strong working links with other services and agencies such as social services, the local hospices, league of friends and the voluntary sector.

Health promotion

Staff worked hard to help patients maintain their independence and manage their own health, to improve their outcomes. Staff engaged patients in regular exercise groups to promote rehabilitation and social interaction. We observed exercise groups which were well attended and provided a positive environment for patients to progress with rehabilitation. At Saffron Waldon, staff ran smoking cessation groups to promote the health of their patients.

Staff encouraged patients to dress in their own clothes, dine in the day room, and to return to their usual daily routines, to promote recovery and rehabilitation. Records confirmed that staff completed home visits to assess home environments and help prepare patients for their discharge from hospital. Therapy staff used assessment kitchens to assess a patient's ability to carry out daily activities before discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (2005) is designed to protect patients who may lack capacity, to make certain decisions about their care and treatment. Information about the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS) was covered as part of staff mandatory training.

From April 2017 to March 2018, the community inpatient wards submitted 76 DoLS applications. Staff could explain the process for submitting a DoLS application and ensured best interest decisions were made in accordance with legislation.

We observed staff seeking consent before starting treatment. There was evidence in patient records that consent had been obtained for certain treatments.

We found Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were completed to a good standard. DNACPR forms were held in the patient's bedside folder to ensure all staff were made aware.

Is the service caring?

Compassionate care

We observed staff providing compassionate care, treating patients with dignity and respect. We saw that curtains were used effectively to protect the privacy and dignity of patients. There were dedicated male and female only bays, as well as side rooms, to help maintain patient dignity. Staff knocked and sought permission before entering patient rooms.

We observed all staff to be courteous, professional and kind when interacting with patients. We observed staff greet patients appropriately, and introduce themselves by name. Patients told us that staff were attentive and we observed that call bells were answered in a timely manner.

Patient feedback was consistently positive. The patients we spoke with said that staff were superb, brilliant and caring. Each ward displayed patient thank you cards. Comments from the cards showed patients felt they had been treated with compassion.

Emotional support

Staff understood the importance of providing emotional support to patients and those close to them. We observed staff providing reassurance to anxious patients on several wards.

Therapy teams helped patients develop their independence and regain confidence. Patients were provided with group activities and rehabilitation sessions to facilitate emotional support from their peers. Staff encouraged patients to have their meals in communal areas where they could socialise with other patients, if they wished. Therapy staff at Mountnessing Court provided hand therapy which can assist with emotional and psychological support, as well as restoration of hand function.

Each site displayed information about the local support services available and the trust helped facilitate support groups in the community. For example, a prostate group had been set up to support patients diagnosed with prostate cancer.

Staff ensured carers received additional support and information when needed. For example, staff could signpost carers to local support groups or request a carer's assessment. A carer's assessment allows carers to discuss with the local council what support services are available to them and to evaluate whether they can continue providing care. Staff at Saffron Walden Community Hospital could signpost carers to the Uttlesford carer support and development worker who ran two monthly support groups for carers.

Staff understood and respected the spiritual and religious needs of patients. The trust chaplain visited wards to offer emotional support to carers and patients at Saffron Walden Community Hospital and St Margaret's Community Hospital had access to a multi-faith room. Quiet rooms were available for staff to take patients and their relatives when they had received upsetting news.

Understanding and involvement of patients and those close to them

We saw staff communicate with patients about their care and treatment in a way they could understand. Staff provided patients with relevant information, both verbal and written, so they could make informed decisions about their care and treatment. Patients knew what their therapy goals were and were involved in their development.

Staff used alternative ways to communicate with patients who had additional needs. For example, the service had adapted information booklets for patients with a learning disability.

Relatives and carers were treated as important partners in the delivery of care. Staff told us how they supported carers and relatives to provide care on the wards, to help prepare them for supporting patients after discharge.

Staff ensured patients and families could find further information and support, including community and advocacy services. Staff referred those with specialist needs to other support services within the trust, such as the psychology or dietician service.

Is the service responsive?

Planning and delivering services which meet people's needs

The trust planned and delivered community inpatient services to meet the needs and demands of local people. Senior leaders worked with the local clinical commissioning groups and neighbouring NHS trusts to improve patient care and access to services. Staff also engaged and involved patients in the design and running of the service. For example, the trust held 'your voice' meetings in various areas to capture the needs of specific districts.

The service delivered rehabilitation and intermediate care, as well as palliative care for patients who could not be supported at home. The service accepted both 'step up' patient admissions, transferred from primary care services, and 'step down' admissions, transferred from acute beds. Each community inpatient ward had their own admission criteria to ensure patients were only accepted if staff could meet their individual needs. For example, only wards with stroke specialists, such as Beech Ward, admitted stroke patients.

The trust had invested in a community car, manned by a paramedic, to support the service. The paramedic assessed patient referrals in the community and determined where best to place patients requiring care. This scheme hoped to reduce the number of patient's receiving care in an inappropriate setting.

Each ward had strong working links with other services and agencies such as social services, the local hospices and the league of friends. The league of friends fundraised to provide community inpatients with specialist equipment and patient comforts. Patients received appropriate information about other local health and support services available.

The facilities and premises on each ward met rehabilitation needs, with adequate space for patients to mobilise. Patients were involved with the design and construction of St Margaret's Community Hospital, ensuring the premises were appropriate for the services delivered. The layout of the wards meant that all areas were accessible for people using a wheelchair or walking aids, although bariatric access was limited in south-east Essex. Day room chairs were a mix of heights to help patients with mobility issues.

Staff told us they had access to interpreting services for patients who did not speak English. All patient leaflets and surveys were available in various languages and formats upon request. Specific dietary needs were recorded on admission. Menu options were available for patients who required special diets, for religious or cultural reasons.

Mixed sex breaches are defined by CQC as a breach of same sex accommodation, as defined by the NHS Confederation definition. From April 2017 to January 2018, community inpatient services reported no mixed sex breaches.

Meeting the needs of people in vulnerable circumstances

The service was delivered to meet the needs of different people, including those in vulnerable circumstances. The service ensured that patients with complex needs had all their requirements met by conducting full multidisciplinary team (MDT) assessments. MDT assessments allowed staff to identify the patient's individual needs and plan their care and treatment in a personalised manner. Staff flagged any additional needs on the patient's records.

Each community inpatient ward had various ‘champions’ who had received additional training in their chosen speciality and attended working groups and conferences. Champions provided their colleagues with training, advice and support. They also worked with staff and patients to ensure reasonable adjustments were made to support patients with complex needs. For example, one of the champions had set up a community support group for patients living with Parkinson’s.

Community staff had access to medical staff with specialist knowledge in dementia. For example, on Beech Ward, medical cover was provided by a geriatric registrar who had extensive experience of caring for patients with memory impairments. The service had also introduced the Butterfly Scheme, which provided staff with simple, practical strategies for meeting the needs of patients living with dementia.

In addition, as part of a new initiative to reduce the number of patients attending emergency departments, staff on Poplar and Plane Ward had started to provide acute care to patients from two of the trust’s older people’s mental health units. The patients attended the wards with a staff member experienced in caring with dementia. This was a good example of multi-disciplinary working and allowed both staff from the acute and mental health wards to learn from one another.

Access to the right care at the right time

Wards received electronic referrals from acute hospitals and from healthcare professionals working in the community. To simplify and improve the admission process, the trust had introduced a single point of access for all community health services. The wards routinely did not accept patient admissions at weekends, as there was no on site medical staff to support the process.

The trust monitored certain patient waiting times to identify trends and ensure services in high demand were managed appropriately. Upon admission, staff aimed to complete a holistic assessment of all patients within four hours of arrival. In January 2018, the quality dashboard showed community inpatient services were meeting this target 100% of the time. The trust did not collect data on response times in relation to referrals made by community inpatient staff to other services. In most cases, these referrals would be to other members of the multidisciplinary team who were already involved in the care of the patient.

The table below shows community inpatient bed occupancy rates and average length of stay, from April 2017 to January 2018.

Team	Average bed occupancy (range)	Average length of stay (range)
Avocet	83% to 97%	11.0 days to 25.3 days
Beech	83% to 98%	28.9 days to 47.0 days
Cumberlege Intermediate Care	89% to 98%	29.0 days to 48.0 days
Mountnessing Court	74% to 96%	16.2 days to 50.4 days
Plane	87% to 99%	8.8 days to 21.6 days
Poplar	85% to 98%	10.6 days to 15.1 days

The table below shows the community inpatient delayed discharges from April 2017 to December 2017.

Total Discharges	Total Delayed Discharged	% Delayed Discharges
1141	**103**	**9%**

Service leads had oversight of the length of stay, bed capacity and delayed discharges. Staff told us the main reasons for delays was due to the limited number of social care packages available.

Ward managers had regular calls with the local clinical commissioning groups to discuss any delayed transfers of care and to identify actions they could take to prevent delays.

Learning from complaints and concerns

There were clear processes for staff to manage complaints and concerns. Staff followed an up-to-date complaints policy, which provided guidance on how to manage complaints efficiently. Staff logged all complaints and concerns onto the electronic recording system. The head of complaints managed the complaints department and would appoint an appropriate investigating manager to each complaint.

From April 2017 to December 2017, community inpatient services received four complaints. The table below shows the location and nature of the complaints received.

Ward	Staff Attitude	Clinical Practice	Communication	Total
Mountnessing Court		1	1	2
Beech Ward		1		1
Avocet Ward	1			1
Total	**1**	**2**	**1**	**4**

The trust aimed to acknowledge complaints within three working days. As of January 2018, 100% of complaints were acknowledged within three working days. The trust would agree a resolution timeline with the complainant and met this in 97% of cases.

There were procedures for sharing and learning from complaints across the service. Complaints were discussed at board level via the performance scorecard and were also discussed locally at team meetings. The learning from complaints was presented at the learning oversight committee and shared with staff via email. Staff gave examples of changes in the service following a complaint. For example, following a patient complaint that medication was dispensed but not received, staff attended additional medicine management training and were observed undertaking a medication round.

Complaints leaflets, describing the complaints procedure, and complaints posters were observed at each site. Patients told us they would feel confident to raise a complaint if necessary. The trust provided patients with information on how to progress a complaint with the ombudsman if they were not satisfied with the trust's internal complaints process.

Culture

The culture within the service centred on high-quality sustainable care. Staff reported an open and honest culture. Staff felt able to raise a concern with their manager and we observed leaders had an open-door policy. The trust had appointed a Freedom to Speak Up Guardian. Guardians promoted an open culture, allowing staff to speak up about concerns easily.

Staff felt valued and well supported in their role. There were positive working relationships and cohesive team work across the service. There was a clear focus on multidisciplinary working to improve patient care. There were opportunities for further learning and development. Staff told us that they were encouraged to go on courses that enabled them to develop both personally and professionally.

The service took measures to protect staff working in remote community locations, for example doors were securely locked at all locations and CCTV was in operation at Saffron Walden Community Hospital. The trust had an up-to-date lone worker policy and staff had a good understanding of these arrangements.

Is the service well-led?

Leadership

The trust's community inpatient services were part of the community services and partnerships directorate, overseen by the Executive Director of Community Services and Partnerships. Community inpatient services were split into two divisions. St Margaret's Community Hospital and Saffron Walden Community Hospital were part of the west Essex division. Cumberlege Intermediate Care Centre and Mountnessing Court were part of the south-east Essex division. Each division was led by a director, both of whom reported to the executive director of community services and partnerships.

At a local level, each unit was led by a ward manager, supported by either a matron in the west or a service manager in the south. Teams were managed by visible, experienced and enthusiastic leaders. They were knowledgeable about their service and strived to continuously improve it. For example, the ward manager at Mountnessing Court had recently held a staff focus group to discuss how the team could improve the service.

Staff spoke positively about both their local and senior leadership. They described feeling valued and supported in their role. Staff who worked remotely still said they felt connected to the team and to the organisation as a whole.

Leaders encouraged a positive working environment and responded to the individual needs of staff. A ward manager told us that they had a flexible approach to working hours, which encouraged bank and agency staff to become full-time employees.

Service leaders understood the challenges to quality and sustainability, and could identify the various actions needed to address them. The service was looking at ways to work collaboratively with partners to provide care closer to home.

Staff had access to leadership skills and development opportunities for example, the trust offered a management development program to team leaders.

Vision and strategy

The community service strategy aligned with the overall trust strategy. The trust aimed to provide high quality services to the population it served. It intended to achieve this through four strategic objectives: by continuously improving patient safety, experiences and outcomes; by attracting, developing, enabling and retaining high performers; by co-designing and co-producing service improvement and quality; and by achieving a top performance for operational, financial and productivity measures. Local leaders were clear on the vision and purpose of the service and their role within it.

The trust objectives were in line with local sustainability and transformation plans. The plans aimed to deliver the significant system transformations needed to manage increasing demand. The plans identified the need for investment in community services, along with redesign, to reduce the pressure on acute services. Senior leaders described the local strategy for community services and their role in achieving it.

The trust reviewed its values annually to ensure they remained appropriate and supported the strategy. The values were 'Compassionate', 'Empowering' and 'Open'. Staff were aware of the trust values as supervision and appraisals were based upon them. Staff incorporated the values into their work and our observations supported this.

Governance

There were clear responsibilities, roles and systems of accountability to support good governance and management. Staff we spoke with could describe the service's senior management structure and discussed their specific roles and responsibilities within it. Staff demonstrated a good awareness of governance arrangements and knew how to escalate their concerns.

There were regular team meetings and management meetings. The minutes for team meetings were circulated to staff via email. These meetings fed into the ward manager team meetings which, in turn, fed into the community health service senior management team meeting. The minutes of these operational meetings showed that incidents, staffing and risks were routinely reviewed by staff at all levels.

Management of risk, issues and performance

There were clear and effective processes for managing risks, issues and performance.

Community inpatient services had two electronic divisional risk registers, one for the south-east Essex division and one for the west Essex division. Each register was maintained by the service managers and matrons. Each risk was given a rating based on the potential consequence of the risk and the likelihood that the risk would happen. Risks were also given a review date, responsible individual and action plan to mitigate. Risks included recruitment difficulties and poor staff compliance with fire training. Progress was regularly recorded on the risk register, demonstrating active management of risks. Staff were aware of the risks in their service area, and knew what mitigations were in place.

The service collected performance data via the quality dashboard, which provided the board with an overview of how the service was comparing to its key quality indicators. There was also a programme of clinical audits across the service which meant senior staff could be assured of the safety of the service.

Where audits had been carried out, there was evidence that service leads had used the results to implement improvements and changes to the service. For example, a falls audit undertaken in February 2018 highlighted that patients who were at risk of falling were not always receiving a cognitive assessment. Actions taken because of this included ensuring that any patients at risk of falling received a cognitive assessment, and the trust was in the process of developing their delirium policy and pathway.

The service produced a monthly quality and safety report, reviewed at directorate and at board level. The report contained detailed information on key areas of quality and safety.

Information management

Information was effectively processed, challenged and acted upon. The trust collected, analysed and managed information using secure electronic systems with security safeguards.

Executive staff had oversight of quality and risk information through monthly quality and safety reports. We reviewed the IPC and safeguarding annual reports from 2017. They included information on trust performance against a wide range of quality and safety indicators. In addition, service risks were recorded on divisional risk registers and any escalated risks were monitored by trust board.

Service leads monitored quality and risk information through a number of systems, such as governance meetings, local audits and performance dashboards. Performance dashboards were submitted each month and contained information on quality and safety indicators. The dashboards included details on bed occupancy, patient safety incidents and falls, staff fill rates, training compliance and appraisal figures. As the dashboards were a monthly snapshot, the information

reported could differ from operational day to day information. To mitigate this, the trust was developing live dashboards which would provide the service leads with the most up-to-date information available.

At local level, staff could access clinical data reports from the trust intranet and use them to manage their service and improve performance. The trust disseminated a regular news bulletin to all staff, which identified key themes and trends from incident reports.

The trust had arrangements to ensure the quality and validity of its data. The trust's information team monitored performance and alerted service leads to any fluctuation in the data. The information team also completed regular data validation exercises to ensure the information held by the trust was correct.

Engagement

Patients and relatives were engaged and involved in the service, improving the care and treatment delivered. Staff used a range of ways to seek feedback from patients. For example, staff set up feedback meetings in Harlow to discuss the discharge to assess process. The trust also set up a stakeholder reference group. Members of the group, drawn from across the trust, were actively involved in the various work streams to deliver service transformation.

Staff encouraged patient feedback via the patient survey. The trust incorporated the NHS Friends and Family Test (FFT) into the patient satisfaction survey. The FFT is a single question survey which asks patients whether they would recommend the NHS service to their friends and family. The results of the FFT in February 2018, showed that 96% of patients would be either 'likely' or 'extremely likely' to recommend community services to their friends and family. Community inpatient services also received 26 patient compliments from April to December 2017.

Staff described how they acted on feedback. For example, stroke patients on Beech Ward had fed back to staff that they were bored. Staff worked with patients to set up a baking group, funded by the league of friends. The group had been a success and other wards were looking to set up other activity groups for patients.

Staff were actively engaged in the planning and delivery of the service. Staff attended regular team meetings to share ideas, opinions and feed back their concerns. Staff also completed an annual staff survey. The trust had developed a detailed action plan to address all poorly performing areas. For example, the trust had introduced a toolkit to support staff report bullying and harassment.

Learning, continuous improvement and innovation

There were systems in place to improve services by learning, continuous improvement and innovation.

The trust's quality academy aimed to develop leaders, enabling teams to continuously improve patient care. Over the last year, the quality academy trained approximately 150 members of staff as quality champions. The champions were trained to deliver improvement through quality projects. The trust also launched quality awards which recognised innovative practice across the trust.

In April 2018, community inpatient services won an award for their 50 day challenge initiative. The initiative supported collaborative working between the community inpatient and older people's mental health wards at St Margaret's Community Hospital. Patients on the mental health ward who required acute care, such as a cannula change, now attended the inpatient ward to receive their care, reducing the strain on the local acute hospital. Patients were accompanied by a staff

member working on the mental health wards, which ensured both safety and allowed for cross directorate learning.

We saw that the service was working hard to build strong links with neighbouring acute NHS trusts, primary care services, hospices and charitable organisations to enable smooth referral, inpatient care and post discharge care for patients using the service.

A community car, manned by a paramedic, supported inpatient and acute services. The paramedic assessed patient referrals in the community and determined where best to place patients requiring care. This scheme hoped to reduce the number of patient's receiving care in an inappropriate setting. For example, patients who attend an emergency department and are then subsequently become an inpatient may be better cared for in a community hospital or at home.

Community end of life care

Facts and data about this service

Location site name	Team/ward/satellite name	Patient group	Number of clinics per month	Geographical area served
Trust Head Office	MacMillan Nurse	Mixed	N/A	Not stated

Is the service safe?

Mandatory training

The service had processes and practices in place to ensure that staff received training in safety systems.

The trust did not provide training data for the teams in this core service in their data submission due to the way that the service is provided.

Training statistics have been given for the whole community directorate as follows:

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Core Service	Grand Total %
Clinical Record Keeping	100%
Dual Diagnosis	100%
LAC e-learning	100%
LAC face to face	100%
Safeguarding Children (Level 3)	100%
Security Training (eLearning)	100%
Venous Thromboembolism	100%
Safeguarding Adults (Level 1)	97%
Corporate Induction	96%
Equality and Diversity	96%
Harassment & Bullying	95%
Dementia Awareness (inc Privacy & Dignity standards)	94%
Duty of Candour (Overview Version)	94%
Induction E-Learning	94%
Cascade Fire Trainer	93%
Conflict Resolution	93%
Consent	93%
Diabetes Training	93%
Personal Safety - MVA	91%
Complaints Handling	90%
Food Hygiene	89%
Medicines Management (community)	87%
Safeguarding Adults (Level 2)	87%
Mental Capacity Act Level 2	85%
Personal Safety Breakaway - Level 1	84%
Safeguarding Adults (Level 3)	84%

Core Service	Grand Total %
Duty of Candour (Detailed Version)	83%
Mental Capacity Act Level 1	83%
Fit for Work	82%
Care Certificate	81%
Information Governance	81%
Anaphylaxis	80%
Infection Prevention, Control & Hand Hygiene	80%
Transfusion Process training	80%
Basic Life Support & AED	79%
Hoisting e-learning	75%
Health and Safety (Slips, Trips and Falls)	65%
Hoisting	65%
Manual Handling - People	65%
Fire In-patient	63%
Fire Safety 2 years	60%
Mental Health Act	57%
PREVENT (WRAP) Training	56%
First Aid Trained	50%
Observation of Service User	50%
Clinical Risk Assessment	44%
Basic Back Care (Face to Face)	42%
Fire Safety 3 years	42%
Basic Back Care (E-Learning)	18%
MERT (Enhanced Emergency Skills)	0%
TASI Trained	0%
Total	83%

The trust set a target of 85% for completion of mandatory training, with the exception of 90% for safeguarding adults (level two) and their overall training compliance was 83%. The trust had a rolling month on month compliance rate for mandatory training. Senior staff we spoke with told us that staff completed a mandatory training matrix according to their role. This meant that staff were not expected to complete every module of mandatory training offered by the trust. The training matrix we reviewed confirmed this.

All staff we spoke with confirmed they had access to mandatory training and completed this as necessary. However, some staff informed us that there was often difficulty booking popular mandatory training courses such as basic life support due to the number of spaces available in the face to face training. This meant that some staff had to wait for this training.

There were processes in place to monitor mandatory training compliance on an individual level and staff were sent reminders as and when training was due for renewal. This system was supported by a policy for induction and mandatory training. The policy was up-to-date with version control with the next review of the policy due in April 2020. The policy set out the responsibilities of all staff grades in relation to mandatory training and induction training.

Safeguarding

The trust had appropriate policies and procedures to deal with safeguarding concerns.

We saw that a localised procedure had been developed which provided staff with relevant internal and external contact numbers.

All staff we spoke with about safeguarding understood their responsibilities to raise safeguarding concerns and could give examples of the types of abuse they would raise concerns about. This included neglect and physical, emotional and sexual abuse. Staff were clear about the reporting arrangements and knew who to contact for advice and support (their manager or the safeguarding lead).

All staff were expected to complete safeguarding training to level two via e-learning. The module covered children and adults. The end of life care teams would also support children with terminal illnesses and in addition completed level three training in children's safeguarding. Safeguarding adults level three training was provided to band six and above. The training covered all types of abuse including female genital mutilation (FGM). The safeguarding training rates were below the trust's target of 90% for safeguarding level two and adults level three but were at 100% for level 3 children's safeguarding.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust provided details of the total number of safeguarding referrals made from 1 April 2017 to 31 December 2017 with 802 referrals made for adults and 180 for children. However, this is for the whole trust and has not been broken down to core service level.

The trust promoted safety in their recruitment practice, staff support arrangements, disciplinary procedures and ongoing checks, for example Disclosure and Barring Service (DBS) checks.

Staff received training in safety systems, processes and practices in relation to safeguarding. All staff had to complete a DBS before their employment with the trust. The trust managed the oversight of the DBS checks centrally in human resources and sent email alerts to team leads when a staff member was required to renew the DBS check.

Cleanliness, infection control and hygiene

The trust had systems and processes in places to reduce the risk of healthcare associated infections.

The bases we visited were visibly clean, tidy, and free from clutter. However, items of equipment and consumable items were stored directly on the floor of storage rooms. This meant we were not assured that these areas had been adequately cleaned.

The trust undertook regular audits for hand hygiene and uniforms. We reviewed the results of the hand hygiene audits from April 2017 to March 2018, which demonstrated 97.5% compliance in South East Essex. West Essex achieved 96.9% overall compliance with hand hygiene. The trust internal target for hand hygiene audits was 95%. However, West Essex did not achieve the trust's target of 95% in quarter two (July to September 2017) with compliance of 94.7% and quarter four (January to March 2018) with compliance of 94.5%.

The trust has an up-to-date uniform policy for staff to follow which set out the responsibilities of all staff in relation to maintaining their uniform. Staff had visibly clean uniforms with short sleeves and staff were bare below the elbows when providing care and treatment to their patients.

Staff we spoke with confirmed that they utilised hand gels, aprons and gloves when visiting patients in their homes.

There was an up-to-date infection prevention and control policy, which set out the responsibilities of all staff in relation to the prevention and control of healthcare associated infections. Staff were expected to complete infection prevention and control training via e-learning on a yearly basis to remain up-to-date with policy and national guidance. At the time of our inspection, the trust was behind its target of 85% compliance with infection control training scoring at 80%.

Environment and equipment

Equipment used for patient care was generally well maintained and up-to-date with safety testing. Staff spent much time working within patient's homes but the areas we visited at nursing bases demonstrated a clean and well organised environment.

We reviewed 15 items of equipment stored at the bases we visited such as suction machines and syringe drivers, of these, 14 items were up to date with safety testing.

The trust had arrangements with the local authority to collect large amounts of contaminated waste where there was a risk of healthcare associated infections. Nurses disposed of small amounts of waste for example soiled dressings within the patient's own domestic waste in line with the trust's policy.

Staff disposed of contaminated used sharps such as needles appropriately. Staff kept sharps containers in patient's own homes. Staff sealed and removed these containers once they had become full and took them to the nursing base ready for collection. Full sharps containers were collected on a weekly basis from the nursing bases.

The community teams utilised syringe drivers to provide people at the end of their lives regular medications. We saw that there were due processes in place for the monitoring of these drivers to ensure they were tracked and maintained. The trust also had in place a standard operating procedure for the use of syringe drivers to support staff in their use of them. However, we reviewed six syringe drivers in the Canvey Island nursing base and found five without lockable covers. This meant we could not be assured these pieces of equipment would be available for patient use. We raised this with staff on site who agreed to source covers immediately.

Staff kept storage cupboards in all nursing bases tidy and well stocked. We sampled 94 dated items single-use equipment and found that of these items 87 were within their expiry date. We found that seven items were outside their expiry date, we escalated this to a senior manager. The manager removed the items immediately and disposed of them.

Assessing and responding to patient risk

The community nursing team had developed a tool called the "Compassion Tool" to enable them to undertake comprehensive risk assessments for their patients. These assessments were also used for patients at the end of their lives or receiving palliative care. Assessments undertaken included Consent, Observation, Medication, Pain, Activities of daily living, Skin, Safeguarding, Infection Control, Other (individual) and Nutrition. We saw that this assessment was utilised in peoples records and reviewed at each visit to enable staff to identify changing needs to risk to the people using services.

The end of life teams also utilised a holistic patient assessment tool as recommended by the Gold Standards Framework 2009 (GSF). This was called the Pepsi-Cola assessment and was used by the teams as an aide memoire to guide holistic discussions with patients and their families. It covered areas such as emotional needs, spiritual and religious beliefs, choice and dignity and the patient's wishes for after their death. We saw this complete in all the records we reviewed in relation to end of life or palliative patients. All staff we spoke with confirmed they utilised it as part of their care assessment and planning process.

Staff also used the Karnofsky Performance Score (KPS), a system which quantified patients' general well-being and activities of daily life. This measure was used to determine the required intensity of palliative care. It was also used as a measure of quality of life.

The service had various electronic risk assessment paperwork to support the above tools and assessments. For example, the Malnutrition Universal Screening Tool (MUST) and the Waterlow pressure ulcer risk assessment tool. We reviewed 11 sets of patient records and found all records to be up to date in relation to risk assessments.

Should a patient's condition be noted to be deteriorating and they were coming into their last days and hours of life, staff would ensure all relevant people, including family members were notified.

Staff arranged for transfers to peoples preferred place of death where this was appropriate and arrange for GP reviews should a patient's level of pain be seen to increase.

Staff could also be flexible and respond within two hours if they were alerted to change in a person's health or mental condition.

Staffing

The trust did not provide staffing data for the teams in this core service in their data submission due to the way that the service is provided. During the inspection, we again asked for data on various staffing indicators but these were not provided to us. This meant that we were unable to make a judgement on the quality and numbers of staff working within end of life services.

Quality of records

We reviewed 16 sets of patient records and found these to be generally complete and up to date. In the majority of cases we found there were detailed plans of care appropriate to the stage of a person's treatment and support. For example, in three of the records we noted that people had been identified as being in their last 12 months of life, a minimal support and advice plan was in place as per the patient's wishes at that time.

In five of the records we reviewed, holistic assessments and plans were not very well documented. Whilst there was evidence of them having been carried out it was their opinion that these were brief and did not describe in detail the full nature of the assessment which should have been carried out. For example, there was not enough detail which would allow staff to have a thorough understanding of a person's choices and preferences. This meant that in these cases we could not be assured a full holistic assessment had been undertaken because it was not documented.

For patients nearing the last weeks and days of life we saw that all appropriate information and documentation was available to support staff to carry out the wishes of their patient. Advance care planning documentation was easily accessible and in each case, we saw that preferred priorities of care and/or preferred place of death had been documented.

Records were held electronically which meant there was ease of access for all healthcare professionals (internal and external to the trust) involved in a person's care to access the most up to date care preferences and information.

The trusts record audit data showed that the service was not meeting its targets in March 2018 for the percentage of patients on an end of life pathway with a preferred place of care identified. The trust scored 56% against a target of 70% for this indicator.

The trust was also not meeting its target of 98% for those patients on an end of life pathway who had declined to state a preferred place of care to be revisited within three months. As at March 2018 the trust scored 67%.

However, the trust was meeting its target of 100% for those patients having been identified as in their last year of life and having been offered a preferred place of care. The trust was also meeting its target of 85% of patients on the caseload being registered on the end of life register being offered an advanced care plan following an informed discussion.

Records were stored securely on the trusts electronic record system to protect people's safety and privacy. Only authorised people had access to patient's health records.

Medicines

The service had a Medicines Management Policy, which was last reviewed on 27th May 2017. The policy set out the responsibilities of staff, for prescribing clinicians and clinicians administering medicines. Staff knew how to access the trust's policy and they had completed training in administering medicines. Staff had awareness of the policies regarding the administration of medications and controlled drugs set out by the Nursing and Midwifery Council, Standards for Medicine Management.

End of life medicines were prescribed by GPs or by select specialist palliative care nurses who were qualified to prescribe medicines.

The end of life specialist nurses and district nursing teams in the south provided day-to-day management of syringe drivers in patients' homes. This including re-filling of syringe drivers. Syringe driver training was provided to staff working within the end of life care teams however, we asked for compliance data from the trust and none was provided. Staff told us that they received update training every two years to ensure they maintained their skills.

Anticipatory medications were prescribed for patients where this was appropriate and stored in an emergency drug box in patient's homes which was checked on each visit staff made. In all records where we reviewed medication administration we saw that nurses had signed to detail that medications had been given and at what time.

The trusts medicine management team had recently undertaken a piece of work in collaboration with the local consultant in palliative medicine and the community teams to identify a list of medications which needed to be readily accessible. This was then shared with local pharmacies and a list of the pharmacies which stocked the medications were shared with staff to ensure that should these medications be required then they could be accessed.

Safety performance

The services completed the safety thermometer monthly.

The Safety Thermometer is used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering

harm free care. Measurement at the frontline is intended to focus attention on patient harm and their elimination.

The safety thermometer data showed that 98.9% of patients received harm free care in South East Essex from April 2017 to March 2018. Patients in West Essex received 98.5% harm free care for the same period.

Incident reporting, learning and improvement

Staff used an electronic system to report incidents in relation to end of life care. The purpose of reporting such incidents was to ensure that action could be taken to address these on an individual basis and where appropriate take prompt action to remedy any associated issues. Secondly, incident reporting is a key learning and improvement mechanism. If utilised appropriately services can analyse and trend incidents to identify wider issues such as gaps in training or service provision and pass this learning on.

We asked the trust to provide us with a breakdown of incidents that took place over the past six months in relation to end of life care. We saw that 46 incidents had been reported and investigated.

We were concerned that the trust did not have in place appropriate systems which allowed them to learn from incidents to ensure a safe end of life service.

Of the 46 incidents reported we noted that only 13 of these had an identified lesson learnt. Each of these 13 incidents related to the development of a pressure sore whilst in the care of the service and in each case the lesson learnt was the same. It stated “All staff are aware of the importance of following the pressure ulcer care pathway to reduce the risks to patients. This learning has been re-enforced by this incident”. We are concerned because the incident investigation did not identify the exact point in which the care pathway may have been better followed. This means that learning is not being identified to protect patients from harm.

We also reviewed a variety of meeting minutes including five sets from the palliative care team meeting dating back to November 2017, the end of life group meeting dating back to January 2018 and the services senior management team meeting dating back to January 2018. We found no reference in any of these meetings that incidents in relation to end of life care had been discussed, shared or learned from. In addition, we spoke with three members of staff who all found it difficult to convey learning from incidents in relation to end of life care.

These staff were all aware of their responsibility to report incidents and knew what they should be reporting. For example; medication errors, equipment failures and pressure sores. One member of staff gave us an example of a recent incident they had reported in relation to a syringe driver not working properly.

Staff were also aware of the principles of the duty of candour and explained that it meant to be open and honest when things went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Incident reporting was supported by an internal policy dated April 2017 and staff knew how to access this via the staff intranet.

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’. Never events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective

barriers are available at a national level, and should have been implemented by all healthcare providers.

From April 2017 to January 2018, there were no reported never events within this service.

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care services, which met the reporting criteria, set by NHS England between, April 2017 and January 2018.

Is the service effective?

Evidence-based care and treatment

The trust had recently developed a framework for the improvement of end of life care services across the organisation. This framework had been developed to ensure it met current national priorities in relation to end of life care services as stated in the Gold Services Framework (GSF). It also referenced guidance issued by the National Institute for Health and Care Excellence (NICE) such as their 'Care of dying adults in the last days of life' and their Quality Standard 13 for end of life care for adults. It also incorporated the Leadership Alliance for the Care of Dying Peoples' review "One Chance to Get it Right".

The framework was supported by localised action plans which teams were working to implement.

However, at the time of our inspection this framework had only recently been introduced so we could not test its implementation to be assured that the trust was working in line with all the evidenced based care and treatment that it aspired.

The specialist palliative care register team had been set up based the guidance issued by the Gold Standards Framework 2003. The purpose of the team was to ensure that patient's preferred priorities of care could be established as early as possible in their palliative care pathway.

The clinical governance and quality team reviewed trust policies to ensure they were in accordance with the latest NICE guidance and updated them when required. We reviewed the trusts policy 'Consent to Examination and Treatment' and noted that it was in date, due for review in May 2020. We saw that it reflected national guidance such as that issued by the Nursing and Midwifery Council and legislation such at the Human Rights Act 1988.

Service leads were alerted to any new policy changes and would disseminate changes to their team.

Pain relief

We reviewed 11 patient care records for patients receiving end of life care and found that anticipatory medicines were prescribed and administered appropriately to manage patients' symptoms. Where appropriate, patients had syringe drivers, which delivered measured doses of drugs over 24 hours.

Pain assessments were also carried out when staff visited patients to ensure that their pain was being controlled effectively. We saw these complete in all 11 of the records that we reviewed. Where a patient's pain was seen to be increased then arrangements were made to review the patient's medication and increase pain relief where this was appropriate.

Anticipatory medicines were prescribed for patients. This meant that patients were not delayed in receiving pain control. This was confirmed by records and staff we spoke with who stated that anticipatory medications were usually obtained well in advance of a person's last days/hours.

Patient outcomes

We asked to be provided with a clinical audit programme of audits which the trust planned to undertake in relation to end of life care. This programme was not provided to us. We did however find that the trust planned to take part in the National Audit of Care at the End of Life in October 2018 as part of their national audit programme.

We were provided with an audit dated August 2017 which looked at the differences in the provision of end of life services across the trusts clinical commissioning areas and it was noted that there was a variance in performance based on the level of commissioned services. The audit stated that the data reported on was not a 'meaningful comparison of services and not indicative of quality or quantity of provision'. It identified that there needed to be a more consistent approach to the way in which the services were delivered. The recommendation was that an end of life group was set up. The group was set up in November 2017 and was taking place regularly. However, there was no follow up to the outcome or recommendations of the 2017 audit in meetings that had taken place since the groups implementation.

The service had completed the End of Life Care Quality Assessment Tool (ELCQuA) for community based end of life services however this was not dated. As we could find no reference to it in any of the committee meeting minutes we reviewed we could not be assured of its current relevance or that any of the identified actions for improvement were being monitored.

The specialist palliative care register team, which had been in place for 18 months, were monitoring the number of referrals they received against the number of patients identified as needing referral. We found that in February 2018, 42 patients were identified at hospital multidisciplinary team meetings as being appropriate to the register but only 10 of those referrals were received. In the same month, 23 patients were identified through GP GSF meetings (MDT meetings held by GPs to discuss their palliative patients) as benefiting from referral but only six referrals were received. It was unclear how this information was being used to inform practice, increase the number of referrals received or demonstrate patient outcomes. We asked the team who received and acted on the information and they did not know.

Competent staff

The trust did not provide any specific clinical supervision data for these services in their data submission.

We spoke with three members of staff who told us that supervision was not routinely carried out but that support was available should this be needed. De-brief sessions were held when staff may have been caring for a patient and there were specific complex issues or needs.

Staff told us that when they were new to post they were supported by senior members of staff. This included going to visits to carry out initial assessments in pairs until the new member of staff became confident with the policies and procedures in use.

Staff took responsibility for their own learning. The trust provided resources and information on training that was available in relation to end of life care. One member of staff we spoke with was currently undertaking a prescribing course and we saw that staff had taken up training provided by Macmillan.

This was supported by an education facilitator who took responsibility for alerting teams to new initiatives and training and ensuring relevant information and teaching was passed down. We saw that the team had recently undertook verification of death training and were working on embedding

the “You Matter – End of life in the Community” training course which had been developed by a health science partnership company.

We asked the trust to provide us with a copy of the competency framework used for end of life care staff and the associated compliance and this was not provided to us. Two members of staff we spoke with stated they did not have access to a competency framework.

We also asked the trust to provide us with a breakdown of specific end of life training provided to its staff and the associated compliance figures. This again, was not provided to us.

The trust’s target rate for appraisal compliance is 90%. As at 31 January 2018, the overall appraisal rates for non-medical staff within this core service was 80%. No appraisal data was submitted by the trust for medical staff in this core service during this period.

Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
5	4	80%

Multidisciplinary working and coordinated care pathways

The end of life staff worked closely with other providers of palliative and end of life care such as local hospitals, hospices and home care providers. They attended a range of multidisciplinary meetings. The purpose of these meetings (attended by a group of health professionals with expert knowledge in specific health topics) were to regularly review patient’s clinical conditions, assess the adequacy of palliative treatment and discuss any further interventions which may benefit the patient.

The specialist palliative care register team attended a number of specialist MDT meetings at the local hospital such as oncology, renal and respiratory. The purpose of their attendance was to listen to discussion about patients and prompt clinicians to consider if their patient was thought to be in their last 12 months of life. If it was agreed that they were, the specialist register team requested a referral so that the patient could be placed on the register and care co-ordinating could begin in relation to their palliative/end of life needs. Monitoring of these referrals took place and we saw a report which confirmed this.

Staff also attended GSF meetings held at local GP Practices. This was an opportunity to again identify patients that were in their last 12 months of life and to discuss current patients receiving palliative care and their symptom management and control.

Handovers took place daily at local bases. We attended one of these handovers and noted that patients were discussed and relevant information such as medication administration, patient deterioration, equipment needs and general patient wellbeing was discussed. This was supplemented by a handover book in patient’s homes whereby staff would leave pertinent written information for other staff and agencies attending to care for the patient.

The specialist palliative register team also provided various training events to other local care providers such as care homes. This training was set up so that they could ensure locally there was a greater understanding of the benefits of identifying people in their last months of life to ensure they received early intervention and care.

Health promotion

Patients were signposted to various services to promote their health and wellbeing in the last months of their lives.

We saw evidence in peoples records that where people smoked they were offered information about the NHS stop smoking service.

Nutritional advice was also available for people who were identified as being at risk of malnutrition.

Mental and emotional health was a key aspect of health promotion for people at the end of their lives. Through our review of records, we noted that people were given the opportunity to talk about their mental and emotional health and offered support such as counselling. Staff confirmed to us that they were aware of various mental health support services which were available through Macmillan and locally.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Nursing staff we spoke with had a good understanding of consent and when consent was required. This included when implied consent was applicable and appropriate and when written confirmation was needed. They were also aware of the Gillick competence and applied this when obtaining consent from young people. Gillick competence is a legal term used to decide whether a child (under the age of 16) can consent to his or her own medical treatment, without the need for parental consent.

We reviewed patient's electronic records and saw that consent had been marked as complete in all visits where this was applicable. Staff confirmed that risks and benefits were discussed with patients and we saw evidence of this in the patients written records.

We also saw in our review of records that conversations were held with people about the use of a Do Not Attempt Resuscitation Order (DNACPR). Where applicable we saw that these orders were in place, appropriately completed and signed by a doctor.

We spoke with two members of nursing staff who both demonstrated a good understanding of the requirements of the Mental Capacity Act 2005. They were aware of the two-stage assessment criteria needed to assess a person's capacity and understood the decision-making processes for people lacking capacity which included the use of best interest decisions. They also understood that capacity was time dependant and that because a person was not able to decide on a particular day, that didn't mean they couldn't make the decision for themselves at another time.

We heard of an example where an Independent Mental Capacity Advocate (IMCA) had been utilised as part of a decision-making process. The role of the IMCA was to enable independent overview in ensuring the principals of the Mental Capacity Act 2005 were followed when making a significant decision in the best interests of a person using services.

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the local authority from1 April 2017 to 31 March 2018 pertinent to end of life care services.

The three members of staff we spoke with also had a working knowledge of the principals of the Deprivation of Liberty Safeguards. They gave examples of when a person might be deprived of their liberty which included the event of a person lacking capacity being moved to a hospice or care home where this was deemed in their best interests. Staff understood that there was an authorisation process which needed to be followed and were confident if they had any concerns about a person's liberty being deprived they would contact managers for support.

Is the service caring?

Compassionate care

Staff we spoke with were clearly passionate about providing care which met the needs of the individuals they were caring for. We heard many examples of staff going above and beyond. In one case a staff member told us how they had visited patients outside of their allotted visits when they were in the final days/hours of life to support the families which they had grown close to and to ensure that patients comfort and dignity was maintained.

Another example we saw was that a member of staff had been recognised for their actions in adverse weather conditions. When roads had become too treacherous to drive upon they walked to see patients to ensure they received the care and support they needed.

In another example, where a child reached the end of their life, the care received by this family had such an impact that the mother of the child changed their career path to nursing so that they could provide the same level of support and compassion to other families.

The Palliative Care support team also gave us examples of how an increase in staffing has recently led them to be able to provide compassionate care for patients and their families. In one example we heard how if a patient deteriorated or was struggling emotionally they could send support workers out within two hours to provide support to that patient.

We also heard of an example whereby a family member who was taking care of a patient at the end of their life was struggling emotionally and was not sleeping because they were caring and staying up for the relative. A support worker was sent to take on caring responsibilities so this family member could get some sleep.

Emotional support

The trust does not currently undertake bereavement surveys in relation to expected deaths.

The West Essex Macmillan Cancer Support and Information Service had been developed as a joint venture between Macmillan Cancer Support and the trust to ensure people affected by cancer had access to good quality, comprehensive and appropriate information and support.

There was an advice line which was open between 09:30 and 14.30 Monday to Friday and there was an answer phone for out of hours calls. The advice line was manned by experienced staff who could take requests for help and support, provide information or signpost onto other agencies. The service was set up to allow patients, relatives and carers to access suitable national and local information about cancer, cancer prevention and local services.

Understanding and involvement of patients and those close to them

The specialist palliative care register team was able to identify a key worker for the patient who was primarily responsible for identifying the care needs for the patient and appropriately referring to other services in line with their identified needs and preferences. Part of the key worker role was to be the first point of contact for the patient and their family in relation to the care and support being provided to them/their family member.

The specialist care register team and the integrated nursing teams in the west provided patients with various booklets and information to explain their role and the services that could be accessed.

However, we were told that staff in the specialist palliative care nursing team did not have information packs which they could provide to patients to ensure they had all relevant information about the service on offer to them or other services in which they could access. We asked to be provided with copies of such information packs and these were not provided to us by the trust. On an initial visit to talk about end of life and palliative care needs patients may not take in all the information which is presented to them verbally. Having information to peruse at their own time

would ensure that they are given more than one opportunity to find out what may be on offer to them.

The service did not collect patient feedback. We asked to be provided with this and were told that no patient feedback other than the friends and family test was being collected. The friends and family test however did not break down to service level which meant there was no information available to the trust to inform it on how patients viewed the end of life services.

Is the service responsive?

Planning and delivering services which meet people's needs

At the time of our inspection clear end of life pathways were not in place. This had been identified by the trust and we were provided with a presentation which demonstrated work had started to address this. Work was being undertaken to review all local services to ensure clear pathways based on patient choice were available and accessible.

Meeting the needs of people in vulnerable circumstances

The trust ensured their staff could meet the needs of people in vulnerable circumstances.

There were a number of specialist nurses which could be accessed for patients as part of their MDT to ensure their specific needs were catered for. Specialist nurses included those in the fields of respiratory, tissue viability, diabetes and Parkinson's disease.

Dementia awareness formed part of mandatory training for clinical staff. Information provided by the trust showed that 94% of staff had completed this training and there were dedicated dementia champions to support staff in providing care to people living with dementia. The service had 14 dementia champions in West Essex. However, the service had no dementia champions in South East Essex at the time of our inspection.

Staff had access to interpreters when their patient's first language was not English. Staff we spoke with knew how to access this service. Managers understood the population of their locality and the nationalities of their patients for example Harlow had a large Polish community.

The trust had a wheelchair service to either assess the needs of wheelchair users with specialist modifications or supply additional equipment such as pressure relieving cushions.

The design of the building we visited, which held patient clinics met the needs of patients with mobility aids such as walking frame and wheelchairs.

Access to the right care at the right time

Patients could access the service in a variety of ways, which included GP, district nursing or hospital referral. There was no patient self-referral system.

The specialist palliative care register team were also working to build a register of people thought to be in their last 12 months of life. They were working closely with care homes, GP surgeries and hospitals to identify people that could be added to the register so that their care needs could be monitored at a frequency which the patient agreed. This was to ensure that any new or worsening symptoms could be identified and treated appropriately.

To assess which patients may benefit from being on the palliative care register, the teams used the Gold Standards Framework (GSF) Prognostic Indicators which were designed to help the earlier identification of people nearing the end of their life to enable better planning and coordinated care. Staff in all areas of the organisation that we visited recognised this tool and were aware of how to utilise it.

Staff told us that patients who had been referred to the service were always contacted and seen with 24 hours of referral. We asked to be provided with monitoring data which confirmed this but none was provided to us.

Data provided also showed that there was an urgent referral system whereby patients would be seen within 2 hours. However, again we were not provided with any monitoring data which confirmed all patients were seen within this timeframe.

The service also supported Fast track NHS Continuing Healthcare (a system designed for patients at the end of their lives to get the care they need in the place that they want to be cared for). This meant that patients have access to support to be cared for in their preferred place of death at short notice when their condition had deteriorated.

There were clear referral pathways in place for the staff to follow when patients became in need of transferring to hospice.

The service provided care 7 days a week from 7am to 11pm. Outside of these hours patients had to contact NHS 111 or their local GP out of hours service.

Learning from complaints and concerns

End of life care services received five complaints between 1 April and 31 December 2017. The main complaints themes were relating to clinical practice with three complaints.

Team	Clinical Practice	Systems & Procedures	Communication	Total
District Nursing Team	2		1	3
Community Integrated Nursing		1		1
Community Nursing South	1			1
Total	**3**	**1**	**1**	**5**

There was a complaints procedure in place for the organisation accessible to both staff and patients via the intranet and internet.

Data prior to our inspection told us that there had been five complaints in relation to end of life services in the past year. We asked to be provided with these complaints and their associated responses so that we could assess timeliness and quality of the response. However, none of these complaints were provided to us.

We did not find reference to end of life care complaints being discussed at any forum during our inspection. We can therefore not be confident relevant learning had been identified and shared to improve practice.

The trust received 661 compliments during the last nine months from 1 April to 31 December 2017. Four of these related to end of life care services, which accounted for 1% of all compliments received by the trust as a whole.

Is the service well-led?

Leadership

The lines of accountability for end of life services at board level were clear the Executive Nurse was identified as the board level lead for this service. There was also a non-executive director who was responsible for overseeing the quality of end of life services. However, this non-executive director had only recently been identified as the end of life lead and as such we could not test how effective oversight of end of life services was.

All non-executive and director appointments were made via the fit and proper person requirement which ensured they were suitably skilled, qualified and experienced for the roles which they undertook.

Locally, staff told us their managers were routinely visible and approachable. Staff felt they could raise concerns without fear or reprimand and they were confident action would be taken as result.

Locally the services were supported by a team of dedicated and proactive managers who received a high amount of praise from the staff they managed. Each manager was fully versed in the challenges and areas of good practice in their individual areas and were committed to making positive change.

Vision and strategy

The end of life care services at this trust had recently received a renewed focus from the trust board. The improvement of end of life services was a key priority in the trusts five-year strategy. A dedicated framework had been developed to support the implementation of a consistent approach to the care delivered to patients at the end of their lives.

We reviewed this framework and noted it was approved in February 2018 by the quality committee. It was clear at the time of our inspection that the implementation of this framework was in the early stages however, staff we spoke with were fully versed in its content and the work it set out to achieve. Local implementation plans were put into place and were due to be monitored via the end of life group.

The vision set out within the framework was that all patients at the end of their lives were 'treated with dignity, respect and compassion as an individual'.

Culture

All the staff we spoke with stated that they felt respected and valued by their managers, peers and team members. We were assured that should behaviour be inconsistent with the trusts visions and values action would be taken to address this. Staff we spoke with were passionate about the people they cared for. They spoke in a manner which gave us confidence the culture within the teams centred on the needs and experiences of the of the people using end of life care services.

Staff were encouraged to demonstrate candour, openness and honesty at all levels. The trust had a policy in relation to duty of candour and this was readily available to staff via the trust intranet.

Governance

Terms of reference for a key committee had only just been signed off, despite the committee having been in place in excess of six months. The terms of reference which were signed off in April 2018 were not clear and did not accurately reflect the responsibilities identified to the group in the end of life framework. For example, there was no reference in the terms of reference of the need for assurance reporting to the quality committee.

There was no dedicated forum where incidents or risks specifically relating to end of life care were reviewed or analysed. This meant the trust was unable to understand areas of weakness within this service to enable learning and improvement. However, incidents and risks on an individual basis were received through the wider governance framework within the community services directorate of the trust.

We reviewed papers for the trust board from May 2017 to April 2018 and found there was no dedicated review or assurance taken on the state of end of life services within the trust. An

Executive Director confirmed no assurance had been received at Board level. They agreed that this was needed and agreed to act to ensure this happened in future.

The framework for end of life services stated that board assurance would be received from the end of life group via the quality committee. We reviewed the minutes of the quality committee dated 15 March 2018 and 13 April 2018 (following the end of life framework approval) and no assurance report for end of life services had been received. In addition, we found no evidence that assurance had been received at a top-level committee prior to the approval of the end of life framework. We reviewed the minutes of the quality committee dated September 2017, 16 November 2017, 14 December 2017 and 11 January 2018 and found no reference to discussions concerning end of life services.

There was also no reference to the quality of end of life services referred to in the last three meeting minutes of the directorate of community services and partnerships community Health service senior management team meeting.

We raised our concerns with a director of the trust and were told that another forum where quality issues may be discussed were the services quality and safety meetings. We reviewed the minutes of the last three meetings held in each locality and noted that there was little reference to quality and performance monitoring relating to end of life services.

Policies to support staff in delivering end of life care services were not in place. The trust did not have in place an end of life or palliative care policy to describe to staff their roles and responsibilities in relation to delivering this service. We were told that the trust worked to the framework in place. However, the framework was an overarching description for what the trust set out to achieve and did not set clear roles and responsibilities.

Following our raising of these concerns with the trust we were provided with a service evaluation report for the south teams and noted that some of the issues identified during this inspection were due to be taken forward for improvement. An evaluation for the west teams was also being undertaken however was not complete at the time of writing this report.

Management of risk, issues and performance

There was a risk register in place which was directorate wide and not just specific to end of life services.

We reviewed the directorate risk register and found that there were no risks identified in relation to end of life care. Our inspection however found that there were risks in relation to end of life services, the most pertinent being the possible failure of successful implementation of the services framework.

Without a clear governance framework, the service is at risk of not being able to raise issues to the correct level within the trust to ensure that appropriate and timely action is taken to protect people using services.

Information management

Staff across the trust could access information from the intranet, including policies and national guidance. Staff we spoke to knew how to access information on end of life care through the intranet and through paper documentation available at main sites across the trust.

We saw that the service was supported by the electronic patient records systems to share and update information on patients. The electronic records systems were accessed securely by all clinicians and allied healthcare professionals involved in the patient's care.

There were limited sources of information being effectively processed to allow a holistic understanding of the performance of this service. For example, the trust was not gathering patient feedback in relation to end of life services so this meant that it could not use this key information to develop and improve the service. There were no assurances that information related to the service was being processed, challenged or acted upon.

Engagement

The specialist palliative care register team undertook various engagement session and were working hard to engage GP surgeries in their local area to educate them about the palliative care register and it's benefits.

Learning, continuous improvement and innovation

Staff from the palliative care teams in the west of the region had worked in collaboration with a local NHS Trust on a project designed to create an integrated service that ensured minimum stress for patients when they were at their most vulnerable. The project was part of the End of Life Collaborative organised by NHS Improvement. The project won an award for the NHS Trust in question but staff from the trust were key in its design.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

None of the services within end of life care service have been awarded an accreditation.

Mental health services

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

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Basildon MHU	Assessment Unit	20	Mixed
Basildon MHU	Grangewaters Ward	28	Mixed
Basildon MHU	Hadleigh PICU	10	Mixed
Basildon MHU	Thorpe Ward	20	Mixed
Chelmer & Stort Mental Health Wards	Chelmer Ward	16	Female
Chelmer & Stort Mental Health Wards	Stort Ward	16	Male
Colchester Mental Health Wards	Ardleigh Ward - Adult Acute	18	Female
Colchester Mental Health Wards	Gosfield Ward	18	Male
Colchester Mental Health Wards	Peter Bruff Unit	17	Mixed
Broomfield Hospital Mental Health Wards	Christopher Unit, The	10	Mixed
Broomfield Hospital Mental Health Wards	Finchingfield Ward - Adult Acute	17	Male
Broomfield Hospital Mental Health Wards	Galleywood Ward	18	Female
Rochford Hospital	Cedar Ward	24	Mixed

Is the service safe?

Safe and clean environment

Safety of the ward layout

All wards inspected complied with mixed sex accommodation guidelines. Mixed sex wards had separate lounges for male and female patients. Patients had separate bedroom areas with access to bathroom facilities or en suites. However, on Peter Bruff unit, female patients had to walk through the male bedroom corridor area to access their bedroom area or the communal areas.

From 1 April 2017 to 31 December 2017 there was one mixed sex accommodation breach within this service at Basildon Mental Health Assessment Unit. The incident was due to no female bed available on the MHAU so the patient was admitted to a bed in a single room in the male corridor.

The trust had undertaken recent (from 1 April 2017 onwards) ligature risk assessments at all 13 locations.

All wards presented a high level of ligature risk due to a vulnerable group of patients who have the potential to self-harm and recent surveys and feedback have identified an increase in finding alternative methods.

The trust had taken actions to have a review of the ligature management policy and has funding agreed by the Executive Operational Steering Committee to make appropriate changes including stripping/replacing protruding fixings (alarm call buttons, light switches, alarms, extractor fans), line of site surveys and mirrors to be installed, toilets to be replaced with reduced ligature design, beverage bays to minimise unsupervised access to the kitchen and replacing door handles and wardrobes in order to mitigate ligature risks.

Managers had not ensured safe environments on six out of 13 wards. Managers had not identified and mitigated against all ligature risks and blind spots at the service.

We found unidentified ligature risks on Grangewaters, Chelmer, Ardleigh and Peter Bruff wards, unidentified blind spots on Chelmer and Ardleigh wards and a lack of risk mitigation on Hadleigh and Gosfield wards.

On Grangewaters ward, managers had completed ligature audits dated September 2017, that were available to staff on the ward. Managers had not identified all ligature risks. We found unidentified risks in the laundry room, kitchen, female toilets and female bathroom. Following our tour of the ward we were provided with a recently completed audit, which included the previously unidentified risks and detailed actions planned to mitigate these risks. However, this audit was not available to staff on the ward prior to our visit and was added to the ligature pack during the inspection.

On Chelmer ward, managers had completed up to date ligature audits but had not identified all ligature risks. The laundry room was not included on the ligature risk assessment. This room had cupboard handles that were a ligature risk. However, patients did not access this room unsupervised. Managers had not identified that the radiators in bedrooms were a ligature risk, although they had identified the radiators in communal areas as a risk. Estates had fitted an anti-barricade door to the bathroom; however, they had fitted this incorrectly. The manager had closed off the bathroom until the issue was resolved. We found a blind spot in the corridor, outside one of the bedrooms that managers had not identified.

On Ardleigh ward, managers had completed up to date ligature audits but had not identified all ligature risks. The garden had numerous ligature risks and was not included in the audit. The ligature risks identified were not room specific. There were a number of ‘hot spot’ photographs but only three ‘hot spot’ areas identified on the heat map, which related to blind spots. No ligature risk areas had been identified on the heat map. We found one unidentified blind spot in a small recess area between the main corridor and bedroom entrance. Higher risk areas that had been identified included blind spots, which were mitigated against by the installation of convex mirrors and increased checks of the areas.

On Peter Bruff unit, managers had completed up to date ligature audits but had not identified all ligature risks. We identified ligature risks with the garden furniture, in the disabled rooms, in the laundry room and the kitchen area. The ‘hot spot’ photographs did not reflect all the ligature risks in the audit and vice versa. Managers had identified all blind spots and convex mirrors and increased observations were in place to mitigate against these.

On Hadleigh psychiatric intensive care unit, managers had completed accurate and up to date ligature audits, however they had not detailed required actions to mitigate against all risks identified. For some other actions, it was not clear whether the work had been completed or not. Ligature cutters were easily accessible.

On Gosfield ward, managers had completed accurate and up to date ligature audits. However, staff were unable to initially locate the audit as it was not in the ligature pack in the office and had been moved to a folder. Although managers had identified all ligature risks, there was no mitigation recorded for the multiple risks in the garden. The door to the garden was unlocked to allow patients free access. The ward manager told us that the risks in the garden would be mitigated by individual patient risk assessments and increased observation. We saw that the trust had completed a lot of work to remove ligature risks and the ward manager told us that hot spots on the ward had reduced from 20 to eight.

Managers had identified and mitigated against environmental risks on the other wards within the service.

On the Mental Health Assessment Unit, managers had completed accurate and up to date ligature audits and risks assessments. Managers had identified all ligature risks and actions were underway to remove these where possible. The ward manager showed us evidence of following up actions required with the estates department. The ward manager had mitigated against risks identified through increased observations and other actions, for example, keeping bedroom windows closed until they could be replaced. The ward manager had displayed a poster in the staff office listing key actions to manage ligature and other environmental risks. The ward had a ligature heat map displayed and ligature cutters were easily accessible and kept maintained. Staff, including bank and agency, had signed to confirm they had read and understood all information regarding environmental risks. There were blind spots on the ward but these were mitigated against using convex mirrors.

On the Christopher psychiatric intensive care unit, managers had completed accurate and up to date ligature audits and had mitigated against all identified risks. Staff were aware of all risk areas and blind spots and convex mirrors were in place to mitigate against these.

On Finchingfield ward, managers had completed accurate and up to date ligature audits and had mitigated against all identified risks. Staff showed us a handover document that the nurse in charge had signed to confirm they were assured that staff on duty that day were aware of all environmental risks and actions required to manage these. Managers had identified all blind spots and convex mirrors and increased observations were in place to mitigate against these.

On Cedar ward, managers had completed accurate and up to date ligature audits and had mitigated against all identified risks. Managers had identified all blind spots and convex mirrors and increased observations were in place to mitigate against these. Not all staff had signed to confirm they had read the contents of the ligature pack.

On Galleywood ward, managers had completed accurate and up to date ligature audits and had mitigated against all identified risks. Actions were underway to remove ligature risks where possible. Staff completed ten minute walk arounds of high risk areas. Managers covered environmental risks in staff induction and discussed them in handovers. We saw completed staff induction forms, including for bank and agency staff. Staff spoken with were aware of the ligature risks on the ward and action required to manage these.

On Stort ward, managers had completed accurate and up to date ligature audits and risks assessments. Managers had identified all ligature risks and mitigated against these through

increased observations and supervised access to high risk areas. There were blind spots in all bedroom en suites, managers had identified these and mitigated against them by increased observation of patients.

On Thorpe ward, managers had completed accurate and up to date ligature audits; however, the completed actions had not been updated. Not all staff had signed to confirm they had read the contents of the ligature pack.

All wards had a ligature pack available to staff in the office. The pack consisted of a ligature audit, risk assessment, heat map, 'hot spot' photographs, ligature cutter, procedure for the use and maintenance of ligature cutters, local induction ligature risk checklist and a list of staff signatures confirming they had read the contents of the pack.

Maintenance, cleanliness and infection control

Wards were clean and well maintained with good quality furnishings. Staff adhered to infection control procedures, for example, handwashing and the application of hand sanitiser. Staff prompted us to apply hand sanitiser before entering the wards.

Seclusion room

Seclusion rooms were compliant with the Mental Health Act code of practice. Four wards had seclusion facilities. These were the two psychiatric intensive care units, Hadleigh and the Christopher unit, Peter Bruff unit and Ardleigh ward. We inspected the facilities on Christopher unit, Peter Bruff unit and Ardleigh ward. We were unable to inspect the seclusion room on Hadleigh as it was occupied during our visit.

The seclusion rooms inspected allowed clear observation, had two-way communication, toilet facilities and a clock. Staff controlled the lighting and heating from outside the rooms. Staff controlled the window blinds electronically from outside the rooms.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment. We inspected nine clinic rooms at Hadleigh, Chelmer, Stort, Ardleigh, Peter Bruff, Christopher unit, Galleywood, Cedar and the Mental Health Assessment Unit. The CQC medicines team inspected Grangewaters clinic room.

Safe staffing

Managers ensured safe levels of staff at the service. All wards displayed safe staffing boards at the entrance. These boards detailed the expected and actual number of staff on duty for that day. All wards had the expected or above number of staff on duty when we visited.

Managers told us they were supported to increase staffing levels as required to meet patients' needs.

We observed qualified staff to be present in communal areas at all times. Patients and staff spoken with also advised this was the case.

Patients spoken with on most wards told us that they could spend 1-1 time with their named nurse. Patients on the Mental Health Assessment Unit advised that staff did not spend time engaging with them.

Escorted leave and activities were rarely cancelled due to lack of staff.

Nursing staff

Managers had ensured that wards had the required number of nursing staff on duty. Managers were recruiting to vacant posts on their wards. Managers told us that they would use regular bank and agency staff to ensure continuity of care for patients. We reviewed local induction forms that evidenced bank and agency staff received thorough inductions before working on the ward.

This service has reported a vacancy rate for all staff of 16% as of 31 January 2018.

This service reported an overall vacancy rate of 20% for registered nurses at 31 January 2018 and 16% for registered nursing assistants.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Ardleigh Ward	-2.56	10.61	-24%	-1.39	10.41	-13%	-3.95	21.02	-19%
Cedar Ward	0.65	9.57	7%	0.72	10.72	7%	1.37	20.29	7%
Chelmer Ward	1.89	10.62	18%	1.81	9.61	19%	3.70	20.23	18%
Finchingfield Ward	5.34	13.54	39%	2.47	10.47	24%	7.81	25.81	30%
Galleywood Ward	7.73	13.13	59%	2.47	9.47	26%	10.20	24	43%
Gosfield Ward	-0.76	10.61	-7%	-0.99	10.41	-10%	-1.75	21.02	-8%
Grangewaters Ward	3.10	9.57	32%	3.87	10.72	36%	6.96	20.29	34%
Hadleigh Unit (Picu)	0.26	9.57	3%	4.06	12.86	32%	4.32	22.43	19%
In Patient Psychology	-	-	-				0.80	3.6	22%
Inpatient Adult Mental Health Wards (North Essex)	-	-	-				7.40	14.5	51%
Mh Assessment Unit	1.82	11.74	16%	2.16	12.88	17%	3.98	24.62	16%
MH Inpatient Discharge Team	0.00	1	0%	1.00	2	50%	1.00	3	33%
Peter Bruff Ward	-0.38	10.62	-4%	0.61	10.01	6%	0.23	20.63	1%
Stort Ward	3.21	11.01	29%	0.61	9.61	6%	3.82	21.62	18%
The Christopher Unit	3.82	14.42	26%	4.59	10.64	43%	7.43	26.48	28%
The Lakes Inpatient Support				0.00	6	0%	1.96	15.16	13%
Thorpe Ward	4.96	9.57	52%	2.11	10.72	20%	7.06	20.29	35%
Core service total	**29.07**	**145.58**	20%	**24.09**	**146.53**	16%	**53.34**	**324.99**	16%

Ward/Team	Registered nurses			Health care assistants			Overall staff figures		
	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Trust total	**1655.28**	**11061.65**	**15.0%**	**1002.03**	**8846.71**	**11.3%**	**4284.55**	**30928.44**	**13.9%**

NB: All figures displayed are whole-time equivalents

Between 1 April 2017 and 31 January 2018, bank staff filled 23% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 11% of shifts for qualified nurses. Six percent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Ardleigh	1,812	179	58	186
Assessment Unit - Basildon	2,414	636	627	76
Cedar Willow	1,857	495	159	31
Chelmer	1,930	510	178	137
Christopher PICU	1,925	480	118	70
Finchingfield	2,396	596	46	352
Galleywood	1,935	543	302	164
Gosfield	1,798	207	47	109
Grangewater	1,810	401	341	28
Hadleigh Unit	1,834	427	15	43
Inpatient MH Magt Team	107	107	0	0
Linden Site Coordinator	77	52	25	0
Peter Bruff	1,735	523	39	51
Stort	1,890	215	614	68
Thorpe	1,904	589	322	106
Core service total	**25,424**	**5,960 (23%)**	**2,891 (11%)**	**1,421 (6%)**
Trust Total	**102,629**	**31,709 (31%)**	**12,577 (12%)**	**795 (<1%)**

***Percentage of total shifts

Between 1 April 2017 and 31 January 2018, 54% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

Over the same period, agency staff covered 3% of shifts. Three per cent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Ardleigh	1,873	455	65	30
Assessment Unit - Basildon	2,897	1,269	119	122
Cedar Willow	3,147	1,259	181	180
Chelmer	1,726	930	7	211
Christopher PICU	2,296	2,071	159	114
Finchingfield	1,729	780	6	25
Galleywood	1,842	757	10	32
Gosfield	1,789	694	83	29
Grangewater	3,030	1,532	67	85
Hadleigh Unit	4,614	2,937	99	130
Peter Bruff	1,928	1,203	21	19
Stort	1,930	1,105	21	33
Thorpe	5,213	3,345	257	101
Core service total	**34,014**	**18,337 (54%)**	**1,095 (3%)**	**1,111 (3%)**
Trust Total	**144,009**	**60,464 (42%)**	**5,916 (4%)**	**804 (<1%)**

***** Percentage of total shifts

This service had 12 (5%) staff leavers between 1 April 2017 and 31 January 2018.

Caveat: Turnover has increased this financial year due to the trust merger and restructure of corporate functions to implement efficiency savings. Turnover is expected to remain high following the leadership restructure and further efficiency savings.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
364 EA504 Hadleigh Unit (PICU)	18.29	2.00	11%
300 Christopher Unit (PICU)	19.172	2.00	10%

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
300 Peter Bruff Ward	20.54	2.00	10%
364 EA502 Grangewaters Ward	13.10	1.00	8%
364 EA510 Thorpe Ward	14.59	1.00	7%
300 Chelmer Ward	17.84	1.00	6%
300 Finchingfield Ward	20.641	1.00	5%
300 Gosfield Ward	21.51	1.00	5%
364 EA501 Cedar Ward	18.92	1.00	5%
364 EA520 Mh Assessment Unit	19.19	0.43	2%
300 Galleywood Ward	15.64	0.00	0%
300 Ardleigh Ward	23.67	0.00	0%
300 Stort Ward	16.38	0.00	0%
Core service total	239.49	12	5%
Trust Total	3127.64	253	7%

The sickness rate for this service was 7% between 1 April 2017 and 31 January 2018. The most recent month's data (January 2018) showed a sickness rate of 8%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
364 EA501 Cedar Ward	18%	8%
364 EA504 Hadleigh Unit (Picu)	5%	6%
364 EA502 Grangewaters Ward	1%	7%
364 EA510 Thorpe Ward	3%	9%
364 EA520 Mh Assessment Unit	17%	9%
300 Chelmer Ward	11%	7%
300 Christopher Unit	0%	5%
300 Finchingfield Ward	7%	4%

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
300 Galleywood Ward	2%	2%
300 Ardleigh Ward	8%	5%
300 Gosfield Ward	4%	5%
300 Peter Bruff Ward	12%	13%
300 Stort Ward	8%	9%
Core service total	**8%**	**7%**
Trust Total	**4%**	**4%**

The below table covers staff fill rates for registered nurses and care staff during September, October and November 2017.

Gosfield, Finchingfield, Galleywood and Chelmer wards had less than 90% of the planned registered nurses for day shifts in September and October 2017.

Ardleigh, Gosfield, Peter Bruff, Christopher unit, Finchingfield, Chelmer and Stort wards had more than 125% of the planned care staff for day and night shifts for two of the three months reported.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	September 2017				**October 2017**				**November 2017**			
Ardleigh Ward	90.8	133.1	85.7	199.6	89.6	137.7	93.7	170.9	93.5	100.0	93.4	101.7
Gosfield Ward	83.7	137.1	100.0	210.3	88.6	138.7	86.7	241.0	94.2	100.0	96.7	106.3
Peter Bruff Unit	104.1	145.3	99.8	320.0	103.3	125.0	100.0	216.1	98.4	96.7	100.0	98.5
Christopher Unit	96.0	114.5	91.7	334.3	92.3	143.5	96.8	378.9	99.2	102.8	98.3	101.6
Finchingfield Ward	49.6	154.7	120.0	109.7	53.6	136.5	103.2	99.7	98.7	99.4	100.0	100.0
Galleywood Ward	77.3	108.5	108.3	91.4	66.9	99.0	124.5	124.2	95.2	100.6	95.0	103.3
Chelmer Ward	84.4	104.4	145.2	210.0	80.1	61.6	134.0	112.9	99.2	103.8	98.6	111.1
Stort Ward	92.9	121.8	96.7	213.2	95.6	131.1	100.0	267.7	98.4	105.4	96.8	101.5

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	September 2017				October 2017				November 2017			
Cedar/Willow	95.8	100.0	98.3	97.4	100.0	100.0	98.4	100.0	97.5	100.0	100.0	97.3
Assessment Unit	95.7	95.1	100.0	100.0	97.8	94.7	100.0	100.0	97.8	93.5	100.0	100.0
Grange water	98.3	93.6	100.0	97.7	98.3	94.4	100.0	103.3	94.9	99.6	92.6	102.2
Hadleigh PICU	96.7	95.5	98.3	98.4	98.4	94.7	96.7	100.0	100.0	94.3	98.3	99.5
Thorpe (Westley)	100.0	100.0	100.0	100.7	93.7	97.1	96.8	101.3	101.7	96.3	98.3	99.3

Medical staff

Wards had access to medical staff when required.

Between 1 April 2017 and 31 January 2018, no shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same period, agency staff covered 608 of shifts, 1,511 shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Assessment unit	Not stated		368	
Adult Inpatient	627		201	426
General Adult	39		39	
General Adult GPST	299			299
General Adult Inpatient ST	299			299
General Adult ST	127			127
Core service total	**1391**	**0**	**608**	**1151**
Trust Total	**6744**	**258**	**3406**	**3080**

Mandatory training

The compliance for mandatory and statutory training courses at 31 December 2017 was 81%. Of the training courses listed 18 failed to achieve the trust target and of those, nine failed to score above 75%.

The trust has a rolling month on month compliance rate for mandatory training.

Managers and staff told us that there had been issues with the trust training tracker recording completed courses. Staff told us they had completed courses numerous times and they were not

recorded as complete. Staff had taken screen shots of the training course to evidence completion to their managers.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	**Compliance**
Basic Back Care (E-Learning)	100%
Care Certificate	100%
Care Programme Approach	100%
First Aid Trained	100%
Safeguarding Adults (Level 3)	98%
Duty of Candour (Overview Version)	98%
Corporate Induction	97%
Mental Capacity Act Level 1	96%
Observation of Service User	94%
Equality and Diversity	94%
Harassment & Bullying	94%
Safeguarding Children (Level 2)	94%
Induction E-Learning	93%
Complaints Handling	93%
Dual Diagnosis	92%
Duty of Candour (Detailed Version)	91%
Hoisting	91%
Basic Life Support & AED	87%
Diabetes Training	86%
Hoisting e-learning	86%
Safeguarding Adults (Level 1)	86%
Cascade Fire Trainer	86%
Medication Management (MH)	86%
Clinical Risk Assessment	85%
Personal Safety - MVA	85%
Fire In-patient	84%
Safeguarding Children (Level 3)	82%
TASI Trained	81%
Mental Health Act	80%
Health and Safety (Slips, Trips and Falls)	78%
Fit for Work	78%
Information Governance	78%
Food Hygiene	76%
Fire Safety 2 years	69%
MERT (Enhanced Emergency Skills)	66%
Personal Safety Breakaway - Level 1	65%
Infection Prevention, Control & Hand Hygiene	62%
PREVENT (WRAP) Training	62%
Mental Capacity Act Level 2	61%
Manual Handling - People	57%
Dementia Awareness (inc Privacy & Dignity standards)	50%
Fire Safety 3 years	19%
Total	81%

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff had completed up to date and detailed risk assessments for most patients. We reviewed 58 patient care records and 90% of these included up to date and detailed risk assessments.

However, we reviewed three patient's records on the Mental Health Assessment Unit and staff had not completed detailed risk assessments or risk management plans. There was no evidence of ongoing assessment of patients' mental state. These patients had presented with serious risk issues on admission to the ward. We spoke with four patients who told us that staff had not assessed them since their admission to the ward.

On Ardleigh, Peter Bruff and Cedar wards, we found one patient record on each ward that did not contain an up to date and detailed risk assessment.

There were no blanket restrictions in place on the wards.

Informal patients could leave at will. There were posters displayed at the exits from the wards advising patients of this. Staff also provided patients with a leaflet explaining their informal rights as an inpatient.

There were policies in place for the use of observation and searching patients, which staff followed. Finchingfield ward was involved in a pilot scheme with NHS Improvement, which aimed to reduce the time patients were on direct observations through staff taking a more positive and proactive approach to engaging with patients whilst observing them.

Use of restrictive interventions

Staff used physical interventions as a last resort and only after de-escalation had failed. Staff spoken with told us this and most patients spoken with told us they experienced and observed staff using de-escalation techniques to good effect.

However, staff had not recorded use of restraint correctly in three incident records reviewed (two on Gosfield and one on the Christopher Unit). On Gosfield, one report describes the patient being restrained, but the 'control and restraint' section of the form was not completed. In the other report, the patient has been administered rapid tranquillisation medicines, but there was no record of restraint. On the Christopher unit, a patient was administered rapid tranquillisation and the staff had stated only 'supportive holds' were used.

Two patients told us that staff were aggressive and rough when restraining them.

This service recorded 622 incidents of restraint (on 327 different service users) and 38 incidents of seclusion between 1 April 2017 and 31 December 2017.

The below table focuses on the last nine months' worth of data: April 2017 to December 2017.

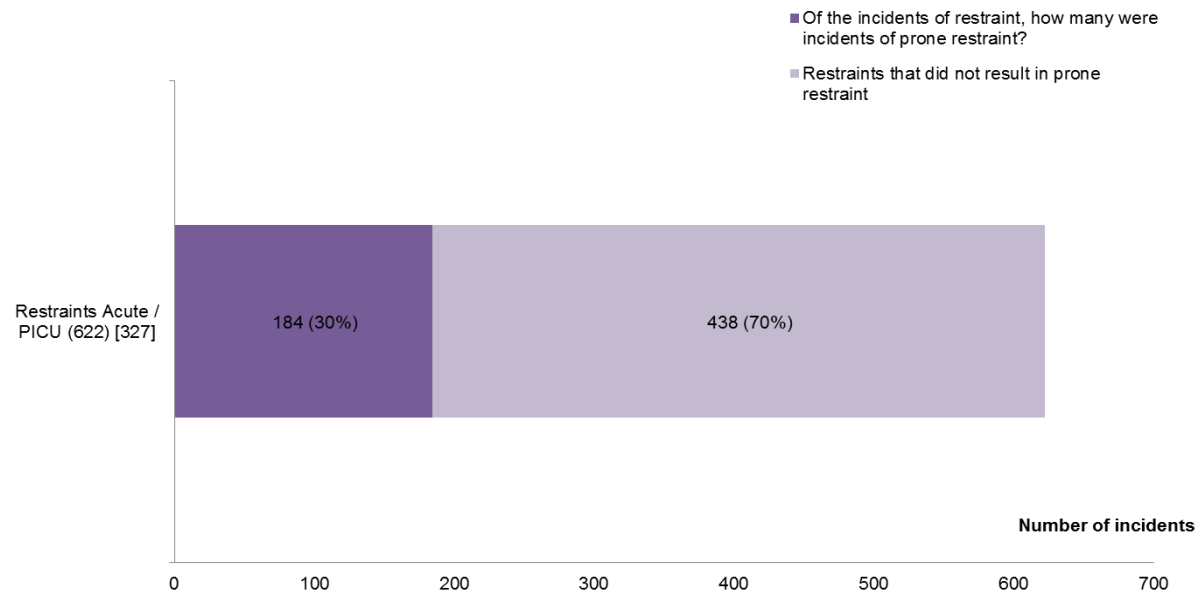
Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Grangewaters Ward	0	55	39	30 (55%)	34 (62%)
Hadleigh Unit (PICU)	12	37	25	13 (35%)	17 (46%)

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Mental Health Assessment Unit Basildon	0	19	14	5 (26%)	6 (32%)
Thorpe Ward	4	79	35	57 (72%)	68 (86%)
Chelmer Ward	0	14	7	3 (21%)	8 (57%)
Stort Ward	0	16	10	2 (13%)	10 (63%)
Cedar Ward	2	73	31	20 (27%)	25 (34%)
Peter Bruff Ward	9	50	25	7 (14%)	17 (34%)
Ardleigh Ward	3	36	25	3 (8%)	10 (28%)
Gosfield Ward	4	26	18	6 (23%)	6 (23%)
Christopher Unit (PICU)	4	100	40	20 (20%)	37 (37%)
Finchingfield Ward	0	39	24	11 (28%)	21 (54%)
Galleywood Ward	0	78	34	7 (9%)	26 (33%)
Core service total	**38**	**622**	**327**	**184 (30%)**	**285 (46%)**

There were 184 incidents of prone restraint which accounted for 30% of the restraint incidents.

There were no instances of mechanical restraint over the reporting period.

Number of incidents of restraint and prone restraint for this core service over the 12 months



Please note the figures in square brackets ,after the total number of restraints, are the number ofdifferent service users restraint was used on during this time period.

There have been two instances of long term segregation over the 12 month reporting period.

Staff had followed National Institute for Health and Care Excellence guidance following the administration of rapid tranquillisation medicine, in patient records reviewed. However, in two incident records reviewed (one on Gosfield and one on the Christopher Unit), staff recorded that rapid tranquillisation medicine was administered but the physical observations section of the form was not completed.

Staff had complied with the requirements of the Mental Health Act code of practice in regard to seclusion practices. We reviewed five seclusion records, two on the Christopher unit and three on Ardleigh. However, there was no evidence of staff attempting de-escalation prior to one episode of seclusion on Ardleigh ward.

Safeguarding

Staff ensured that patients were safeguarded from abuse. Staff described what would be a safeguarding concern and how to report it. All staff had completed level one safeguarding training, with 89% of eligible staff completing level two and 87% of eligible staff level three.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust provided details of the total number of safeguarding referrals made between 1 April 2017 and 31 December 2017 with 802 referrals made for adults and 180 for children. However, this is for the whole trust and has not been broken down to core service level.

The trust told us that there were no serious case reviews commenced or published in the last 12 months that related to this service.

There were safe procedures in place for children visiting the wards, including access to family rooms located off the wards.

Staff access to essential information

All information needed to deliver patient care was available to relevant staff (including bank and agency staff) when needed and was in an accessible form. The service operated three electronic records systems. One for wards based in the north and another for wards in the south. The trust had introduced a third system that enabled staff to access key patient information from both north and south records.

Medicines management

The service had robust medicines management practices in place for transport, storage, dispensing and medicines reconciliation. Pharmacists visited the wards regularly and supported staff and patients with medication. However, there were some issues with emergency drugs, which related to staff keeping non-emergency drugs, for example creams and aspirin in a plastic tub labelled 'emergency drugs'. We brought this issue to the attention of the pharmacy team. There were also issues with medicines fridges not being clean and some unlabelled liquid medicines.

On Peter Bruff unit, we found one medicine with a limited life that staff had not labelled with the date of opening and the medicines fridge was not clean. There was no adrenaline available. On Ardleigh ward, we found one bottle of liquid medicine that staff had not labelled with the date of opening and the medicines fridge was not clean. There was a bag of medication that staff had not signed in to the ward. Staff advised that this was due to short staffing on the ward the previous day.

On Chelmer ward, staff were not checking patients' vital signs following the administration of oral lorazepam.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 January 2018 there were nine STEIS incidents reported by this service. Of the total number of incidents reported, the most common type of incident was *apparent/actual/suspected self-inflicted harm meeting SI criteria* with eight. Two of the three of the unexpected deaths were instances of apparent/actual/suspected self-inflicted harm meeting SI criteria.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was not comparable with STEIS. There was one incident which appeared within STEIS but not their serious incident spreadsheet 2017/20129.

	Number of incidents reported		
Type of incident reported on STEIS	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Pending a review	Total
Chelmer Ward	2		**2**
Basildon MHAU	3		**3**
Finchingfield Ward	1		**1**
Gosfield Ward	2	1	**3**
Total	**88**	**11**	**99**

Managers had made improvements following incidents at the service. These included strengthening discharge procedures to ensure staff follow patients up once they are back in the community, challenging other health providers to ensure they are taking the right action for patients, introducing ligature packs, introducing the use of electronic cigarettes and removing shower rails.

Reporting incidents and learning from when things go wrong

Staff spoken with knew what incidents to report and how to report them. Staff reported incidents on the trust electronic database. Managers reviewed incidents.

Staff spoken with were aware of the Duty of candour and would explain to patients when things went wrong.

Managers had not ensured learning from incidents was shared consistently across the service. Staff spoken with were not always aware of relevant incidents that had occurred on other wards within the service. An example of this was an incident we reviewed where a patient had grabbed a

member of staff's identification badge from them. This badge also served as a swipe card to gain access on and off the ward. We interviewed a member of staff on another ward and the same incident had recently happened to them and they were not aware of this happening elsewhere. We reviewed 25 incidents, of these, 16 did not include any lessons learned and in three, lessons learnt had not been shared.

Staff told us they were supported following incidents. This included formal de briefing sessions, ongoing support from managers and access to an employee assistance programme.

Is the service effective?

Assessment of needs and planning of care

Staff assessed the majority of patients' needs and planned their care. Staff had completed up to date, personalised, holistic and recovery focused care plans in 98% of 59 patient records reviewed. Staff had completed a full physical health assessment in 95% of records reviewed. For patients requiring ongoing monitoring of their physical health, staff had completed this in 93% of records. On Peter Bruff ward, we found a patient with a physical health condition who did not have a care plan to meet their physical health needs. On Ardleigh ward, a patient with diabetes did not have a clear plan as to how staff should manage their condition and another patient did not have a care plan to address their specific physical healthcare need.

Care records were stored securely on three electronic databases. Most wards held all records electronically. Staff from other services could access records as required. The trust had created an additional database that held key information for staff to access from different areas of the trust.

Best practice in treatment and care

This core service participated in three clinical audits as part of their clinical audit programme.

Audit name / title	Key Successes	Key concerns	Key actions following the audit
Record Keeping/Care planning Audit	Baseline Audit to identify areas for improvement. Wards in the North of EPUT appear to have performed better and therefore duplicating work from this area across the south will be beneficial	For “physical health” theme eight wards achieved below 80% compliance, so the overall results came as 71.2%. The monitoring of aspects of a patient’s physical health continues to be an area of concern. So the Trust continues to prioritise the physical health agenda in 2017 to ensure all patients with enduring mental health conditions receive the necessary care to ensure their physical health is not compromised by their condition or treatment.	Harmonise North and South processes on Health records completion Physical Health findings to be feed backed to PHAIG (Physical Health Action Implementation Group) Recommendations have to be carried forward to the Older People Inpatient Quality and Safety Committee. Individual ward action plan to be created especially for Cedar, Thorpe, MHAU (Mental Health Assessment Unit). Nursing Staff to ensure all relevant records has been completed and updated as required by the Record keeping policy CP61 Re-audit of Record Keeping Audit in Adult MH wards
Record Keeping/Care planning Audit- Mother and Baby Unit	Baseline Audit to identify areas for improvement. Wards in the North of EPUT appear to have performed better and therefore duplicating work from this area across the south will be beneficial	Overall results show that Essex Partnership University NHS Foundation Trust (EPUT) is compliant with the record keeping; based on care plan and Risk assessment completed in the mother and baby ward. Individual standards such as providing the patient or carer with relevant information regarding their medication have to be improved using robust process. The Trust continues to prioritise the physical health agenda in 2017 to ensure all patients with enduring mental health conditions receive the necessary care to ensure their physical health is not compromised by their condition or treatment.	Physical Health findings to be feed backed to PHAIG (Physical Health Action Implementation Group). Recommendations have to be carried forward to the Specialist Service Quality Group. Nursing Staff to ensure all relevant records has been completed and updated as required by the Record keeping policy CP61.

Audit name / title	Key Successes	Key concerns	Key actions following the audit
Physical Health Adult MH In - patients	Re-audit in South Area and Baseline audit in the North Wards to establish compliance against Physical Health Guidance.	Baseline assessments: Both Hadleigh and Peter Bruff Unit are scoring low against the standard 6hrs. However overall results are promising with 42 of 45 applicable patients having baseline observations within 6hrs of admission. The Physical exam is a hot spot on Thorpe ward with no patients audited having a full physical exam on admission. Finchingfield, Cedar, Peter Bruff and Stort ward all score low against this standard.	The Audit will be used to inform the Physical Health Action and Implementation Group. The findings will be lead to actions from this group to improve physical health of MH in-patients in a standardised way

Staff had followed National Institute of Health and Care Excellence guidelines in the prescribing of medication. We reviewed 49 medication records that evidenced this.

Staff provided psychological therapies across all wards. These included one to one assessments to develop psychological formulations, cognitive behavioural therapy, focused interventions, for example, dealing with suicidal thoughts and voices and group work. Groups on offer included emotional coping skills, open talking group, unusual experiences group and an anxiety and depression group. Some wards also offered Systems Training for Emotional Predictability and Problem Solving (STEPPS).

Most patients had access to physical healthcare. Staff could refer patients to the trust wide physiotherapist, diabetic nurse and dietician when required.

Staff used recognised rating scales to assess severity and outcomes, for example Health of the Nation Outcome Scales and a ward climate questionnaire to assess the therapeutic climate of the wards.

Clinical staff participated in audits including physical healthcare, medication, care plans and venous thromboembolism.

Skilled staff to deliver care

The service provided skilled staff to deliver care. Ward teams consisted of nurses, healthcare assistants, psychologists, occupational therapists, art therapists, movement therapists, recreational workers, gym instructors, pharmacists and discharge coordinators.

Staff were experienced and qualified. We saw local staff induction records, which evidenced a thorough induction onto the ward.

Staff told us they had good access to supervision. We reviewed performance data that recorded staff had received supervision.

The trust's target rate for appraisal compliance is 90%. As at 31 January 2018, the overall appraisal rates for non-medical staff within this service was 67%.

Of the 17 wards/teams 12 failed to achieve the trust's appraisal target, the lowest appraisal compliance rates were Peter Bruff Ward with an appraisal rate of 24% and King's Wood Centre General at 21%.

No appraisal data was submitted by the trust for medical staff in this service during this period.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Hadleigh Unit (PICU)	14	14	100%
The Christopher Unit	18	17	94%
Galleywood Ward	15	14	93%
Grangewaters Ward	13	12	92%
Stort Ward	13	12	92%
Finchingfield Ward	18	16	89%
Chelmer Ward	16	14	88%
Brian Roycroft Unit (Closed)	15	13	87%
Thorpe Ward	10	8	80%
Cedar Ward	16	9	56%
Mh Assessment Unit	20	11	55%
The Lakes General	14	7	50%
Gosfield Ward	21	9	43%
Ardleigh Ward	22	9	41%
Peter Bruff Ward	21	5	24%
King's Wood Centre General	14	3	21%
Core service total	**260**	**173**	67%
Trust wide	4121	3386	82%

Between 1 April 2017 and 31 January 2018, the average clinical supervision rate across all 23 teams in this core service was 85% against the trust's 90% target.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Ardleigh Ward	240	126	53%
Brian Roycroft Unit (Closed)	150	127	85%
Cedar Ward	187	180	96%
Chelmer Ward	149	126	85%
Clinical Support the Lakes	56	35	63%
Finchingfield Ward	171	167	98%
Galleywood Ward	153	136	89%

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Gosfield Ward	230	174	76%
Grangewaters Ward	130	128	98%
Hadleigh Unit (PICU)	162	161	99%
Mh Assessment Unit	196	168	86%
Peter Bruff Ward	225	182	81%
Stort Ward	123	117	95%
The Christopher Unit	181	170	94%
Thorpe Ward	137	127	93%
Core Service total	2490	2124	**85%**
Trust Total	**24,386**	**21,061**	**86%**

Staff received the training they required to perform their roles. In addition to mandatory training staff had accessed crisis resolution training, suicide awareness training, enhanced emergency support training and venepuncture training.

Multidisciplinary and interagency team work

There was effective multi-disciplinary and inter-agency teamwork across the service. Teams held regular and effective multi-disciplinary meetings across all wards. We observed three multi-disciplinary meetings. The teams discussed all current patients and reviewed their treatment plans and risks. The teams discussed discharge plans and the discharge coordinator fed back community team plans.

There were effective handovers within the teams; we reviewed handover documents that evidenced this.

Staff told us that they invited community team care coordinators to ward reviews for their patients. Care coordinator attendance varied, with some remaining very involved whilst their patient was on the ward, whilst others took a more hands off approach. Staff worked closely with the crisis team and a member of this team often attended ward reviews.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

The service adhered to the Mental Health Act and the Mental Health Act code of practice. A competent member of staff examined patients Mental Health Act papers on admission. The trust had a Mental Health Act team, which staff could access for support. The service kept clear records of leave granted to patients.

Most staff spoken with had a good understanding of the Mental Health Act.

As of 31 December 2017, 74% of staff had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

Staff adhered to consent to treatment and capacity requirements. In 59 patient records reviewed, 98% had details of consent recorded. Staff had attached consent to treatment forms to medication charts where required.

Patient's rights under the Mental Health Act were upheld. Staff explained rights to patients on admission and routinely thereafter. The trust had produced booklets explaining rights for both detained and informal patients. In 59 records reviewed, 34 patients were detained under the Mental Health Act. Staff had correctly completed up to date detention paperwork for all 34 patients and had stored this appropriately.

The Mental Health Act administration staff visited the wards to complete Mental Health Act audits three times a year. The Mental Health Act administration manager was responsible for oversight of Mental Health Act audits and securely stored legal documentation. The Mental Health Act team of staff we spoke with had a good understanding of the guiding principles of the Mental Health Act. They provided examples of a range of systems in place to support nursing and medical staff in meeting the responsibilities of the Act including checklists to support staff with Mental Health Act legal documentation. Staff referred to a copy of the Mental Health Act Code of practice available on all wards.

Patients had access to advocacy services. Information about advocacy services was displayed on all wards. Advocates visited the wards regularly and patients could book one to one appointments.

Good practice in applying the Mental Capacity Act

The service evidenced good practice in applying the Mental Capacity Act. Most staff spoken with had a good understanding of the Mental Capacity Act.

As of 31 December 2017, 47% of the workforce in this service had received training in the Mental Capacity Act level one and 98% in Mental Capacity Act level two. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

The trust had a policy on the Mental Capacity Act and Deprivation of Liberty safeguards that staff could refer to.

Staff had completed capacity assessments in 92% of records reviewed. Staff assumed patients to have capacity and would support patients who lacked capacity to make decisions.

Staff could get advice regarding mental capacity from the Mental Health Act team within the trust.

The trust told us that four Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 April 2017 and 31 March 2018. Staff had made one Deprivation of Liberty Safeguard application for each of the months April, June, September 2017 and January 2018.

CQC received three direct notifications from Essex Partnership University NHS Foundation Trust between 1 April 2017 and 31 March 2018 relating to this service.

	Number of DoLS applications made by month												
	Apr 17	**May 17**	**Jun 17**	**Jul 17**	**Aug 17**	**Sep 17**	**Oct 17**	**Nov 17**	**Dec 17**	**Jan 18**	**Feb 18**	**Mar 18**	**Total**
Applications made	1	0	1	0	0	1	0	0	0	1	0	0	**4**
Applications approved	0	0	0	0	0	0	0	0	0	0	0	0	**0**

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Patients were treated with care by staff. We observed staff behaving in a kind, respectful and compassionate manner when interacting with patients.

We spoke with 47 patients. Patients told us that staff were respectful, kind, polite, compassionate and fair. Patients told us that staff kept them safe, listened to them and were responsive to their needs. One patient told us that staff were awesome. Another told us they could not praise the staff highly enough. However, two patients told us some staff could be aggressive and rough when carrying out restraints. Five patients told us that there were not enough staff or that staff were not available when needed.

Most patients told us that staff were understanding of their needs.

Involvement in care

Involvement of patients

The service involved most patients in their care. Staff provided patients with induction packs when they were admitted to the wards. These packs contained information about the ward; the patient's rights, as a detained or an informal patient and my care and recovery plan.

Of 16 patients asked, 11 told us they had been involved in their care and treatment plan. Of 17 patients asked, nine told us they had been given a copy of their plan.

Patients told us that they had access to advocacy.

Staff facilitated daily community meetings on all wards, where patients were encouraged to feedback on the service. We observed two community meetings and reviewed minutes of meetings which confirmed this.

Involvement of families and carers

The service involved carers and families. Patients told us that their families and carers could be involved in their care and treatment. We saw evidence in care records reviewed of carer's involvement in patients care.

Is the service responsive?

Access and discharge

Bed management

The service did not always have beds available when needed. Patients often did not have a bed to return to following leave.

The trust provided information regarding average bed occupancies for 12 wards in this service between 1 April 2017 and 31 January 2018.

Twelve of the wards within this service reported average bed occupancies ranging above the provider benchmark of 85% over this period. Hadleigh psychiatric intensive care unit had the highest bed occupancy levels with 155% and Thorpe ward had the lowest with 74%. Ten wards had a maximum bed occupancy level above 100%.

Thorpe ward was commissioned to provide 10 beds for patients from North Essex. The trust used Thorpe ward flexibly, based on demand, as there were 28 beds available.

We requested data from the trust in relation to bed occupancy rates per ward from January to March 2018 but had not received a response at the time of writing.

We spoke with 14 approved mental health professionals. They expressed concerns about issues relating to the lack of available beds within the trust. Staff provided examples of people waiting for over 24 hours to be admitted from the 136 suite, which often presented a risk to the patient and sometimes presented risks to the approved mental health professionals.

We reviewed a complaint made by a patient on one of the psychiatric intensive care units in April this year. The patient was ready to be discharged to an acute ward but had to wait ten days for a bed to become available. This impacted on the patient as they did not feel safe on the ward.

The trust had introduced regular bed management meetings and discharge coordinators supported the service to ensure smooth transfers of care.

Ward name	Average bed occupancy range (1 April 2017 to 31 January 2018)
Ardleigh	98% - 112%
Assessment Unit – Basildon	78% - 97%
Chelmer, Derwent	86% - 109%
Finchingfield	86% - 105%
Galleywood	97% - 114%
Gosfield	84% - 111%
Inpatient - Adult - Basildon – Grangewater	109% - 130%
Inpatient - Adult - Basildon – Thorpe	74% - 97%
Inpatient - Adult - Rochford – Cedar	106% - 117%
Inpatient - PICU - Basildon - Hadleigh Unit	91% - 155%
Peter Bruff	90% - 102%
Stort	90% - 101%

The trust provided information for average length of stay for the period 1 April 2017 to 31 January 2018.

The Mental Health Assessment Unit had the shortest length of stay with two days and Ardleigh had the longest with 178 days.

Ward name	Average length of stay range (1 April 2017 to 31 January 2018)
Ardleigh	23 days to 178 days
Assessment Unit – Basildon	2 days to 8 days
Chelmer, Derwent	15 days to 57 days
Finchingfield	14 days to 108 days
Galleywood	16 days to 54 days
Gosfield	10 to 170 days
Inpatient - Adult - Basildon – Grangewater	68 days to 92 days
Inpatient - Adult - Basildon – Thorpe	57 days to 82 days
Inpatient - Adult - Rochford – Cedar	76 days to 106 days
Inpatient - PICU - Basildon - Hadleigh Unit	71 days 157 days
Peter Bruff	15 days to 72 days
Stort	22 days to 65 days

This service reported 261 out area placements between 1 April 2017 and 31 January 2018.

As of 1 February 2018, this service had six ongoing out of area placements. There were two placements that lasted less than one day, and the placement that lasted the longest amounted to 93 days.

Out of the 261 out of area placements, 260 were due to capacity issues, while one placement was because of specialist needs.

We spoke with the trust 'flow and capacity' lead, who advised at the time of inspection there were ten out of area placements.

Bed managers prioritised available beds for people living in the catchment area of the service. The trust monitored out of area placements and it was a priority to reduce people receiving treatment outside of their area. Data provided by the trust showed a reduction in out of area placements and a reduction in the length of time people were in out of area beds.

Managers told us that patients often did not have a bed to return to following leave. Staff spoken with told us that there was pressure to admit new patients to leave beds. Staff on Gosfield ward told us that they were pressurised to release a bed from a patient who was in general hospital and due to be discharged back to the ward imminently.

Managers told us that patients would also be discharged following leave if there was no bed available. One patient told us they were due to go on leave for three days and that their bed would not be available when they returned. They were hoping to access another bed on the ward and had been told their belongings would have to go into storage.

There had been a serious incident on one ward in January 2018, which indicated bed occupancy may have been a contributing factor. The trust was investigating this incident.

Managers told us that patients could access a bed on one of the psychiatric intensive care units when required. They advised that often the psychiatric intensive care units would have a patient ready for discharge to an acute ward and they were then able to facilitate the correct placement for patients.

Number of out of area placements	Number due to specialist needs	Number due to capacity	Range of lengths (completed placements)	Number of ongoing placements
261	1	260	0-93 days	6

This service reported 160 readmissions within 28 days between 1 April 2017 and 31 January 2018. Seventy six of readmissions (48%) were readmissions to the same ward as discharge. Chelmer ward and Galleywood ward both had 25 readmissions.

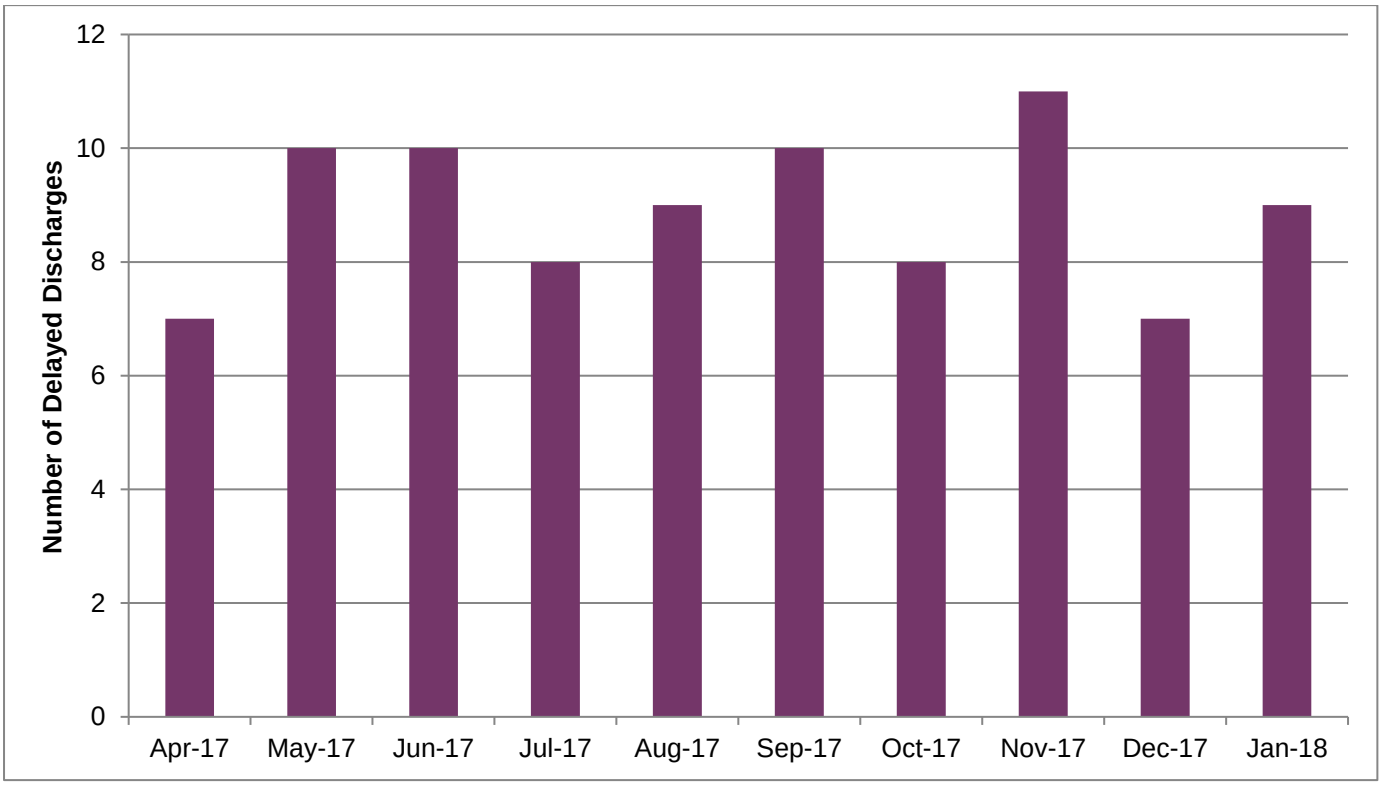
The average of days between discharge and readmission was 12 days. There were six instances whereby patients were readmitted on the same day as being discharged and there were 10 instances where patients were readmitted the day after being discharged.

Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
160	76	48%	0-28	12

Discharge and transfers of care

Between 1 April 2017 and 31 January 2018, there were 89 delayed discharges within this service.

The graph below shows the trend of delayed discharges across the 10-month period.



Managers told us that the most common reasons for delayed discharges were lack of suitable housing and waiting for the Ministry of Justice to authorise discharges for patient's subject to their restrictions.

Facilities that promote comfort, dignity and privacy

The service had a full range of rooms to support treatment and care. These included clinic rooms, therapy rooms and activity rooms. Some wards had recently introduced 'chill out' boxes, with items to help de-escalate and distract patients. These included sensory items, such as aromatherapy oils and scented hand creams.

Patients had access to quiet spaces on the wards and access to rooms off the wards to meet visitors.

Patients could make phone calls in private. Wards had payphones that patients could use, although these were not always in a private place. Some wards allowed patients to use their mobile phones, following risk assessments, or the office cordless phone to make calls in private.

Patients had access to outside space, although on some wards they had to be escorted by staff. Two patients told us they had difficulty getting off the ward to have a cigarette.

We received variable feedback about the food. Thirteen patients told us the food was good and six told us the food was ok. However, seven patients told us that the food was not good, with comments ranging from it being bland to disgusting.

Patients could access hot drinks 24/7. Patients either had access to a drinks area, where they could make their own hot drinks or they would be available upon request from staff.

Patients had swipe cards to gain access to their bedrooms and could access them during the day. Patients could personalise their own bedrooms and staff had made efforts to make bedrooms more welcoming. Thorpe and Grangewaters wards had dormitories; however, the trust is aiming to eliminate these by 2020. There was no evidence of impact on patient's privacy and dignity during our visit.

Patients had somewhere secure to store their belongings.

Patients had access to activities. The service had recently appointed recreational workers on some wards to provide a greater range of activities, including at weekends. Patient feedback on activities was variable with some telling us they had access to a range of activities and others advising there were not enough activities. Activities on offer included gym sessions, table tennis, basketball, gardening groups, making cakes, arts and crafts and music groups.

Meeting the needs of all people who use the service

The service met the needs of all people using it. Wards had disabled facilities, including assisted bathrooms and disabled bedrooms.

Managers told us they could request leaflets to be provided in a different language as required and they could access interpreters as needed.

Patents dietary needs were met. Staff told us that they could order food to meet patient's specific dietary needs, for example, halal, kosher and vegetarian meals. Information about patients' needs, for example, if they were diabetic or had a food allergy, was available in the servery area for staff to refer to.

Patients had access to spiritual support. Chaplains visited the wards regularly. Staff would facilitate visits to places of worship for patients.

Listening to and learning from concerns and complaints

The service listened to and learnt from complaints. This service received 40 complaints between 1 April and 31 December 2017. Four complaints were referred to the Ombudsman during this period. Complaints relating to clinical practice had the highest number with 19, accounting for 48% of the complaints received for these services.

Not all patients knew how to complain. The service provided complaints information in patient's admission packs. We asked 28 patients if they knew how to complain, 16 said they did, 12 did not. Two patients told us that they did not feel confident to complain whilst they were still on the ward and would wait until they had been discharged. Two other patients told us that they had complained but nothing had been done.

Staff were aware of the complaints process and told us they would try to resolve complaints locally if possible. Staff would escalate serious complaints to the ward manager. Staff could describe how complaints made by patients had led to improvements. This included allowing access to bedrooms, increasing activities and the use of electronic cigarettes on the wards.

Findings from complaints investigations were shared on the trust intranet, in team meetings and via email cascades.

Wards	Clinical Practice	Staff Attitude	Communication	Assault / Abuse	Systems & Procedures	Environment	Total
MHAU Basildon	3	8			1		12
Stort Ward	2	1		1	1	1	6

Wards	Clinical Practice	Staff Attitude	Communication	Assault / Abuse	Systems & Procedures	Environment	Total
Hadleigh Unit (PICU)	1	1	1	2			5
Cedar Ward	3						3
Finchingfield Ward	2		1				3
Ardleigh Ward	2						2
Chelmer Ward	2						2
Thorpe Ward			1	1			2
Peter Bruff Ward	1						1
Christopher Unit (PICU)				1			1
Grangewaters Ward	1						1
Galleywood Ward	1						1
Gosfield Ward	1						1
Total	**19**	**10**	**3**	**5**	**2**	**1**	**40**

This service received 68 compliments during the last nine months from 1 April to 31 December 2017, which accounted for 10% of all compliments received by the trust as a whole.

Is the service well-led?

Leadership

The service had strong leadership. Each ward had a permanent manager in place. Managers on ten out of thirteen wards were experienced in their roles. Managers who were less experienced were supported by peers and senior managers to develop their leadership skills.

The trust supported ward managers to develop leadership skills through leadership and management training and mentorship

Vision and strategy

The trust's vision was "working to improve lives".

The trust's values were to be "open, empowering, compassionate".

All staff asked could describe the trust's vision and values. We saw posters of the trust's vison and values displayed on wards.

Culture

The service demonstrated a supportive and open culture. All 41 staff asked said they felt supported and valued by their managers. Staff were mostly positive about working for the trust and their team.

Staff told us that they felt able to raise concerns without fear of retribution and were aware of the trust's whistleblowing policy. Staff advised that they could raise concerns anonymously on the trust's intranet and told us about the trust's Freedom to Speak Up Guardian.

Staff told us they were given the opportunity to feedback on service developments.

Managers told us the trust's human resources team supported them to deal with staff performance issues.

Managers provided staff with opportunities to progress their career in the trust. The trust facilitated access to nurse practitioner training and registered mental nurse training for healthcare assistants.

The service reported a sickness rate of 7% for the period 1 April 2017 to 31 December 2017. This was above the trust rate of 4%.

Governance

There were effective governance processes in place. Managers told us they attended monthly quality meetings. They discussed ward issues, such as incidents, safeguarding and staffing concerns with other managers in the trust. Managers participated in daily calls to discuss staffing and bed management.

Managers gave examples of where they had implemented changes following learning from incidents, such as offering post discharge follow up and medication to all patients as standard. Managers implemented this change following the death of a patient who had discharged himself against medical advice and without any follow up planned.

Staff participated in audits on the ward, including care records, physical health care and medication.

Staff worked well with other teams within the trust and with external parties. We observed staff working with community teams, crisis teams and discharge coordinators.

Management of risk, issues and performance

Staff could escalate concerns and submit items to the trust risk register.

We saw no evidence of the trust making cost improvements that compromised patient care.

Information management

Systems were in place to manage information. The trust used electronic systems to collect data from wards. These included an electronic system to record incidents and risks and a system to record staff sickness, training and appraisals. The trust used this data to provide monthly compliance reports for managers to review. Wards had a 'performance station', which displayed the data collected and supported managers to assess the performance of their ward.

Staff had access to the information technology they required to do their work.

Staff submitted notifications to external bodies as required, and we saw evidence of this in the incident reports we reviewed.

Engagement

Patients had the opportunity to feedback in daily community meetings. The service facilitated carers groups to engage with relatives of patients. Managers used the results of friends and family tests to inform improvements to the wards.

Learning, continuous improvement and innovation

There were innovations taking place in the service. Finchingfield ward was involved in a pilot project with NHS Improvement. This project trialled a new approach to observation and engagement with patients, focusing on encouraging patients to interact with activities whilst on direct observations. The result of this was that patients were spending less time on direct observations. As part of this work the ward had received an award for the 'most innovative idea

that can be implemented' for staff on patient observations wearing a different coloured lanyard. The trust is planning to implement this idea.

The manager of Stort ward was a member of a national working group for workforce race equality standards. The manager had given a presentation about how the trust provides compassionate care at an external mental health conference.

Galleywood ward had piloted new training to support staff to become more resilient and confident and then transfer these skills to patients.

Peter Bruff ward and the Mental Health Assessment Unit had been working with a national helpline to support patients following discharge.

The manager on Cedar ward was part of the quality champions network at the trust and had developed a resource of up to date information and publications to share with teams.

NHS Trusts can participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

The table below shows which wards within this service had been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
AIMS - WA (Working Age Units)	Grangewaters Ward	(July 2017) Suspended by AIMS March 2018
AIMS - PICU (Psychiatric Intensive Care Units)	Hadleigh Ward	(June 2017) Suspended by AIMS March 2018
AIMS - AT (Assessment and triage wards)	Assessment Unit (Basildon)	(November 2016) Suspended by AIMS March 2018

Long stay/rehabilitation mental health wards for working age adults

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
439 Ipswich Road	439 Ipswich Road	11	Mixed

Is the service safe?

Safe and clean environment

Safety of the ward layout

The unit was set in an old converted rectory and coach house. Managers mitigated blind spots in the unit with the recent installation of four convex mirrors in corridors, hourly observations of patients and walk arounds by staff. There was close circuit television at the front door area and at the back of the property. Staff had undertaken a risk assessment of the environment and had mitigated the risks adequately.

A fire officer visited the unit in April 2018 and the fire risk assessment was under review. Fire records showed completion of fire evacuation drills.

The unit met the Department of Health guidance on the management of mixed sex accommodation. There was the option of reconfiguring bedrooms and bathrooms for use when both male and female patients were admitted. All patients admitted at the time of inspection were male. Over the 12 month period from 1 April 2017 to 31 January 2018 there were no mixed sex accommodation breaches within this core service. There was one accessible bedroom with a separate bathroom on the ground floor.

Staff had access to personal alarms, and patients had access to nurse call systems to seek assistance in an emergency.

There were ligature risks on the ward, which presented a lower risk as the rehabilitation unit had a low risk client group. The trust had taken actions to review operational service procedure including no sleepovers from higher risk wards, units or teams and all patients on the unit are risk assessed prior to admission by the MDT in order to mitigate ligature risks. The unit was equipped with several anti-ligature fittings. Ligature is the term used to describe a place or anchor point to which patients, intent on self-harm, might tie something to for the purposes of strangling themselves. Staff managed and reduced risks using individual risk assessments. The unit had a detailed ligature risk assessment and staff knew where the risks were and how they should manage them. Patients said they felt safe on the unit.

Maintenance, cleanliness and infection control

The unit was clean, tidy and furnishings were well maintained. Cleaning records and schedules showed that the unit was cleaned regularly. We checked some of the patients' bedrooms, which were in good condition. The main kitchen and the kitchen in the coach house were clean, and well maintained. The patients and family member we spoke to all commented on how clean the unit was. Staff kept hazardous substances in locked storage.

Staff completed environmental risk assessments and audits in relation to health and safety and infection control. The unit manager showed us training records that confirmed staff were up to date with infection control and hand hygiene training.

Clinic room and equipment

The clinic room was clean and tidy. Staff kept records of equipment checks completed including the defibrillator, fridge temperatures and emergency equipment. We checked the resuscitation equipment grab bag and found ten items missing. There was no evidence the items had been ordered. The digital scales were broken, but still in use. The blood pressure machine was broken and gave minor electric shocks, but was still in use. Safe checking systems and processes were not in place. We raised these issues with the ward manager who immediately followed up the ten missing items and labelled equipment with out of order signs.

Staff kept some stock medicines in a box labelled as 'emergency medicines.' The trusts chief pharmacist and medicines safety officer confirmed that these should not be stored in this way but are part of the regular stock. Patients requiring emergency treatment would be managed by the acute trust via 999.

Safe staffing

Nursing staff

This core service has reported a vacancy rate for all staff of 15% as of 31 January 2018.

This core service reported an overall vacancy rate of 21% for registered nurses at 31 January 2018 and 10% for nursing assistants.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
439 Ipswich Road	1.21	5.81	21%	1.01	10.61	10%	2.99	19.82	15%
Core service total	1.21	5.81	21%	1.01	10.61	10%	2.99	19.82	15%
Trust total	**250.46**	**1585.55**	**16%**	**147.04**	**1207.08**	**12%**	**709.54**	**4999.15**	**14%**

NB: All figures displayed are whole-time equivalents

Between 1 April 2017 and 31 January 2018, bank staff filled 31% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 13% of shifts for qualified nurses. Less than one percent of shifts were unable to be filled by either bank or agency staff.

The trust had estimated the number of staff needed to provide safe staffing on the unit. The ward manager had the authority to increase staffing levels if needed. The unit operated a shift system which ensured there were qualified nurses on duty at all times and sufficient staff to meet patients' needs safely. This was confirmed by staffing rotas.

The unit had 17 whole time equivalent staff and one ward manager. The team consisted of nurses, senior health care assistants, health care assistants, occupational therapist, and housekeeping and clerk staff. There was one vacancy for a nurse filled by a regular bank nurse. Regular bank staff covered a part time occupational therapist assistant post. There was a part time ward clerk post vacant. All three posts were advertised.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
439 Ipswich Road	923	283	116	5
Core service total	923	283 (31%*)	116 (13%*)	5 (<1%*)
Trust Total	**102629**	**31709**	**12577**	**5890**

***Percentage of total shifts

Between 1 April 2017 and 31 January 2018, 17% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, agency staff covered 0% of shifts. One per cent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
439 Ipswich Road	1,536	260	0	20
Core service total	1536	260 (17%*)	0 (0%*)	20 (1%*)
Trust Total	**144009**	**60464**	**5916**	**4396**

***** Percentage of total shifts

This core service had no staff leavers between 1 April 2017 and 31 January 2018. From January to February 2018, the turnover rate was 0% and March and April 2018 6%. The core staff team were made up of long serving staff. However, there had been a high turnover of ward managers over four to five years.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
300 439 Ipswich Road	18.15	0.00	0%
Core service total	18.15	0.00	0%
Trust Total	3127.64	253	7%

The sickness rate for this core service was 8% between 1 April 2017 and 31 January 2018. The most recent month's data (January 2018) showed a sickness rate of 5%. As of April 2018, the sickness rate was 7%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
439 Ipswich Road	5%	8%
Core service total	**5%**	**8%**

Trust Total	4%	4%

The below table covers staff fill rates for registered nurses and care staff during September, October and November 2017.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	September 2017				October 2017				November 2017			
Ipswich Road	102.4	102.1	100.2	100.0	108.2	98.2	100.0	103.3	101.7	101.7	100.0	100.0

Medical staff

An on-call doctor provided out of hours cover to the service. Consultants were also available. This was part of an out of hours trust wide on call system.

No shifts were filled by bank or agency staff to cover sickness, absence or vacancy for medical locums between 1 April 2017 and 31 January 2018.

Mandatory training

The compliance for mandatory and statutory training courses at 31 December 2017 was 89%. Of the training courses listed 10 failed to achieve the trust target and of those, six failed to score above 75%. The ward manager said staff had received and were up to date with mandatory training, or booked on training. The trusts training tracker did not capture all the training staff attended. The ward manager showed us individual staff training records. Some staff told us they had difficulty accessing the trust e- learning training site.

Following on from the inspection the trust provided mandatory training data up to April 2018 with 90% compliance for this service. Examples of training completed included: Fire in- patient 94%, clinical risk assessment 88%, food hygiene 94%, diabetes training 94%, infection prevention, control and hand hygiene 80%, Mental Capacity Act Level 2 100%, prevent (WRAP) 100%. Data showed staff were 80% compliant with restraint and breakaway training (known as TASI) Managers had ensured that two staff were booked to attend this training in June and July.

However, some mandatory training was below 85% and trust target. This included: enhanced emergency skills 34% Mental Health Act 63%, and basic life support 71%.

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	Compliance
Complaints Handling	100%

Fire Safety 2 years	100%
Information Governance	100%
Mental Capacity Act Level 2	100%
Safeguarding Adults (Level 1)	100%
Safeguarding Adults (Level 3)	100%
Safeguarding Children (Level 2)	100%
Corporate Induction	100%
Duty of Candour (Detailed Version)	100%
Harassment & Bullying	100%
Hoisting	100%
Medication Management (MH)	100%
Observation of Service User	100%
PREVENT (WRAP) Training	100%
Equality and Diversity	95%
Fit for Work	95%
Fire In-patient	94%
Food Hygiene	94%
Diabetes Training	93%
Clinical Risk Assessment	88%
Manual Handling - People	88%
Infection Prevention, Control & Hand Hygiene	80%
TASI Trained	80%
Health and Safety (Slips, Trips and Falls)	75%
Personal Safety Breakaway - Level 1	75%
Basic Life Support & AED	71%
Mental Health Act	63%
MERT (Enhanced Emergency Skills)	33%
Fire Safety 3 years	0%
Safeguarding Children (Level 3)	0%
Anaphylaxis	0%
Total	**89%**

Assessing and managing risk to patients and staff

Assessment of patient risk

We looked at six patient records on the trust's electronic care record system. All patients had risk assessments completed before admission. Two out of the six risk assessments were poorly completed, lacked detail and had not been updated regularly. Staff used historical information to identify risks. Four out of six assessments were updated regularly. Staff reviewed risks at weekly clinical review meetings and care programme approach meetings to update. Staff used the trusts electronic risk assessment as the recognised risk assessment tool.

Management of patient risk

Patients needed to be at low risk to themselves and others and motivated to participate in the rehabilitation programme at the unit. This was assessed as part of the admission criteria. Staff were aware of and dealt with any specific risk issues such as falls or pressure ulcers.

Patients could leave and access the unit when they needed to according to their agreed leave arrangements and care plan. Staff assessed patients for unescorted leave to outside areas.

Staff decided patient observation levels on an individual basis following risk assessment. Levels of observation could be increased or decreased as required. Staff recorded observation levels in patients' care records. Most patients were on level one hourly observation at the time of our inspection.

The ward manager participated in a daily teleconference meeting to discuss risks on the unit. These were around management of patient risk, availability of beds, and any other issues or concerns.

The unit did not allow alcohol, illegal drugs, smoking or dangerous weapons. When patients arrived at the unit as part of the admission process patients would sign to agree to random screenings of breath and urine to check for alcohol or illegal drug use. Items such as razors and other sharp objects were individually risk assessed. Staff randomly searched patients following unescorted leave. There was a search policy in place and staff had been trained in its use.

Staff applied blanket restrictions on patient's freedom only when justified. Patients had mobile phones and could make calls in the privacy of their bedroom. Patients were asked not to take pictures with cameras or mobile phones on the unit, to protect the confidentiality and privacy of others. Patients were not allowed food in their bedrooms due to infection control requirements.

Staff recognised the importance of working to least restrictive practice and linked restrictions to individualised patient risks.

Informal patients could leave at will and knew that. There were information posters on display in communal area around patients' rights.

Use of restrictive interventions

This core service had no incidents of restraint and no incidents of seclusion between 1 April 2017 and 30 December 2017. There were no instances of long term segregation during the reporting period. There had been no recent episodes of restraint, long term segregation, or rapid tranquilisation.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include physical, emotional, financial, sexual, neglect and institutional.

Each authority had their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust have provided details of the total number of safeguarding referrals made between 1 April 2017 and 31 December 2017 with 802 referrals made for adults and 180 for children. However, this for the whole trust and has not been broken down to core service level.

Staff were trained in safeguarding adult's levels 1 and 2 with 100% compliance rate. Staff knew how to make a safeguarding alert and did so when appropriate. Staff would also seek support and guidance from the trusts safeguarding team. Staff also reported incidents and concerns through the trust's electronic incident system.

Children could visit the ward when agreed in advance, and staff followed procedures for this to happen in a safe way. A room would be available on the ground floor.

The trust told us that there were no serious case reviews commenced or published in the last 12 months that related to this core service.

Staff access to essential information

All information needed to deliver patients care was available to all relevant staff (including bank and agency staff) when needed and was in an accessible form. This included when patients moved between teams. Staff knew where information was stored and showed us how it was organised.

Medicines management

We looked at eight patient medication records. Staff managed medicines effectively. Medicines, including controlled drugs were stored safely. Staff calibrated glucose-testing kits. Staff managed pharmaceutical, sharps and cytotoxic waste appropriately. Systems were in place for the ordering and disposing of medications. Pharmacy visited the unit weekly for medicine checks. Managers ensured all staff received medication management training; and staff could access policies online. Staff supported patients to take their medicines, and could self-administer if assessed as safe to do so. Staff monitored any side effects of medicines with patients; this included monthly metabolic reporting for anti-psychotic medicines. Medicines were prescribed safely.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 January 2018 there were no STEIS incidents reported by this core service.

A ‘never event’ is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period. There had been no serious incidents in the last 12 months.

Reporting incidents and learning from when things go wrong

Staff reported incidents on the trust’s electronic system. They knew what incidents to report and how to report them. Not all staff were aware of the trust wide ‘five key incidents learnt’ bulletin. This included incidents that had happened in other services within the trust.

Staff understood the duty of candour requires providers to be open and transparent with patients when something has gone wrong. The trust had a duty of candour policy, which the service followed. Duty of candour training achieved 100% compliance.

Is the service effective?

Assessment of needs and planning of care

We looked at six patient records. The multidisciplinary staff team completed care plans with basic information. They covered aspects of the patient’s history and needs together with an assessment of risk. Staff updated these plans regularly. Staff had also developed ‘My Care, My Recovery’

documents alongside the use of the recovery star tool. (The spectrum star tool is a holistic way of addressing multiple and complex areas of a person's life). Together all the care plans provided a personalised and holistic overview of patient care.

Staff completed a full physical health check on, or shortly after admission, and monitored patients' physical health regularly. Patients registered with a local GP and staff supported them to access healthcare support as needed. Staff encouraged patients to participate in smoking cessation schemes.

The service held clinical reviews fortnightly on Thursdays and care programme approach meetings regularly with the patient, their families and relevant professionals. This included junior doctors and consultants. Staff used these reviews to monitor progress, update assessments and set new goals and targets.

Best practice in treatment and care

Staff created a holistic and robust overview of patient care and treatment. Staff used care plans, recovery star and 'My Care, My Recovery' documents to achieve this with every patient.

Occupational therapist work was central to assessments and care planning. Occupational therapists had devised therapeutic programmes, with a mix of individual and group activities for each patient.

Staff encouraged patients to gain/regain their confidence and skills to live successfully in the community. Staff supported patients to manage their medication, self-care, housework, laundry, shopping. Staff supported patients to budget plan, buy their own food, prepare and cook two meals each day. Some patients were supported with staff to use local transport and access shops until they could do this independently. Patients had access to vocational training and the Recovery College where they could develop a wide range of skills to support them in the future.

Patients did not have access to psychology support as part of a rehabilitation programme. The ward manager told us currently none of the patients required psychology input. If required this could be accessed via the patients GP. Senior managers were still in consultation with psychology services around this aspect.

This core service participated in no specific clinical audits as part of their clinical audit programme 2017. Staff completed medicine, and health and safety audits.

Skilled staff to deliver care

The team consisted of one ward manager, nurses, health care assistants, consultant psychiatrists, speciality doctors and occupational therapists. The unit also had support from pharmacists and pharmacy technicians, housekeepers and ward clerks.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Staff received appropriate training at induction.

The trust's target rate for appraisal compliance is 90%. As at 31 January 2018, the overall appraisal rates for non-medical staff within this core service was 77%.

No appraisal data was submitted by the trust for medical staff in this core service during this period. We sampled appraisal records, the ward manager had completed 18 appraisals with three left to complete out of 21 staff.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
439 Ipswich Road	22	17	77%
Core service total	22	17	77%
Trust wide	4121	3386	82%

Between 1 April 2017 and 31 January 2018, the clinical supervision rate for this core service (439 Ipswich Road) was 98% against the trust target of 90%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Managers provided staff with management supervision every four to six weeks. The managers told us they discussed performance issues within supervision. The ward manager did not hold any data for staff clinical supervision. Staff were encouraged to seek a clinical supervisor and arrange these meetings as part of their clinical development. None of the staff we spoke with received clinical supervision, except the ward manager.

Managers ensured that staff had access to regular team meetings.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
439 Ipswich Road	180	177	98%
Core service total	**180**	**177**	**98%**
Trust Total	**24,386**	**21,061**	**86%**

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings. Staff shared information about patients at handovers within the team, for example when shifts changed.

There were good links with external professionals from health and social care agencies and the trust Recovery College. Community care coordinators/ care manager were invited to attend regular review meetings and multidisciplinary meetings, to review patients progress and agree plans.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

One patient was detained. Informal patients were free to come and go as they wished. Staff ensured that patients understood their rights by going through them with patients regularly.

Mental Health Act paperwork was in date and correct in all cases. We looked at medication charts, which had the correct consent to treatment forms T2. Form T2 is a certificate of consent to treatment. It is a form completed by a doctor to record that a patient understands the treatment being given and has consented to it.

As of 31 December 2017, 28% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is mandatory for all staff and renewed every three years. The Mental Health Act training compliance rate for April were 63%, this was below the trust target of 85%.

Staff we spoke with about the Mental Health Act demonstrated knowledge appropriate to their position. Staff were aware of where to go if they required more detailed advice. The consultant psychiatrist granted section 17 leave after assessment. Paperwork was in good order.

Patients had access to independent mental health advocates. There were posters displaying this information on noticeboards in the unit and in the welcome pack. Advocates visited the unit, the last Thursday of each month.

Good practice in applying the Mental Capacity Act

Staff could describe how they would apply the principles of the Mental Capacity Act in their roles. Some staff did not have a good understanding of what capacity meant. Patients had decision specific capacity assessments in their care records. The trust had a policy on the Mental Capacity Act and staff knew where to locate it. Staff knew where to get advice regarding the Mental Capacity Act in the trust.

As of 31 December 2017, 29% of the workforce in this core service had received training in the Mental Capacity Act level one and 100% in Mental Capacity Act level two. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years. The Mental Capacity Act training compliance rate for April was 100%.

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 April 2017 and 30 March 2018. The ward manager confirmed there were no deprivation of liberty safeguard applications between April 2018 to 1st May 2018.

CQC received 193 direct notifications from Essex Partnership University NHS Foundation Trust between 1 April 2017 and 31 March 2018[1]. None of which were pertinent to this core service.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We spoke with four patients and observed how staff cared for patients on the unit. Patients told us staff treated them with kindness and respect and their overall experience of living on the unit was positive. We saw staff knock on patient's door before entering, and asking patient's permission for the CQC team to look at bedrooms. One patient told us staff knocked on bedroom doors but did not always wait before entering.

We saw examples of staff treating patients with kindness and understanding, individually and as part of group sessions. Staff understood the individual needs of patients.

Involvement in care

Involvement of patients

[1] RPM Analysis\20180418 Deprivation of Liberty Safeguards analysis - PIR and CRM.xlsx

The ‘My Care, My Recovery plans’ showed details of patients’ views and demonstrated that patients had been involved in formulating their plans, including their goals and aspirations. Some patients said staff provided them with copies of their care plans.

Patients had opportunities to express their views through daily “start-up” meetings and weekly community meetings. Patients gave feedback through ‘You said, we did.’ The trust smoke free policy allowed e-cigarettes. Patients asked for a smoking shelter in the garden. Managers were considering the provision of a shelter.

The ward manager told us advanced decisions had not been developed with patients. Advanced decision plans would detail how patients wanted staff to treat them in difficult situations. The unit doctors were scheduled to lead this discussion at the next multidisciplinary meeting.

Staff ensured that patients could access advocacy.

Involvement of families and carers

Staff informed and involved families and carers appropriately. One carer told us staff were supportive and had looked after their relative well. We saw in one patients care records, staff provided a carers care plan.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for one ward in this core service between 1 April 2017 and 31 January 2018.

Ward name	Average bed occupancy range (1 April 2017 to 31 January 2018)
439 Ipswich Road	80% to 97%

The trust provided information for average length of stay for the period 1 April 2017 and 31 January 2018.

Ward name	Average length of stay range (1 April 2017 to 31 January 2018)
439 Ipswich Road	0 days to 1,732 days

The ward manager said the length of stay was down to individual patient need. There had been patients who had stayed with the service over four years. Other patients stayed on average between one and six months. This core service reported no out of area placements between 1 April 2017 and 31 January 2018.

This core service reported one readmission within 28 days between 1st April 2017 and 31st January 2018. This readmission was not to the same ward and there were six days between the initial discharge and readmission.

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Average days between discharge and readmission
439 Ipswich Road	1	0	0%	6

Discharge and transfers of care

Between 1 April 2017 and 31 January 2018, there were two delayed discharges within this core service. Staff said the main reasons for delays were due to lack of suitable move on accommodation.

Staff discussed discharge with patients on admission and patient's records included detailed discharge planning. We saw from patient records there were regular liaisons with care managers/co-ordinators. Once a discharge placement had been identified there would be graduated visits and leave so that the patient can familiarise themselves with their new environment. The patients GP were kept informed about their discharge from the unit.

When patients were moved or discharged, this happened at an appropriate time of day. Staff followed up the patients discharge with a telephone phone call and a visit to provide support.

A bed was always available in a psychiatric intensive care unit (PICU) if a patient required more intensive care. This was sufficiently close for the patient to maintain contact with family and friends.

Facilities that promote comfort, dignity and privacy

Patients could personalise bedrooms. Patients held a key to their bedroom and had access to their room at all times. Patients had a designated area to store their possessions.

Patients provided mixed feedback about the heating in their bedrooms. Staff told us they could not control the heating and had to contact Estates to alter the unit heating. Estates would attend within the day. The You said, We did, notice board showed patients had raised concerns 11th April that some bedrooms were too hot at night. Staff had responded and turned the heating turned down. However, there appeared to be ongoing issues with the unit heating.

The unit had rooms for leisure and therapeutic activities. There were quiet areas where therapeutic groups could meet or where patients could spend 1:1 time with their allocated nurse. Patients could meet visitors on the ground floor. However, there was no staff room. The ward manager had raised this with managers.

There were programmes of activities, both on and off the unit including at weekends and evenings, with weekly plans for each patient. Patients were encouraged to gain/regain their confidence and skills for self-care, and activities of daily living. There were a games area and a pool table on the unit. Activities included newspaper group, vocational training and access to the Recovery College where they could develop a wide range of skills to help them live independently. The unit had extensive gardens including vegetable plots for the gardening group.

Patients used their mobile phones, and a telephone on the unit to make free calls. Patients had access to drinks and snacks including fresh fruit. There was a cold-water dispenser in the dining area.

Patients' engagement with the wider community

Staff ensured that patients had access to education and work opportunities. Staff supported patients to maintain contact with their families and carers.

Meeting the needs of all people who use the service

The service provided one accessible bedroom and separate bathroom on the ground floor. Staff provided information about services such as advocacy, including independent mental health advocates, the Mental Health Act and treatments, and how to complain.

Staff could access information leaflets in languages spoken by patients, if required. Patients had access to interpreters and /or signers.

Occupational therapists had devised therapeutic programmes that included a mix of individual and group activities for each patient. Programmes included days out to recovery cafes, libraries, mindfulness group, anxiety management, practical skills groups and cooking groups.

Staff supported patients to buy food, and prepare and cook their own lunch and dinner in the kitchen. Patients had a dedicated space in the kitchen fridge and cupboard for their ingredients. Patients had a choice of food to meet dietary requirements.

Patients told us the chaplain no longer visited but there was a plan for chaplaincy support workers to visit the unit. Some patients attended the local church.

Listening to and learning from concerns and complaints

Staff provided information telling patients how they could make a complaint. While most posters on notice boards and leaflets were in English this information could be made available in other languages as well. Patients knew how to complain.

There were weekly patient community meetings. Patients could raise their concerns at these meetings. However, minutes of the community meetings showed items for discussion were around what staff wanted to discuss, rather than what patients wanted to discuss.

This core service received six complaints between 1 April and 31 December 2017. One complaint was referred to the Ombudsman during this period. The complaints related to clinical practice, communication and staff attitude.

This core service received no compliments during the last nine months from 1 April to 31 December 2017. The ward manager kept cards and letters with compliments received from patients, families and carers. These were regularly shared with staff.

Is the service well-led?

Leadership

The ward manager had the skills knowledge and experience to perform their role. The ward manager had a good understanding of the services they managed. They could explain clearly how the team were working to provide high quality care.

Some staff told us the ward manager would be present at the unit, but not accessible.

Staff told us senior managers were not visible at the unit.

Leadership development opportunities were available. However, staff said opportunities had been difficult to access due to changes within the trust.

Vision and strategy

Staff described the trust's vision and values, of "working to improve lives" and being "open, empowering and compassionate." The provider's senior leadership team had successfully communicated the trust visions and values.

Staff had the opportunity to contribute to discussions about the strategy for their service, at team meetings. However, staff were concerned about the future of the service.

Culture

Relationships between some members of the multidisciplinary team were mixed. Not all staff felt respected, supported and valued. Some staff did not feel able to raise concerns without fear of retribution.

The ward manager had been in post a year and six months and due to leave 14 May, when an interim manager comes into post. There had been a turnover of four managers over four years. Staff found this concerning and affected staff morale and stability of the team. Sickness and absence rates were similar to the average for the provider.

Staff knew how to use the whistleblowing process and about the role of the Freedom to Speak Up Guardian.

Managers dealt with poor staff performance when needed.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

Governance

There were systems and procedures to ensure that the unit were safe and clean. We saw faulty equipment in the clinic room and some items of resuscitation equipment were not available. Safe checking systems and processes were not in place. The ward manager had not followed up the faulty equipment. Managers were not aware of the issues with incomplete risk assessments; and audits on the quality of patient records had not been completed.

There were enough staff; and were trained and supervised. Not all mandatory training met the trusts training target 85%, this included enhanced emergency skills 34%, Mental Health Act 63%, and basic life support 71%. However, the ward manager had staff booked on training in May and June.

Patients were assessed and treated well and the unit adhered to the Mental Health Act and Mental Capacity Act, and beds were managed well.

Managers knew the types and frequency of incidents that occurred within the service and investigated appropriately. Managers shared lessons learnt with the team.

Management of risk, issues and performance

The ward manager had not maintained a complete risk register at unit level. Identified risks were around security of the premises, the smoke free policy and its implementation and single sex provision. The issues around no staff room and heating were not included.

Some staff were aware of the trusts "five key incidents." These were available on the intranet and linked to significant trust wide incidents. Staff told us the trust highlighted a "policy of the month". The trust were still in the process of harmonising trust polices.

The ward manager followed up management of risk during a daily teleconference call with senior managers. We saw medicine, and health and safety audits.

Information management

Managers used information and technology to assist them in their role.

Staff used the information technology available to them and reported they felt they had sufficient equipment and technology. Staff made notifications to external bodies as needed.

Engagement

Staff had access to information about the trust through the intranet, bulletins and newsletters. The ward manager and staff said they were disappointed 439 Ipswich Rd was not listed on the trust website. Managers had previously raised this with the trust.

Patients and carers had opportunities to give feedback on the service, with surveys provided upon discharge. However, feedback had been limited, with few responses. A new “friends and family test” leaflet had recently been developed but there had been no responses.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

None of the services within this core service have been awarded an accreditation.

Forensic inpatient/secure wards

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Brockfield House	Alpine	13	Male
Brockfield House	Aurora	12	Mixed
Brockfield House	Causeway	16	Female
Brockfield House	Dune	15	Male
Brockfield House	Forest	15	Male
Brockfield House	Fuji	12	Female
Brockfield House	Lagoon Ward	15	Male
Broomfield Hospital Mental Health Wards	Edward House	20	Male
Robin Pinto Unit	Robin Pinto Unit	18	Male
Wood Lea Clinic	Wood Lea Clinic	9	Male

Is the service safe?

Safe and clean environment

Safety of the ward layout

Over the 12 month period from 1 April 2017 to 31 January 2018 there were no mixed sex accommodation breaches within this core service.

There were ligature risks on all 10 wards within this core service. All 10 of the wards presented a high level of ligature risk due to patients being a vulnerable group of patients who have the potential to self-harm and, as the obvious ligature risks are removed recent surveys and feedback identified an increase in finding alternative methods.

The trust had taken actions to mitigate ligature risks: Funding agreed by EOSC to replace patient toilets, line of site survey and mirrors installed as required, review of ligature management policy, eLearning package and hotspot photos on the ward to be shared and discussed during handover and team meetings. Alteration to ensuite shower doors (Edward House Ward).

The CCTV on Fuji ward did not cover all the garden area. However, staff identified ligature points (places to which patient's intent on self-harm might tie something to strangle themselves) on all wards as part of the monthly environmental risk assessment audit and actions had been identified to reduce the risk to patients. Staff knew where to locate ligature cutters on each ward.

Staff completed individual patient risk assessments, searching property and the use of increased staff observations of patients who presented as high risk. Staff locked some rooms when not in use and maintained a presence in patient areas.

Staff had access to personal alarms for use in an emergency.

Maintenance, cleanliness and infection control

Ward areas were visibly clean, had good furnishings and were well maintained.

Staff had access to protective personal equipment, such as gloves and aprons in accordance with infection control practice. Posters advising staff of the principles of effective handwashing techniques were on display on all wards.

The kitchen fridge on Dune and Alpine wards and at Edward House contained open items of food. However, labels were not in place indicating when the food had been opened and when it should have been consumed by.

Seclusion room

There were seclusion rooms on Fuji ward, Alpine ward, Robin Pinto ward and at Edward House. Each room allowed clear observation and two-way communication, and had toilet facilities and a clock.

Clinic room and equipment

Wards had fully equipped clinic rooms with examination couches and accessible resuscitation equipment, which staff checked regularly.

Staff maintained equipment; stickers were in place specifying when it had been cleaned.

Safe staffing

Nursing staff

This core service has reported a vacancy rate for all staff of 18% as of 31 January 2018.

This core service reported an overall vacancy rate of 30% for registered nurses at 31 January 2018 and 8% for nursing assistants.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Alpine	1.99	11.52	17%	0.33	9.33	4%	2.32	20.85	11%
Aurora	1.09	6.34	17%	0.79	7.46	11%	1.88	13.8	14%
Causeway	3.30	10.15	33%	2.20	14	16%	5.50	24.15	23%
Dune	1.90	9.4	20%	0.74	9.34	8%	2.64	18.74	14%
Edward House	6.42	20.42	31%	4.22	19.22	22%	10.64	41.64	26%
Forest	3.95	10.09	39%	0.00	6.53	0%	2.95	16.62	18%
Fuji	5.84	12.01	49%	1.86	18.66	10%	7.70	30.67	25%
Lagoon	4.51	11.51	39%	1.14	10.74	11%	5.65	22.25	25%
Robin Pinto	1.97	8.47	23%	-2.07	9.33	-22%	0.70	21.6	3%
Secure Service	0.00	1	0%	-	-	-	0.06	2.06	3%

Ward/Team	Registered nurses			Health care assistants			Overall staff figures		
	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Management (Robin Pinto & Wood Lea)									
Wood Lea	1.00	5.67	18%	0.57	13.4	4%	2.17	20.47	11%
Core service total	**31.97**	**106.58**	**30%**	**9.78**	**118.01**	**8%**	**42.21**	**232.85**	**18%**

NB: All figures displayed are whole-time equivalents

Between 1 April 2017 and 31 January 2018, bank staff filled 26% of shifts to cover sickness, absence or vacancy for qualified nurses.

Managers calculated the number of staff required to cover shifts, the staffing rotas showed there was the appropriate number of staff on each shift. Ward managers reported that they could adjust staffing levels to take account of increased clinical need.

The number of nurses and healthcare assistants matched this number on all shifts.

The ward manager could adjust staffing levels daily to take account of the needs of the patients.

When necessary, managers used agency and bank nursing staff to maintain safe staffing levels.

When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward.

We saw a qualified nurse was often in the communal areas of the wards, and a healthcare support worker was present in the communal areas at all times

Staffing levels allowed for patients to have regular one to one time with their named nurse. Patients and staff we spoke with said that one to one time, activities or escorted leave was rarely cancelled but sometimes was rearranged due to staffing issues.

Staffing levels were sufficient to carry out physical interventions and increased observation levels.

In the same period, agency staff covered 8% of shifts for qualified nurses. Four percent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Alpine	1,855	460	3	48
Aurora	963	202	4	3
Causeway	1,539	435	153	91
Dune	1,530	308	0	61
Edward House	3,497	720	457	271
Forest	1,520	471	2	57

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Fuji	1,826	570	241	117
Lagoon	1,838	599	12	75
Robin Pinto Unit	1,526	282	471	5
Wood Lea Clinic	968	411	17	8
Core service total	**17,062**	**4458 (26%)**	**1,360 (8%*)**	**736(4%*)**
Trust Total	**102629**	**31709 (X%)**	**12577 (X%)**	**1356 (X%)**

***Percentage of total shifts

Between 1 April 2017 and 31 January 2018, 34% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, agency staff covered 3% of shifts. Two per cent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Alpine	3,343	1611	10	47
Aurora	1,579	417	2	21
Causeway	2,890	1157	28	95
Dune	1,948	421	1	12
Edward House	3,736	1795	111	223
Forest	1,394	375	0	3
Fuji	3,978	1028	229	140
Lagoon	3,494	1345	10	30
Robin Pinto Unit	1,941	416	321	6
Wood Lea Clinic	2,257	594	44	43
Core service total	**26,560**	**9159 (34%)**	**756 (3%)**	**620 (2%)**
Trust Total	**144009**	**60464**	**5916**	**4396**

***** Percentage of total shifts

This core service had 18 (10%) staff leavers between 1 April 2017 and 31 January 2018.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
300 Edward House	26.00	2.00	8%
336 EC570 Robin Pinto	20.68	5.40	26%
336 EC950 Secure Services Mgmt Beds	2.00	0.00	0%

364 EC303 Fuji	26.09	4.00	15%
336 EC565 Wood Lea	19.57	2.00	10%
364 EC302 Causeway	18.51	4.00	22%
364 EC300 Alpine	19.55	0.00	0%
364 EC301 Lagoon	17.13	1.00	6%
364 EC304 Dune	17.10	0.00	0%
364 EC305 Aurora	11.07	0.00	0%
364 EC308 Forest	13.36	0.00	0%
Core service total	191.05	18	10%
Trust Total	3127.64	253	7%

The sickness rate for this core service was 6% between 1 April 2017 and 31 January 2018. The most recent month's data (January 2018) showed a sickness rate of 5%.

Robin Pinto had the highest annual sickness rate with 14%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Robin Pinto	6%	14%
Secure Services Mgmt Beds	0%	13%
Wood Lea	8%	11%
Trainee Doctors	0%	1%
Causeway	6%	9%
Fuji	12%	9%
Forest	0%	4%
Secure Services Inpatient Occupational Therapy	0%	4%
Dune	8%	3%
Alpine	3%	4%
Lagoon	0%	2%
Secure Services Inpatient Occupational Therapy (Ot)	0%	0%
Secure Services Inpatients Medical Staff	14%	8%
Aurora	1%	5%
Secure Services Inpatient Peripatetic Team	0%	13%
Secure Services Inpatient Activity Coordinators	0%	4%
Secure Services Inpatient Vocational Services	0%	1%
Secure Services Inpatient Mgmt	0%	0%
Secure Services Inpatient Reception	0%	1%
Secure Services Inpatient Housekeeping	1%	1%
Secure Services Inpatient Psychology	17%	3%
Edward House	0%	6%
Core service total	**5%**	**6%**
Trust Total	**4%**	**4%**

The below table covers staff fill rates for registered nurses and care staff during September, October and November 2017.

Edward House had less than 90% of the planned registered nurses for day shifts in September and October 2017. In addition, they had less than 90% of the planned day care staff in October 2017.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	September 2017				October 2017				November 2017			
Edward House	60.5	91.9	49.6	107.8	57.4	87.0	52.3	111.6	98.4	98.3	100.0	100.8
Alpine	98.4	102.6	98.3	103.5	97.8	101.3	98.4	97.9	96.7	100.0	96.7	101.8
Aurora	101.4	98.3	100.0	100.0	100.0	99.2	100.0	100.0	98.4	100.0	100.0	100.0
Causeway	86.1	98.9	100.0	98.9	95.2	98.5	100.0	98.9	93.5	97.2	96.7	101.1
Dune	89.7	105.7	100.0	100.0	92.9	105.7	100.0	100.0	95.9	102.9	100.0	100.0
Forest	87.4	121.2	100.0	100.0	99.2	103.9	100.0	100.0	99.2	101.5	100.0	100.0
Fuji	92.2	98.2	94.8	100.7	96.2	97.1	95.1	98.6	95.9	93.7	96.7	95.8
Lagoon	90.9	102.8	98.3	108.0	95.2	101.2	100.0	100.0	95.8	97.1	98.3	100.0
Wood Lea Clinic	115.5	105.6	100.0	100.0	104.1	101.1	100.0	100.0	109.7	100.5	103.3	98.3
Robin Pinto	100.0	97.8	100.0	100.0	100.0	98.5	100.0	100.0	100.0	99.2	100.0	100.0

Medical staff

Between 1 April 2017 and 31 January 2018, no shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same period, agency staff covered 348 shifts, 161 shifts were unable to be filled by either bank or agency staff.

The service had adequate medical cover during the day and night. This ensured a doctor could attend the wards quickly in an emergency.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Forensic	212	0	212	
Forensic ST	297	0	136	161
Core service total	**509**	**0**	**348**	**161**
Trust Total	**6744**	**258**	**3406**	**3080**

Mandatory training

The compliance for mandatory and statutory training courses at 31 December 2017 was 91%. Of the training courses listed 13 failed to achieve the trust target and of those, eleven failed to score above 75%.

The trust has a rolling month on month compliance rate for mandatory training.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	This core service %
Hoisting e-learning	100%
Personal Safety - MVA	100%
Safeguarding Adults (Level 1)	100%
Duty of Candour (Overview Version)	98%
Observation of Service User	98%
Mental Capacity Act Level 1	98%
Care Certificate	97%
Complaints Handling	96%
Equality and Diversity	96%
Health and Safety (Slips, Trips and Falls)	96%
Corporate Induction	95%
Harassment & Bullying	95%
Diabetes Training	95%
Safeguarding Children (Level 2)	95%
Induction E-Learning	95%
Mental Health Act	94%
Care Programme Approach	94%
Information Governance	93%
Safeguarding Adults (Level 3)	93%
First Aid Trained	92%
Security Training	92%
Fit for Work	91%
Dual Diagnosis	91%
Clinical Risk Assessment	90%
Cascade Fire Trainer	90%
Duty of Candour (Detailed Version)	89%
Infection Prevention, Control & Hand Hygiene	89%
Food Hygiene	89%
Security Training (eLearning)	88%
Medication Management (MH)	88%
TASI Trained	88%
Basic Life Support & AED	87%
Fire In-patient	83%
MERT (Enhanced Emergency Skills)	77%
PREVENT (WRAP) Training	71%
Hoisting	70%
Manual Handling - People	69%
Conflict Resolution	67%
Mental Capacity Act Level 2	67%
Safeguarding Children (Level 3)	64%
Fire Safety 2 years	60%
Personal Safety Breakaway - Level 1	53%
Basic Back Care (E-Learning)	50%
Dementia Awareness (inc Privacy & Dignity standards)	43%
Fire Safety 3 years	40%
Basic Back Care (Face to Face)	0%
Consent	0%

Training course	This core service %
Total	**91%**

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 46 care records. Staff completed individualised risk assessments of patients on admission and updated these on a regular basis. Staff used the Historical Clinical Risk Management 20, (HRC-20) risk assessment tool. Staff completed an individualised risk assessment on admission and updated this on a regular basis.

Management of patient risk

Staff identified and dealt with specific risk issues and gave examples where they provided specialist equipment to meet the needs of a patient who was terminally ill to prevent pressure sores.

Staff identified and recorded changing risks on the risk assessment form in the electronic care record.

There were no blanket restrictions in place in this service. Staff and patients worked together to identify and reduce restrictive interventions.

Staff and patients on Fuji ward won an award for working together to develop a least restrictive environment.

Staff adhered to best practice in implementing the smoke free policy. Staff offered patients the use of electronic cigarettes and nicotine replacement products.

Use of restrictive interventions

This core service had 92 incidents of restraint (on 41 different service users) and 30 incidents of seclusion between1 April 2017 and 31 December 2017. Edward House had the highest number of restraint incidents with 30.

Staff reported that they used restraint as a last resort and only after de- escalation had failed, we saw episodes of restraint were recorded on the trust electronic incident system.

We reviewed five rapid tranquilisation records. Staff had completed physical health monitoring records of patients following rapid tranquilisation which is in line with National Institute for Health and Care Excellence (NICE) guidelines.

Staff collaborated with patients about the use of restrictive interventions. Staff held meetings with patients to discuss the use of blanket restrictions and to allow patients to have their say on what worked and what needed to be improved. Managers from the wards had lead roles for reducing restrictive interventions across the trust.

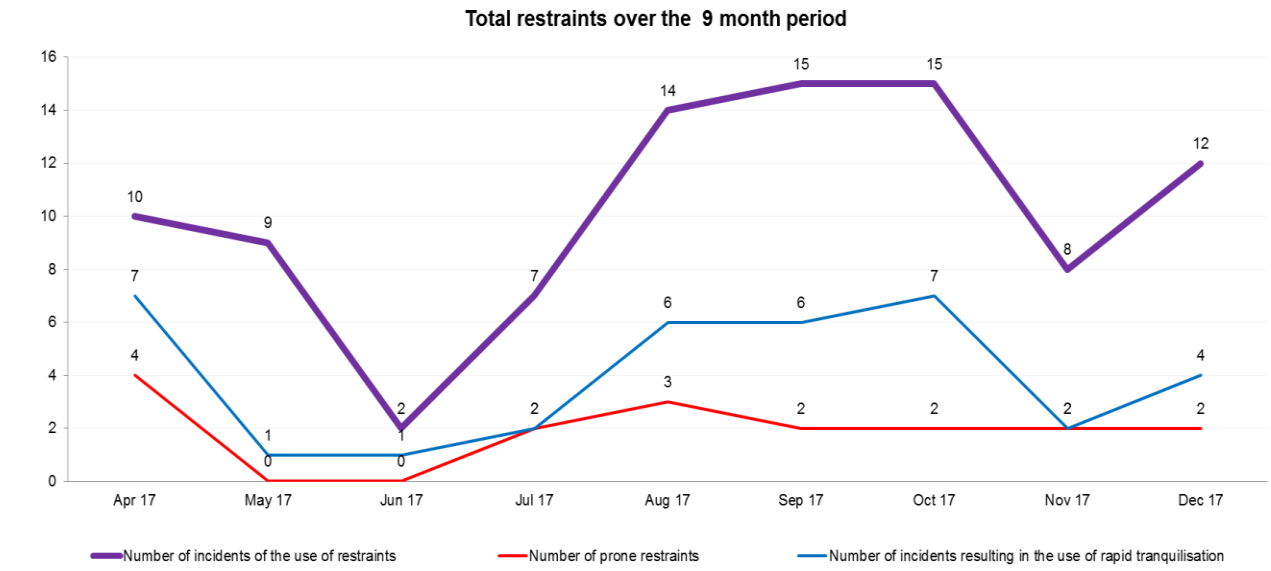
The below table focuses on the last 9 months' worth of data: April 2017 to December 2017.

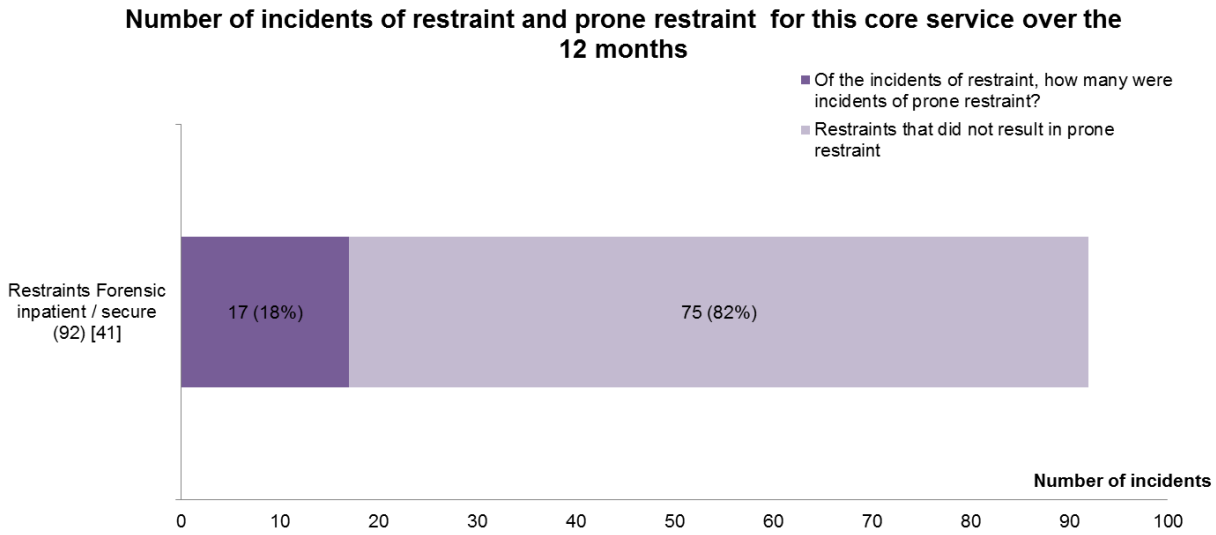
Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Alpine	10	11	8	3 (27%)	4 (36%)
Causeway	3	11	5	3 (27%)	5 (45%)
Dune	1	0	0	0 (N/A)	0 (N/A)

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Fuji	7	27	12	6 (22%)	7 (26%)
Lagoon	3	8	5	0 (0%)	3 (38%)
Robin Pinto Unit	1	2	2	2 (100%)	2 (100%)
Edward House	5	30	8	3 (10%)	12 (40%)
Wood Lea Clinic	0	3	1	0 (0%)	3 (100%)
Aurora	0	0	0	0 (N/A)	0 (N/A)
Core service total	**30**	**92**	**41**	**17 (18%)**	**36(39%)**

There were 17 incidents of prone restraint which accounted for 18% of the restraint incidents.

There have been no instances of mechanical restraint over the reporting period.





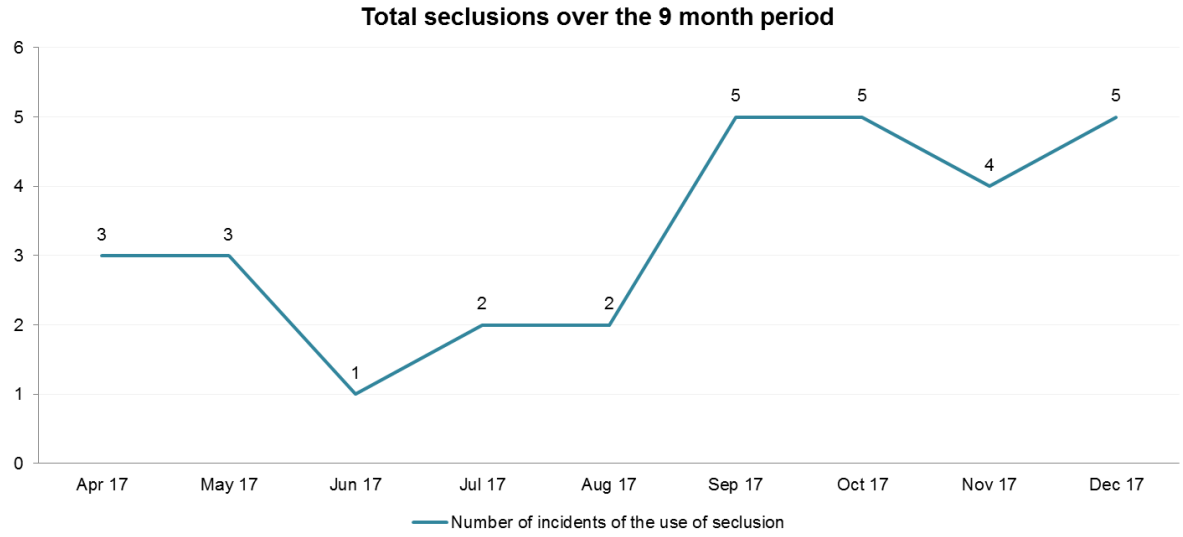
Please note the figures in square brackets ,after the total number of restraints, are the number ofdifferent service users restraint was used on during this time period.

Alpine ward had the highest number of seclusions with 10 which accounted for one third of total seclusions for this core service.

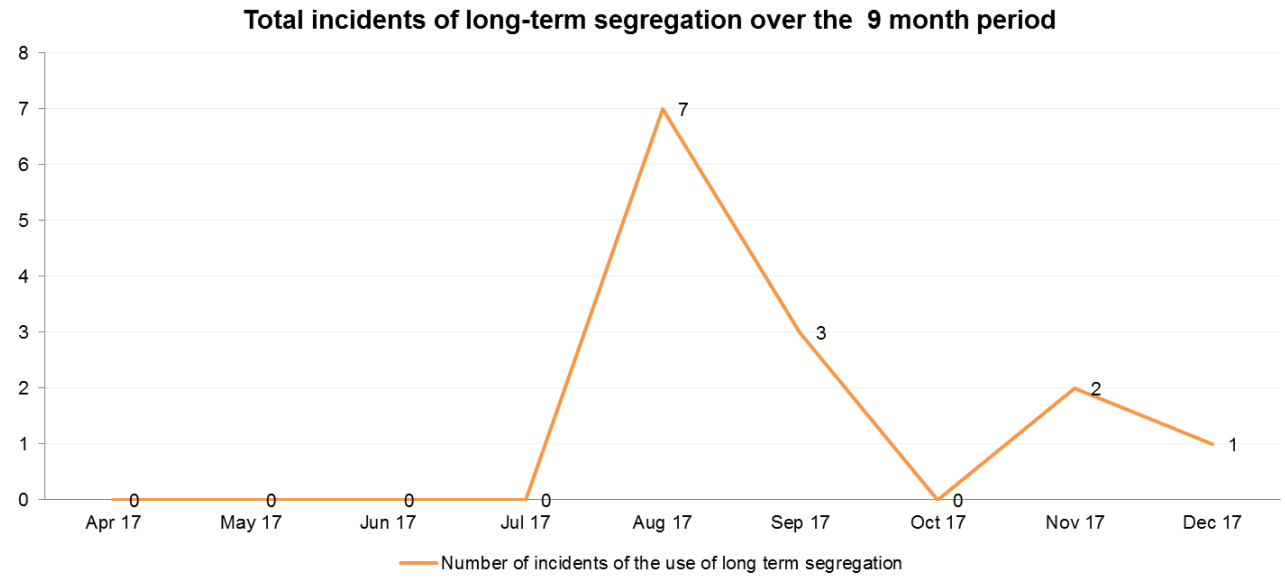
Staff told us that one patient on Alpine ward was being cared for under the trust long term segregation policy, however at times the patient also required periods of seclusion. We reviewed

the records and found staff had not implemented the appropriate trust documentation when seclusion commenced. Staff had not completed the checks required for secluded patients under the Mental Health Act Code of Practice.

We reviewed two seclusion records at the Robin Pinto unit. We found gaps in the recording of two hourly nursing and four hourly medical reviews. We also found that one patient had not had a medical review for 11 hours which is not in line with the Mental Health Act Code of Practice.



There have been 13 instances of long-term segregation over the nine month reporting period, seven of which took place during the month of August 2017.



Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will

work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust have provided details of the total number of safeguarding referrals made between 1 April 2017 and 31 December 2017 with 802 referrals made for adults and 180 for children. However, this for the whole trust and has not been broken down to core service level.

Staff demonstrated how they identified and made a safeguarding referral. Safeguarding training compliance for this service was 100%. Staff described how they would protect patients from harassment and discrimination including those with protected characteristics under the Equality Act 2010. Protected characteristics which are, age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity.

The trust had safe procedures for children that visited the wards. Family rooms were available.

The trust told us that there were no serious case reviews commenced or published in the last 12 months that related to this core service.

Staff access to essential information

The service used a combination of electronic and paper records. Staff had access to the electronic patient record system and could input patient information in a timely way.

Medicines management

Staff followed good practice in the storage of medicines.

We reviewed the prescription and medicine administration records for 110 patients. The trust had appropriate arrangements in place for recording the administration of medicines. Staff completed accurate records, which showed patients were receiving their medicines when they needed them. Medical staff recorded patient allergies on the medication administration record.

Patients detained under the Mental Health Act (MHA) received medicines that were authorised and administered in line with the MHA Code of Practice. Staff had access to T2 (consent to treatment) and T3 (record of second opinion) for reference when administering medication for patients.

Staff reviewed and recorded the effects of medication on patient's physical health in line with National Institute for Health and Care Excellence (NICE) guidance especially when high doses of antipsychotic medication was prescribed.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 January 2018 there were 15 STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was *unauthorised absence meeting SI Criteria* with 14. No unexpected deaths were reported for this core service.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

	Number of incidents reported			
Type of incident reported on SIRI	Alpine Ward	Edward House	Robin Pinto Unit	Total
Unauthorised absence meeting SI criteria	1	11	2	14
Disruptive/aggressive/violent behaviour meeting SI criteria		1		1
Total	1	12	2	15

Reporting incidents and learning from when things go wrong

Staff described the electronic system to report incidents and their role in the reporting process. Managers reviewed incidents and identified learning to be shared with the team. We saw each ward had access to an online electronic system to report and record incidents and near misses.

Staff described the various examples of serious incidents that had occurred within the services.

Staff demonstrated the duty of candour placed on them to inform people who use the services of any incident affecting them.

Staff discussed incidents and learning points in team meetings. We saw minutes of these meetings where staff had discussed changes needed to prevent further incidents occurring.

Managers held formal and informal debrief meetings with staff and patients after incidents. Staff told us they could access support from the trust occupational health team for both physical and mental health issues.

Is the service effective?

Assessment of needs and planning of care

Staff completed comprehensive mental health assessments for patients on admission. We looked at 46 care plans, 37 were up to date, personalised, holistic, recovery orientated and included physical health checks. Nine care plans lacked detail in relation to the patients' physical health needs and seven patients on Wood Lea ward did not have a fully completed health passport.

Staff assessed patients' physical health needs in a timely manner after admission using the Modified Early Warning Score assessment tool.

Staff developed care plans that met the needs identified during assessment and updated care plans when necessary.

Best practice in treatment and care

Staff followed National Institute for Health and Care Excellence (NICE) guidelines in relation to practice and when prescribing medications. These included regular reviews and physical health monitoring. Staff described applicable NICE guidelines and how they used these with patients.

Psychologists used a variety of treatments including offence based therapy and offender behaviour groups.

Patients were supported to access specialists when required for physical healthcare needs. Staff assessed and met patients' need for food and drink. Staff supported patients to live healthier lives; there was access to smoking cessation services, healthy cooking groups and access to fitness equipment.

Staff supported patients with everyday living skills and to access meaningful occupation. Staff helped patients to gain the confidence and skills to live successfully outside of hospital. The trust provided some patients with self-contained accommodation, in the form of flats, to encourage patient independence. Staff provided patients with food allowances and supported them to plan and budget meals. Staff supported patients to develop links with local resources and the community. Patients had access to part time employment and training courses that increased their skills for future employment. Staff encouraged patients to take part in activities in the community, including running marathons and accessing a recovery college.

Information about the outcomes of people's care and treatment were routinely collected and monitored using Health of the Nation Outcome Scales (HoNOS).

This core service participated in two clinical audits as part of their clinical audit programme.

Audit name / title	Key Successes	Key concerns	Key actions following the audit
Record Keeping /Care planning Audit	Baseline Audit to identify areas for improvement. Wards in the North of EPUT appear to have performed better and therefore duplicating work from this area across the south will be beneficial	Secure service wards achieved 77.4% compliance with "physical health" theme and four wards came below 80%. This was due to the smoking status and VTE assessments not being care planned for majority of the patient records included in the sample. The monitoring of aspects of a patient's physical health continues to be an area of concern. The Trust continues to prioritise the physical health agenda in 2017 to ensure all patients with enduring mental health conditions receive the necessary care to ensure their physical health is not compromised by their condition or treatment. Number of wards that achieved less than 80% compliance in "crisis plans" theme was four and this has to be improved using robust process.	Physical Health findings to be feedback to PHAIG (Physical Health Action Implementation Group) Recommendations have to be carried forward to the Secure Service Quality Group Individual ward action plan to be created especially for Causeway, Fuji and Edward House (If required) Nursing Staff to ensure all relevant records has been completed and updated as required by the Record keeping policy CP61 Re-audit of Record Keeping Audit in Secure Service MH wards
Physical Health Secure and Specialist	Re-audit in South Area and Baseline audit in the North Wards to establish compliance against Physical Health Guidance.	Medicines reconciliation is at 100% for 7/10 wards, of the applicable sample 35/45 patients had basic medicines reconciliation within 6 hrs of admission to secure and specialist services; 77%. However, to note it is the 2 CAMHS wards who are non-compliant in this area and any further work should be targeted here. Baseline observations should be recorded within 6 hrs of a patient admission, of the applicable patients 6/50 patients did not have baseline observations recorded. Compliance across Specialist services is 88% Patients will require different blood tests dependant on their condition, presenting symptoms and	The Audit will be used to inform the Physical Health Action and Implementation Group. The findings will be lead to actions from this group to improve physical health of MH in-patients in a standardised way

Audit name / title	Key Successes	Key concerns	Key actions following the audit
		medications. 100% of the patients audited who are prescribed lithium in specialist areas had Lithium Levels recorded. It would be expected that all patients in Adult wards would have Cholesterol checked as this is directly linked to Heart Disease, 87% of adult patients had fasting lipids taken. Full blood count is being recorded in the majority or wards however Bone markers such as Calcium and phosphate levels are being overlooked in many areas.	

Skilled staff to deliver care

The wards had a range of disciplines to provide care and treatment. The multidisciplinary team (MDT) consisted of consultants, doctors, qualified nurses, healthcare support workers, psychologists, vocational support workers and occupational therapists. Staff were experienced and had the right skills and knowledge to meet the needs of the patient group.

The trust provided a formal induction period for new permanent staff. This involved attending a corporate induction, learning about the ward and trust policies and a period of shadowing existing staff before working alone.

The trust provided training for health care support workers in the care certificate. The care certificate aims to equip health care support workers with the knowledge and skills which they need to provide safe, compassionate care.

The trust provided opportunities to develop their skills and knowledge by attending both internal and external training, for example personality disorder and leadership training.

The trust had processes for identifying and managing poor staff performance, including involvement from occupational health and the human resources (HR) departments. Managers said they had good support to manage poor staff performance.

The trust's target rate for appraisal compliance is 90%. As at 31 January 2018, the overall appraisal rates for non-medical staff within this core service was 88%.

Four wards failed to achieve the trust's appraisal target, the lowest appraisal compliance rates were Robin Pinto ward with an appraisal rate of 60% and Edward House at 74%.

No appraisal data was submitted by the trust for medical staff in this core service during this period.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Causeway	13	13	100%
Forest	14	14	100%
Fuji	16	15	94%
Lagoon	16	15	94%

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Dune	14	13	93%
Aurora	12	11	92%
Alpine	17	15	88%
Wood Lea	17	15	88%
Edward House	23	17	74%
Robin Pinto	10	6	60%
Core service total	**152**	**134**	**88%**
Trust wide	4121	3386	82%

Between 1 April 2017 and 31 January 2018, the average clinical supervision rate across all 10 wards in this core service was 96% against the trust's 90% target. Edward House had the lowest clinical supervision rate with 80%. Ten of the fifteen teams had a rate of 100%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Alpine	184	184	100%
Aurora	120	120	100%
Causeway	141	141	100%
Dune	149	149	100%
Forest	140	140	100%
Fuji	204	203	100%
Lagoon	183	183	100%
Wood Lea	171	168	98%
Robin Pinto	177	156	88%
Secure Services Inpatient Psychology	12	10	83%
Edward House	207	166	80%
Core service total	**1,688**	**1,620**	**96%**
Trust Total	**24,386**	**21,061**	**86%**

Multidisciplinary and interagency team work

Staff supported patients to attend multidisciplinary team meetings. We attended five meetings: they were effective in enabling staff to share information about patients and review their progress.

Occupational therapists and technical support workers worked as part of the team and we saw that they worked closely with patients. The patients we talked with spoke positively about the support they received.

We attended one handover meeting. Staff provided details including each patient's level of observations, risks, and Mental Health Act status. Staff received information on diagnosis, current presentation, and activities for the day and physical health care, as appropriate.

Ward managers reported they had good relationships with community mental health teams, GP's, dentists and local housing services.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

As of 31 December 2017, 93% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is mandatory for all staff and renewed every three years.

We reviewed the systems in place to ensure compliance with the Mental Health Act (MHA) and adherence to the guiding principles of the MHA Code of Practice. All patients whose care records we reviewed were lawfully detained and treatment was given under an appropriate legal authority.

Staff completed MHA paperwork correctly, the trust had an up to date MHA policy. There was administrative support to ensure paperwork was up to date and regular audits took place. Staff scanned MHA paperwork onto the electronic patient record for staff reference.

MHA administrators were available to offer support and legal advice to staff on the implementation of the MHA and its Code of Practice. The MHA administration office provided reminders to consultants for section renewals and consent to treatment.

The trust provided access to Independent Mental Health Act advocates for patients and contact details were contained in admission packs and displayed on wards for patient reference, this included an easy access version. Staff described how they supported patients to access the service.

Staff ensured that patients could take Section 17 leave where appropriate. Staff explained patients their rights under section 132 MHA in a way they could understand, on admission and regularly thereafter.

Good practice in applying the Mental Capacity Act

As of 31 December 2017, 98% of the workforce in this core service had received training in the Mental Capacity Act level one and 67% in Mental Capacity Act level two. The trust stated that this training is mandatory for all staff and renewed every three years.

Staff demonstrated how capacity was assessed for significant decisions and told us both nursing and medical staff completed mental capacity assessments for patients.

Staff gave patients assistance to make specific decisions for themselves before they assumed that the patient lacked capacity to make it.

Staff described how they made decisions in the patient's best interest, recognising the importance of the person's wishes, feelings, culture and history.

Staff knew where to get advice from regarding the Mental Capacity Act (MCA) and could refer to the trust policy if needed.

The trust has not reported any Deprivation of Liberty Safeguard (DoLS) applications for this core service.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with kindness, compassion and respect. We observed interactions between staff and patients during the inspection and saw staff responding to patient's needs in a discreet and respectful manner. Staff treated patients with dignity and remained interested when engaging patients in meaningful activities. Staff interacted with patients in a timely way and at a level that was appropriate to individual needs.

We spoke with 51 patients who told us that staff were generally kind and caring.

We spoke with nursing staff who described how they took patient's personal, cultural, social and religious needs into account when care planning.

Staff said they could raise concerns about discriminatory, disrespectful or abusive behaviour towards patients without fear of recrimination.

Staff described how they maintained the confidentiality of information about patients.

Involvement in care

Involvement of patients

Staff gave patients an information pack on admission; this gave details about the ward and the service.

From the 46 patient notes reviewed, 37 showed that the patient had received a copy of their care plan. We spoke with 51 patients, 41 said they knew about their care plan and been involved in developing it"

Patients had access to advocacy services on the wards and information and contact details were contained in patient admission packs and on posters and leaflets available on the wards.

Weekly community meetings took place, these allowed patients to raise concerns and provide feedback about the wards. The minutes of the meetings showed that actions had been taken following the meetings, for example, the introduction of mobile phones where appropriate.

Staff invited patients to attend the multi-disciplinary reviews along with their family where appropriate.

Involvement of families and carers

We spoke with seven carers, all of whom said staff kept them up to date regarding their loved one's progress.

Three carers told us staff had asked for feedback about the ward and service.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for ten wards in this core service between 1 April 2017 and 31 January 2018.
All the wards within this core service reported average bed occupancies ranging above the provider benchmark of 85% over this period. Eight wards had maximum occupancy levels of 100% or above.

Ward name	Average bed occupancy range (1 April 2017 to 31 January 2018)
Forensic - Brockfield – Alpine	92% to 108%
Forensic - Brockfield – Aurora	75% to 92%
Forensic - Brockfield – Causeway	86% to 98%
Forensic - Brockfield – Dune	92% to 100%
Forensic - Brockfield – Forest	94% to 100%
Forensic - Brockfield – Fuji	89% to 100%
Forensic - Brockfield – Lagoon	94% to 100%
Forensic - Luton - Robin Pinto	113% to 126%
Edward House	83% to 100%
Forensic – The Glade - Wood Lea Clinic	89% to 110%

The trust provided information for average length of stay for the period 1 April 2017 to 31 January 2018.

Alpine Ward had the shortest length of stay with 240 days and Fuji had the longest length of stay with 1,319 days.

Ward name	Average length of stay range (1 April 2017 to 31 January 2017)
Forensic - Brockfield – Alpine	240 days to 579 days
Forensic - Brockfield – Aurora	744 days to 907 days
Forensic - Brockfield – Causeway	715 days to 943 days
Forensic - Brockfield – Dune	419 days to 595 days
Forensic - Brockfield – Forest	912 days to 1,146 days
Forensic - Brockfield – Fuji	941 days to 1,319 days
Forensic - Brockfield – Lagoon	304 days to 410 days
Forensic - Luton - Robin Pinto	655 days to 797 days
Forensic – The Glade - Wood Lea Clinic	1,102 days to 1,490.22 days
Edward House	0 to 1108 days

This core service reported no out area placements between 1 April 2017 and 31 January 2018.

This core service reported no readmissions within 28 days between 1 April 2017 and 31 January 2018.

Discharge and transfers of care

Between 1 April 2017 and 31 January 2018, there were three delayed discharges within this core service.

Staff planned for patients' discharge in partnership with community care co-ordinators and other agencies such as housing, employment and probation services.

Staff supported patients during referrals and transfers between services. We were told about staff supporting patients whilst they received treatment at the acute hospital.

Facilities that promote comfort, dignity and privacy

Patients had their own bedroom, which they could personalise.

Patients had lockers which were adjacent to their bedroom to store their possessions.

Wards had payphones for patient use in communal areas; however, staff facilitated private phone calls in ward offices or by use of cordless telephones when needed. Some patients were supported to use their own mobile phones.

All wards had good access to outside space.

Patients had 24 hour access to a beverage area to make hot and cold drinks and access to fresh fruit and snacks.

Facilities that promote comfort, dignity and privacy

Staff supported patients to maintain contact with their families and carers and invited them to attend multi-disciplinary meetings where appropriate.

The trust employed a vocational worker to support patients with education and work.

Patients' engagement with the wider community

Staff supported patients to maintain contact with their families and carers and invited them to attend multi-disciplinary meetings where appropriate.

The trust employed a vocational worker to support patients with education and work.

Meeting the needs of all people who use the service

The service did not have specific facilities for disabled people. However; bedrooms and bathrooms were large enough to accommodate specialist equipment if required. Staff told us the trust could access mobility aids and equipment when needed.

Staff could access information leaflets in a variety of languages for patients whose first language was not English.

Patients had access to a wide range of information leaflets in ward areas. There was information on advocacy, patients' rights, how to complain and local services.

Staff had access to interpreters to ease communication with patients, as needed. Staff had access to contact telephone numbers in ward offices.

The service provided a choice of food to meet differing dietary needs and choices. However, one carer told us halal options were limited.

The trust provided a chaplaincy service that provided patients with access to support from a variety of religions and faiths.

Listening to and learning from concerns and complaints

This core service received six complaints between 1 April and 31 December 2017. No complaints were referred to the Ombudsman during this period.

Ward	Systems & Procedures	Clinical Practice	Security	Environment	Total
Wood Lea Clinic		1	1	1	3
Edward House	2				2
Lagoon		1			1
Total	**2**	**2**	**1**	**1**	**6**

Patients had access to information on how to make a complaint. Wards had information on the complaints process available to patients on ward notice boards and in leaflets. Staff supported patients to raise concerns when needed.

Staff described how they protected patients who raised concerns or complaints from discrimination and harassment.

The trust had systems for the recording and management of complaints. We saw minutes of team meetings where the outcomes and learning from complaints were discussed.

This core service received seven compliments during the last nine months from 1 April to 31 December 2017 which accounted for 1% of all compliments received by the trust as a whole.

Is the service well-led?

Leadership

Leader's had a good understanding of their service, explained how the teams provided high quality care and had the knowledge and experience to perform their role.

Staff we spoke with said that managers were visible and approachable.

Leader's told us the trust provided them with opportunities to develop their own and their team's skills.

Vision and strategy

Staff we spoke with were aware of the organisation's values and how they were applied within their service, for example being open and honest with patients. They identified that these were displayed on the trust's intranet system and were regularly highlighted in meetings and training.

Staff we spoke with knew who the most senior managers in the organisation were. They told us that senior staff within the trust had visited the wards during the day and at night and weekends. These included the chief executive and various executive directors.

Manager's explained how they were working to deliver high quality care within the budget available.

Culture

Staff said they felt respected and supported by their manager and they were proud to work for the trust and that morale was good.

Staff we spoke with said they felt able to raise concerns without fear of retribution and knew the trust had a whistle blowing policy which they would use if they needed to and were aware of the trust speak up policy.

Managers were supported by colleagues in the human resource department to manage poor staff performance.

Staff we spoke with said the trust promoted equality and diversity and there was an equality champion for forensic services.

Staff appraisals included conversations about career development.

Staff sickness for the service was variable. Robert Pinto, Wood Lea, Causeway and Dune wards was above the trust target of 4.3%. Managers were working with the human resource team to support staff back to work following long term sickness.

Staff said they could access the trust occupational health service for support with both physical and mental health issues.

The trust recognised success within the service; we saw certificates displayed where staff had received awards.

Governance

Manager's used a standard agenda for ward meetings, items covered at the meeting included safeguarding, feedback and actions following incidents and performance data.

The trust had systems for monitoring compliance with annual appraisal of staff. Data provided on this inspection showed two wards; Robert Pinto and Edward House did not meet the trust target of 90%.

Vacancy rates across the wards were variable, the highest number of vacancies of registered nurses was 49% on Fuji ward, and the lowest number was 17% on Alpine and Aurora wards. Staff told us the trust had ongoing recruitment and retention processes to address this. The highest number of vacancies of healthcare support workers was 26% at Edward House; the lowest number was 3% on Robert Pinto ward. Managers told us they could book bank staff in advance to ensure consistency of care.

Staff participated in several audits, for example record keeping, physical health monitoring and medicine reconciliation.

Compliance rates for supervision at Edward House was 80% and Robert Pinto ward was 83% which were below the trust target of 90%.

Managers ensured clinical areas were clean and that equipment was maintained in a timely way.

Managers supported staff to work in collaboration with community teams and external agencies such as, housing and the criminal justice service to meet the need of patients.

Management of risk, issues and performance

Managers supported staff to submit issues to the trust risk register. Staff told us they could escalate concerns to managers when required.

Staff told us that there had been no impact on the service by the ongoing trust cost improvement programme.

The services had contingency plans in place; they referred to managers working on the wards clinically during recent bad weather.

Information management

The trust collected data from wards to produce a performance dashboard which monitored for example: sickness levels, medication errors, training compliance, appraisals and supervision rates.

Staff had access to equipment and information technology needed to do their work. Staff scanned appropriate paper records into the electronic system to enable them to be located easily.

Managers used information and technology to assist them in their role; they described how they looked at trends in the types of incidents on the wards.

Information was in an accessible format and was timely and accurate.

Engagement

Wards had information boards detailing the staff on duty and staffing levels. These informed patients of the staff available for care and treatment for that day.

Manager's and staff facilitated weekly community meetings, these allowed patients to raise concerns and provide feedback about the wards. The minutes of the meetings described actions taken following the meetings.

Patients told us they had met with senior leaders when they visited the wards.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

None of the services within this core service have been awarded an accreditation.

Managers told us they were taking part in peer reviews as part of the Quality Network for Forensic Mental Health Services.

Staff collected data on performance. Ward managers completed a database that recorded their performance against a range of indicators, for example agency use and staff sickness. Ward managers reported this monthly to the senior managers.

The ward managers could provide us with an up to date picture of how the wards were performing and had a good understanding of where improvements were required.

Child and adolescent mental health wards

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Rochford Hospital	Poplar Unit	14	Mixed
The St Aubyn Centre	Larkwood Ward	10	Mixed
The St Aubyn Centre	Longview Ward	15	Mixed

Is the service safe?

Safe and clean environment

Safety of the ward layout

Ward layouts allowed staff to observe all parts of the ward, and staff had placed viewing mirrors at ceiling height to eliminate blind spots. Staff had easy access to alarms and patients had easy access to nurse call systems where this was necessary.

Wards complied with guidance on eliminating mixed-sex accommodation. They had grouped male and female bedrooms together. Bedrooms had ensuite shower rooms. Over the 12 month period from 1 April 2017 to 31 December 2017 there were no mixed sex accommodation breaches within this core service.

The trust had undertaken recent (from 1 April 2017 onwards) ligature risk assessments at all three wards. All three of the wards presented a high level of ligature risk due to being a vulnerable group of patients.

The trust had taken actions to mitigate ligature risks. Funding had been agreed to replace all patient toilets with reduced ligature design and install door top alarms on all bedroom doors. Line of site surveys were undertaken and mirrors installed as required. Staff reviewed the ligature management policy and eLearning package. Staff shared hotspot photos of the ward during handover and team meetings.

Longview and Larkwood wards were using assessments dated 26 October 2017, whilst waiting for senior managers to ratify their new ones. Staff identified, assessed and mitigated ligature risks on all wards. Staff responded appropriately to changes in risk relating to the environment. At the time of inspection, there were ongoing refurbishment works on Longview and Larkwood.

Managers carried out daily risk assessments to mitigate the changing risks. Managers met with the building contractors daily to understand and assess the building schedule and the risks this may pose. Managers communicated changing risk to staff in handover and multidisciplinary meetings. Staff reviewed individual patient risk based on the environmental changes

Maintenance, cleanliness and infection control

Ward areas were clean, had good furnishings and staff maintained them well. On Larkwood ward, the provider had taken on board findings of the last report and managers had arranged for

remedial works, including replacement easy clean wall coverings, refurbished flooring and redesigned courtyard / garden area.

Cleaning records were up to date and demonstrated that staff cleaned the ward areas regularly. However, the PLACE survey score for condition, appearance and maintenance and for cleanliness was not available.

Managers had been unsuccessful in addressing two infection control issues on Larkwood ward. We found two incidents that posed an infection control issue and additional risk to people with respiratory difficulties. We saw black mould patches on the ceiling in the ensuite showers. The manager told us this had been a long-standing problem with the embedded ceiling showers. Managers had reported the problem, and the estates department had investigated it, but all attempts to rectify the problem had been unsuccessful. We also saw damp, that could indicate mould, on the inside of plastic boxes containing patient's belongings that they could not have in their bedrooms.

Seclusion room

The seclusion room on Larkwood ward met the standards set out in the Mental Health Act code of practice. The trust had recently invested capital to re design the seclusion and long term segregation facilities. Rooms allowed clear observation and two-way communication; there were toilet facilities and a clock. When required, Longview ward used the facilities on Larkwood, or patient's bedrooms, for seclusion. On Longview and Larkwood staff used seclusion appropriately and followed best practice when they did so.

Poplar ward did not have a seclusion room and used an identified area off the main ward area. Staff generally ensured seclusion records were up to date, we found 24 of the 29 seclusion records we reviewed were complete. However, there was potential for patient's privacy and dignity and staff safety to be affected throughout any period of seclusion or segregation, as staff had to remain in the room with patients at all times. This breached patients' dignity and privacy.

Clinic room and equipment

Clinic rooms on all wards were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment and kept it clean, and clean stickers were visible and in date.

Safe staffing

Nursing staff

Managers had calculated the number and grade of nurses and healthcare assistants required for each ward. The number of nurses and healthcare assistants matched this number on all shifts. The ward manager could adjust staffing levels daily to take account of case mix, and when necessary, managers deployed known agency and bank nursing staff to maintain safe staffing levels. Records showed staff shortages rarely resulted in staff cancelling escorted leave or ward activities, and there were enough staff to carry out physical interventions such as observations, restraint and seclusion safely. However, staff on Larkwood and Longview wards felt the base line establishment for staffing was not sufficient to meet the more complex and demanding needs of the patient group. Patients, staff and managers described the impact of this. Three patients told us staff were not always available when there was an incident on the ward and staff had to respond. Staff told us they felt under pressure on these wards, and band 5 nurses who were still in preceptorship were key working complex patients. While managers stated they sometimes could not give as much support to staff as they would have liked. Staff acknowledged that they

occasionally had to rearrange patient's section 17 community leave particularly if scheduled for early evenings. The Trust, along with managers, completed an establishment review and presented it to Board in March 2018.

All staff, including temporary staff, had undergone a Disclosure and Barring Service check and had been checked against the Protection of Children Act register before appointment. Where agency and bank nursing staff were used, those staff received an induction and were familiar with the ward. During our inspection we saw a qualified nurse was present on communal areas of the ward at all times. Staff and patients confirmed that they could have regular one-to-one time with their names nurse.

This core service reported a vacancy rate for all staff of 12% as of 31 January 2018. This core service reported an overall vacancy rate of 8% for registered nurses and 11% for nursing assistants. At the time of inspection, managers informed us their recent recruitment drives had resulted in a vacancy rate for all staff being 6%, with 3% for registered nurses and 7% for nursing assistants.

	Registered nurses			**Health care assistants**			**Overall staff figures**		
Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Camhs I/P Poplar Ward	-0.05	9.55	-1%	0.74	14.77	5%	0.87	29.6	3%
Larkwood Ward	1.53	10.33	15%	2.34	12.14	19%	4.27	22.87	19%
Longview Ward	0.86	9.86	9%	2.14	10.74	20%	3.00	20.6	15%
Poplar Unit	-	-	-	-	-	-	2.00	13	15%
The St. Aubyn Centre (Larkwood & Longview)	0.00	1	0%	-0.75	4.25	-18%	2.74	21.89	13%
Core service total	**2.34**	**30.74**	**8%**	**4.47**	**41.9**	**11%**	**12.88**	**107.96**	**12%**
Trust total	**2448.81**	**15642.73**	**15.7%**	**1304.38**	**11954.48**	**10.9%**	**7236.01**	**50151.20**	**14.4%**

NB: All figures displayed are whole-time equivalents

Between 1 April 2017 and 31 January 2018, bank staff filled 13% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered less than 1% of shifts for qualified nurses. Twelve percent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Larkwood	1,514	169	19	209
Longview	1,575	168	14	306
Poplar Ward - Rochford	1,557	266	2	51
Core service total	**4646**	**603 (13%)**	**35 (<1%)**	**566 (12%)**
Trust Total	**102629**	**31709**	**12577**	**1356**

***Percentage of total shifts

Between 1 April 2017 and 31 January 2018, 49% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same period, agency staff covered 2% of shifts. Three percent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Larkwood	2,601	1,508	55	91
Longview	2,265	1,166	44	51
Poplar Ward - Rochford	3,415	1,355	37	136
Core service total	**8,281**	**4029 (49%)**	**136 (2%*)**	**278 (3%)**
Trust Total	**144009**	**60464**	**5916**	**4396**

***** Percentage of total shifts

This core service had three (4%) staff leavers between 1 April 2017 and 31 January 2018.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
300 Larkwood Ward	19.60	0.80	4%
300 Longview Ward	18.46	1.00	5%
364 EC490 Camhs I/P Poplar Ward	28.20	1.00	4%
Core service total	66.26	3	4%
Trust Total	3127.64	253	7%

The sickness rate for this core service was 4% between 01 April 2017 and 31 January 2018. The most recent month's data (January 2018) showed a sickness rate of 2%.

Longview Ward had the highest annual staff sickness level.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
364 EB136 Poplar Unit	0%	4%
364 EC490 Camhs I/P Poplar Ward	2%	3%
300 The St Aubyn Centre (Longview & Larkwood)	2%	4%
300 Larkwood Ward	4%	3%
300 Longview Ward	1%	5%
Core service total	**2%**	**4%**
Trust Total	**4%**	**4%**

The below table covers staff fill rates for registered nurses and care staff during September, October and November 2017.

Longview and Larkwood wards had less than 90% of the planned registered nurses for all day shifts. They also had more than 125% of the planned care staff for day and night shifts.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	September 2017				**October 2017**				**November 2017**			
Longview	54.4	176.7	84.0	170.4	87.1	130.7	97.1	195.3	87.5	102.9	110.0	96.7
Larkwood	83.3	188.9	105.7	318.0	71.7	145.5	95.4	300.0	106.8	92.0	82.8	103.3
Poplar Unit	95.8	95.1	100.0	101.0	103.7	97.3	106.5	100.8	96.0	100.0	100.0	100.0

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Between 1 April 2017 and 31 January 2018, 2017, none of the shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same period, agency staff covered 349 of shifts. All the shifts could be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
CAMHS Inpatient	210	0	210	0
Poplar ward	139	0	139	0
Core service total	**349**	**0**	**349**	**0**
Trust Total	**6744**	**258**	**3406**	**3080**

Mandatory training

Staff were below the trusts target for mandatory training. At the time of the inspection training compliance was: Larkwood 75%, Longview 70% and Poplar 62%. Managers explained that figures were impacted by long term sickness and maternity leave. Managers also explained difficulty in accessing some courses due to the significant distance of trust training venues.

The compliance for mandatory and statutory training courses at 31 December 2017 was 80%. Of the training courses listed 18 failed to achieve the trust target and of those, 10 failed to score above 75%.

The trust has a rolling month on month compliance rate for mandatory training.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	This core service %	Trust target %
Mental Capacity Act Level 2	100%	85%
Dementia Awareness (inc Privacy & Dignity standards)	100%	85%
Clinical Record Keeping	100%	85%
Care Certificate	100%	85%
Dual Diagnosis	100%	85%
Care Programme Approach	100%	85%
Safeguarding Adults (Level 3)	100%	90%
Cascade Fire Trainer	100%	85%
First Aid Trained	100%	85%
Induction E-Learning	97%	85%
Corporate Induction	97%	85%
Duty of Candour (Overview Version)	97%	85%
Personal Safety - MVA	94%	85%
PREVENT (WRAP) Training	93%	85%
Safeguarding Adults (Level 1)	93%	90%
Equality and Diversity	91%	85%
Safeguarding Children (Level 3)	90%	90%
Safeguarding Adults (Level 2)	90%	90%
Observation of Service User	90%	85%
Harassment & Bullying	89%	85%
Medication Management (MH)	88%	85%
Duty of Candour (Detailed Version)	85%	85%
Complaints Handling	84%	85%

Training course	This core service %	Trust target %
Fire In-patient	82%	90%
Mental Health Act	80%	85%
Diabetes Training	77%	85%
Basic Life Support & AED	77%	85%
Information Governance	76%	85%
Fire Safety 2 years	75%	90%
Fit for Work	75%	85%
Clinical Risk Assessment	72%	85%
TASI Trained	67%	90%
Health and Safety (Slips, Trips and Falls)	65%	85%
Personal Safety Breakaway - Level 1	63%	85%
Food Hygiene	62%	85%
MERT (Enhanced Emergency Skills)	57%	85%
Mental Capacity Act Level 1	53%	85%
Infection Prevention, Control & Hand Hygiene	52%	85%
Hoisting e-learning	50%	85%
Fire Safety 3 years	4%	90%
Core service Total	**79%**	85%

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 21 patient care records. Twenty records were comprehensive and demonstrated holistic, person centred risk assessments. Staff carried out a comprehensive risk assessment of every patient on admission and updated it regularly, including after any incident. Staff used recognised risk assessment tools such as START and patient's psychological formulation of risk developed through MDT meetings. However, one record did not fully reflect the vulnerability of one patient who had been subject of a safeguarding concern.

Management of patient risk

Staff were aware of, and dealt with any specific risk issues, such as physical health conditions. Staff identified and responded to changing risks to, or posed by, patients. Staff followed policies and procedures for risk management and management of behaviours that challenge. This included use of observation, minimising patients risk from potential ligature points and for searching patients or their bedrooms.

Staff applied blanket restrictions on patients' freedom only when justified and they reviewed these regularly. Staff adhered to best practice in implementing a smoke-free policy. Informal patients could leave at will and staff ensured they knew how to do this. Where permission had been given carers were kept informed of their relative's present level of risk.

We saw appropriate and robust risk assessments for people in seclusion and for when staff needed to carry out nasal gastric feeding of patients.

Use of restrictive interventions

The wards in this service participated in the provider's reducing restrictive interventions programme. The manager on Poplar ward was a lead for this programme. Staff followed the

service's policy on physical restraint, and only used as a last resort, and for the shortest time possible.

Fifty eight out of 72 (80%) of staff had been trained to use TASI (an advanced personal safety, restraint and breakaway technique) and encouraged to use de-escalation rather than restraint. Three patients described their experience of being restrained as well handled and they felt staff had been respectful while needing to manage their difficult behaviour. Staff were encouraged to anticipate a patient's distress tolerance level and de-escalate this at the earliest opportunity.

Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation.

We were concerned that staff continued to use prone (face down) restraint when physical interventions were needed to maintain safety. The MHA code of practice (26.70) states that prone restraint should be avoided due to the risk to patient safety, and should only be used in exceptional circumstances. The trust provided data which showed that 20% of all restraints resulted in patients being placed in the prone position. We considered this to be a significant number and not in adherence to the code. Staff we spoke to were clear prone restraint should not be used unless absolutely necessary, however prone restraint was still being used on occasions to administer intra muscular injections (such as rapid tranquilisation). The MHA code of practice (26.98) states where rapid tranquilisation in the form of an intramuscular injection is needed, the person prescribing the injection should state the preferred injection site, having taken full account of the need to avoid prone restraint. Staff were unable to clarify whether prone restraint techniques continued to be taught as technique in physical intervention training.

This core service had 334 incidents of restraint (on 87 different service users) and 47 incidents of seclusion between 1 April 2017 and 31 December 2017. Larkwood Ward had the highest incidence of both restraint and seclusion.

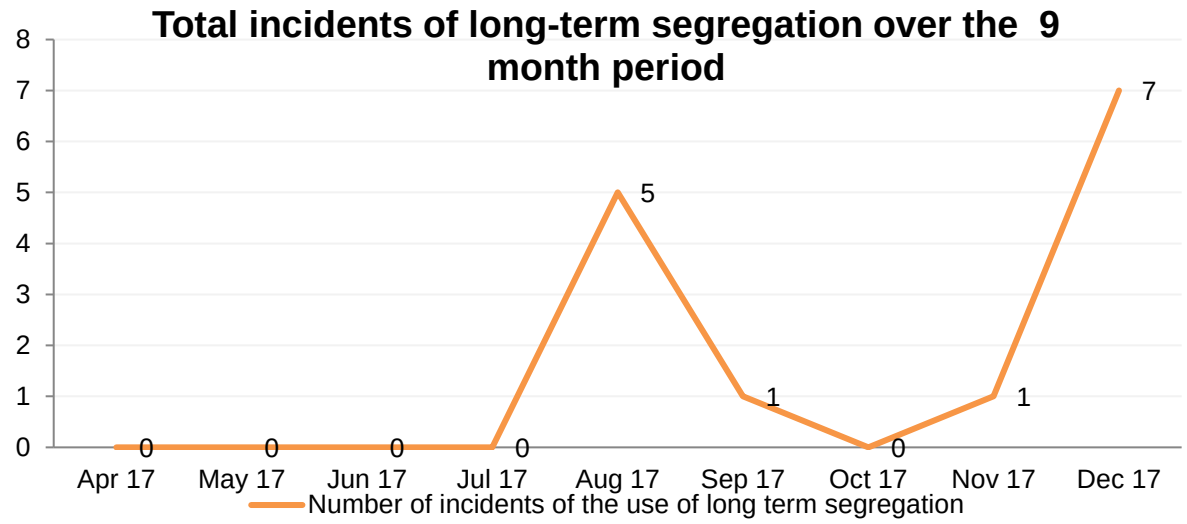
The below table focuses on the last nine months' worth of data: April 2017 to December 2017.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Poplar Ward (Essex)	10	111	25	27 (24%)	40 (36%)
Larkwood Ward	26	153	36	26 (17%)	33 (22%)
Longview Ward	11	71	26	14 (20%)	18 (25%)
Core service total	**47**	**335**	**87**	**67 (20%)**	**91 (27%)**

There were 67 incidents of prone restraint, which accounted for 20% of the restraint incidents.

There were no instances of mechanical restraint over the reporting period.

There have been 14 instances of long-term segregation over the nine-month reporting period.



Safeguarding

At the time of inspection 93% of staff were trained in safeguarding level 2 adults and children; 87% of staff were trained in safeguarding level 3 children, and 98% level three adults. Staff knew how to make a safeguarding alert, and did that when appropriate. They knew how to identify children at risk of, or suffering significant harm, this included working in partnership with other agencies. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

The service had a named child protection lead and staff knew who this was. The service was compliant with Local Safeguarding Children Board procedures and appropriate national guidance, e.g. The Children's Act. The safeguarding lead worked with the local authority to safeguard and promote the welfare of children and young people. They made them aware if a young person remained on the unit for a consecutive period of 3 months, in line with section 85 of the Children Act 1989.

Staff followed safe procedures for children visiting the ward, and there were family friendly visiting rooms away from the main ward areas.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust provided details of the total number of safeguarding referrals made between 1 April 2017 and 31 December 2017 with 802 referrals made for adults and 180 for children. However, this is for the whole trust and has not been broken down to core service level.

The trust told us that there were no serious case reviews commenced or published in the last 12 months that related to this core service. However, at the time of inspection we heard of one serious incident that had progressed to case review, which had occurred in February 2018, and which was still undergoing investigation.

Staff access to essential information

Staff had access to the information they required to deliver patient care. This included when patients moved between wards. The trust used two electronic systems across the county of Essex. Staff felt some information was difficult to find so kept hard copies of documents for the ward. This resulted in duplication of records.

Medicines management

On all wards staff followed good practice in medicines management including transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication) and did it in line with national guidance.

On Poplar ward we found some of the diagnostic testing consumables were out of date. We informed management of this and the manager corrected this immediately. The manager's investigation showed this to have been an error when staff had rotated out of date stock, and having consumables on two shelves of a cupboard rather than one. The out of date consumables were found on a bottom shelf in a cupboard while in date stock, that staff used, was on a shelf above. Staff had rotated stock on the upper shelf but not the lower one

Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence guidance, especially when the patient was prescribed a high dose of antipsychotic medication.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 January 2018 there were five STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was *'Apparent/actual/suspected self-inflicted harm meeting SI criteria* with three. *There were no unexpected deaths for this core service.* There was serious incident in February 2018, management were still investigating this incident. Staff and patients received external counselling and debriefing following this incident.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS.

	Number of incidents reported		
Type of incident reported	Larkwood ward	Longview ward	Total
Abuse/alleged abuse of child patient by staff	1		**1**
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1	2	**3**
Disruptive/ aggressive/ violent behaviour meeting SI criteria	1		**1**
Total	**3**	**2**	**5**

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. Review of the data showed that staff reported all incidents that they should report.

Staff understood the duty of candour. Review of incident data showed staff were open and transparent, and gave patients and families a full explanation if things went wrong. Staff received feedback from investigation of incidents, both internal and external to the service, and met to discuss that feedback through their multi-disciplinary meetings, supervision, and handovers.

Managers made changes because of feedback, such as removal and replacement of light fittings, ward refurbishment, and inclusion of patients when designing parts of the ward.

Is the service effective?

Assessment of needs and planning of care

We reviewed 18 patient care records. There was a holistic approach to assessing, planning and delivering care and treatment to the patients who use services. Care plans demonstrated how occupational therapy, psychology medical and physical healthcare assessments were complimentary and supported each other.

The ward had robust arrangements for collecting information from all agencies involved with patients and their families.

Staff completed comprehensive mental health and physical health assessments of the patient in a timely manner at, or soon after, admission. Robust physical health assessments had been adapted from those used in acute hospitals and made age appropriate. However, staff had not completed a specific care plan for a patient with epilepsy in line with the National Institute for Health and Care Excellence guidance.

Staff developed care plans in collaboration with the patients and their carers, using a goal based approach that met the needs identified during assessment. Care plans were personalised, holistic and recovery-oriented and clearly included the patient's views, like and dislikes: including how they would like staff to apply any restrictive practice. Staff updated care plans when necessary, staff understood the need to confirm who they should consult about treatment decisions and other aspects of the patients care plan when a care order was in place.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. The structured and individualised therapeutic programme comprised of a mixture of group work activities, exercise, individual sessions to encourage self-management of their health conditions, and education. Staff planned the programme of activities in consultation with patients.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration when indicated. Staff developed specialised eating plans for patients who were experiencing eating disorders. Staff supported patients to live healthier lives for example, offering advice on healthy eating, cooking skills, managing stress and distress, and dealing with issues relating to substance misuse when necessary.

Staff used outcome measures to evaluate program effectiveness and treatment interventions such as Health of the Nation Outcome Scales for Children and Adolescents (HONOSCA) and Children's Global Assessment Scale (CGAS). Occupational therapists used Model of Human Occupation (MOHO) and Model of Creative Ability (MOCA) to formulate and evaluate the effectiveness of their therapy plans.

Staff were actively engaged in activities to monitor and improve quality and outcomes, including a range of clinical audits and benchmarking that was relevant to their area of work. Staff acted on clinical audits and made changes accordingly. The psychology assistant co-ordinated clinical audits and supported colleagues to carry out audit when necessary. Staff used technology to support patients effectively, for example, for prompt access to blood test results and online access to self-help tools.

Staff across the service were committed to working collaboratively and had found efficient ways to deliver more joined-up care to people who use services. Such as shared learning through peer group supervision across wards and group supervision with the services safeguarding lead to discuss complex safeguarding cases. Staff were encouraged and made a point of understanding the work and perspective of their colleagues so they can work together more effectively. There were effective inter-professional training sessions.

This core service participated in one clinical audit as part of their clinical audit programme

Audit name / title	Key Successes	Key concerns	Key actions following the audit
Record Keeping / Care planning Audit	Baseline Audit to identify areas for improvement. Wards in the North of EPUT appear to have performed better and therefore duplicating work from this area across the south will be beneficial	Overall results show that Essex Partnership University NHS Foundation Trust (EPUT) is partially compliant with the record keeping; based on care plan and Risk assessment completed in the CAMHS inpatient wards. CAMHS wards achieved 63.4% compliance with "physical health" theme and two out of three wards came well below 80%. This was due to the smoking status not being care planned for the patient records included in the sample. Individual standards such as evidence of monitoring side effects if the patient is on a medication has to be improved using robust process The monitoring of aspects of a patient's physical health continues to be an area of concern. The Trust continues to prioritise the physical health agenda in 2017 to ensure all patients with enduring mental health conditions receive the necessary care to ensure their physical health is not compromised by their condition or treatment. Longview ward needs particular attention as they had three themes below 80% compliance.	Physical Health findings to be feedback to PHAIG (Physical Health Action Implementation Group) Recommendations have to be carried forward to the Secure Service Quality Group Individual ward action plan to be created especially for Longview (If required) Nursing Staff to ensure all relevant records has been completed and updated as required by the Record keeping policy CP61 Re-audit of Record Keeping Audit in CAMHS & LD wards

Skilled staff to deliver care

The service included the full range of specialists required to meet the needs of patients on the ward. This included doctors, nurses, occupational therapists, clinical psychologists, family therapists, teaching staff and pharmacists. Staff knew how and when to access social workers, physiotherapists and dieticians.

Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. Managers recognised that the continuing development of staff skills, competence and knowledge was integral to ensuring high quality care. Although staff did not routinely receive specialist training for autism despite several patients being admitted with or being suspected of having the diagnosis. Psychologists provided systemic case study training to enable staff to develop specialist knowledge about conditions affecting the patient group including Autistic spectrum disorder, eating disorder, and gender dysmorphia.

Managers ensured that all staff including bank and agency staff, had appropriate induction, using the care certificate standards as the benchmark for healthcare assistants. Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers ensured that staff received the necessary specialist training for their roles.

Managers provided staff with supervision meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development. Managers carried out appraisal of their staffs work performance, and dealt with poor staff performance promptly and effectively. Managers ensured that staff had access to regular team meetings.

The trust's target rate for appraisal compliance is 90%. As at 31 January 2018, the overall appraisal rates for non-medical staff within this core service was 78%. All three wards failed to achieve the trust's appraisal target.

No appraisal data was submitted by the trust for medical staff in this core service during this period.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Camhs I/P Poplar Ward	28	24	86%
Longview Ward	18	14	78%
Larkwood Ward	18	12	67%
Core service total	**64**	**50**	**78%**
Trust wide	**4121**	**3386**	**82%**

Between 1 April 2017 and 31 January 2018, the average clinical supervision rate across all three teams in this core service was 81% against the trust's 90% target. Poplar Ward had the highest supervision rate with 91%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it is important to understand the data they provide.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Camhs I/P Poplar Ward	264	240	91%
Larkwood Ward	174	133	76%
Longview Ward	194	141	73%
Core service total	**632**	**514**	**81%**

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Trust Total	**24,386**	**21,061**	**86%**

At the time of inspection supervision rates for non-medical staff were Larkwood ward 100%, Longview ward 88%, and Poplar ward 100%. Appraisal rates were Larkwood ward 82%, Longview ward 94%, and Poplar ward 98%. All but one doctor had in date supervision and appraisal. Managers identified those staff that did not have in date supervision and appraisals and explained the reasons for this including long-term sickness, and maternity leave.

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings, which included case discussion as part of their continuing professional development. Staff shared information about patients at effective handover meetings within the team, for example from shift to shift and at multidisciplinary team meetings.

The ward teams had effective working relationships, including good handovers, with other relevant teams within the organisation such as care co-ordinators, community mental health teams, crisis teams and the safeguarding team. They also had effective working relationships with external bodies including paediatricians, social services, general practitioners, educational establishments, local authority looked after children and safeguarding children teams. Staff engaged in activities and initiatives to improve joint working and liaison.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Doctors ensured that the legal authority for admission and treatment was clear if a young person is detained under the Mental Health Act. All staff were either trained in, or had knowledge of and understood the legal frameworks for working with children such as the Children's Act. Staff were trained in how to manage relationships and boundaries between young people and staff, including what was appropriate touch.

As of 31 December 2017, 80% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years. At the time of inspection managers confirmed the training figures for Mental Health Act was Larkwood ward 100%; Longview ward 89%, and Poplar ward 92%. Staff we spoke with had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were. The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice. Staff requested an opinion from a second opinion appointed doctor when necessary.

Patients had easy access to information about independent mental health advocacy. Staff explained to patients their rights under the Mental Health Act in a way that they could understand,

repeated it as required and recorded that they had done it. Staff ensured that patients could take Section 17 leave, (permission for patients to leave hospital), when this has been granted.

Staff ensured that informal patients could leave the wards on request, subject to risk assessment, and there were notices on the wards to inform patients of this. Carers and families were fully involved in decisions about their loved ones leave from the wards.

Staff stored copies of patients' detention papers and associated records, such as Section 17 leave forms, correctly so that they were available to all staff that needed access to them. Care plans referred to identified Section 117 aftercare services to be provided for those who had been subjected to section 3 or equivalent part III powers authorising admission to hospital for treatment, where applicable. Staff carried out regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Good practice in applying the Mental Capacity Act

As of 31 December 2017, 53% of the workforce in this core service had received training in the Mental Capacity Act level one and 100% in Mental Capacity Act level two. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

At the time of inspection, managers confirmed the training figures for staff completion of Mental Capacity Act level two; Larkwood ward 33%; Longview ward 39%, and Poplar ward 79%. These compliance figures were under the trust target. Managers gave reasons for this shortfall specifically that St Aubyn's staff had not been able to access the provider's e-learning package and assessment since the merger. Managers confirmed that senior managers were aware of this problem, and had assured the wards that the training would be made available to them in the very near future.

Staff demonstrated a good understanding of the Mental Capacity Act, in particular the five statutory principles as it applied to young people, aged 16 years and over. Staff knew how to seek advice from specialist advisers or a national professional adviser when required. Staff were aware of the need to conduct all patients' examinations and treatment with the appropriate consent and consultation, where a local authority had parental responsibility because of a care order. Staff ensured that each patient had a named nurse/key worker and patients knew the names of the staff looking after them.

The trust has a policy on the Mental Capacity Act, staff were aware of the policy and had access to it. Staff routinely considered Gillick competence, a test in medical law to decide whether a child under 16 years of age is competent to consent to medical examination or treatment without the need for parental permission or knowledge. The service had arrangements to monitor adherence to the Mental Capacity Act and acted on any learning that resulted from it.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it. For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis regarding significant decisions. When patients lacked capacity, staff collaborated with carers and guardians before making decisions that were in the best interest of the young person, recognising the importance of the person's wishes, feelings, culture and history.

As part of their duties under the Mental Capacity Act, staff provided all patients with a written care plan as part of the care programme approach, along with written and verbal information about the ward in a way that they could understand. Staff ensured that personal information about their

patients was kept confidential, unless this was detrimental to their care and taking into consideration relevant guidelines, such as Gillick competency and Fraser guidelines.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We spoke with 18 patients and six carers during the inspection.

We observed staff interactions with patients noting that staff were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Staff supported patients to understand and manage their care, treatment or condition. Three patients told us that when they had needed restraining staff had done this in a way that was helpful and kind for them. Other patients told us that most of the time staff understood their needs and often anticipated when they needed help and support.

When necessary staff directed patients to other services, and if required, supported them to access those services, while maintaining confidentiality about the patient. Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. The PLACE survey score for privacy, dignity and wellbeing was not available.

Involvement in care

Involvement of patients

Staff used the admission process to inform and orientate patients, parents and carers to the ward and to the service. Staff developed workbooks for both patients and carers to help them understand how the ward worked, its philosophy and who and where to go when they had a problem or concern.

Staff involved patients in care planning and risk assessment, and at multidisciplinary team reviews. Patients and their parents or carers, were involved in the care planning by setting and reviewing treatment goals and monitoring progress and outcomes.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Staff involved patients when appropriate in decisions about the service, for example, as part of the refurbishment plans for Larkwood, and when designing the ‘chill out’ room on Poplar ward. We also heard how patients had been involved in the recruitment of new staff for Poplar ward.

Staff enabled patients to give feedback on the service they received, for example, via surveys, comment cards or in community meetings. We saw how managers had taken on board these comments and made changes accordingly.

Staff enabled patients to formulate wellness recovery plans, and make decisions about how they wished to be treated when not well, such as if a restraint procedure had to be used.

Staff ensured that patients understood what advocacy was and how they could access this service. We spoke to an advocate who confirmed they felt very welcome on the child and adolescent mental health wards and the young people there understood how they could help them.

Involvement of families and carers

We spoke with four family members who felt they were involved in their relative's care planning and staff provided them with support when needed. Two family members confirmed that the manager on Larkwood ward had made a point of ringing them, on a weekly basis to offer an update on the treatment and progress of their relative while in hospital.

All managers explained they had an open-door policy if families and carers wanted to ask any questions about the running of the ward. Families and carers could give feedback about the service via comment cards available in the reception areas of the wards and hospitals.

Staff ensured that carers knew what a carers' assessment was and how to access this if they wished.

Is the service responsive?

Access and discharge

Bed management

There was close monitoring of length of stay for patients. Research by the assistant psychologist showed that the services integrated model of care reduced the length of stay for patients. On Larkwood ward their average length of stay since February 2018 had reduced from nine weeks to eight weeks. Managers across all wards were also able to identify the reasons for any longer stays than this.

Managers explained that occasionally beds were not available for patients living in the 'catchment area', and on these occasions bed managers had to consider transferring patients who were not from the area to other hospitals. Despite this, managers did not use leave beds for new patients and there was always a bed available when patients returned from leave.

The trust provided information regarding average bed occupancies for all three wards in this core service between 1 April 2017 and 31 January 2018.

All the wards within this core service reported average bed occupancies ranging above the provider benchmark of 85% over this period. Poplar ward had both a minimum and maximum occupancy level above 100%.

Ward name	Average bed occupancy range (1 April 2017 to 31 January 2018)
Child MH - Rochford - Poplar	101% to 111%
Larkwood ward	30% to 90%
Longview Ward	42% to 96%

The trust provided information for average length of stay for the period 1 April 2017 to 31 January 2018.

Ward name	Average length of stay range (1 April 2017 to 31 January 2018)
Child MH - Rochford - Poplar	30 days to 60 days
Larkwood ward	28 days to 259 days
Longview Ward	46 days to 146 days

This core service reported no out area placements between 1 April 2017 and 31 January 2018.

When managers had to place patients some distance from their homes they always attempted to find a bed in the catchment area or closer by at the earliest opportunity.

This core service reported two readmissions within 28 days between 1 April 2017 and 31 January 2018. All of the readmissions were readmissions to the same ward as discharge.
In one instance the patient was readmitted on the same day as being discharged.

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Average days between discharge and readmission
Larkwood	1	1	100%	0
Longview	1	1	100%	18

Managers did not move patients between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient, and if this did happen managers assured us it would be at an appropriate time of day.

Longview could transfer patients to Larkwood psychiatric intensive care unit (PICU) if required. Poplar ward did not have access to a local PICU. Trust leaders, in conjunction with Poplar managers, had converted an area of the ward to provide extra care to patients if they require intensive support.

Discharge and transfers of care

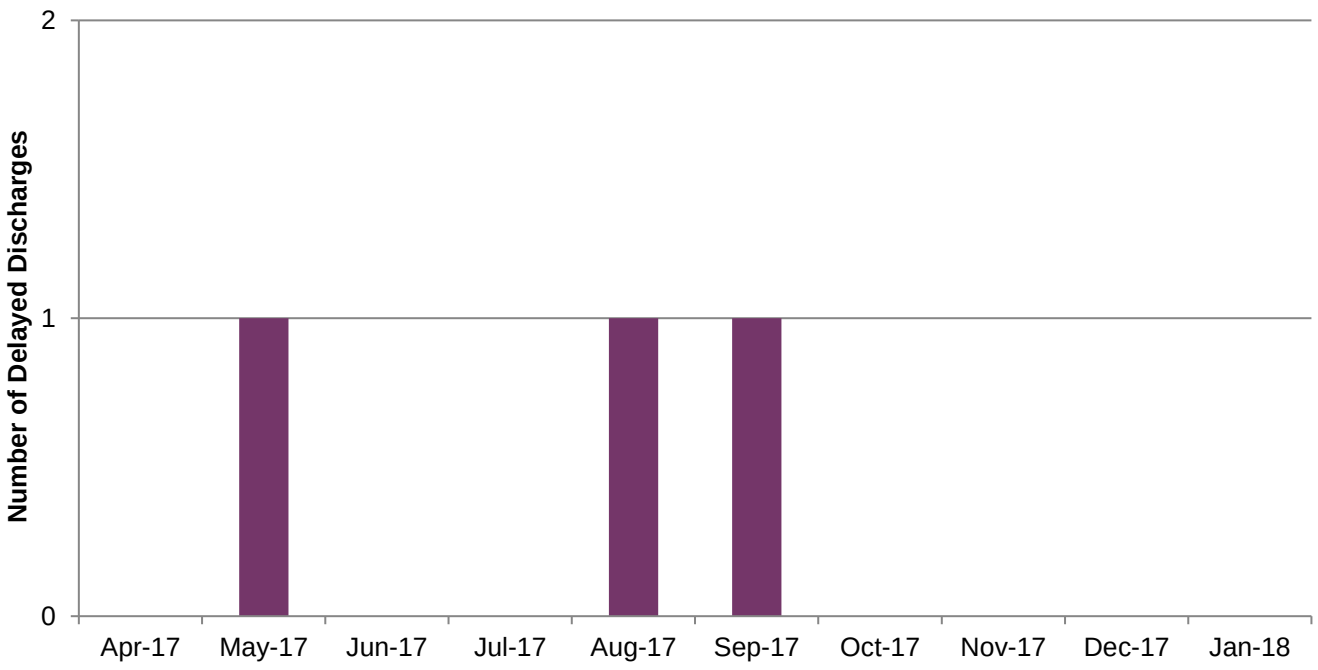
The wards were discharge-oriented and staff considered discharge planning as part of the admission process. Staff carried out discharge planning in collaboration with the CAMHS case managers to ensure facilitation of all discharge needs. Staff rarely delayed discharge for other than clinical reasons.

Staff supported patients during referrals and transfers between services – for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit. The service complied with transfer of care standards such as those set in the national Children and Young People Mental Health Transitions Commissioning for Quality and Innovation. However, there was no provision for patients reaching 18 years of age to stay on the wards, they had to transfer to adult services, unless they were out of area patients and there was an alternative service in the home areas. When this happened, staff took all possible measures to help prepare the young person for this transition.

Between 1 April 2017 and 31 January 2018, there were three delayed discharges within this core service.

The graph below shows the trend of delayed discharges across the 12-month period.

The graph shows delays in May, August & September 2017 with one each. Seven of the 10 months had no delayed discharges within this core service at all.



Facilities that promote comfort, dignity and privacy

Patients had their own bedrooms, they could personalise their bedrooms and had somewhere secure to store their possessions.

Staff and patients had access to the full range of age appropriate rooms and equipment to support treatment and care including clinic rooms for examinations, activity and therapy rooms including a gym and age appropriate outside space with basketball and games area. There were quiet rooms where patients could meet visitors, and a family friendly visiting room away from the main ward area to meet with children.

Patients told us they had been involved in the planning and design of areas of the wards Patients had been involved in designing the colour scheme for the outside courtyard area on Larkwood ward and the garden at Poplar.

However, we found the activity rooms off the main communal area used easy remove curtains to cover windows. At the time of the inspection, staff had removed the curtains as a temporary risk management strategy, but had not replaced the curtains with any other screening. The rooms were overlooked by houses and offices; this could have impacted on patients' privacy when they were using these rooms. This was referred to the manager who assured us she would address the issue as soon as possible.

Patients could make private telephone calls. Patients stated the food was reasonable and they could choose from the menus. Patients had access to hot and cold drinks and snacks throughout the day and night.

Patients' engagement with the wider community

Patients had access to education and training opportunities, there was a classroom on site at both locations. Patients retained links with their usual schools and teachers to help maintain consistency with schoolwork. Staff supported patients to maintain contact with their families and carers, and encouraged them to develop and maintain relationships with people that mattered to them, both within the services and the wider community

Meeting the needs of all people who use the service

The service made adjustments for disabled patients by ensuring disabled people's access to premises and by meeting patients' specific communication needs. Staff provided a range of age appropriate, age relevant information including; health promotion information that was available both written and online.

Staff ensured that patients could obtain information on treatments, local services, patients' rights, how to complain and so on. Staff made information leaflets available in languages spoken by patients. Managers ensured that staff and patients had easy access to interpreters and/or signers. However, staff had not updated one patients' care plan to reflect their communication need.

The service complied with equality of access in relation to race, ethnic origin, social status, disability, physical health and location of residence. Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. Staff ensured that patients had access to appropriate spiritual support. Staff gave support to patient's regarding any transgender needs.

Listening to and learning from concerns and complaints

Patients knew how to complain or raise concerns and when they did staff gave feedback following investigation of the complaint. Staff protected patients who raised concerns or complaints from discrimination and harassment. Staff knew how to handle complaints appropriately. Staff received feedback on the outcome of investigation of complaints and acted on the findings.

This core service received five complaints between 1 April and 31 December 2017. One complaint was referred to the Ombudsman during this period. Three complaints related to clinical practice, one for staff attitude and one for assault/abuse during an incident of restraint.

Ward	Clinical Practice	Assault / Abuse	Staff Attitude	Total
Longview Ward	2	1		3
Poplar Ward (Essex)			1	1
Larkwood Ward	1			1
Total	**3**	**1**	**1**	**5**

This core service received two compliments during the last nine months from 1 April to 31 December 2017, which accounted for less than 1% of all compliments received by the trust as a whole.

Is the service well-led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed, and could explain clearly how the teams were working to provide high quality care. Leaders were visible in the service and approachable for patients and staff. Leadership development opportunities were available, including opportunities for staff below team manager level.

Staff felt their managers had guided them through the merger well. They said they had been kept informed along the way and overall the CAMHS wards had benefitted from the merger.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to them, their work and the work of their team. The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff felt respected, supported and valued, they felt positive and proud about working for the provider and their team. Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistleblowing process and about the role of the Freedom to Speak Up Guardian.

Governance

The service had robust governance systems that managers were familiar with. There were systems and procedures to ensure that wards were safe and clean, there were enough trained staff to keep the wards safe, and staff received regular supervision and appraisal. Staff carried out comprehensive assessment of patients and treated them well, and the wards adhered to the Mental Health Act and Mental Capacity Act. Managers monitored bed usage and planned discharges. Managers ensured that staff reported incidents, and following investigation, they shared any learning with other colleagues.

There was a clear framework of what to discuss at ward, and / or team meetings to ensure the sharing and learning of essential information, such as lessons learned from incidents and complaints. Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

Staff undertook or participated in local clinical audits, and psychology assistants coordinated the audits. The audits were sufficient to provide assurance and staff acted on the results when needed. Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

Staff maintained and had access to the risk register at ward level. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register. The service had plans for emergencies – for example, adverse weather or a flu outbreak. Where cost improvements were taking place, they did not compromise patient care.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. Information governance systems included confidentiality of patient records. Staff made notifications to external bodies as needed.

Staff had access to all essential information, using the equipment and information technology provided. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the service through the intranet, bulletins, and newsletters.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and carers were involved in decision-making about changes to the service. Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback. Directorate leaders engaged with external stakeholders – such as commissioners and Healthwatch.

Learning, continuous improvement and innovation

Managers gave staff time and support to consider opportunities for improvements and innovation and this led to changes. Staff had opportunities to participate in research. Innovations were taking place in the service. Qualified staff used quality improvement methods and knew how to apply them.

Staff participated in national audits relevant to the service and learned from them. Wards participated in accreditation schemes relevant to the service and learned from them.

Wards for older people with mental health problems

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Basildon MHU	Gloucester Ward	25	Mixed
Broomfield Hospital Mental Health Wards	Ruby Ward	17	Mixed
Broomfield Hospital Mental Health Wards	Topaz Ward	17	Mixed
Colchester Mental Health Wards	Henneage Ward	16	Mixed
Landmere Centre Mental Health Wards	Bernard Ward	14	Male
Landmere Centre Mental Health Wards	Tower Ward	15	Female
Rochford Hospital	Beech Ward (Rochford)	24	Mixed
Rochford Hospital	Maple Ward (Ashingdon)	24	Mixed
St Margaret's Community Hospital	Kitwood Ward	16	Mixed
St Margaret's Community Hospital	Roding Ward	14	Mixed
Thurrock Hospital	Meadowview Ward	24	Mixed

Is the service safe?

Safe and clean environment

Safety of the ward layout

Over the 12 month period from 1 April 2017 to 31 January 2018 there were no mixed sex accommodation breaches within this core service.

The trust had undertaken recent ligature risk assessments at 11 locations. Five of the wards presented a high level of ligature risk due to patients being a vulnerable group of patients who have the potential to self-harm and as the obvious ligature risks are removed recent surveys and feedback have identified an increase in finding alternative methods.

Six wards presented a lower risk due to being older people's wards for organic conditions, with a low risk client group.

The trust had taken actions to mitigate ligature risks:

- Line of site survey undertaken and mirrors installed as required.
- Reviewed ligature management policy, introduced e-learning training package and introduced hotspot photos on the ward to be shared.
- For High risk wards: Funding was agreed by EOSC to replace all patient toilets with reduced ligature design and for Gloucester and Beech ward four door top alarms to be installed on identified bedrooms to be used for high patient risks.

Ward managers implemented the trusts new ligature risk assessment which was stored in the nursing office. The risk assessment highlighted ligature points with use of photos (A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation). The trust had identified ligature hotspots map on each ward that were displayed in the nursing office.

Managers ensured all staff had read and signed the signature sheet within the ligature risk assessment pack to agree they had read and understood the risk assessment and were aware of where the ligature hotspots were on their ward.

The ligature assessment on Bernard Ward and Tower ward did not include the garden areas. However, ward managers had identified the ligature points within their environmental risk assessment and had implemented control measures for example, nursing staff completed individual risk assessments for patients who were identified as ligature risks and access to the garden area was supervised.

Henneage ward had poor lines of sight and did not have sufficient convex mirrors; however, the trust had an action plan in place to install additional mirrors. Meadowview ward did not have any convex mirrors. The ward was identified low risk within the trusts line of sight and ligature assessment they are managed locally by risk assessing patients and staff observations and ward managers informed us the trust had plans in place to install convex mirrors.

Henneage ward had removed the handrails in the toilet areas as they were identified as a ligature risk. However, the trust had not replaced them with a suitable alternative. We found that the toilet paper was positioned over an arm's length away from the toilet which presented a falls risk. This was brought to the immediate attention of ward based staff.

Staff and visitors to the wards had access to personal alarms and were shown how to use the alarms in case of an emergency.

Maintenance, cleanliness and infection control

Ward areas and patient bedrooms were visibly clean. Furniture and equipment was well maintained. The house keeping team followed a structured cleaning schedule that ensured equipment and areas were cleaned regularly.

Kitchen staff followed best practice guidelines with food safety, recording fridge temperatures and service food temperatures. Items in the fridge were labelled with opened and use by dates.

Wards had hand wash signs in key areas such as the toilets and kitchens. There were hand sanitisers at the entrance to each ward which staff encouraged visitors to use.

Clinic room and equipment

The clinic rooms were well maintained and stocked. the clinical team regularly reviewed health monitoring equipment that included resuscitation equipment in line with the manufacturer's guidelines.

On Henneage ward we found gaps in the daily recording of staff checks of emergency equipment. The ward manager told us that this would be addressed with staff. Our checks confirmed that the equipment was present and working.

Safe staffing

Nursing staff

The trust provided the following staffing information.

This core service has reported a vacancy rate for all staff of 10% as of 31 January 2018.

This core service reported an overall vacancy rate of 16% for registered nurses at 31 January 2018 and 7% for nursing assistants.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Beech Ward	-0.04	9.57	0%	4.86	12.86	38%	4.82	22.43	21%
Bernard Ward	3.61	8.61	42%	1.81	12.01	15%	6.62	22.62	29%
Gloucester Ward	-0.23	9.57	-2%	0.11	10.72	1%	-1.12	20.29	-6%
Henneage Ward	1.62	10.62	15%	-0.59	8.61	-7%	0.83	20.03	4%
Kingswood Inpatient Support				1.60	3.27	49%	1.23	11.51	11%
Kitwood Ward	1.01	11.01	9%	-0.79	10.61	-7%	0.22	21.62	1%
Maple Ward	1.97	9.57	21%	1.12	10.72	10%	3.98	21.18	19%
Meadowview Ward	0.96	9.57	10%	-0.08	10.75	-1%	0.88	20.32	4%
Roding Ward	-0.99	9.01	-11%	0.18	10.91	2%	-0.81	19.92	-4%
Ruby Ward	2.73	10.33	26%	-0.03	10.27	0%	2.70	21.6	13%

Topaz Ward	5.34	10.34	52%	1.86	9.46	20%	7.20	21.8	33%
Tower Ward	1.01	8.61	12%	-0.99	12.01	-8%	0.02	21.62	0%
Core service total	**16.98**	**106.81**	**16%**	**9.11**	**124.2**	**7%**	**26.75**	**270.13**	**10%**
Trust total	**2448.81**	**15642.73**	**15.7%**	**1304.38**	**11954.48**	**10.9%**	**7236.01**	**50151.20**	**14.4%**

NB: All figures displayed are whole-time equivalents

Managers calculated the number of staff and skill mix of staff required to meet the needs of the patients. Ward managers could increase staffing numbers if required. Ward managers participated in a daily safer staffing teleconference. Staff could be redeployed to adjacent wards if required. Ward managers could request agency or bank staff if required. These staff were familiar with the wards and patient needs.

A qualified nurse was present in communal areas to provide support to patients if required.

Staffing levels were calculated to allow patients to have one to one time with their named nurse. Staff and patients spoken with told us there was always enough staff around to have one to one time with and to interact with during activities.

Patients told us escorted leave was rarely cancelled. Staff confirmed that if escorted leave was cancelled it would be rearranged at the earliest opportunity.

There was enough staff on shift to engage in physical interventions if required.

Between 1 April 2017 and 31 January 2018, bank staff filled 22% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 3% of shifts for qualified nurses. Thirteen per cent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Beech - Rochford	1,770	329	51	92
Bernard	1,513	326	51	326
Gloucester	1,786	337	18	49
Henneage	1,272	345	8	196
Kitwood	1,545	122	1	57
Maple	1,811	299	256	146
Meadowview	1,825	467	3	10
Roding	1,573	646	2	14
Ruby	1,834	206	31	800
Topaz	1,546	358	91	277
Tower	1,374	423	20	335

Core service total	**17,849**	**3,858 (22%*)**	**532 (3%*)**	**2302 (13%*)**
Trust Total	**102629**	**31709**	**12577**	**1356**

***Percentage of total shifts

Between 1 April 2017 and 31 January 2018, 47% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, agency staff covered 3% of shifts. Three per cent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Beech - Rochford	3,426	1,599	57	124
Bernard	2,143	1,133	148	57
Gloucester	2,473	676	37	52
Henneage	1,516	706	17	59
Kitwood	2,147	1,440	10	10
Maple	3,225	1,476	159	162
Meadowview	2,574	421	9	48
Roding	1,991	939	0	10
Ruby	2,058	1,381	28	142
Topaz	2,288	1,440	70	133
Tower	1,980	832	131	61
Core service total	**25,821**	**12,043 (47%*)**	**666 (3%*)**	**858 (3%*)**
Trust Total	**144009**	**60464 (X%)**	**5916 (X%)**	**4396 (X%)**

***** Percentage of total shifts

This core service had 14 (7%) staff leavers between 1 April 2017 and 31 January 2018.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
364 EA300 Maple Ward	20.32	4.80	24%
300 Bernard Ward	16.46	2.80	17%
364 EA313 Meadowview Ward	21.15	2.80	13%
300 Ruby Ward	18.44	1.00	5%
300 Henneage Ward	19.68	1.00	5%

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
364 EA310 Gloucester Ward	21.51	1.00	5%
364 EA304 Beech Ward	18.81	1.00	5%
300 Topaz Ward	17.16	0.00	0%
300 Tower Ward	18.40	0.00	0%
300 Kitwood Ward	19.30	0.00	0%
300 Roding Ward	19.23	0.00	0%
Core service total	210.47	14	7%
Trust Total	3127.64	253	7%

The sickness rate for this core service was 7% between 1 April 2017 and 31 January 2018. The most recent month's data (January 2018) showed a sickness rate of 7%.

Maple Ward had the highest annual sickness rate with 15% and the highest rate at the latest month with 22%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
364 EA300 Maple Ward	22%	15%
364 EA310 Gloucester Ward	16%	7%
300 Kitwood Ward	8%	6%
300 Roding Ward	6%	6%
364 EA313 Meadowview Ward	5%	3%
300 Topaz Ward	5%	2%
300 Ruby Ward	4%	7%
300 Tower Ward	4%	8%
300 Henneage Ward	3%	3%
364 EA304 Beech Ward	1%	10%
300 Bernard Ward	1%	10%
300 Inpatient Mental Health Medical	0%	0%
Core service total	**7%**	**7%**

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Trust Total	**4%**	**4%**

The below table covers staff fill rates for registered nurses and care staff during September, October and November 2017.

Five wards had less than the 90% planned shifts for registered nurses for day shifts in September and October 2017. Six wards had more than 125% of the planned care staff for day and night shifts for September and October 2017.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	September 2017				**October 2017**				**November 2017**			
Bernard Ward	74.4	180.1	121.8	114.6	62.4	165.8	104.5	119.4	65.0	101.7	100.0	98.4
Hennea ge Ward	160.8	257.4	96.7	125.1	138.9	249.5	165.9	118.7	100.8	98.5	100.0	100.0
Tower Ward	63.0	131.8	109.0	153.8	53.1	162.9	97.6	161.7	94.7	95.1	100.0	97.8
Ruby Ward	39.7	111.3	96.9	182.1	38.3	93.5	87.0	128.2	76.8	113.1	96.8	98.5
Topaz Ward	80.4	134.9	104.3	136.6	71.1	101.8	100.0	141.6	73.3	124.8	100.0	103.0
Kitwood Ward	97.1	154.0	100.1	152.3	101.5	149.9	100.0	154.6	100.0	98.9	103.3	98.9
Roding Ward	110.0	197.6	99.8	173.5	120.4	162.4	99.9	125.8	99.3	98.1	103.3	97.3
Brian Roycrof t (closed Nov 17)	93.4	169.4	96.1	210.0	85.0	120.7	98.4	109.7	92.6	106.7	100.0	100.0
Beech	97.5	94.6	91.4	102.6	97.8	92.7	91.9	100.0	98.4	99.6	96.7	100.0
Maple	97.3	95.5	95.0	101.3	88.5	88.9	93.4	101.3	92.6	90.4	88.3	100.0
Glouce ster	94.6	102.1	98.3	100.0	100.8	97.5	96.6	101.3	94.9	103.6	96.6	100.0
Meado wiew	102.5	100.0	98.5	98.7	101.6	98.4	98.6	100.0	101.7	96.6	97.3	101.6

Medical staff

Between 1 April 2017 and 31 January 2018, none of the shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same period, agency staff covered nine of the shifts, all shifts could be filled by either bank or agency staff.

There were adequate numbers of medical staff during the day and night. This meant there was a doctor who could attend in an emergency to support patients if required.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Elderly	9	0	9	0
Core service total	9	0	9	0
Trust Total	**6744**	**258**	**3406**	**3080**

Mandatory training

The compliance for mandatory and statutory training courses at 31 December 2017 was 83%. Of the training courses listed 16 failed to achieve the trust target and of those, 10 failed to score 75% or above.

The trust has a rolling month on month compliance rate for mandatory training.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	This core service %
Conflict Resolution	100%
Safeguarding Adults (Level 1)	100%
Safeguarding Children (Level 3)	100%
Care Certificate	100%
Cascade Fire Trainer	100%
Dual Diagnosis	100%
First Aid Trained	100%
Hoisting e-learning	100%
Medicines Management (community)	100%
PREVENT (WRAP) Training	100%
Security Training (eLearning)	100%
Corporate Induction	98%
Induction E-Learning	98%
Duty of Candour (Overview Version)	97%
Mental Capacity Act Level 1	96%
Equality and Diversity	94%
Safeguarding Children (Level 2)	94%
Harassment & Bullying	94%

Training course	This core service %
Medication Management (MH)	94%
Observation of Service User	94%
Complaints Handling	92%
Duty of Candour (Detailed Version)	92%
Safeguarding Adults (Level 3)	90%
Mental Health Act	86%
Personal Safety - MVA	86%
Personal Safety Breakaway - Level 1	86%
Fire In-patient	86%
Clinical Risk Assessment	85%
Diabetes Training	85%
Food Hygiene	82%
Basic Life Support & AED	81%
Health and Safety (Slips, Trips and Falls)	79%
Fit for Work	79%
Information Governance	78%
MERT (Enhanced Emergency Skills)	75%
TASI Trained	73%
Dementia Awareness (inc Privacy & Dignity standards)	72%
Infection Prevention, Control & Hand Hygiene	71%
Mental Capacity Act Level 2	67%
Hoisting	66%
Manual Handling - People	65%
Fire Safety 2 years	50%
Fire Safety 3 years	50%
Care Programme Approach	50%
Security Training	33%
Total	**83%**

The trusts training data did not reflect local ward training data; staff training recorded by ward managers was meeting the trust's own target. For example, Mental Health Act level two training was 100%.

Ward managers were working with administrators and the trust's information technology team to ensure that the trust's training tracker was updated accurately. Where training had expired, managers had requested additional training dates for staff.

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 47 care records over 11 wards. We found that all patients had an individualised risk assessment on admission which was updated regularly and after an incident.

Management of patient risk

Staff were aware of specific patient risk. For example, patients who were at high risk of choking had an at risk eating plan. Nursing staff updated risk assessments on the electronic recording system as required.

Where patients were at risk of falling, the trust had installed assistive technology into bedrooms. For example, on Ruby and Topaz wards bedrooms had sensors that were turned on at night for patient's movement. This meant that staff could react promptly to support patients who may be at risk of falling.

The trust had a smoke free policy. Patients were offered smoking cessations therapy if required.

Use of restrictive interventions

This core service had 377 incidents of restraint (on 150 different service users) and four incidents of seclusion between 1 April 2017 and 31 December 2017.
The below table focuses on the last nine months' worth of data: April 2017 to December 2017.

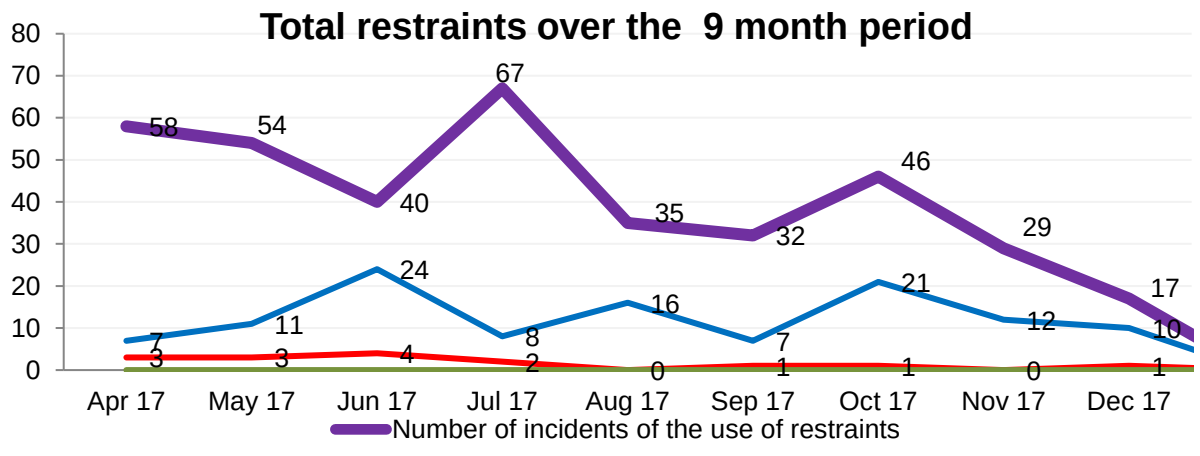
Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Gloucester Ward	0	5	5	1 (20%)	1 (20%)
Beech Ward (Essex)	0	18	14	1 (6%)	4 (22%)
Maple Ward	0	124	38	7 (6%)	15 (12%)
Kitwood Ward	0	1	1	0 (0%)	1 (100%)
Roding Ward	0	15	8	0 (0%)	3 (20%)
Ruby Ward	0	47	14	1 (2%)	24 (51%)
Topaz Ward	0	49	25	1 (2%)	14 (29%)
Henneage Ward	1	17	12	1 (6%)	4 (24%)
Bernard Ward	3	49	19	2 (4%)	23 (47%)
Tower Ward	0	50	12	1 (2%)	27 (54%)
Meadowview Ward	0	2	2	0 (0%)	0 (0%)
Core service total	**4**	**377**	**150**	**15 (4%)**	**116 (29%)**

There were 15 incidents of prone restraint which accounted for 4% of the restraint incidents.

There have been no instances of mechanical restraint over the reporting period.

Physical restraint was used as a last resort by staff after alternative de-escalation techniques such as talk down and diversion failed.

We reviewed four rapid tranquilisation records. We saw staff had completed all physical health monitoring following the use of rapid tranquilisation in line with the National Institute for Health and Care Excellence guidelines.



There have been three instances of long term segregation over the nine month reporting period with one per month for August 2017, September 2017 and November 2017.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust have provided details of the total number of safeguarding referrals made between 1 April 2017 and 31 December 2017 with 802 referrals made for adults and 180 for children. However, this is for the whole trust and has not been broken down to core service level.

Staff described how they would identify any potential safeguarding concerns. They knew how to escalate these appropriately.

All wards had provision for visitors, and had designated meeting rooms outside of the main ward area.

The trust told us that there were no serious case reviews commenced or published in the last 12 months that related to this core service.

Staff access to essential information

The trust used a secure electronic information storage system which all staff had access to. This meant that staff could update and input and record patient information in a timely manner.

Medicines management

Clinical staff followed best practice guidelines in the safe storage of medications. Trust pharmacists completed regular audits which included medication opening and expiry dates. The audit findings were shared with ward managers. This had a positive effect in reducing the number of errors made.

We reviewed 64 prescription charts and medication administration records. We saw appropriate assessments were in place for patients receiving medicines covertly. Staff completed accurate records which highlighted that patients had received their medication when they needed them.

Patients detained under the Mental Health Act received medications that were authorised and administered in line with the code of practice. Staff had access to T2 (consent to treatment) and T3 (record of second opinion) records for reference to when administering medication.

Prescribers took in to account specific risks associated with prescribed medications. Clinical staff monitored side effects for those patients who were prescribed high doses of medication.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 January 2018 there were 21 STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was 'slips/trips/falls meeting SI criteria' with 15.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

	Number of incidents reported					
Type of incident reported on SIRI	**Abuse/alleged abuse of adult patient by third party**	**Apparent/actual/ suspected self-inflicted harm meeting SI criteria**	**Other**	**Pressure Ulcer meeting SI Criteria**	**Slips/trips/falls meeting SI criteria**	**Total**
Beech Ward				1	3	**4**
Bernard Ward	1				2	**3**
Brian Roycroft Unit		1			1	**2**
Clifton Lodge				1		**1**
Kitwood Ward					1	**1**
Maple Ward				1	1	**2**
Meadowview Ward					1	**1**
Ruby Ward					1	**1**
Topaz Ward		1	1	1	3	**6**
Total	**1**	**2**	**1**	**4**	**13**	**21**

Reporting incidents and learning from when things go wrong

Staff described the trusts electronic incident reporting system used to report incidents and they knew how to use this.

The trust had a duty of candour policy in place and staff could describe how they would use this.

Staff received feedback about incidents during team meetings, supervision and via email. This included incidents that happened elsewhere in the trust. Ward managers also printed and displayed the trusts incident newsletter in the staff rom. The trust incident newsletter shared information and learning points from incidents that occurred trust wide.

Is the service effective?

Assessment of needs and planning of care

Staff completed comprehensive assessments on admission. Care plans were recovery focused, up to date and person centred.

Patients received a comprehensive physical health care assessment on admission and ongoing health monitoring assessments, which included monitoring weight, blood pressure both standing and sitting, pulse and temperature. Staff knew how to escalate identified concerns appropriately.

Best practice in treatment and care

Staff followed National Institute for Health and Care Excellence (NICE) guidelines in relation to best practice. Medical staff followed guidelines when prescribing medications. These included regular reviews and physical health monitoring. Patients were supported to access specialist services such as speech and language therapists and physiotherapy when required for their physical healthcare needs.

Psychologists used a variety of treatments including memory groups and cognitive behavioural therapy where appropriate. Physiologists also contributed to advanced care planning, they worked with other staff groups on the ward to support them to deliver psychological therapies to patients.

All wards had dementia friendly signage. For example, the signage on toilet doors were colour mapped and in a large font.

Patients were supported to live healthier lives. We saw that staff provided patient access to healthy cooking groups.

This core service participated in four clinical audits as part of their clinical audit programme.

Audit name / title	Key Successes	Key concerns	Key actions following the audit
Record Keeping/ Care planning Audit	Baseline Audit to identify areas for improvement. Wards in the North of EPUT appear to have performed better and therefore duplicating work from this area across the south will be beneficial	Some individual ward areas did not perform well (MNC)	Harmonise North and South processes on Health records completion Recommendations have to be carried forward to the Older People Inpatient Quality and Safety Committee. Individual ward action plan to be created (if required) especially for Mountnessing Court (MNC). Nursing Staff to ensure all relevant records has been completed and updated as required by the Record keeping policy CP61 Re-audit of Record Keeping Audit in MHOP wards
Physical Health older adults In patients	Re-audit in South Area and Baseline audit in the North Wards to establish compliance against Physical Health Guidance.	In key areas such as medicines reconciliation the majority of wards are doing well. The baseline observations within 6 hours of admission is another area where teams are achieving consistently with the standard. VTE assessments are clearly in place and appear to be embedded. Some ward areas need to show improvement across the audit criteria, Kitwood, Mountnessing Court and Henneage in particular need to review the findings of this audit. 8/12 wards do not meet the standards for Continence assessments, this is also noted in RCA's for falls.	The Audit will be used to inform the Physical Health Action and Implementation Group. The findings will be lead to actions from this group to improve physical health of MH in-patients in a standardised way

Audit name / title	Key Successes	Key concerns	Key actions following the audit
Audit EOL Mental health	All patient identified as End of life on the MH wards had care plans in place to reflect this.	Variable use of DNAR	EOL group to be re started Write EOL framework for EPUT
Local Falls Audit	variable Findings across the wards	Delirium noted for further work	Falls group to review and take actions

Ward managers monitored the outcome of audits to improve clinical practice.

Skilled staff to deliver care

Wards had a range of suitably qualified staff that met the needs of patients. The multidisciplinary team (MDT) consisted of psychiatrists, psychologists, occupational therapists, nurses and health care assistants.

Wards had a dedicated catering team, housekeepers and estates team.

The trust had an induction programme and policy in place that was mandatory for all new starters. Newly recruited staff were required to complete an induction programme which included elements of e- learning, face to face training and shadowing experienced staff on the wards before they could work independently with patients.

Ward managers monitored staff performance. If concerns were identified managers would meet with the staff member in a timely manner to address the concerns. Ward managers also had support from the trust's human resources team as required.

The trust's target rate for appraisal compliance is 90%. As at 31 January 2018, the overall appraisal rates for non-medical staff within this core service was 83%.

Eight wards failed to achieve the trust's appraisal target, the lowest appraisal compliance rates were Henneage ward with an appraisal rate of 22% and Bernard ward at 75%.

We reviewed appraisal data on each ward and found 100% of staff had received an annual appraisal. Ward managers explained that the trust's new electronic appraisal recording system had errors which were being resolved by the trust's information technology team.

No appraisal data was submitted by the trust for medical staff in this core service during this period.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Gloucester Ward	19	19	100%
Maple Ward	13	13	100%
Meadowview Ward	23	23	100%
Kitwood Ward	19	17	89%
Roding Ward	19	17	89%
Beech Ward	16	14	88%

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Tower Ward	17	15	88%
Topaz Ward	12	10	83%
Ruby Ward	18	14	78%
Bernard Ward	12	9	75%
Henneage Ward	18	4	22%
Core service total	**186**	**155**	83%
Trust wide	4121	3386	82%

Between 1 April 2017 and 31 January 2018, the average clinical supervision rate across all thirteen teams in this core service was 80% against the trust's 90% target. Henneage Ward had the lowest clinical supervision rate with 32%, followed by Bernard Ward with 41%. Liaison Services (Mental Health Inpatient) had a supervision rate of 100%.

We reviewed current supervision data and found that all wards were above the trust's 85% target.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Gloucester Ward	203	200	99%
Meadowview Ward	230	224	97%
Kitwood Ward	180	171	95%
Inpatient Occupational Therapy Older People	77	72	94%
Roding Ward	173	162	94%
Topaz Ward	160	150	94%
Beech Ward	167	150	90%
Maple Ward	161	135	84%
Ruby Ward	201	159	79%
Tower Ward	174	110	63%
Bernard Ward	152	63	41%
Henneage Ward	184	58	32%
Core service total	**2,062**	**1,654**	**80%**
Trust wide	**24,386**	**21,061**	**86%**

Multidisciplinary and interagency team work

Multidisciplinary team meetings took place for patients. Clinical staff discussed patient need, and reviewed individual progress. Patients were encouraged to take part in these meetings.

We attended two handover meetings. Handovers took place at the start of each shift. Staff followed a set template and discussed each patient's needs in detail for example, their current Mental Health Act status, presenting risks, and changes in needs.

Staff reported that they had good relationships with the local authority and community mental health teams for older adults.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

We found all patients, whose care records were reviewed were lawfully detained in accordance with the Mental Health Act and its principles. All required paper work was completed correctly and stored securely.

Mental Health Act administrators worked from a central location and ward managers told us they were available to give support and guidance if required to staff. The administrators sent out reminders to relevant clinical staff for section renewals and consent to treatment.

Ward staff referred patients to Independent Mental Health Act advocates. Mental Health Act advocacy details were also included in the patient welcome pack and displayed in various formats on the wards which included easy read information.

Staff explained to patients their rights under the Mental Health Act on admission and regularly thereafter. Informal patients were told they about their rights to leave the ward and posters were in place informing people of their rights.

As of 31 December 2017, 83% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is mandatory for all staff and renewed every three years.

Good practice in applying the Mental Capacity Act

The trust had a Mental Capacity Act policy in place that staff were aware off.

Qualified staff could demonstrate their knowledge in applying the Mental Capacity Act and could describe the five principles of the Act.

As of 31 December 2017, 57% of the workforce in this core service had received training in the Mental Capacity Act level one and 99% in Mental Capacity Act level two. The trust stated that this training is mandatory for all staff and renewed every three years.

We reviewed care records on all 11 wards and found nine Mental Capacity Assessments and Best Interest Assessments were not complete in full, on five wards; these were on Bernard, Roding, Kitwood, Topaz and Tower wards.

We found gaps ranging from two to 13 days between the dates where patients who were detained under the Mental Health Act became informal and when clinical staff had applied for Deprivation of Liberty Safeguards as the patients lacked the capacity to consent to their care and treatment. This meant that patients were being treated on these wards without a lawful basis to do so.

However, the manager on Ruby ward had completed an audit of Mental Capacity Act practice and applications for Deprivation of Liberty Safeguards and had identified areas for improvement which was fed back to relevant staff.

The trust told us that 209 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 April 2017 and 31 March 2018.

The greatest numbers of DoLS applications were made in June 2017 with 26.

CQC received 193 direct notifications from Essex Partnership University NHS Foundation Trust between 1 April 2017 and 31 March 2018. Eighty-eight of which were pertinent to this core service.

Number of DoLS applications made by month													
	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	**Total**
Applications made	23	25	26	24	15	16	11	16	14	15	12	12	**209**
Applications approved	3	4	4	2	1	3	3	3	3	1	2	0	**29**

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with kindness, compassion and respect. We observed positive interactions and noted that staff were responsive to patients needs in a confidential manner.

Staff engaged in meaningful activities with patients and showed a good understanding of individual patient's needs and preferences.

We spoke with 35 patients who told us that staff were generally kind and caring and that staff were there to help them get better.

Involvement in care

Involvement of patients

Care and treatment records showed that patients or carers had been offered a copy of their care plan. Patients and carers were offered the opportunity to develop their own care plans with staff.

Every ward had staff pictures and details of who was working on shift. These informed patients of the staff available to support them for that day.

Staff held community meetings enable patients to be involved in the running of the ward and share their views. Ward managers displayed you said we did posters which showed patients requests were being actioned. For example, we saw evidence of patients requesting equipment and activities that were then provided by the trust.

The multidisciplinary team invited patients to reviews where they could discuss plans for their care where appropriate.

Involvement of families and carers

We spoke with 18 carers and received six comment cards. Carers told us patients were kept safe on the wards and that staff were friendly and caring. Carers confirmed that staff were available to speak to and kept them up to date with relevant information.

Ward managers regularly asked family and carers for their feedback through completing satisfaction surveys. The feedback was displayed on the ward which showed that families and carers were satisfied with the care provided.

Carer meetings were held. This enabled carers to meet with ward managers and other staff to discuss the care and treatment being given. Ward managers told us they planned the meetings at

different times and days such as evenings and weekends to provide people the opportunity to attend.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for 17 wards/teams in this core service between 1 April 2017 and 31 January 2018.

Twelve of the wards/teams within this core service reported average bed occupancies ranging above the provider benchmark of 85% over this period. Six teams had a maximum occupancy level of 100% or above.

Bed occupancy levels were discussed at the daily safer staffing meetings. Ward managers told us if a patient was on leave they would not admit another patient in to their bed. However, if a patient was admitted to an acute NHS bed for more than three days the patient would be considered as discharged and the bed may be used for another patient.

Two patients on Henneage ward were on leave and their beds were occupied by another patient. This meant that these patients did not have a bed to return to if required. Staff told us that these patients were likely to be discharged whilst on leave.

Ward/Team name	Average bed occupancy range (1 April 2017 to 31 January 2018)
Bernard	97% to 103%
Henneage	79% to 118%
Inpatient - Older - Basildon - Gloucester	59% to 85%
Inpatient - Older - Rochford - Beech	80% to 88%
Inpatient - Older - Rochford - Maple	48% to 71%
Inpatient - Older - Thurrock - Meadowview	56% to 71%
Kitwood, St Mgt's	86% to 100%
Roding	76% to 99%
Ruby Ward	94% to 108%
Topaz Ward	90% to 103%
Tower	60% to 98%

*Data only provided for the month of January 2018

The trust provided information for average length of stay for the period 1 April 2017 to 31 January 2018.

Ward/Team name	Average length of stay range (1 April 2017 to 31 January 2018)
Bernard	49 days to 382 days
Henneage	35 days to 116 days
Inpatient - Older - Basildon - Gloucester	57.65 days to 128 days
Inpatient - Older - Rochford - Beech	46.48 days to 78.92 days
Inpatient - Older - Rochford - Maple	93.07 days to 194.82 days
Inpatient - Older - Thurrock - Meadowview	71 days to 102.80 days
Kitwood, St Mgt's	87 days to 191 days
Roding	22 days to 163 days
Ruby Ward	59 days to 258 days
Topaz Ward	63 days to 273 days
Tower	43 days to 143 days

*Data was provided for January 2018 only.

This core service reported one out area placements between 1 April 2017 and 31 January 2018. As of 1 February 2018, this core service had no ongoing out of area placements. The out of area placement was due to capacity issues.

Number of out of area placements	Number due to specialist needs	Number due to capacity	Range of lengths (completed placements)	Number of ongoing placements
1	0	1	4 days	0

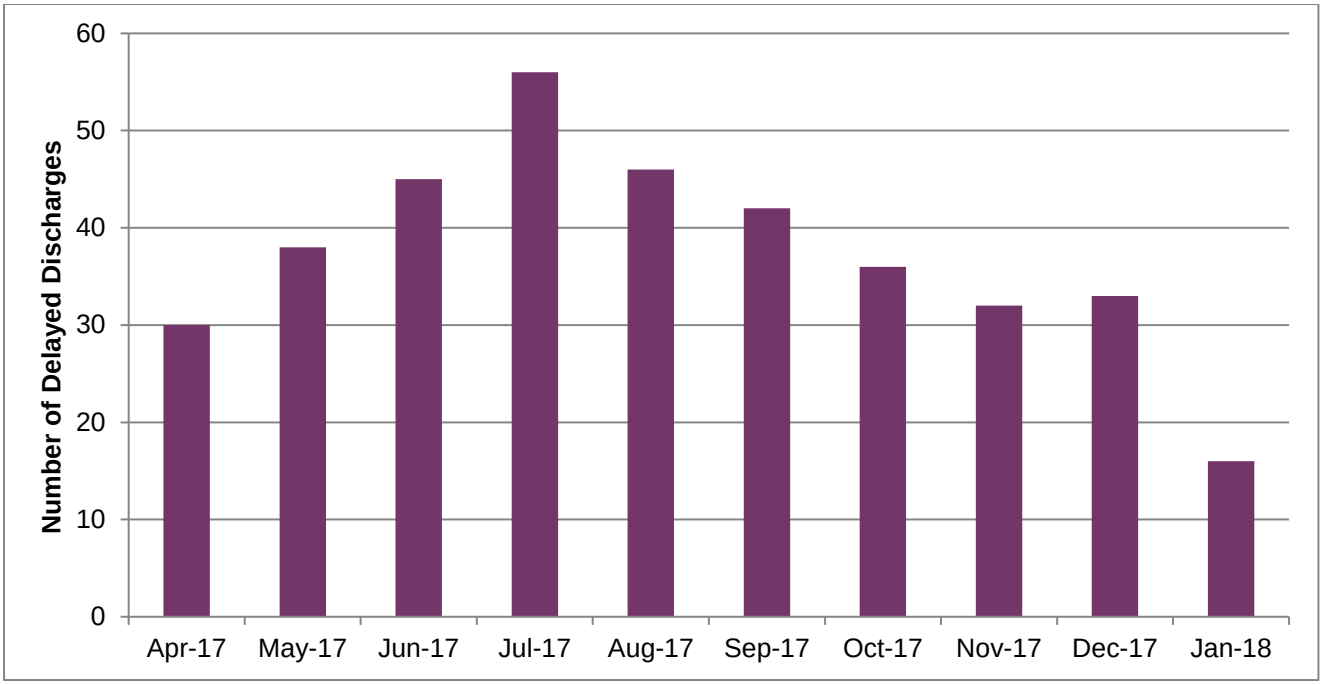
This core service reported 24 readmissions within 28 days between 1st April 2017 and 31st January 2018. Seventeen readmissions (71%) were readmissions to the same ward as discharge.

The average of days between discharge and readmission was 15 days. There were no instances whereby patients were readmitted on the same day as being discharged or the day after being discharged.

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
Beech	1	1	100%	3 - 3	3
Bernard	3	3	100%	7 - 23	16
Gloucester	3	3	100%	20 - 21	20
Henneage	2	1	50%	9 - 18	14
Kitwood	2	2	100%	14 - 16	15
Meadowview	1	0	0%	28 - 28	28
Roding	5	2	40%	9 - 27	18
Ruby Ward	1	0	0%	11 - 11	11
Topaz Ward	3	3	100%	4 - 23	10
Tower	3	2	67%	6 - 11	9

Discharge and transfers of care

Between 1 April 2017 and 31 January 2018 there were 144 delayed discharges within this core service. The graph below shows a downward trend of delayed discharges from July to November 2017, a strong sign of improvement in this area.



Facilities that promote comfort, dignity and privacy

Tower and Bernard Ward had two double bedrooms each. Gloucester ward had dormitories and some single rooms. The trust had taken some action to mitigate any privacy concerns using partitions and curtains. Senior managers informed us that there plans to redevelop the layout of Gloucester by 2020.

On all other wards patients had access to their own bedroom that they could personalise. Patients had access to lockable cabinets on wards to keep personal possessions safe. Carers and relatives were encouraged to take valuables home.

Wards had adequate space for patients to engage in therapeutic activities, for example, separate day rooms, female only lounges and activity rooms.

Patients had access to the wards pay phones in a private space. Some patients had access to their personal mobile phones that was risk assessed on an individual basis.

All wards had access to secure outdoor garden spaces which were well designed and maintained. The garden area on Meadowview ward was fitted with low impact flooring and equipment to meet the needs of patients.

Memory boxes were located outside patient's bedrooms. Inside the memory boxes were items/objects the patient liked. This helped orientate patients to the wards.

Patients could request hot drinks and snacks throughout the day that health care staff made for them. The trust provided a choice of meals for patients including culturally appropriate foods such as kosher, halal and vegetarian meals.

Patients' engagement with the wider community

Ward staff supported patients to maintain contact with family and carers, for example, inviting family and carers to ward reviews. We noted that staff supported patients to access the local community.

Meeting the needs of all people who use the service

Patients had access to information leaflets on the ward, for example information on how to complain, patients' rights and local services. This information was available in a variety of formats

such as pictorial and easy read. Wards had access to an interpreter service if required. Patients had access to spiritual facilities if required. There were multi faith rooms located on each ward.

Patients had access to assisted bathrooms or shower rooms if needed. Where required, staff had access to manual handling lifting equipment and personal protective equipment.

Listening to and learning from concerns and complaints

This core service received six complaints between 1 April and 31 December 2017. No complaints were referred to the Ombudsman during this period. Four of the complaints were regarding clinical practice and two related to communication.

Ward/Team	Clinical Practice	Communication	Total
Tower Ward		1	1
Topaz Ward	1		1
Ruby Ward		1	1
Kitwood Ward	1		1
Bernard Ward	1		1
Beech Ward (Essex)	1		1
Total	**4**	**2**	**6**

This core service received 101 compliments during the last nine months from 1 April to 31 December 2017 which accounted for 15% of all compliments received by the trust as a whole.

The trust had a current complaint policy. All patients had access to information on how to raise a complaint. Staff confirmed that they would support patients to raise complaints and concerns if required. Learning points from complaints were discussed at team meetings.

Staff received compliments. This included thank you cards and small gifts for the ward.

Is the service well-led?

Leadership

Ward managers had a good understanding of their service and could demonstrate how they supported staff to deliver good quality care. For example, managers encouraged staff to develop their careers.

Staff spoken with told us ward managers and senior managers were approachable and visible on the ward. This included senior trust leaders who had visited the wards.

Vision and strategy

Staff were aware of the trust's vision which was working to improve lives and the trusts values which were being Open, Empowering and Compassionate. These were on display on each ward. The trust had recently launched the Quality Star which staff were proud of. Evidence was seen of staff demonstrating the trust's values in their everyday work.

Culture

Staff spoken with told us they felt respected by their manager and that morale was generally good.

Staff knew the trust's whistleblowing policy. Staff said they felt able to raise concerns without fear of retribution.

Governance

The trust held monthly governance meetings which had a standard agenda that was followed. Examples of items on the agenda were: safeguarding, risk register, training, patient experience surveys and staffing.

Ward managers completed local audits that were fed back to senior managers. Examples of these included environmental, care plans, risk assessments, and staffing audits. The results were monitored monthly and improvement plans implemented if required.

Management of risk, issues and performance

The trust collected data to produce a performance dashboard. The dashboard was used by the trust to gauge the performance of each ward and to track where improvements or a decrease in performance was made. Examples of the information monitored were staff sickness, complaints, number of restraints and patient experience.

Managers told us they did not have a local ward risk register. However, they could add their risks to a directorate risk register. Environmental concerns were escalated to the estates team as required.

The trust had developed a new ligature risk assessment that ward managers had implemented on all wards.

Managers addressed staff performance concerns in a timely manner with the support of the trust's human resource department.

Information management

The trust had an information management policy and process. Patient information was stored securely and password protected.

Staff were aware of the need to protect the confidentiality of patients. For example, when talking to relatives and carers.

The trust had a Caldicott Guardian in place and had displayed posters on ward areas informing all staff of who this was.

Engagement

Ward staff held weekly community meetings for patients where patients were invited to have their say in the running of the ward.

Staff were encouraged to make suggestions about how the service could improve for patients.

Learning, continuous improvement and innovation

Monthly staff meetings were held to share learning across the trust.

Staff were encouraged to attend suitable training opportunities based on supervision and appraisal feedback.

Trust staff supported patients to attend local community services rather than accident and emergency services at the acute trust for non-urgent care.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

None of the services within this core service have been awarded an accreditation.

Wards for people with a learning disability or autism

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Heath Close	Byron Court (5 Heath Close)	7	Mixed

Is the service safe?

Safe and clean environment

Safety of the ward layout

Over the 12 month period from 1 April 2017 to 30 December 2017 there were no mixed sex accommodation breaches within this core service.

There were ligature risks on the one ward within this core service. The ward presented a high level of ligature risk due to patients being a vulnerable group who have the potential to self-harm.

The trust had taken actions to mitigate ligature risks: Funding agreed by EOSC to replace all patient toilets with reduced ligature design. Line of site survey to be undertaken and mirrors installed as required. Review of ligature management policy, eLearning package and hotspot photos on the ward to be shared and discussed during handover and team meetings.

The service had undergone considerable change since the last inspection in November 2017. This included reducing the number of beds from 12 to seven, increasing staffing numbers and a significant refurbishment of the physical environment. All bedrooms were en-suite and staff had installed anti-ligature fittings to en-suite bathrooms in all but one of the bedrooms.

The trust mitigated against blind spots on the ward. The trust had fitted further viewing mirrors at ceiling height to allow staff to view hidden areas and staff regularly observed patients in areas that they could not see from the ward office.

The ward was compliant with guidance on same sex accommodation. The trust had separate male and female areas; all bedrooms were en-suite and the assisted bathroom was located between the two areas so female patients did not walk past men's bedrooms to access it or vice versa. However, we observed that staff were supporting a male patient in the female lounge as a calm area. We discussed this with the manager who planned for the patient to be supported in the new "chillout room" to allow for the dedicated female only lounge to be available at all times.

Staff completed ligature audits for the ward and garden areas. We observed that staff were aware of ligature risks and discussed the ligature 'heatmap' during their shift handover.

Staff had access to personal alarms and used them to summon assistance when needed.

Managers completed environmental audits to ensure the trust undertook repairs in a timely manner.

Maintenance, cleanliness and infection control

The ward areas were clean and had recently been refurbished. Managers had recently upgraded furnishings which were sturdy and of good quality. The trust addressed all environmental issues from the previous inspection. We saw schedules for cleaning the ward which covered all areas.

Staff replaced radiator covers with new lockable covers which they could remove and clean. Staff cleaned these when needed, when they discharged patients or every six months, whichever was sooner.

The 2017 patient-led assessment of the care environment score was 99% for cleanliness and 96% for condition, appearance and maintenance.

Staff adhered to infection control principles and handwashing signs and hand gels were on the ward.

Seclusion room

The trust had created a new seclusion room and de-escalation area. The seclusion room did not contain ligature risks and complied with the Mental Health Act Code of Practice. There was a two-way communication for staff and patients to use, secure bedding, and en-suite toilet facilities. Staff had clear observation of patients; patients could see a clock through the internal windows, to check the time.

The trust had also built a low stimulus room next to the seclusion room for staff to use to verbally de-escalate patients where possible and appropriate and not place them in seclusion unless this was necessary.

Clinic room and equipment

The clinic room was clean, tidy, well organised and fully equipped. Staff had easy access to emergency resuscitation equipment and emergency drugs. Staff checked equipment daily and cleaned equipment regularly; the pharmacist audited medications weekly.

Safe staffing

Nursing staff

The trust reviewed staffing levels and increased staff on the ward to ensure patient safety. Managers allocated two nurses and three support workers to day shifts and two nurses and two support workers on night shifts. This ensured enough staff were present to complete observations. Staffing rotas showed this level operated as planned; managers employed additional staff when needed.

Bank or agency staff were familiar with the ward and with patients. Staff told us that although bank staff covered a lot of shifts, they made efforts to ensure they used staff who were familiar with the ward wherever possible. A review of staff rotas showed that 75% of bank staff who worked in April 2018 completed two or more shifts. Staff and patients told us that it was rare for staff to cancel activities or leave due to staffing shortages. Patients told us they could have individual time with their named nurse. Staff records for section 17 Mental Health Act community leave showed that patients could get leave daily, apart from newly admitted patients who required assessment to establish appropriate leave arrangements. All staff told us that staffing levels were safe and enabled them to give appropriate time to patients.

This core service has reported a vacancy rate for all staff of 14% as of 31 January 2018.

This core service reported an overall vacancy rate of 20% for registered nurses at 31 January 2018 and 20% for nursing assistants.

The ward had recently increased their complement of nursing staff. The manager was recruiting to all vacant posts to increase the number of permanent staff on the ward and knew where each post was in the recruitment process.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Bronte Place (4a Heath Close)	-	-	-	0.00	0	0%	0.00	0	0%
Byron Court (5 Heath Close)	1.27	6.47	20%	1.74	8.7	20%	3.01	16.17	19%
LD Overheads1 - Heath Close	-	-	-	-	-	-	0.00	1.75	0%
OT LD	-	-	-	-	-	-	1.00	10	10%
Core service total	**1.27**	**6.47**	**20%**	**1.74**	**8.70**	**20%**	**4.01**	**27.92**	**14%**
Trust total	**250.46**	**1585.55**	**16%**	**147.04**	**1207.08**	**12%**	**709.54**	**4999.15**	**14%**

NB: All figures displayed are whole-time equivalents

Between 1 April 2017 and 31 January 2018, bank staff filled 39% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 7% of shifts for qualified nurses. Seven per cent of shifts were unable to be filled by either bank or agency staff.

Caveat: Shifts filled by bank and agency staff and unfilled shifts do not add up to the total number of available shifts. However, we reviewed rotas for a three-week period in April 2018 which showed that there were enough staff to cover all shifts. Staff told us that staffing levels had improved on the ward.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Heath Close	1,519	588	99	108
Core service total	1,519	588 (39%*)	99 (7%*)	108 (7%*)
Trust Total	**102629**	**31709**	**12577**	**5890**

***Percentage of total shifts

Between 1 April 2017 and 31 January 2018, 73% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, agency staff covered 3% of shifts. Three per cent of shifts were unable to be filled by either bank or agency staff.

Caveat: Shifts filled by bank and agency staff and unfilled shifts do not add up to the total number of available shifts.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Heath Close	4,783	3,500	148	122
Core service total	4,783	3,500 (73%*)	148 (3%*)	122 (3%*)
Trust Total	**144009**	**60464**	**5916**	**4396**

***** Percentage of total shifts

This core service had one (6%) staff leaver between 1 April 2017 and 31 January 2018.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
364 ED553 Byron Court (5 Heath Close)	14.62	1.20	8%
364 ED555 Bronte Place (4a Heath Close)	5.60	0.00	0%
Core service total	20.22	1	6%
Trust Total	3127.64	253	7%

The sickness rate for this core service was 14% between 1 April 2017 and 31 January 2018. The most recent month's data (January 2018) showed a sickness rate of 22%. Sickness rates for the ward stood at 4% for February and 0% for March 2018. This is below the national average.

Bronte Place (4a Heath Close) had the highest annual sickness rate with 37%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Byron Court (5 Heath Close)	26%	10%
Bronte Place (4a Heath Close)	0%	37%
Byron Court	0%	0%
LD Overheads1 - Heath Close	0%	0%
Core service total	**22%**	**14%**
Trust Total	**4%**	**4%**

The below table covers staff fill rates for registered nurses and care staff during September, October and November 2017.

Byron and Bronte ward had less than 90% of the planned registered nurses for day shifts in September and October 2017.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	September 2017				October 2017				November 2017			
Byron and Bronte	79.6	94.5	100.0	98.5	89.0	99.1	100.0	99.2	91.5	99.2	100.0	98.8

Medical staff

No shifts were filled by bank or agency staff to cover sickness, absence or vacancy for medical locums between 1 April 2017 and 31 January 2018.

Three consultants and two staff-grade doctors covered the ward and admitted patients. There was an on-call rota for out-of-hours and a doctor could attend the ward quickly in an emergency.

Mandatory training

Overall mandatory training compliance was 94%, above the trust target of 85%. The manager was aware of who required training and the reasons why training had become out of date. For example, a member of staff had not completed restraint refresher due to an injury at work. We saw the manager had put plans in place to ensure they had booked staff on the course as soon as it was safe for them to complete this.

The compliance for mandatory and statutory training courses at 31 December 2017 was 92%. Of the training courses listed nine failed to achieve the trust target and of those, seven failed to score 75% or above.

The trust has a rolling month on month compliance rate for mandatory training.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	**Compliance**
Complaints Handling	100%
Equality and Diversity	100%
Health and Safety (Slips, Trips and Falls)	100%
Mental Capacity Act Level 2	100%
Mental Health Act	100%
Personal Safety - MVA	100%
Personal Safety Breakaway - Level 1	100%
Raising concerns and whistleblowing	100%
Safeguarding Adults (Level 1)	100%
Safeguarding Adults (Level 3)	100%
Care Certificate	100%
Care Programme Approach	100%
Corporate Induction	100%
Diabetes Training	100%
Dual Diagnosis	100%

Training course	Compliance
Fit for Work	100%
Food Hygiene	100%
Harassment & Bullying	100%
Hoisting e-learning	100%
Induction E-Learning	100%
Medication Management (MH)	100%
MERT (Enhanced Emergency Skills)	100%
Observation of Service User	100%
Information Governance	96%
Infection Prevention, Control & Hand Hygiene	96%
Safeguarding Children (Level 2)	96%
Basic Life Support & AED	95%
Clinical Risk Assessment	95%
Duty of Candour (Overview Version)	95%
TASI Trained	93%
Fire In-patient	92%
Mental Capacity Act Level 1	88%
Duty of Candour (Detailed Version)	86%
Hoisting	80%
Manual Handling - People	78%
Cascade Fire Trainer	67%
Fire Safety 2 years	50%
First Aid Trained	50%
Fire Safety 3 years	42%
Basic Back Care (E-Learning)	0%
Basic Back Care (Face to Face)	0%
PREVENT (WRAP) Training	0%
Total	**92%**

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed six patient care records on the trust's electronic record system. Staff completed risk assessments for patients on admission and updated them regularly. The service admitted a patient on the day of our visit and we saw staff carried out a risk assessment in a timely manner. Records were holistic, thorough and person centred. Staff involved patients where this was possible. One patient was not involved because they had declined and staff had clearly recorded this.

Risk assessments clearly linked to care plans and to positive behaviour support plans, which were in place for all patients except for one newly admitted patient. Positive behavioural support plans contained a functional analysis of the patient's behaviour.

Staff discussed patient risks in shift handovers; staff offered additional interventions, monitoring and observation where required, due to changing risk; shift leaders had clearly documented this to enable staff to manage patients safely.

Management of patient risk

Staff managed specific patient risk issues, such as challenging behaviours and physical health conditions. Staff managed these risks proactively, where possible, through observations, staff engagement and minimising potential risks such as ligature anchor points. There were good systems in place to ensure patients received appropriate levels of observations.

Staff used positive behaviour support plans to manage patient risk. Staff explored the causes of patients' behaviours and how specific behaviours could be triggered and how they could escalate. Staff divided behaviours into red, amber and green categories and gave clear strategies about how to manage patients safely at each stage. Staff identified changes to patient risk in handovers and discussed strategies for managing them.

The ward did not have blanket restrictions; where there were restrictions, such as on mobile phones on internet use, these were based on individual risk assessments. Access to the garden area was with staff supervision for all patients in order to manage ligature risks safely. However, there were sufficient staff to ensure that patients could access the garden areas when they wished. Informal patients could leave when they wanted.

Use of restrictive interventions

This core service had 208 incidents of restraint (on 19 different service users) and four incidents of seclusion between 1 April 2017 and 30 December 2017.

The below table focuses on the last nine months' worth of data: April 2017 to December 2017.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Byron Court	4	208	19	11 (5%)	33 (16%)
Core service total	**4**	**208**	**19**	**11 (5%)**	**33 (16%)**

Between 1 January and 30 April 2018, there were 71 incidents of restraint, of which three were in the prone position. A prone restraint occurs when someone is placed face down on a surface and is physically prevented from moving out of this position. There are concerns that face down, or prone, restraint can result in dangerous compression of the chest and airways and put the person being restrained at risk.

Most staff, 85%, had been trained to use TASI (an advanced personal safety, restraint and breakaway technique) and encouraged to use de-escalation rather than restraint. Staff told us they considered restraint as a last resort, after positive behaviour support strategies and verbal de-escalation had proved unsuccessful. Staff debriefed patients after incidents. One patient said that staff explained calmly after an incident why they had restrained them so they understood why staff had taken the action they had. Another patient said staff had not restrained them and helped them to calm down when they were angry.

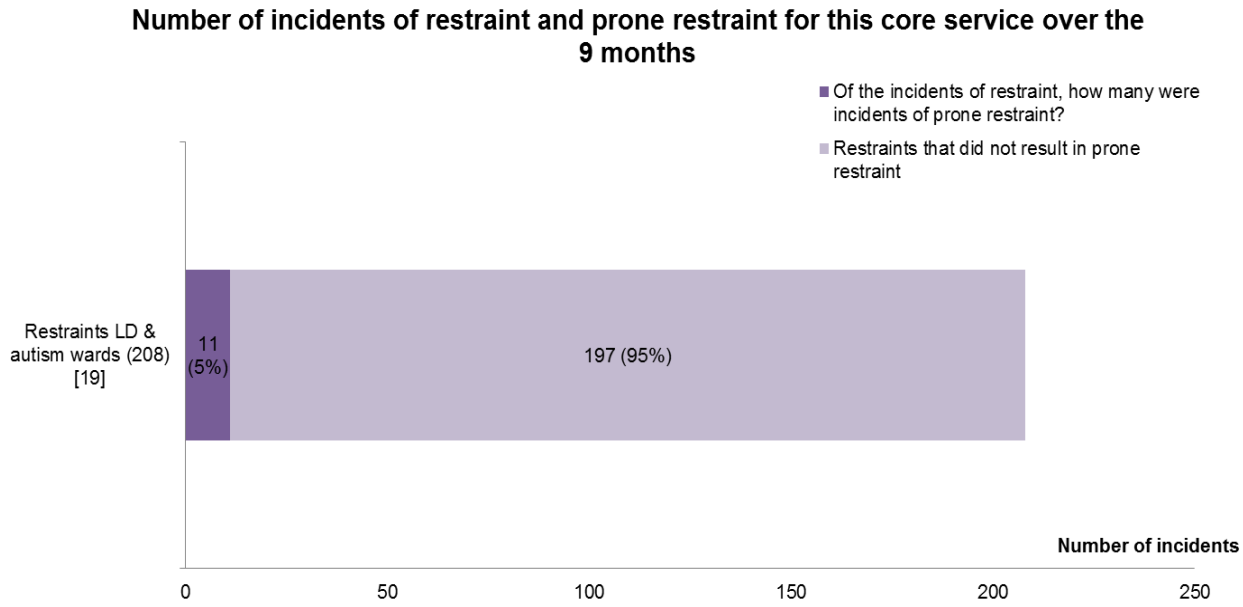
Managers and staff were working to reduce the number of times staff restrained patients. Data from the trust indicated that staff restraints had showed a downward trend in 2018 compared to the last quarter of 2017.

There were two episodes of seclusion from 1 January to 30 April 2018. The most recent occasion was in March 2018 when staff secluded a patient for a short period in their bedroom as there were no dedicated seclusion facilities available. Staff completed seclusion paperwork correctly. Staff

followed national institute for health and care excellence guidance when using rapid tranquilisation.

There were 11 incidents of prone restraint which accounted for 5% of the restraint incidents.

There have been no instances of mechanical restraint over the reporting period.



Please note the figures in square brackets ,after the total number of restraints, are the number ofdifferent service users restraint was used on during this time period.

There have been no instances of long-term segregation over the nine month reporting period.

Safeguarding

All staff received training in safeguarding adults at levels one, two and three. Staff recognised safeguarding concerns and knew how to make a safeguarding alert. Staff knew how to get further advice and guidance if they needed it. Staff received feedback from agencies in relation to their involvement in safeguarding processes.

The trust had systems in place to ensure that children could visit the unit. There were rooms available with toys where visits took place. The service did not allow children into patient living areas.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust have provided details of the total number of safeguarding referrals made between 1 April 2017 and 31 December 2017 with 802 referrals made for adults and 180 for children. However, this for the whole trust and has not been broken down to core service level.

The trust told us that there were no serious case reviews commenced or published in the last 12 months that related to this core service.

Staff access to essential information

Staff accessed information on the trust's electronic recording system. Staff kept some documents, such as positive behaviour support plans, electronically on a different system and printed them out when needed on the ward. Staff told us that in most cases they accessed information easily and could locate documents when they needed them.

Medicines management

Staff managed medicines safely on the ward. Staff stored medicines securely and managed clinical waste appropriately. All staff received training in medicines management and had access to clinical pharmacy support.

Doctors prescribed medicines safely and in line with national institute of health and care excellence guidance. There was one example of staff giving a patient medication covertly; they had prescribed this safely and within the correct legal framework.

However, there were out of date medical consumables, such as wound dressings and blood collection tubes, and one out of date medication which did not pose a risk to patients. The trust did not have a system in place to ensure staff checked and replaced these items when necessary. We raised this with the trust during the inspection and staff removed and replaced all these items immediately. The manager also put a system in place to conduct regular checks and take appropriate action.

Staff had not attached patient photographs to medication charts to reduce the risk of medication errors.

Track record on safety

Trusts must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 January 2018 there were no STEIS incidents reported by this core service.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

Reporting incidents and learning from when things go wrong

Staff were aware of what incidents to report and how to report them. These included injuries to patients or staff, violence and aggression, staff shortages and near misses. All staff accessed the trust's electronic incident reporting system and completed incident forms. Staff told us that they were open and transparent with patients and their families after incidents.

Staff received debriefs after incidents for support and to learn lessons from incidents. This happened immediately after incidents or later, depending on what staff thought would be most helpful. Managers shared learning from incidents with the wider staff team through the monthly team briefs. There was evidence of change because of incidents. Examples of this included the trust acting to change the ward environment and staffing levels.

Is the service effective?

Assessment of needs and planning of care

We reviewed six patient care records. Staff completed assessments on admission, including a physical health examination. Staff monitored physical health issues throughout the patient's stay

on the ward. Records were thorough and holistic; they took account of patients' strengths and worked towards recovery and discharge. There were clear signs of multidisciplinary involvement from the behavioural therapist, occupational therapist and speech and language therapist.

The trust kept information securely, both electronically and within the nursing office where staff used some paper records for handovers.

Care plans were up to date and person centred. They included patients' views and where patients declined to be involved in them, or levels of learning disability made this difficult, staff had clearly recorded this.

Staff developed positive behaviour support plans to support patients. Staff updated plans monthly and were evidence based and individualised. They contained a description of the patient, including their profile, needs and communication skills. Plans explored the functions of a patient's behaviours and examined how these were triggered and could escalate. There were clear strategies identified to enable staff to support patients and reduce the likelihood of behaviours escalating.

Best practice in treatment and care

Staff followed national institute of health and care excellence when prescribing medication.

Patients had access to psychological therapies through the multidisciplinary team. At the time of inspection, the ward shared psychology input with the community learning disability team. This was insufficient to pick up new admissions quickly. The trust had advertised for a part-time psychologist to fill this gap but had not yet appointed to this post. Staff used a variety of other tools to engage with patients including social story books and a series of easy read documents, for example on food, depression and bereavement.

Multidisciplinary staff ran several individual and group sessions for patients. We observed a group of four patients with three therapists exploring emotions and facial expressions. Staff engaged with patients in a relaxed way and the session enabled patients to interact with therapists and each other.

Staff completed full and thorough physical health examinations within 72 hours of admission. Staff monitored patients' physical health throughout their stay and supported patients to access physical health appointments where required. Staff used easy read documents to work through issues such as cancer, epilepsy, sexual health, blood tests, having an x-ray and keeping healthy. Staff facilitated patients to access GP, outpatients and other physical health appointments when needed.

Staff assessed patients' nutritional needs. The speech and language therapist worked with patients to ensure that the chef prepared food appropriately for patients who required a 'soft' diet. Staff referred patients requiring a dysphagia assessment to a separate team.

Staff completed the health equalities framework outcome measurement on admission and discharge, to measure patients' progress throughout their stay on the ward. They also used the model of creative ability activity participation outcome measure to assess patients' progress and level of functioning.

Staff actively undertook audits and made suggestions about the development of the service. The speech and language team had reviewed information given to patients and had developed an extensive library of easy read material and an easy read notice board. The trust pharmacist completed weekly medication audits.

This core service participated in no specific clinical audits as part of their clinical audit programme 2017.

Skilled staff to deliver care

The ward had access to the full range of professionals to meet the needs of patients on the ward. This included a behavioural therapist, psychologists, occupational therapists, doctors, nurses, speech and language therapists and physiotherapists. The trust pharmacists also offered support when needed and made weekly visits.

Staff were qualified and most had extensive experience of working with this client group. Some nursing staff were newly qualified and the wards took student nurses on placement. There was a good skill mix within the staff group; qualified nurses were a mix of both mental health nurses and learning disability nurses.

The trust ensured that all new staff received an appropriate induction to the ward, including appropriate training. Staff received specialist training to ensure they could meet patients' needs. Members of the multidisciplinary team offered training in autism, positive behaviour support, sensory awareness and communication.

Staff received regular supervision so they could learn from incidents and reflect on their own practice. However, clinical supervision took place alongside management for most members of the service. Staff did not meet separately with a clinical supervisor. All staff had access to the monthly, three-hour team brief; bank staff covered the ward to allow all permanent staff to attend. Managers dealt with work performance issues quickly within supervision.

The trust's target rate for appraisal compliance is 90%. As at 31 January 2018, the overall appraisal rates for non-medical staff within this core service was 81%. Byron Court failed to achieve the trust's appraisal target with an appraisal rate of 67%.

No appraisal data was submitted by the trust for medical staff in this core service during this period.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Byron Court (5 Heath Close)	12	8	67%
Intensive OT LD	9	9	100%
Core service total	**21**	**17**	81%
Trust wide	4121	3386	82%

Between 1 April 2017 and 31 January 2018, the average clinical supervision rate across both teams in this core service was 88% against the 90% trust target.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

The manager told us that there had been an issue with completing staff appraisals in the past but this was improving. At the time of the inspection 83% of staff had received an appraisal in the previous 12 months. Staff compliance with supervision was 88%, slightly below the trust's target of 90%. Data provided by the trust showed that in December 2018, all staff had received supervision

in the previous eight weeks. In March 2018, this figure stood at 93%. The managers knew which staff were due supervision and appraisals and the reasons for this delay such as sickness or injury. Bank staff also had access to supervision on the ward.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Byron Court (5 Heath Close)	115	98	85%
OT LD	30	29	97%
Core service total	**145**	**127**	**88%**
Trust Total	**24,386**	**21,061**	**86%**

Multidisciplinary and interagency team work

Staff held weekly multidisciplinary meetings to review patients. Staff also attended monthly team meetings to discuss current patients and new referrals. Patients and staff, including some of the multidisciplinary team also met daily for a morning meeting to discuss issues on the ward and the activities planned for that day. Staff also participated in care programme approach meetings and community treatment reviews.

Staff handovers took place between each shift and were thorough and effective. Staff used patients' positive behaviour support plans when discussing patient behaviours and presentation. This enabled staff to discuss the positive and effective strategies they could employ for each patient to prevent behaviour from escalating. Staff therefore became familiar with patients' positive behaviour support plans and how best to respond to patients in the most appropriate way.

The team worked closely with the community learning disability team located adjacent to the ward. Some of the multidisciplinary staff worked across both teams. This meant that there was good communication between the ward and community team.

The service had good relationships with outside agencies such as commissioners and safeguarding teams. Outside teams gave feedback on staff performance which managers discussed with staff during their appraisal.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

At the time of inspection, there were four patients detained under the Mental Health Act 1983/2007 on Byron Court. Staff completed legal documentation correctly and updated when necessary. Staff could access this easily when needed.

We looked at medication charts for all four detained patients. Consent to treatment forms 'T2' and 'T3' were correctly in place and attached for staff reference to ensure they administered medication under the appropriate legal authority. A form T2 is a certificate of consent to treatment. It is a form completed by a doctor to record that a patient understands the treatment being given and has consented to it. A form T3 is a certificate issued by a second opinion appointed doctor and is a form completed to record that a patient is not capable of understanding the treatment prescribed or has not consented to treatment but that the treatment is necessary and can therefore, be provided without the patient's consent.

Patients accessed S17 Mental Health Act 1983/2007 leave appropriately, with most patients getting out every day. Risk assessments were in place for this and staff documented leave appropriately and clearly. Informal patients could leave the ward when they wanted

Staff were knowledgeable about the Mental Health Act and knew how it applied to their work with patients. Staff knew where to get further help from Mental Health Act administrators when needed.

Patients had easy access to independent mental health advocates and they had produced an easy read document for patients to explain what their role was and how to contact them. Staff explained to patients regularly what their legal rights were under the Mental Health Act. They made efforts to help patients understand, using easy read material where appropriate, and where it was not possible for patients to understand, they recorded this clearly.

As of 31 December 2017, 92% of the workforce in this core service had received training in the Mental Health Act. The trust stated that this training is mandatory for all staff and renewed every three years.

Good practice in applying the Mental Capacity Act

As of 31 December 2017, 100% of the workforce in this core service had received training in the Mental Capacity Act level one. The trust stated that this training is mandatory for all staff and renewed every three years.

The trust told us that staff had made three Deprivation of Liberty Safeguard (DoLS) applications to the Local Authority for this core service between 1 April 2017 and 31 March 2018. At the time of inspection, two patients were under DoLS. The service had correctly completed and submitted appropriate applications for two patients.

The greatest numbers of DoLS applications were made in October 2017 and January and February 2018 with one each.

	Number of DoLS applications made by month												
	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total
Applications made	0	0	0	0	0	0	1	0	0	0	1	1	**3**
Applications approved	0	0	0	0	0	0	0	0	0	0	0	0	**0**

Staff had a good understanding of the Mental Capacity Act and how it applied to patients. The trust had a policy which staff could access and staff knew where to go for further support and guidance.

Staff made significant efforts to support patients to make decisions for themselves.

We looked at six patient records. Staff had completed Mental capacity assessments in four of these records. One record clearly recorded that the patient had capacity. Where patients took medication covertly (without knowing they were taking it), staff assessed and recorded this appropriately.

Staff understood and worked within the Mental Capacity Act's definition of restraint. Staff worked to reduce incidents of restraint and towards the least restrictive option.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We spoke with four patients and three carers during the inspection. All spoke positively about how staff supported them.

Staff interacted with patients in kind, compassionate and caring ways. Staff spent time with patients and responded when they needed care and support. We observed staff talking to patients about their feelings and behaviours, exploring options and solutions and helping patients to make choices and decisions. Staff demonstrated they understood patients, were aware of their needs and how they should support them.

Patients told us that staff treated them well and were respectful and polite. They said that staff were genuinely interested in their wellbeing and wanted them to get better and move on. One patient told us that staff had restrained them and although they did not like it, staff explained calmly afterwards, so they knew why staff had intervened.

Involvement in care

Involvement of patients

Staff spoke to patients about the service on admission, showed them round the ward and explained how they would support them. We observed staff admitting a new patient during the inspection; staff were clear, friendly and welcoming and put them at ease. Staff had developed a welcome pack in easy read format which they gave to patients on admission and went through it with them when requested.

Staff involved patients in their risk assessments, care plans and positive behaviour support plans and offered patients a copy of their plan where appropriate. Where patients did not wish to be involved or where communication needs or the severity of learning disability made this difficult, they had clearly recorded this. Two patients told us that staff explained their condition and treatment options to them, including medication. Carers confirmed that patients were involved in care planning.

Staff involved patients in their reviews and encouraged them to lead and take minutes of the daily morning meetings. Staff involved patients in the development of the service, for example in planning the new ‘chill-out’ room and menu choices. All patients we spoke with said staff arranged lots of activities with them and involved them in what they wanted to do.

Staff assisted patients to access advocacy. However, patients we spoke to were not sure what an advocate was.

Staff helped patients to attend and lead monthly patient forum meetings. Patients made suggestions and requests, staff agreed actions and patients gave updates on what had happened to their requests at the last meeting.

Involvement of families and carers

Staff involved carers when planning how to care and support patients. Staff listened to carers’ experiences and took account of them when developing support plans. Carers felt confident that most staff knew patients well and that treatment plans were helping their relatives get better. Carers also said that when they raised issues, staff dealt with them in a transparent manner.

Staff kept carers informed of their relative’s progress appropriately, and any incidents that had taken place. Staff maintained good relationships with carers, facilitated visits and communicated with them regularly.

Is the service responsive?

Access and discharge

The service admitted up to seven patients from south Essex, Southend and Thurrock, although there was an additional eighth bed available for 'spot purchase' by commissioners. Staff worked with 18-65 year olds although did have an older person admitted in 2017. Beds were available for people living in the catchment area unless the unit was full.

Staff spent time with patients who had been admitted to the ward. Patients received an easy read welcome pack. Staff went through this with patients if required and helped settle them and complete the necessary assessments and paperwork.

There was good communication between the ward and community team when discharging patients back into community placements and when accepting referrals. This was particularly notable with young people making the transition from children's' to adult services. The behaviour therapist was involved at the point of discharge, reviewed the positive behaviour support plans and supported the transition to the community team.

Bed management

There were no out of area placements of patients at the time of inspection.

Although bed occupancy exceeded the 85% recommended by the Royal College of Psychiatrists, patients on leave always returned to their own room.

Staff did not move patients from the ward except for clinical reasons. The ward supported patients with high levels of challenging behaviour and complexity. Should a patient require admission to a psychiatric intensive care unit, there was a facility in Basildon, about seven miles away. However, a bed was not always available on this unit as it was frequently full.

The trust provided information regarding average bed occupancies for this core service between 1 April 2017 and 31 January 2018. The ward reported average bed occupancies ranging above the trust benchmark of 85% over this period.

Ward/Team name	Average bed occupancy range (1 April 2017 to 31 January 2018)
Learning Disability – Heath Close - Byron Court	70% to 111%

The trust provided information for average length of stay for the period 1 April 2017 to 31 January 2018.

Ward/Team name	Average length of stay range (1 April 2017 to 31 January 2018)
Learning Disability – Heath Close - Byron Court	64.17 days to 145 days

This core service reported no out area placements between 1 April 2017 and 31 January 2018.

This core service reported one readmission within 28 days between 1st April 2017 and 31st January 2018. This readmission was to the same ward and there were 28 days between the initial discharge and readmission.

Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Average days between discharge and readmission
Byron Court	1	1	100%	28

Discharge and transfers of care

Between 1 April 2017 and 31 January 2018, there were no discharges within this core service.

Between 1 February and 30 April 2018, there were three patient discharges. Some had been waiting for a discharge but had no placement identified to go to so was outside the trust's control. The service had responded by arranging care and treatment reviews with commissioners and local community teams to explore options available.

Managers stated that they worked towards early discharges but that early discharges were not always possible due to a lack of community placements.

The service worked closely with the community learning disability team adjacent to the ward. This team worked intensively with people living in the local community who had learning disability and mental health needs. Some workers worked across both services and this aided the transition from one service into the other. This helped when staff discharged patients from the ward; staff reviewed risk assessments and positive behaviour support plans prior to discharge and shared this information with the community team.

Facilities that promote comfort, dignity and privacy

The ward had a full range of rooms and equipment to support treatment and care. This included a fully equipped clinic room and rooms where patients met with therapists for individual sessions and rooms where they could be quiet or meet with visitors. The service did not allow children to visit patient living areas, but carers could visit their relative's bedroom subject to risk assessment. The service was developing a quiet, low-stimulus, 'chill-out' room for patients, which was not yet complete.

The service provided a range of therapeutic activities for patients. The service had recently created a new activity room for patients containing a variety of different activities. For example, patients and staff used a map of the world to show where they came from or would like to visit. Staff would share information about the culture, traditions and food of their country. There were also pictorial books to aid exploration of a wide variety of topics and adult colouring books. Each patient had an individualised activity box, containing things they particularly enjoyed doing or helped keep them calm. Patients told us that they liked this because they could use it whenever they wanted. Other activities included a boccia group which covered several different sports, cycling, therapy dogs and gardening. Staff supported patients to plan an activity timetable. They supported patients with activities seven days a week although therapy staff were not available at weekends.

Patients could make phone calls in their bedrooms subject to risk assessment. However, two patients told us they were not able to make private phone calls but did not provide further information about this.

Patients told us that the food was good. They told us there was always a choice and the chef would cook something else if they did not like either of the choices. Healthy choices were available and the chef asked patients to suggest things they would like to eat. Carers also said their relatives enjoyed the food. Patients requested drinks whenever they wanted. Staff encouraged patients to make drinks for themselves if they could. Staff supported patients to choose snacks and cold drinks for individualised snack boxes which staff replenished regularly. The patient-led assessment of the care environment for food at this service was 100% in 2017.

Patients had access to outside space. Staff locked the garden when nobody was in it due to ligature risks, but patients accessed this on request. During the inspection we observed staff supervising and supporting patients in all the outside areas. Patients also accessed outside activities after this had been risk assessed.

Patients could personalise their bedrooms. We observed that some bedrooms were homely and had pictures on the walls. Other patients had chosen not to personalise their bedroom. One patient thought that they were not allowed to put pictures up and staff discussed this with them during our visit. There was no secure storage area within patient bedrooms for patients to keep their valued possessions but staff stored these securely in locked storerooms.

Patients' engagement with the wider community

Patients accessed the wider community, usually with staff support, within the service's leave arrangements. Patients attended community groups and staff encouraged patients to keep up links with the community that they had prior to admission.

Meeting the needs of all people who use the service

The ward was on the ground level and had full disabled access. There was an assisted bathroom and a bedroom for patients with additional physical health and mobility needs, which included an integral hoist.

The service had an easy read notice board and had produced information leaflets and documents on a range of subjects in easy read format. The service had easy access to leaflets in other languages and interpreters when needed.

There was access to spiritual support on request or when identified in assessments. The chef on the ward responded to dietary requirements of religious groups and patients' needs and requests.

Listening to and learning from concerns and complaints

Patients told us they felt confident to complain if they needed to. Staff were aware of how to manage complaints and fed back to patients.

Patients raised concerns through patient forum meetings and staff acted as a result.

The service received a verbal complaint about noise by a neighbour during the inspection. Staff resolved this quickly and appropriately. We saw many compliments expressed on cards that patients and carers had sent in the previous six months thanking staff for their help and support.

This core service received one complaint between 1 April and 31 December 2017 which related to clinical practice. No complaints were referred to the Ombudsman during this period.

This core service received no compliments during the last nine months from 1 April to 31 December 2017.

Is the service well-led?

Leadership

Ward managers, in conjunction with senior trust staff, had made significant changes over the past six months to the way the ward operated. They had the skills, knowledge and experience to undertake their role; they had developed a shared culture amongst the entire staff team, which focused on the patient and the provision of high quality care. The ward manager was approachable for patients and staff and was highly valued by the team.

Vision and strategy

The trust's values were compassionate, empowering and open. Staff knew what the trust's values were and reflected them in the way the team operated. Senior managers were known to the team and had come to visit the service to look at the environmental changes to the ward.

Culture

Staff morale was high. Staff felt supported and valued by their manager and the organisation. All staff said they felt confident to raise issues without fear of any retribution and that the culture was extremely open and supportive. Staff were aware of the whistleblowing policy and how to use it.

The service was person centred and focused on recovery and discharge. The service established good links with the community service which helped patients on admission and discharge. Arrangements were in place to ensure a smooth transition for those moving from children to adult services.

The manager encouraged and empowered staff to make suggestions and, where agreed, to put them into practice. We saw an example of this in the easy read notice board and library of easy read documents produced by the speech and language team.

Managers supported staff to do their jobs. Staff told us that there were enough staff to support patients. Managers were approachable and supportive; debriefs after incidents were routine and managers ensured staff received appropriate support and made changes when appropriate. Staff received regular supervision and feedback about their performance.

Staff sickness had reduced over the past six months. Staff had access to the trust's occupational health service where needed.

Governance

Managers used key performance indicators to monitor team performance. Managers were aware when staff needed to refresh their mandatory training. Where there were gaps, managers knew the reasons, such as staff sickness or injury, and had made plans to ensure staff became compliant as soon as possible.

Systems were in place to ensure and improve the quality of the ward environment. Managers monitored staffing levels to ensure there were sufficient staff to support patients and ensure their safety. Staff received regular supervision, appraisal and training and ensured that the staff team met regularly to discuss patients and shared learning from incidents and good practice. The ward manager had access to supervision data via a supervision tracker. Trust policy did not require management and clinical supervision to be separate. There were no separate clinical supervision arrangements for staff. None of the staff we spoke with received clinical supervision, except the ward manager.

Recruitment remained a significant issue with high levels of bank staff. However, managers ensured that staff were regular and familiar with the ward and patients and that the use of agency staff was low.

Systems were in place to ensure that when staff reported incidents, managers followed them up. Managers updated staff about the development of the service by regular briefings and information displayed on notice boards. Managers encouraged staff to make suggestions about the development of the service and to put these into practice.

Managers had driven several improvements since the last inspection. These were in relation to the ward environment, staffing levels and the introduction of positive behaviour support plans. Staff

prioritised their time to support patients and ensure patients participated in meaningful and therapeutic activities on and off the ward. The manager told us they sufficient authority to perform their role and felt supported by their immediate manager and by the trust.

Managers ensured that staff followed safeguarding, Mental Health Act and Mental Capacity Act procedures.

Management of risk, issues and performance

Managers and staff were aware of risk issues in relation to the service. Staff submitted items to the trust risk register through the ward manager.

Staff undertook audits in relation to the environment. However, we discovered several out-of-date consumables in the clinic room and managers had not put a system in place to address this. The manager set up a system to ensure staff audited these items regularly and replace out-of-date stock.

Staff discussed ligatures risks and how to mitigate these in handovers.

Managers knew why staff were off work and supported them appropriately when necessary. Managers dealt with issues of poor performance appropriately and quickly. There were no cases of bullying or harassment; managers addressed between staff members in a timely fashion.

Information management

The trust kept confidential patient records on the trust's electronic record systems. This gave easy access to staff. However, the trust kept some records, such as positive behaviour support plans, separately. Managers told us plans were in place to integrate this into the main system. Positive behaviour support plans were easily accessible and staff kept printed copies in the ward office for ease of use at handovers.

The ward manager received electronic data in relation to the performance of the service. This information was easily accessible and enabled the manager to identify areas for improvement or clarification.

Engagement

Managers kept staff and patients up to date about the service by bulletins on notice boards and meetings. Staff kept carers up to date with service developments.

Patients and carers had the opportunity to feed back about the service. Patients made requests, staff acted as a result and patients received feedback.

Staff were open and transparent with patients and carers when they raised issues or when something went wrong. One carer told us they had raised issues and staff had been open when feeding back to them.

The multidisciplinary team worked well together and with nursing staff on the ward. Staff worked effectively with external agencies.

Learning, continuous improvement and innovation

The service had introduced several improvements and innovations. For example, patients had personalised activity boxes where they kept things they particularly enjoyed doing. Patients could access these at any time and staff used them to de-escalate and distract patients if they were becoming distressed or agitated. Patients could also choose to use these as they wished.

Staff made positive efforts to enable patients to lead, contribute to and take the minutes of patient meetings.

Staff used positive behaviour support plans at handovers to embed proactive green and amber strategies to manage patients' behaviour. The shift leader would read out the plans during the meeting to ensure staff knew the patient's current presentation and the strategies identified to manage this.

The team worked closely with the community service to ensure good outcomes for patients. Some staff worked across the two services.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

None of the services within this core service have been awarded an accreditation.

Community-based mental health services for adults of working age

Facts and data about this service

Location site name	Team name	Address	Number of clinics	Patient group (male, female, mixed)
Trust Head Office	Adult Community Psychology	Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	N/A	Mixed
Trust Head Office	Basildon Recovery & Wellbeing	Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	20	Mixed
Trust Head Office	Complex Needs & Psychotherapy Service	Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	-	Mixed
Trust Head Office	First Response (Basildon, Billericay, Wickford)	Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	-	Mixed
Trust Head Office	OT Adult Community - Basildon	Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	24	Mixed
Trust Head Office	OT Intensive Outreach Team	Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	N/A	Mixed
Trust Head Office	Adult Community Psychology	Brentwood Resource Centre, Greenwich Avenue, Brentwood	N/A	Mixed
Trust Head Office	First Response	Brentwood Resource Centre, Greenwich Avenue, Brentwood	20	Mixed
Trust Head Office	Medical Adult	Brentwood Resource Centre, Greenwich Avenue, Brentwood	N/A	Mixed
Trust Head Office	Recovery & Wellbeing	Brentwood Resource Centre, Greenwich Avenue, Brentwood	20	Mixed
Trust Head Office	Family Group Conferencing (Trustwide & South Essex)	Chelmsford & Essex (C&E) Centre, New London Road, Chelmsford	-	Mixed
Trust Head Office	Specialist Mental Health Team	Chelmsford & Essex (C&E) Centre, New London Road, Chelmsford	12	Mixed
Trust Head Office	Stroke & Neuropsychology	Cherry Trees, Maldon & District Hospital, Spital Road, Maldon	Varies each month. Rota can be obtained upon request	Mixed
Trust Head Office	Access & Assessment	Cherry Trees, Maldon & District Hospital, Spital Road, Maldon	N/A	Mixed
Trust Head Office	Family Group Conferencing (Trustwide & South Essex)	Cherry Trees, Maldon & District Hospital, Spital Road, Maldon	-	Mixed

Location site name	Team name	Address	Number of clinics	Patient group (male, female, mixed)
Trust Head Office	Specialist Mental Health Team	Cherry Trees, Maldon & District Hospital, Spital Road, Maldon	12	Mixed
Trust Head Office	Specialist Psychosis	Cherry Trees, Maldon & District Hospital, Spital Road, Maldon	20	Mixed
Trust Head Office	Adult Community Psychology	Coombewood Centre, 1 Websters Way, Rayleigh, Essex	N/A	Mixed
Trust Head Office	Castle Point, Rayleigh & Rochford Recovery & Wellbeing	Coombewood Centre, 1 Websters Way, Rayleigh, Essex	N/A	Mixed
Trust Head Office	CMHT OT – Coombewood Resource Centre	Coombewood Centre, 1 Websters Way, Rayleigh, Essex	N/A	Mixed
Trust Head Office	Access & Assessment	Derwent Centre, Princess Alexandra Hospital Hamstel Road Harlow, Essex	N/A	Mixed
Trust Head Office	Specialist Mental Health Team	Derwent Centre, Princess Alexandra Hospital Hamstel Road Harlow, Essex	28	Mixed
Trust Head Office	Specialist Psychosis	Derwent Centre, Princess Alexandra Hospital Hamstel Road Harlow, Essex	80	Mixed
Trust Head Office	Access & Assessment	The Gables, Bocking End Road, Braintree	N/A	Mixed
Trust Head Office	Family Group Conferencing (Trustwide & South Essex)	The Gables, Bocking End Road, Braintree	-	Mixed
Trust Head Office	Specialist Mental Health Team	The Gables, Bocking End Road, Braintree	Occasional clinics on request	Mixed
Trust Head Office	Specialist Psychosis	The Gables, Bocking End Road, Braintree	20	Mixed
Trust Head Office	OT CMHT – Grays Hall	Grays Hall, Orsett Road, Grays, Essex	25	Mixed
Trust Head Office	Adult Community Psychology	Grays Hall, Orsett Road, Grays, Essex	N/A	Mixed
Trust Head Office	First Response (Grays)	Grays Hall, Orsett Road, Grays, Essex	4	Mixed
Trust Head Office	Medical Adult	Grays Hall, Orsett Road, Grays, Essex	N/A	Mixed
Trust Head Office	Thurrock Recovery & Wellbeing	Grays Hall, Orsett Road, Grays, Essex	20	Mixed
Trust Head Office	Specialist Mental Health Team	35 East Stockwell Street, Colchester	-	Mixed
Trust Head Office	Family Group Conferencing (Trustwide & South Essex)	35 East Stockwell Street, Colchester	-	Mixed

Location site name	Team name	Address	Number of clinics	Patient group (male, female, mixed)
Trust Head Office	Psychotherapy	35 East Stockwell Street, Colchester	N/A	Mixed
Trust Head Office	Recovery Support Team	Herrick House 35 East Stockwell Street, Colchester	N/A	Mixed
Trust Head Office	Specialist Psychosis	Holmer Court, Essex Street, Colchester	96	Mixed
Trust Head Office	Southend Resource Therapy Centre	Jubilee Centre, 112a-114a South Church Road, Southend On Sea	-	Mixed
Trust Head Office	Adult Community Psychology	Knightswick Clinic, Folksville Road, Canvey Island, Essex	N/A	Mixed
Trust Head Office	Intensive Outreach Team (covering all South services excluding Thurrock)	Knightswick Clinic, Folksville Road, Canvey Island, Essex	-	Mixed
Trust Head Office	Access & Assessment	The Lakes Turner Road Colchester Essex	N/A	Mixed
Trust Head Office	NHS Transition, Intervention and Liaison (TIL) Veterans Mental Health Service	The Lakes Turner Road Colchester, Essex	N/A	Mixed
Trust Head Office	Psychotherapy	The Lakes Turner Road Colchester, Essex	N/A	Mixed
Trust Head Office	Specialist Mental Health Team	The Lakes Turner Road Colchester, Essex	-	Mixed
Trust Head Office	Specialist Mental Health Team	Latton Bush, Latton Bush, Southern Way, Harlow,	20	Mixed
Trust Head Office	Specialist Psychosis	Latton Bush, Latton Bush, Southern Way, Harlow,	N/A	Mixed
Trust Head Office	Access & Assessment	Puddings Wood Drive Broomfield Chelmsford, Essex	N/A	Mixed
Trust Head Office	Family Group Conferencing (Trustwide & South Essex)	Puddings Wood Drive Broomfield Chelmsford, Essex	-	Mixed
Trust Head Office	Specialist Psychosis	Puddings Wood Drive Broomfield Chelmsford, Essex	N/A	Mixed
Trust Head Office	Early Intervention	Pride House, Christy Close, Laindon, Essex	N/A	Mixed
Trust Head Office	Adult Community Psychology	Union Lane Rochford, Essex	N/A	Mixed
Trust Head Office	Early Intervention	Union Lane Rochford, Essex	N/A	Mixed
Trust Head Office	First Response South East	Union Lane Rochford, Essex	-	Mixed

Location site name	Team name	Address	Number of clinics	Patient group (male, female, mixed)
Trust Head Office	Medical Adult	Union Lane Rochford, Essex	N/A	Mixed
Trust Head Office	Community Stroke Psychology	Southend Hospital, Prittlewell Chase, Westcliff-on-Sea, Essex	N/A	Mixed
Trust Head Office	Complex & Psychotherapy Team (East)	Warrior House, 42-82 Southchurch Road, Southend-on-Sea, Essex	N/A	Mixed
Trust Head Office	Personality Disorder Service	Warrior House, 42-82 Southchurch Road, Southend-on-Sea, Essex	N/A	Mixed
Trust Head Office	Psychotherapy Department - Southend, Castlepoint & Rayleigh	Warrior House, 42-82 Southchurch Road, Southend-on-Sea, Essex	N/A	Mixed
Trust Head Office	Adult Community Psychology	Warrior House, 42-82 Southchurch Road, Southend-on-Sea, Essex	N/A	Mixed
Trust Head Office	Medical Adult	Thurrock Community Hospital Long Lane Grays Essex	N/A	Mixed
Trust Head Office	Medical Adult (Inc Lithium clinic)	Warrior House, 42-82 Southchurch Road, Southend-on-Sea, Essex	N/A	Mixed
Trust Head Office	Psychotherapy	Warrior House, 42-82 Southchurch Road, Southend-on-Sea, Essex	N/A	Mixed
Trust Head Office	Southend Recovery & Wellbeing	Warrior House, 42-82 Southchurch Road, Southend-on-Sea, Essex	N/A	Mixed
Trust Head Office	Access & Assessment	Chelmsford & Essex (C&E) Centre, New London Road, Chelmsford	N/A	Mixed
Trust Head Office	Medical Adult	Basildon Resource Centre, Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	N/A	Mixed
Trust Head Office	Basildon Recovery & Wellbeing	Basildon Resource Centre Basildon Mental Health Unit Nethermayne Basildon, Essex	4	Mixed
Trust Head Office	Specialist Mental Health Team	1st Floor Rectory Lane Health Centre Loughton, Essex	28	Mixed
Trust Head Office	Specialist Psychosis	Chelmsford & Essex (C&E) Centre, New London Road, Chelmsford	16	Mixed
Trust Head Office	Access & Assessment	Latton Bush, Latton Bush, Southern Way, Harlow,	12	Mixed

Location site name	Team name	Address	Number of clinics	Patient group (male, female, mixed)
Trust Head Office	Access & Assessment	Western House, Chapel Hill, Stansted	8	Mixed
Trust Head Office	Access & Assessment	Rectory Lane Community Clinic, Rectory lane, Loughton, Essex	12	Mixed

Is the service safe?

Safe and clean environment

Staff undertook annual audits of the environment assessing for potential ligatures. A ligature point is a place to which patient's intent on self-harm could tie something to harm themselves.

Managers identified ligature points and recorded how to minimise the risk to patients. This was communicated to staff.

Patients could access the Chelmsford team site without staff knowledge as access was not restricted. Managers stated in the ligature risk assessment that staff mitigated any risk through use of observation and patients would not be left alone in interview rooms.

Staff had access to lone worker tracking devices and there were appropriate alarms in case of an incident. All services used the lone worker policy and where staff had identified risks with patients, two staff members visited.

Maintenance, cleanliness and infection control

All areas were clean, had good furnishings and were well maintained. We observed housekeepers cleaning the team bases during inspection. Cleaning records were up to date and demonstrated that staff cleaned areas regularly. Managers monitored the cleanliness of building.

Staff adhered to infection control principles including handwashing. Hand gel dispensers were in place in all clinical areas and we observed staff using these during our inspection.

Clinic room and equipment

Clinic rooms were fully equipped with accessible equipment. The clinic was shared with other services in Basildon, and there was a lack of clarity about which team was responsible for maintaining the clinic. Consequently, we found several medications that were out of date. This was reported to staff who immediately removed the medication and raised the issue as an incident.

Staff maintained equipment well, ensured calibration was undertaken and was kept clean. We found that green 'clean' stickers were visible and in date.

Safe staffing

This core service has reported a vacancy rate for all staff of 13% as of 31 January 2018.

This core service reported an overall vacancy rate of 14% for registered nurses at 31 January 2018 and 9% for nursing assistants.

Team	Registered nurses			Health care assistants			Overall staff figures		
	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Access & Assessment / Home Treatment Team	1.09	68.09	2%	3.61	36.36	10%	15.19	134.8	11%
Adult Community Psychology							-0.32	16.44	-2%
Adult Psychology							-1.37	8.83	-16%
AOT Thurrock	2.60	3.6	72%	0.00	1.6	0%	2.60	5.2	50%
Arts Therapies East							-0.07	1.05	-7%
Community Adult Mental Health Team (North Essex)							5.15	24.4	21%
Community Mental Health Social Care Adult	0.00	1	0%				1.19	11.76	10%
E- Specialist Mental Health	2.90	14	21%	0.66	12.46	5%	5.57	45.7	12%
E- Specialist Psychosis	0.79	16	5%	1.11	11.71	9%	6.49	44.9	14%
Early Intervention	1.74	23.25	7%	0.00	3	0%	1.64	31.75	5%
First Response Basildon	1.53	4.53	34%				1.53	4.53	34%
First Response Brentwood	1.00	1	100%				1.00	1	100%
First Response South East	4.14	9.7	43%	0.00	1	0%	4.14	10.7	39%
First Response Thurrock	2.01	4	50%	0.00	1	0%	2.01	5	40%
Intensive Outreach Team	3.21	8.01	40%	0.53	2.33	23%	5.74	13.34	43%
M- Specialist Mental Health	3.55	15	24%	3.24	14.63	22%	11.97	50.57	24%
M- Specialist Psychosis	2.80	14	20%	-0.03	9.5	0%	5.02	40.46	12%

	Registered nurses			Health care assistants			Overall staff figures		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Personality Disorder Service	0.00	1	0%				-0.05	2.75	-2%
Psychology Trainees							-5.50	30	-18%
Psychotherapy							0.30	5.45	5%
Psychotherapy East							0.00	1.8	0%
Recovery Support Team	0.00	1	0%				1.00	5.4	19%
Recovery Wellbeing Basildon	0.00	6.75	0%	0.01	1.3	1%	0.01	9.05	0%
Recovery Wellbeing Brentwood	0.65	2.65	25%				0.65	2.65	25%
Recovery Wellbeing Cpr	0.00	11	0%	0.00	1.5	0%	0.20	13.5	1%
Recovery Wellbeing Southend	2.05	14	15%	0.50	2.3	22%	2.55	16.3	16%
Recovery Wellbeing Thurrock	0.00	5	0%	0.00	0.33	-1%	0.00	5.33	0%
Southend Resource Therapy Centre	1.00	1	100%				1.00	2.6	38%
Stroke & Neuro Psychology				0.00	1.6	0%	1.10	4.7	23%
Stroke Community Service							-0.88	1	-88%
Stroke Southend Hospital Ft							0.29	1.5	20%
Veterans Mental Health Service				0.00	2	0%	0.00	4	0%
W- Specialist Mental Health	3.00	15	20%	2.35	12.6	19%	8.97	42.4	21%
W- Specialist Psychosis	1.60	15	11%	-1.04	9.09	-11%	4.02	41.39	10%
Core service total	**35.67**	**254.58**	**14%**	**10.93**	**124.31**	**9%**	**81.15**	**640.25**	**13%**
Trust total	**1655.28**	**11061.65**	**15.0%**	**1002.03**	**8846.71**	**11.3%**	**4284.55**	**30928.44**	**13.9%**

NB: All figures displayed are whole-time equivalents

Between 1 April 2017 and 31 January 2018, bank staff filled 4,735 shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 3757 shifts for qualified nurses. No shifts were left unfilled by either bank or agency staff.

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
AOT Essex	4	0	4	0
AOT Thurrock	136	2	134	0
CRHT West	232	75	167	0
Early Intervention Team	277	0	277	0
East Adult Home Treatment	403	403	0	0
First Response Basildon	432	128	304	0
First Response Brentwood	79	0	79	0
First Response South East	668	274	394	0
First Response Thurrock	133	0	133	0
Health Outreach	95	95	0	0
Intensive Outreach Team	686	107	579	0
Liaison Service West	313	196	119	0
MH Recovery Team	46	46	0	0
Mid Access/Assess Home Treatment	167	149	0	0
NE Access & Assess	808	808	0	0
NE Recovery Support Service	12	12	0	0
NE Specialist MH	235	186	0	0
NE Specialist Psychosis Team	131	131	0	0

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Perinatal MH SE Essex	37	37	0	0
Raid East	1190	1085	105	0
Raid West	375	346	29	0
Recovery Wellbeing Basildon	139	60	79	0
Recovery Wellbeing Brentwood	360	1	359	0
Recovery Wellbeing CPR	322	161	161	0
Recovery Wellbeing Southend	818	383	435	0
Recovery Wellbeing Thurrock	128	15	113	0
Specialist MH	235	35	198	0
West Specialist Psychosis	21	0	21	0
Core service total	**8,482**	**4,735**	**3757**	**0**
Trust Total	**102,629**	**31,709**	**12,577**	**795**

***Percentage of total shifts

Between 1 April 2017 and 31 January 2018, 744 shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, agency staff covered 11 shifts. No shifts were left unfilled by either bank or agency staff.

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Adult Eating Disorders	49	49	0	0
Adult Home Treatment	17	17	0	0
CRHT West	54	54	0	0
East Adult Home Treatment	112	112	0	0
Eating Disorders	99	99	0	0
Health Outreach	24	24	0	0
Liaison Service West	2	2	0	0

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Mid Access/Asses s Home Treatment	1	1	0	0
NE Access & Assess	4	4	0	0
NE Recovery Support Service	125	125	0	0
Raid East	160	149	11	0
Recovery Wellbeing Basildon	43	43	0	0
Specialist MH	59	59	0	0
Specialist Psychosis	6	6	0	0
Core service total	**755**	744	11	0
Trust Total	**144,009**	**60,464**	**5,916**	**804**

This core service had 31 (6%) staff leavers between 1 April 2017 and 31 January 2018.

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
300 Veterans Mental Health Service	4.00	0.00	0%
300 Martello Acute Recovery Team	2.74	0.00	0%
300 Dietetics East	1.00	0.00	0%
300 E- Specialist Mental Health	40.43	6.00	15%
300 Stroke & Neuro Psychology	4.00	0.30	8%
300 W - Specialist Psychosis	51.44	2.70	5%
300 W- Specialist Mental Health	40.85	4.70	12%
300 Medical Psychotherapy Epping	0.50	0.00	0%
300 Marginal'd & Vulnerable Adults	16.62	0.00	0%
336 EF893 Bedfordshire CH Psychology	1.00	0.00	0%
364 EB134 Medical Adult and Older People	49.30	3.00	6%

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
364 EE323 Recovery Wellbeing Cpr	13.80	0.00	0%
364 EE324 Recovery Wellbeing Southend	14.50	4.00	28%
364 EE326 First Response South East	8.02	0.80	10%
364 EE570 Early Intervention	28.31	0.00	0%
364 EF329 Physiotherapy	5.34	0.10	2%
364 EF421 OT Adult Community	20.06	0.00	0%
364 EA730 MH Discharge Team	2.50	1.00	40%
364 EE703 Recovery Wellbeing Basildon	9.04	0.00	0%
364 EE710 First Response Basildon	4.03	1.12	28%
364 EF730 Psychotherapy	5.76	0.00	0%
364 EF784 Adult Community Psychology	9.67	0.80	8%
364 EF831 Personality Disorder Service	2.37	0.00	0%
364 EE356 Resource Centre Southend	2.60	0.00	0%
364 EE700 AOT Thurrock	3.60	0.00	0%
364 EE701 Recovery Wellbeing Thurrock	5.30	0.00	0%
364 EE702 First Response Thurrock	2.99	0.00	0%
364 EE707 Recovery Wellbeing Brentwood	2.04	0.00	0%
364 EE711 First Response Brentwood	1.00	0.00	0%
300 Veterans Mental Health Service	4.00	0.00	0%
300 Martello Acute Recovery Team	2.74	0.00	0%
300 Dietetics East	1.00	0.00	0%
300 E- Specialist Mental Health	40.43	6.00	15%
300 Stroke & Neuro Psychology	4.00	0.30	8%
300 W - Specialist Psychosis	51.44	2.70	5%

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
300 W- Specialist Mental Health	40.85	4.70	12%
300 Medical Psychotherapy Epping	0.50	0.00	0%
Core service total	497.14	31	6%
Trust Total	3127.64	253	7%

The sickness rate for this core service was 4% between 1 April 2017 and 31 January 2018. The most recent month's data (January 2018) showed a sickness rate of 4%.

'Mental Health Discharge Team' had the highest annual sickness rate with 19%.

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
364 EE323 Recovery Wellbeing Cpr	23%	8%
364 EE324 Recovery Wellbeing Southend	0%	1%
364 EE326 First Response South East	2%	7%
364 EE570 Early Intervention	5%	5%
364 EF421 OT Adult Community	4%	4%
364 EA730 MH Discharge Team	0%	19%
364 EE703 Recovery Wellbeing Basildon	16%	12%
364 EE707 Recovery Wellbeing Brentwood	0%	0%
364 EE710 First Response Basildon	0%	5%
364 EF421 Occupational Therapy (OT) Adult Community Mental Health	15%	2%
364 EF730 Psychotherapy	2%	3%
364 EF784 Adult Community Psychology	0%	4%
364 EF831 Personality Disorder Service	0%	3%
364 EE501 Intensive Outreach Team	5%	2%
364 EE356 Resource Centre Southend	2%	0%
364 EE700 AOT Thurrock	0%	0%

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
364 EE701 Recovery Wellbeing Thurrock	1%	5%
364 EE702 First Response Thurrock	0%	0%
364 EE711 First Response Brentwood	0%	0%
364 EE509 AOT Essex	0%	0%
300 Stroke & Neuro Psychology	25%	15%
300 West Occupational Therapy Services	4%	1%
300 E- Specialist Psychosis	3%	2%
300 Art & Drama Therapy East	0%	0%
300 Psychotherapy East	0%	0%
300 CPA	0%	0%
300 M- Specialist Mental Health	4%	5%
300 M- Specialist Psychosis	6%	4%
300 M-Access/Assess & Home Treat	5%	3%
300 Medical Adult Mid	0%	0%
300 Psychology in Acute Spec. Teams	1%	2%
300 Heads Up Service	1%	1%
300 E- Recovery	7%	3%
300 E- Access/Assess &Treatment	0%	3%
300 Veterans Mental Health Service	0%	9%
300 Physiotherapy East	0%	0%
300 E- Specialist Mental Health	1%	3%
300 W - Specialist Psychosis	0%	1%
300 W- Specialist Mental Health	4%	1%

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
300 Day Serv Hub & Adult Inpat OT	3%	2%
300 W- Access/Assess & Home Treat	8%	5%
300 Marginal'd & Vulnerable Adults	3%	3%
Core service total	**4%**	**4%**
Trust Total	**4%**	**4%**

Managers had calculated the number and grade of members of the multi-disciplinary team required. The number of staff did not match this number in all teams, due to staff vacancies and long-term sickness. Resources in Southend, Basildon and, in particular, Brentwood did not meet demand and identified patient need, which had resulted in high caseloads.

The team manager could adjust staffing levels. However, there was no cover available for social workers who had been seconded from the county council. Cover for social care staff was provided from within the service via a buddy system, which had resulted in higher caseloads and increased stress for staff within the teams.

Managers, where possible, arranged agency and bank nursing staff to maintain safe staffing levels. Managers used agency staff who knew the service. Where agency and bank staff were used, they received an induction to the team.

Staffing levels allowed patients to have regular appointments and one-to-one time with their care coordinator. Staff within some of the teams inspected raised concerns about caseload sizes and available resources to meet demand. We found that this was particularly an issue in Basildon, Southend and Brentwood, where caseloads were more than 40 patients. Managers were assessing caseloads in terms of risk and we did not however find any impact of high caseload on incidents.

Medical staff

Between 1 April 2017 and 31 January 2018, none of the shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same time period, agency staff covered 569 shifts, 635 shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Adult Community / Psychotherapy CT	127			127
Adult Community CT	326		72	254
Adult Community ST	127			127
General Adult	290		290	

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
General Adult Community ST	127			127
Specialist Dementia	179			
Specialist Mental Health	118		118	
Specialist Psychosis	89		89	
Core service total	1383	0	569	635
Trust Total	**6744**	**258**	**3406**	**3080**

Access to psychiatrists was a challenge across the service. Consultants were covering the caseloads of vacant posts and there was a lack of junior medical input in Clacton. Managers had not filled the posts with temporary staff.

There was no allocated consultant for the intensive outreach team. This was described as difficult and challenging by both staff and patients due to the availability of consultants from core teams.

We found some good examples of joint working arrangements with general practitioners. This included shared care arrangements for patients on certain medications and rapid access to consultant psychiatrists for general practitioners when patients were in crisis.

Patients described medical staff as helpful and caring. We were told that doctors had explained to patient's different medication and treatment options, their side effects and had checked the patient's level of understanding.

Mandatory training

The compliance for mandatory and statutory training courses at 31 December 2017 was 78%. Of the training courses listed 29 failed to achieve the trust target and of those, 21 failed to score above 75%.

Managers made us aware that there had been issues with recording training on the trusts training database following the merger. Managers gave examples of staff who had successfully completed training, but this had not registered on the system. Managers showed us local records which showed that mandatory training was around 80%.

The trust has a rolling month on month compliance rate for mandatory training.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	Compliance
Health and Safety (Slips, Trips and Falls)	100%
Care Certificate	100%
Cascade Fire Trainer	100%
Diabetes Training	100%
First Aid Trained	100%
LAC e-learning	100%
Medicines Management (community)	100%

Training course	Compliance
Dual Diagnosis	97%
Mental Capacity Act Level 1	97%
Corporate Induction	97%
Duty of Candour (Overview Version)	96%
Induction E-Learning	96%
Care Programme Approach	92%
Harassment & Bullying	92%
Equality and Diversity	91%
PREVENT (WRAP) Training	90%
Complaints Handling	88%
Safeguarding Adults (Level 1)	88%
Safeguarding Adults (Level 3)	87%
Safeguarding Children (Level 3)	85%
Duty of Candour (Detailed Version)	85%
Conflict Resolution	85%
Clinical Risk Assessment	84%
Safeguarding Children (Level 2)	83%
Information Governance	78%
Fit for Work	77%
Fire In-patient	75%
Fire Safety 2 years	72%
Mental Capacity Act Level 2	72%
Basic Life Support & AED	71%
Personal Safety - MVA	70%
Mental Health Act	69%
Food Hygiene	69%
Consent	67%
Dementia Awareness (inc Privacy & Dignity standards)	67%
Hoisting	67%
TASI Trained	67%
Personal Safety Breakaway - Level 1	66%
Infection Prevention, Control & Hand Hygiene	58%
Medication Management (MH)	57%
Manual Handling - People	54%
MERT (Enhanced Emergency Skills)	50%
Security Training	50%
Observation of Service User	45%
Fire Safety 3 years	26%
Anaphylaxis	0%
Hoisting e-learning	0%
Security Training (eLearning)	0%
Total	78%

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 40 patient records. Staff within the first response team undertook a risk assessment of patients on referral to the service. Staff updated risk assessments every six months as a

minimum, or when there was any change in the patients' level of risk. Staff discussed the outcome in the multi-disciplinary meetings to create the treatment plan for patients.

Staff used the trust risk assessment tool, and completed further specialised assessment tools where required.

Management of patient risk

Staff were aware of and dealt with any specific risk issues as they arose. Patients were seen quickly where required, and there was a duty system in place to ensure that staff were available to respond.

Staff included crisis and contingency plans in risk management documents. This was not the case in Canvey Island and Basildon. Five records in each team did not contain crisis and contingency plans.

The treatment team in Chelmsford rated patient risk as high medium or low, and closely tracked patient risks on an ongoing basis. This was an objective ongoing dynamic process, where all members of the multidisciplinary team could review clinical outcomes. We found that since the introduction of the specialised treatment team, there had been a reduction in the patients who were rated as a high risk within the service.

Staff sign posted patients to other services where appropriate. This included services within the third sector, education and employment services. Staff also shared a range of self-help information with both patients and carers.

Staff identified and responded to changing risks to, or posed by patients. Staff discussed these in the multidisciplinary meetings where the appropriate plan of care was agreed.

The service had developed good personal safety protocols, including lone working practices. In the community staff had access to satellite badges that enabled staff to have a third party listen in to the conversation and track their whereabouts in order to send help. Staff also recorded their location in their electronic diary and operated a buddy system with colleagues whom they would call at the end of the day to let them know they were safe. Staff visited high risk patients in pairs.

Staff adhered to best practice in implementing a smoke-free policy across the Trust. We found that staff offered patients advice and support regarding smoking cessation.

We found a robust procedure in place for responding to patients who did not attend planned appointments. Staff actions included assertive outreach, including cold calls to the patient's home address, contacting family and carers and contacting the police to request a welfare check.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

We were unable to provide a breakdown of safeguarding referrals for this core service, as the data was provided at trust level.

Staff were not all up to date with safeguarding training. Managers advised that staff, however, knew how to make a safeguarding alert, and did so when appropriate. This was evident when staff were interviewed. Staff understood safeguarding processes and procedures. Staff reported all safeguarding incidents and concerns.

Staff gave examples of how to protect patients from harassment and discrimination. This included patients with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.

Staff knew how to identify adults and children at risk of, or suffering significant harm. We found a number of examples where the action of staff had identified safeguarding issues. One of these was a high-risk situation involving a child, staff had responded swiftly and the child was protected.

There was a safeguarding team in the trust. The service reported good working relationships with the safeguarding team, and worked in partnership with other agencies.

Staff access to essential information

The service used an electronic health record. Information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form. This included when patients moved between teams. Over a third of staff reported problems with the electronic health record.

Staff told us that the information systems were poor and time consuming. Improvement plans were in place to address this.

Medicines management

Staff had not always followed good practice in medicines management. We found that there was a week's gap in the recording of medication fridge temperatures in the Linden Centre, Chelmsford and the Taylor centre Southend. This was not an immediate safety concern however, as the medication used could be stored for seven days at room temperature. On three days in May the maximum fridge temperature in Chelmsford had been recorded as 26.1°C. This temperature is higher than the maximum temperature should be. Pharmacy had not been advised of either lapse in fridge temperature recordings, and staff had not reported as incidents. All room temperature records were within normal range.

We found drugs that had expired in the shared clinic in Basildon. Staff removed these immediately and reported as an incident. There were also three blood bottles that expired in April 2018, a saliva testing kit, which expired in December 2017, and a bottle of solution for testing saliva which had expired in February 2018. There was no system to date check non-medicine stock in the clinic room.

We found that out of the 18 prescriptions for depot medication, 15 did not have a review date in place. The service stored blank prescription forms securely Therefore the service would not necessarily identify if blank prescription forms went missing.

The service did not receive regular visits from the pharmacy team. The pharmacy lead for the service was aware that there was a gap in the service and they were in the process of going through a consultation to expand the pharmacy team.

Staff reviewed the effects of medication on patients' physical health regularly and in line with the National Institute for Health and Care Excellence guidance, especially when the patient was prescribed a high dose of antipsychotic medication.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 January 2018 there were 50 STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was 'Apparent/actual/suspected self-inflicted harm meeting SI criteria' with 45.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable/ with STEIS. There were two differences, which appeared in the STEIS data, two incidents had been reported in the trust serious incidents. However, they were not within STEIS.

Type of incident reported on STEIS	Apparent/actual/suspected homicide meeting SI criteria	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Pending review (a category must be selected before incident is closed)	Slips/trips/falls meeting SI criteria	Total
AMHP Hub		1			1
Basildon MHU (CMHT)		2			2
Chelmsford & Essex Adult Recovery Team		1			1
Chelmsford and Essex Adult Recovery Team		2			2
Chelmsford and Essex Adult Recovery Team		1			1
CMHT Thurrock		1			1
Early Intervention & Psychosis		1			1
Epping Forest Adult Recovery Team		1			1
First Response Team (East) (CMHT)		1			1
FRT Basildon		3	1		4
FRT Brentwood		1			1
FRT East		3			3
FRT Thurrock		1			1
Grays Hall (CMHT)		1			1
Grays Hall CMHT		1			1
Harlow Adult Recovery Team		1			1
IAPT		2			2
Mid Essex CMHT	1				1
Mid-Essex Specialist Psychosis Service		3			3
Mid-Essex Specialist Psychosis Service	1				1
North East Area AMHP		1			1
Psychotherapy		1			1
Recovery & Wellbeing Brentwood		1			1
Recovery & Wellbeing CP&R		1			1
Recovery & Wellbeing Southend		3			3
Recovery and Wellbeing Brentwood - Community Mental Health Team (CMHT)		1			1

Type of incident reported on STEIS	Apparent/actual/suspected homicide meeting SI criteria	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Pending review (a category must be selected before incident is closed)	Slips/trips/falls meeting SI criteria	Total
Recovery and Wellbeing Southend - Community Mental Health Team (CMHT)		1			**1**
Specialist Mental Health Team		1			**1**
Specialist Mental Health Team (North Essex)				1	**1**
Specialist Mental Health Team Mid		1			**1**
Specialist MH Team		1			**1**
Specialist MHT		2			**2**
Specialist MHT East		1			**1**
Specialist Psychosis			1		**1**
Specialist Psychosis Team		2			**2**
Total	**2**	**45**	**2**	**1**	**50**

Of the ten adult community mental health teams inspected, Harlow, Southend and Clacton had no serious incidents requiring investigation over the previous 12 months. There had been nine serious incidents requiring investigation across the remaining seven teams. These were in Brentwood, Stansted and Basildon.

Staff described learning from the investigations completed to date. One example shared from a serious incident highlighted the need to update risk assessments and care plans following any change in the patients' presentation. This had been shared across teams.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. Incidents were reported via the electronic incident reporting system, and any staff could report an incident. Staff reported all incidents that they should report in most teams; however, the manager reported that there had been a low reporting culture in Brentwood. The team manager, was actively working with the team to increase awareness of reporting low-level incidents.

Staff understood the duty of candour. Staff were open and transparent, and gave patients and families a full explanation if things went wrong. Staff offered face to face feedback following incidents and where this was not possible, telephoned the patient and or carer.

Staff confirmed that they received feedback from investigation of incidents, both internal and external to the service. We found that there was learning shared widely across the service, both from individual team incidents, and from across the service. Staff met to discuss that feedback in team meetings, business meetings, lessons learned meetings, learning from incidents support groups and via team briefs.

Managers made changes because of feedback. Staff could share examples of learning, including recent changes which had been made around transitions of care and arrangements for follow up following discharge from hospital.

We found that staff had been debriefed and received support after all serious incidents, and arrangement for ongoing support and staff wellbeing via occupational health had been provided.

Is the service effective?

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of patients in a timely manner, including an assessment of the patients' physical health. We found that all teams had physical health clinics and specialised physical healthcare assessments for patients who were taking certain medications. There were also well-being clinics in place.

Staff developed care plans, which met the needs identified during assessment. We found that across all team's staff discussed the outcome of patient assessments in the multidisciplinary meetings. The team discussed and agreed care plans and treatment options.

We inspected forty patient care records. We found that the majority of patient care plans were personalised, holistic and recovery-oriented. However, of the forty care plans inspected, five were not personalised, six were not holistic and nine were not recovery focused.

Staff updated care plans when necessary. Patients told us that they were involved in their care planning process, including ongoing care plan reviews.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. This included medication and access to psychological therapies, education and employment via employability.

Teams had input from psychologists who provided a range of psychological assessments, including psychological profiling, and support and training for other members of the multidisciplinary team. Staff also provided a range of psychological interventions including cognitive and dialectical behavioural therapies.

Staff ensured that patients had good access to physical healthcare, including physical health clinics and referrals to specialists when needed. We found that there was joint working in place with general practitioners, and there were shared care arrangements in place for a range of physical health tests including blood tests and electrocardiograms. There were dedicated physical health workers in Stansted and nurses led on physical healthcare within other teams.

Staff supported patients to live healthier lives. This included providing advice and support on smoking cessation schemes and providing advice on healthy eating and exercise.

Staff used recognised rating scales to assess and record severity and outcomes. The main outcome measure in use was the health of the nation outcome scale.

Staff used technology to support patients effectively, for prompt access to blood test results in the majority of teams, and online access to self-help tools.

Staff participated in a national and local clinical audits, benchmarking and quality improvement initiatives. This included record keeping at a team level and a national audit on the use of depot medications.

This core service participated in two clinical audits as part of their clinical audit programme.

Audit name / title	Key Successes	Key concerns	Key actions following the audit
Audit Record	Baseline Audit to identify areas for	Particular attention is required by teams to address a number	Physical Health findings to be feedback to PHAIG (Physical Health Action

Keeping/CPA Community MH services	improvement. Wards in the North of EPUT appear to have performed better and therefore duplicating work from this area across the south will be beneficial	of issues within the individual standards for record keeping, particularly where teams struggled to meet the minimum target for compliance for Physical health, Consent/capacity, Crisis, Carers & involvement. Robust processes need to be put into place to address the improvements required by teams with some shared learning to support teams to address their individual record keeping issues.	Implementation Group) Recommendations have to be carried forward to the Secure Service Quality Group Individual ward action plan to be created where required) Nursing Staff to ensure all relevant records has been completed and updated as required by the Record keeping policy CP61 Re-audit of Record Keeping Audit
POMHuk 17a Use of Depot	Findings under review- action plan in progress		

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients. Multidisciplinary teams included doctors, nurses, occupational therapists, clinical psychologists, social workers, employment workers and peer support workers. Input from other specialists including pharmacists, speech and language therapists and dieticians, were accessed from a central team.

Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. Staff in the assessment teams had expertise in mental health assessments and worked in close collaboration with colleagues in the acute hospitals. We found that the treatment team in Brentwood had a good understanding and expertise in working with patients with personality disorders. Psychology staff had good arrangements in place for continual professional development and ongoing training.

Managers provided new staff with appropriate induction. This included bank, agency and locum staff.

Managers provided staff with supervision to discuss case management, to reflect on and learn from practice, and for personal support and professional development. All staff interviewed told us that they had received an annual appraisal of their work performance, which was linked to personal development plans. Managers ensured that staff in all teams had access to regular team meetings.

The trust's target rate for appraisal compliance is 90%. As at 31 January 2018, the overall appraisal rates for non-medical staff within this core service was 70%. Of the 47 teams, 17 failed to achieve the trust's appraisal target, 20 of the teams achieved an appraisal compliance rate of 100%.

No appraisal data was submitted by the trust for medical staff in this core service during this period.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Adult Community Psychology	5	5	100%
AOT Southend	1	1	100%
Art Therapy	1	1	100%
First Response Basildon	3	3	100%
First Response South East	8	8	100%
First Response Thurrock	2	2	100%
Health and Well-Being OT Ld	10	10	100%
Intensive Outreach Team - Essex	6	6	100%
MH Arts & Drama Therapy	2	2	100%
MH Discharge Team	1	1	100%
NORTH - ECC Family Group Conferences	4	4	100%
Open Arts	1	1	100%
OT Management and Training	1	1	100%
Personality Disorder Service	3	3	100%
Physiotherapy	9	9	100%
Psychotherapy	2	2	100%
Raid West	8	8	100%
Recovery Wellbeing Brentwood	1	1	100%
Recovery Wellbeing Thurrock	5	5	100%
Stroke Southend Hospital FT	1	1	100%
Early Intervention	26	25	96%
Recovery Wellbeing Southend	14	13	93%
OT Adult Community	20	18	90%
Recovery Wellbeing Cpr	14	12	86%
Specialist Mental Health	36	27	75%
Specialist Psychosis	39	29	74%
Specialist Psychosis	38	27	71%
AOT Thurrock	3	2	67%
Stroke & Neuro Psychology	6	4	67%
Specialist MH Recovery	29	19	66%
Access/ Assessment & Home Treat	71	42	59%
Recovery	4	2	50%
Arts Therapies East	2	1	50%
Resource Centre Southend	2	1	50%
Specialist Mental Health	39	19	49%
Access/Assessment &Treatment	41	14	34%
Adult Home Treatment	13	3	23%
Martello Acute Recovery Team	1	0	0%
Psychotherapy East	1	0	0%
Veterans Mental Health Service	3	0	0%
Core service total	**476**	**332**	70%
Trust wide	4121	3386	82%

Between 1 April 2017 and 31 January 2018, the average clinical supervision rate across all 27 teams in this core service was 75% against the trust's 90% target.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Adult Community Psychology	10	10	100%
First Response Basildon	30	30	100%
NORTH - ECC Family Group Conferences	30	30	100%
Personality Disorder Service	10	10	100%
Recovery Wellbeing Brentwood	11	11	100%
Stroke Southend Hospital FT	4	4	100%
Recovery Wellbeing Basildon	90	89	99%
Castle Point, Rayleigh & Rochford Recovery & Wellbeing	130	127	98%
First Response Thurrock	23	22	96%
Intensive Outreach Team - Essex	53	51	96%
OT Adult Community	70	67	96%
Recovery Wellbeing Thurrock	50	48	96%
Early Intervention	244	231	95%
First Response South East	80	76	95%
Recovery Wellbeing Southend	140	125	89%
AOT Thurrock	32	28	88%
Specialist Psychosis	461	390	85%
AOT Southend	10	8	80%
Recovery Support Team	209	165	79%
Specialist Mental Health	436	346	79%
Access/ Assessment & Home Treat	564	436	77%
Recovery	20	15	75%
Access & Assessment	194	118	61%
W- Specialist Psychosis	9	5	56%
Access/Assessment &Treatment	230	90	39%
Veterans Mental Health Service	30	10	33%
Recovery Support Team (Psychology Trainees)	229	10	4%

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Core service total	**3,399**	**2,552**	**75%**
Trust Total	**24,386**	**21,061**	**86%**

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers ensured that staff received the necessary specialist training for their roles.

Staff advised that managers were supportive in relation to ongoing development. Recent staff training had included psychological based training, relational trauma training and associate practitioner training for support workers. In line with trust policy, access to specialist training was dependant on staff completion of mandatory training. Staff told us that due to current problems with the training database, this was a potential barrier to ongoing development.

Managers dealt with poor staff performance promptly and effectively. Managers provided several good examples where concerns had been raised, and described how they had been responded to quickly and proactively.

Multidisciplinary and interagency team work

Staff in all teams held regular and effective multidisciplinary meetings and shared information about patients at team meetings. We found that there were close multidisciplinary working arrangements in place across all teams.

The community mental health teams had effective working relationships, including good handovers with other relevant teams within the organisation. This included the access and assessment team, ward staff and care co-ordinators from other community mental health teams. However, staff in the treatment teams described a number of barriers in accessing out of hours support from the crisis team.

The community mental health teams reported effective working relationships with teams outside the organisation. This included the local authority, safeguarding boards, police, other providers and general practitioners.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

As of 31 December 2017, 58% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years. We found that staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. Patients being cared for under community treatment orders were generally care coordinated by social workers or other professional groups who were trained approved mental health act professionals.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and how to contact them for advice and support.

The provider had relevant policies and procedures that reflected the most recent guidance.

Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice. Staff knew that these were in place and how to access them.

Patients had easy access to information about independent mental health advocacy.

Good practice in applying the Mental Capacity Act

As of 31 December 2017, 55% of the workforce had received training in the Mental Capacity Act level one and 95% in Mental Capacity Act level two. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

We found that the majority staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it. Staff knew where to get advice from within the organisation regarding the Mental Capacity Act, including deprivation of liberty safeguards.

Staff assumed that patients had capacity, and gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis regarding significant decisions. When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

During inspection we did not observe any arrangements to monitor adherence to the Mental Capacity Act. Staff did not identify any audits undertaken on the application of the Mental Capacity Act and action on any learning that resulted from it.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive. Staff provided patients with help, emotional support and advice at the time they needed it. Patients told us that staff showed genuine compassion towards them and their families.

Staff supported patients to understand and manage their care, treatment or condition. Patients told us that they had received a full explanation of their diagnosis, treatment options and side effects of medication.

Staff directed patients to other services when appropriate and if required, supported them to access those services. We saw good examples of patients accessing employment, education and local amenities for health and well-being including gyms and yoga using funding from personal health budgets.

Patients said staff treated them well and behaved appropriately towards them. All the 21 patients interviewed described staff as polite, respectful and caring. Patients identified a number of staff who had gone the extra mile, in terms of giving of their own time. One patient described staff as being "spot on and really professional".

We found that staff understood the individual needs of patients, including their personal, cultural, social, and religious needs, and considered these as integral to the care planning process.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. Staff told us that they would not hesitate to raise any concerns in relation to patient care.

Staff maintained the confidentiality of information about patients.

Involvement in care

Involvement of patients

Staff used the assessment process and during on-going appointments at which to inform patients about the service, and describe the treatments available. Staff had involved the majority of patients in care planning and risk assessment process.

Patients told us that staff had communicated with them so that they understood their care and treatment. This included staff finding effective ways to communicate with patients with communication difficulties. Patients told us that staff had taken time to explain diagnosis, treatment and side effects of medications to ensure that they understood.

Staff involved patients when appropriate in decisions about the service. Patients had been involved in the recruitment of staff. Staff told us that further patient involvement could be improved.

Staff enabled patients to give feedback on the service they received via surveys, although staff told us that the number of surveys undertaken was limited.

Care plan templates prompted staff to discuss with patients, the option of making an advance decision (to refuse treatment, sometimes called a living will) when appropriate. Staff ensured that patients could access advocacy.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. All Carers told us that they had been consulted regarding their relative's care, and had been given an explanation of treatment options and side effects. All carers described the service received as positive.

Staff enabled families and carers to give feedback on the service they received via surveys and carers groups.

Staff provided carers with information about how to access a carer's assessment.

Is the service responsive?

Access and waiting times

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

The trust has provided days from referral to initial assessment targets for five teams. Of these five targets, the core service met one.

Targets have not been provided for 'days from assessment to treatment'.

Name of hospital site or location	Name of team	Service Type	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
			Target	Actual (mean)	Target	Actual (mean)	
Linden Centre	ACCESS/ASSESSMENT	Adult MH Service	*Not provided*	**1**	*Not provided*	**1**	-
Crystal Centre	MEDICATION MONITORING	MH Medical	*Not provided*	**6**	*Not provided*	**124**	-
Linden Centre	SPECIALIST MENTAL HEALTH	Specialist MH Service	*Not provided*	**14.5**	*Not provided*	**8**	-
The Gables	SPECIALIST PSYCHOSIS	Specialist MH Service	*Not provided*	**8**	*Not provided*	**3.5**	-
The Lakes	ACCESS/ASSESSMENT	Adult MH Service	*Not provided*	**12**	*Not provided*	**23**	-
Kingswood Centre	PHYSIOTHERAPY KINGS WOOD	Adult MH Service	*Not provided*	**1.5**	*Not provided*	**15.5**	-
The Lakes	RECOVERY SUPPORT TEAM	Adult MH Service	*Not provided*	**31**	*Not provided*	**0**	-
The lakes	SPECIALIST MENTAL HEALTH	Specialist MH Service	*Not provided*	**17.5**	*Not provided*	**14**	-
Reunion House	SPECIALIST PSYCHOSIS	Specialist MH Service	*Not provided*	**11**	*Not provided*	**5**	-
Derwent Centre	ACCESS/ASSESSMENT	Adult MH Service	*Not provided*	**5**	*Not provided*	**27**	-
Derwent Centre	SPECIALIST MENTAL HEALTH	Specialist MH Service	*Not provided*	**17.5**	*Not provided*	**7**	-
Derwent Centre	SPECIALIST PSYCHOSIS	Specialist MH Service	*Not provided*	**7.5**	*Not provided*	**8**	-
The Lakes	CMHT VETERANS	Adult MH Service	*Not provided*	**4**	*Not provided*	**7**	-
Cherry Trees	STROKE PYSCHOLOGY	Adult MH Service	*Not provided*	**0**	*Not provided*	**24**	-
Basildon Hosp	Assertive Outreach Team - Essex	Assertive Outreach	*Not provided*	3	*Not provided*	3	-
Rochford Hosp	Assertive Outreach Team - Southend	Assertive Outreach	*Not provided*	38	*Not provided*	6	-
Grays Hall	Assertive Outreach Team - Thurrock	Assertive Outreach	*Not provided*	22	*Not provided*	16	-
Pride House	Early Intervention Service - South Essex	EIP	2 weeks	11	*Not provided*	12	-
Basildon Hosp	First Response - Adult - Basildon	Adult MH Service	2 weeks (moving to 6 weeks)	35	*Not provided*	40	-
Brentwood Hosp	First Response - Adult - Brentwood	Adult MH Service	2 weeks (moving to 6 weeks)	37	*Not provided*	36	-
Rochford Hosp	First Response - Adult - South East Essex	Adult MH Service	2 weeks (moving to 6 weeks)	27	*Not provided*	39	-
Grays Hall	First Response - Adult - Thurrock	Adult MH Service	2 weeks (moving to 6 weeks)	35	*Not provided*	38	-
Various	Medical - Adult MH	MH Medical	*Not provided*	26	*Not provided*	121	-

Name of hospital site or location	Name of team	Service Type	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
			Target	Actual (mean)	Target	Actual (mean)	
Basildon Hosp	Psychotherapy MH - South East Essex	Adult MH Service	*Not provided*	61	*Not provided*	28	-
Basildon Hosp	Psychotherapy MH - South West Essex	Adult MH Service	*Not provided*	53	*Not provided*	20	-
Basildon Hosp	Recovery Wellbeing - Adult - Basildon	Adult MH Service	*Not provided*	37	*Not provided*	32	-
Brentwood Hosp	Recovery Wellbeing - Adult - Brentwood	Adult MH Service	*Not provided*	7	*Not provided*	20	-
Knightswick	Recovery Wellbeing - Adult - Castle Point	Adult MH Service	*Not provided*	22	*Not provided*	35	-
Coombewood	Recovery Wellbeing - Adult - Rochford Rayleigh	Adult MH Service	*Not provided*	14	*Not provided*	22	-
Rochford Hosp	Recovery Wellbeing - Adult - Southend	Adult MH Service	*Not provided*	31	*Not provided*	25	-
Grays Hall	Recovery Wellbeing - Adult - Thurrock	Adult MH Service	*Not provided*	9	*Not provided*	16	-

There were no waiting list for psychological therapies once a patient had commenced treatment. Emergency referrals were responded to within one to two days of receipt of referral.

Staff supported patients during referral to and transfers between services. We found evidence of good transition practices across all teams, and that the transition protocol for children and young people transferring to adult services, had been reviewed. This complies with transfer of care standards set in the national Children and Young People Mental Health Transitions Commissioning for Quality and Innovation.

Facilities that promote comfort, dignity and privacy

Staff and patients had access to the full range of rooms and equipment to support treatment and care within community bases. This included clinic rooms and interview facilities. There was no blood analysis machine available for testing patient's white blood cell count in Southend. The size of the room was too small. Consequently, staff could not manage patient bloods within the team, and blood samples that had been sent for testing had often gone missing.

Patients' engagement with the wider community

Staff ensured that patients had access to education and work opportunities. We saw excellent examples of staff working to get patients back into employment and having access to education or training.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients. This included access to ramps, lifts and access to disabled toilets.

Staff ensured that patients could obtain a range of information on treatments, local services, patients' rights, how to complain and so on. Patients confirmed that staff had provided them with information and explained their diagnosis, care and treatment options.

The provider made information leaflets available in languages spoken by patients. Staff t could access these quickly and easily.

Managers ensured that staff and patients had easy access to interpreters and/or signers to meet patients' specific communication needs.

Listening to and learning from concerns and complaints

This core service received 66 complaints between 1 April and 31 December 2017. One complaint was referred to the Ombudsman during this period. Complaints relating to clinical practice had the highest number with 40, accounting for 61% of the complaints for these services.

Team	Clinical Practice	Communication	Staff Attitude	Systems & Procedures	Total
Outpatients	7		3	1	11
Chelmsford and Essex Adult Recovery Team	5	3	1		9
Specialist Psychosis Team	3	3			6
Access & Assessment	3		1	1	5
Home Treatment Service	3			1	4
Psychology	2	1			3
Specialist Mental Health Team	3				3
Harlow Adult Recovery Team	2		1		3
Epping Forest Adult Recovery Team	3				3
Admin Hub	1			1	2
Southend East & Central CRHT	1	1			2
Rapid Assessment, Interface and Discharge (RAID)	1			1	2
Uttlesford Adult Recovery Team	1		1		2
First Response Team (East)	2				2
Gloucester Ward			1		1
First Response Team Thurrock	1				1
Recovery and Wellbeing Southend		1			1
Psychotherapy				1	1
Mid-Essex Specialist Psychosis Service			1		1
First Response Team Basildon		1			1
Grays Hall (AOT)	1				1
Recovery and Wellbeing CPR	1				1
Early Intervention - West (Essex)			1		1
Total	**40**	**10**	**10**	**6**	**66**

The majority of patients told us that they knew how to complain or raise concerns. Those who did not know how to complain stated that they were very happy with their care and that they had not had to consider making a complaint.

Patients told us that when they had complained or raised concerns, they had always received feedback

Staff protected patients who raised concerns or complaints from discrimination and harassment. We found that there was an open culture to complaints. Staff perceived complaints as a form of patient feedback and an opportunity to improve practice and learning for the team.

Staff knew how to handle complaints appropriately and there was oversight of complaints and concerns by each team manager. Staff could describe the providers process for dealing with both concerns and complaints.

Staff received feedback on the outcome of investigation of complaints and acted on the findings. We found that the findings and learning from complaint investigations and associated learning was discussed in team meetings.

This core service received 51 compliments during the last nine months from 1 April to 31 December 2017 which accounted for 8% of all compliments received by the trust as a whole.

Is the service well-led?

Leadership

We found that leaders had the skills, knowledge and experience to perform their roles. Staff told us that their team leaders supported them and that the service was being well managed.

Team leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Staff told us that the leader in Brentwood and Basildon had supported clinical staff by allocating staff with protected days for administration. Staff reported that this had reduced stress and improved staff morale.

Leaders were visible in the service and approachable for patients and staff. However, staff told us that managers above team level were not seen often, although had held meet and greet events which staff could attend.

Staff told us that leadership development opportunities were not always available to staff following the recent reorganisation. Opportunities for staff below team manager level were currently limited, although there was opportunity for skill development within the teams.

Vision and strategy

Staff knew and understood the provider's vision and values of being open, empowering and compassionate. The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service, and the provider values were reflected in the work of the teams.

Staff told us that they had not had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff told us that morale had been poor due to poor communication regarding proposed service changes.

Staff could explain how they were working to deliver high quality care within the budgets available. Available resources had, however adversely affected patient caseloads in Southend, Basildon and in particular Brentwood, where caseloads were between 40 and 50 patients.

Culture

Staff felt respected, supported and valued by their team leaders and felt that they had authority to undertake their role. Overall staff felt positive and proud about working for the provider and their team.

Staff felt able to raise concerns without fear of retribution. There were no examples of bullying and harassment in the teams. Staff knew how to use the whistle-blowing process and about the role of the Freedom to Speak Up Guardian.

Manager dealt with poor performance when needed. Leaders provided several examples where poor performance had been dealt with promptly and effectively by managers.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

Staff appraisals include conversations about career development and how the trust could support through training and development and other forms of development opportunities within the service.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression.

The service's staff sickness and absence were similar to the average for the provider.

Staff had access to support for their own physical and emotional needs through the process of debriefing following incidents, ongoing appraisal and supervision and access to the provider's occupational health service.

The trust recognised staff success within the service, through staff awards, including long service awards.

Governance

There was a clear framework of what must be discussed at a team and directorate level. This ensured that essential information, such as learning from incidents and complaints, was shared and discussed. Staff and leader described an open culture of sharing lessons both at team and directorate level.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

Staff undertook or participated in a limited number of local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. All learning from audits was shared at directorate and team level.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

Staff maintained and had access to the risk register which was held at directorate level. Staff at team level could escalate concerns when required and add these to the risk register. Staff concerns matched those on the risk register.

The service had plans for emergencies – for example, adverse weather or a flu outbreak.

We were not advised of any ongoing cost improvements plans currently being implemented.

Information management

The service used systems to collect data from teams and directorates; however, staff described these as being over-burdensome for frontline staff. Over a third of the staff interviewed, told us that

there were issues with the electronic health record. They said the system was difficult to navigate; and that staff could not access key information. This had resulted in some staff undertaking additional work, setting up a separate system at team level for recording key information.

Staff had access to the equipment and information technology needed to do their work. However, staff reported problems with connectivity and told us that work had been lost as a result. Staff and patients reported that the care plan within the patient record was not patient focused and was difficult to print.

The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. However, the team in Southend did not have a blood analysis machine for testing patient blood samples of patients being prescribed Clozaril. This created delays in staff receiving blood results and blood samples often went missing. Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information on mandatory and specialist training however was not always accurate and there had been a number of false reports and inaccuracy in mandatory training figures.

Information was in an accessible format however, access to information was not always timely or accurate. The trust had identified a number of areas for improvement, and were working on these.

Staff made notifications to external bodies as needed.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, newsletters and meetings.

Patients and carers had limited opportunities to give feedback on the service they received in a manner that reflected their individual needs. However, managers and staff had used feedback from patients, carers and staff to make improvements.

Patients and carers told us that they had been involved in some decision-making about changes to the service.
Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback.

Directorate leaders engaged with external stakeholders including the police, acute hospital commissioners and universities.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this had led to changes. Staff had opportunities to participate in research, and there were a number of innovations taking place in the service.

The treatment team in Chelmsford, had introduced the national health service accelerator serenity integrated mentoring project. This project involved specialist police officers being based within the community mental health team to help support service users struggling with complex, behavioural disorders.

There was a pilot project in place where general practitioners were provided with quick access to consultant psychiatrists to discuss patient care and receive specialist advice in a timely manner, and specific pathways for patients with personality disorder, which have resulted in measurable improvements in patient risk.

The provider had also commenced a new service for the treatment of depression using repetitive transcranial magnetic stimulation. This is an effective, drug-free, non-invasive treatment for depression which uses magnetic stimulation to stimulate areas of the brain that regulate mood.

Staff used quality improvement methods and knew how to apply them. The provider had received several awards from external bodies. This included an award from the royal college of psychiatrists, for a monitoring adherence programme, which focused on patient compliance with treatment. Leeds University also gave the provider an award for a practice development initiative. This involved putting standards in place and embedding them in clinical practice.

Staff participated in one national audit which was relevant to the service and learned from this.

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed, and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

None of the services within this core service had been awarded an accreditation.

Mental health crisis services and health-based places of safety

Facts and data about this service

Location site name	Team name	Address for location	Number of clinics	Patient group (male, female, mixed)
Trust Head Office	RAID (West)	Basildon Hospital, Nethermayne, Basildon, Essex	N/A	Mixed
Trust Head Office	Essex West CRHT	Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	N/A	Mixed
Trust Head Office	OT CRHT - West	Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	N/A	Mixed
Basildon MHU	Section 136 Suite	Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	N/A	Mixed
Trust Head Office	Street Triage	Police Force Control Room, Essex Headquarters, Chelmsford	N/A	Mixed
Trust Head Office	Home Treatment Service	Derwent Centre, Princess Alexandra Hospital Hamstel Road Harlow Essex	N/A	Mixed
Trust Head Office	Home Treatment Service	The Gables, Bocking End Road, Braintree	N/A	Mixed
Trust Head Office	Home Treatment Service	The Lakes Turner Road Colchester Essex	N/A	Mixed
Colchester Mental Health Wards	The Harbour Suite (Section 136)	The Lakes Turner Road Colchester Essex	N/A	Mixed
Broomfield Hospital Mental Health Wards	Section 136 Suite	Puddings Wood Drive Broomfield Chelmsford Essex	N/A	Mixed
Trust Head Office	Home Treatment Service	Puddings Wood Drive Broomfield Chelmsford Essex	N/A	Mixed
Trust Head Office	OT CRHT - East	Herb Garden, Rochford Hospital Union Lane Rochford Essex	N/A	Mixed

Location site name	Team name	Address for location	Number of clinics	Patient group (male, female, mixed)
Trust Head Office	CRHT Psychology	Union Lane Rochford Essex		Mixed
Trust Head Office	Essex East CRHT	Union Lane Rochford Essex	N/A	Mixed
Rochford Hospital	Section 136 Suite	Union Lane Rochford Essex	N/A	Mixed
Trust Head Office	RAID (East)	Southend Hospital, Prittlewell Chase, Westcliff-on-Sea, Essex	N/A	Mixed

Is the service safe?

Safe and clean environment

Except for the Lakes the environment for the health based places of safety was safe, clean and ensured clear sight for observation. Staff had access to a ligature cutter at all four health based places of safety.

The ligature assessment for the Lakes health based place of safety was incorrect. The author had described the furniture incorrectly as too heavy to throw when the furniture could be lifted and thrown. There were also electric sockets in the room which had not been identified as a risk. These posed a potential risk to patients and staff. The windows did not have security screws.

Cleaning records were up to date. Staff adhered to infection control principles, including hand washing and use of antiseptic hand gel.

There were blind spots in the place of safety at Basildon and the trust had installed mirrors as mitigation. Closed circuit television was in place for the east team, Linden and Lakes. However, there were no signs up to inform patients of this in the Linden and Lakes health based place of safety.

Staff held alarms for when they needed assistance. The health based place of safety in the west team had an emergency alarm in the room. However, the other health based places of safety did not however, patients were under constant observation.

Safe staffing

Staffing was sufficient to meet need and managers could bring in additional staff when needed. Increased demand was escalated as a risk to senior managers. Managers were recruiting to vacant posts. Managers held twice daily safer staffing calls to monitor staffing.

This core service reported a vacancy rate for all staff of 14% as of 31 January 2018.

This core service reported an overall vacancy rate of 16% for registered nurses at 31 January 2018 and 12% for registered nursing assistants.

	Registered nurses			Health care assistants			Overall staff figures		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Crht East	1.30	21.71	6%	0.60	1.6	38%	1.90	24.4	8%
Crht West	2.20	19	12%	0.00	2	0%	2.20	21	10%
E- Adult Home Treatment	0.00	9	0%	1.00	4	25%	1.01	14.61	7%
Raid East	2.52	9.52	26%	2.66	5.66	47%	5.18	15.18	34%
Raid East - Medical South							0.40	2	20%
Raid West	3.00	9	33%	0.00	1	0%	3.00	10	30%
Raid West - Medical South							1.50	1.5	100%
Street Triage	3.22	6.22	52%				3.22	6.22	52%
Core service total	**10.63**	**74.45**	**14%**	**4.26**	**14.26**	**30%**	**15.80**	**94.91**	**17%**
Trust total	**250.46**	**1585.55**	**16%**	**147.04**	**1207.08**	**12%**	**709.54**	**4999.15**	**14%**

NB: All figures displayed are whole-time equivalents
Some of the services listed were not part of this core service inspection.

Between 1 April 2017 and 31 January 2018, bank staff filled 651 shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered no shifts for qualified nurses. No shifts were left unfilled filled by either bank or agency staff.

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
CRHT East	408	408	0	0
CRHT West	73	73	0	0
Street Triage	170	170	0	0
Core service total	651	651	0	0
Trust Total	**102629**	**31709**	**12577**	**1356**

Between 1 April 2017 and 31 January 2018, 13 shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, agency staff covered no shifts. No shifts were left unfilled by either bank or agency staff.

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
CRHT West	13	13	0	
Core service total	13	13	0	0
Trust Total	**144009**	**60464**	**5916**	**4396**

This core service had two (3%) staff leavers between 1 April 2017 and 31 January 2018.

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
300 E-Adult Home Treatment	13.52	0.00	0%
364 EA760 Raid East	11.69	1.00	9%
364 EA705 Crht East	21.04	1.00	5%
364 EA735 Crht West	19.40	0.00	0%
364 EA721 Street Triage	2.73	0.00	0%
364 EA769 Raid West	7.50	0.00	0%
364 EB130 Raid East - Medical	2.00	0.00	0%
364 EF890 RAID-Liaison Psychology East	1.00	0.00	0%
364 EE805 RAID Liaison Community Service	0.60	0.00	0%
Core service total	**79.48**	**2**	**3%**
Trust Total	**3127.64**	**253**	**7%**

The sickness rate for this core service was 5% between 1 April 2017 and 31 January 2018. The most recent month's data (January 2018) showed a sickness rate of 1%. Raid East – Medical had the highest annual staff sickness rate with 10%.

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
364 EA705 Crht East	1%	2%
364 EA735 Crht West	2%	5%
364 EA760 Raid East	1%	8%
364 EB130 Raid East - Medical	0%	10%

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
364 EA522 136 Suite Basildon	0%	0%
364 EA721 Street Triage	0%	7%
364 EA769 Raid West	2%	2%
364 EF890 RAID-Liaison Psychology East	0%	0%
300 Adult-Home Treatment Team	0%	0%
300 E-Adult Home Treatment	0%	1%
Core service total	**1%**	**3%**
Trust Total	**4%**	**4%**

Managers monitored caseloads which were usually between 25 and 28. If a caseload went above 28 it was rated red and escalated. The caseload at the Lakes was 47 and at Linden 30 at the time of our visit. This put pressure on the team to see patients in a timely manner. Additional bank staff were used to cover where needed.

Medical staff

Teams and staff could access a psychiatrist when needed.

Between 1 April 2017 and 31 January 2018, none of the shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums. In the same time period, agency staff covered 453 shifts, 117 of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
AAT / Liaison	64			64
Access and Assessment	101		101	
Assessment Unit	368		209	
CRISIS	142		89	53
Crisis Team	54		54	
RAID	209		209	
Core service total	**938**	**0**	**453**	**117**
Trust Total	**6744**	**258**	**3406**	**3080**

Mandatory training

The compliance for mandatory and statutory training courses at 31 December 2017 was 81%. Of the training courses listed 13 failed to achieve the trust target and of those, eight failed to score above 75%. There were staff on long term leave which made them unavailable; they are included

in these numbers. Staff reported that the system to record their training was not always accurate and administration staff kept local records to monitor training.

The trust has a rolling month on month compliance rate for mandatory training.

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	This core service	Trust target %
Personal Safety - MVA	100%	85%
Induction E-Learning	100%	85%
TASI Trained	100%	90%
Care Certificate	100%	85%
Observation of Service User	100%	85%
Cascade Fire Trainer	100%	85%
Duty of Candour (Overview Version)	100%	85%
First Aid Trained	100%	85%
Corporate Induction	98%	85%
Equality and Diversity	98%	85%
PREVENT (WRAP) Training	97%	85%
Clinical Risk Assessment	97%	85%
Harassment & Bullying	97%	85%
Safeguarding Adults (Level 3)	96%	90%
Mental Capacity Act Level 2	95%	85%
Dual Diagnosis	95%	85%
Complaints Handling	93%	85%
Duty of Candour (Detailed Version)	90%	85%
Safeguarding Children (Level 3)	89%	90%
Medication Management (MH)	87%	85%
Safeguarding Adults (Level 2)	83%	90%
Care Programme Approach	78%	85%
Mental Health Act	77%	85%
Fit for Work	76%	85%
Basic Life Support & AED	71%	85%
Personal Safety Breakaway - Level 1	68%	85%
Information Governance	67%	85%
Infection Prevention, Control & Hand Hygiene	62%	85%
Fire Safety 2 years	60%	90%
Fire Safety 3 years	24%	90%
Medicines Management (community)	9%	85%
Food Hygiene	0%	85%
Total	81%	85%

Assessing and managing risk to patients and staff

We looked at 42 patient records.

Assessment of patient risk

Staff in the crisis service assessed risk at initial contact and every follow up contact. Staff developed the risk assessment with the patient and family where appropriate. The risk management plan was developed with the patient. Staff also discussed risks at daily handovers and multidisciplinary meetings. Staff in the health based places of safety assessed risk on admission and updated the assessment as required during the patient's stay.

Staff discussed crisis plans with patients and drafted plans. However, these could have been more detailed. They mainly consisted of contacted the crisis service, or Samaritans. Two out of the six records we looked at in the Linden team had no plan.

Management of patient risk

Staff responded promptly to changes in a patient's health. Staff wore lone working devices which could summon help when needed and the trust had an in date lone working policy. Staff gave examples of when they had used these to good effect. The use of devices was discussed in team meeting. Staff took appropriate action following a failed visit (when the patient was not at home) and staff were aware of, and followed the trust protocol.

Safeguarding

Staff were trained in safeguarding. The compliance rate was 89% for children safeguarding and 83% for adults, this was below the trust target of 90%, however, some staff were on long term leave and so unavailable for the training. Staff gave us examples of when they had raised safeguarding concerns and these had been discussed within the team and with the trust's safeguarding team. Staff felt confident they would report a safeguarding concern directly if urgent.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.
Each authority has its own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust has provided details of the total number of safeguarding referrals made between 1 April 2017 and 31 December 2017 with 802 referrals made for adults and 180 for children. However, this is for the whole trust and has not been broken down to core service level.

The trust told us that there were no serious case reviews commenced or published in the last 12 months that related to this core service.

Staff access to essential information

Care records were stored on two different electronic systems – one for the north of the county and one for the south of the county. Any paper records were scanned onto the system by administration staff. Except for the Lakes where section 136 records were not scanned into the system. This issue was identified in previous inspections and has not been rectified. All staff could access the system within their team and the trust was working on how to facilitate interface between the systems. With the system used in the north of the county information could be recorded in different parts of the record which made it more difficult to immediately find the information unless very familiar with the system. Staff we spoke with were aware of this and said it wasn't an issue for them.

Medicines management

Patients' medicines were stored on site on an individual basis and records were kept of receipt and removal of any medicines. In the south of the county the pharmacist carried out six monthly audits and we reviewed the last audit from November 2017 following which all actions had been completed. In the north of the county a pharmacist visits three times a week to check the medicines. The psychiatrist reviewed patient's medication on a regular basis, and would visit the patient at home if required and medication was discussed at the multidisciplinary team meetings.

We reviewed 19 prescription cards and found no issues. Where required, staff took patients' blood for testing to monitor therapeutic level of the medicines. For example, patient taking lithium medication required regular blood tests in line with national institute for health and care excellence guidance.

However, the recording system for the scripts (FP10s) was not easy to audit and we did not see evidence of checking. We were told that they would review this process.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 January 2018 there were 16 STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was *apparent/actual/suspected self-inflicted harm meeting SI criteria* with 14.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

	Number of incidents reported			
Type of incident reported on STEIS	**Apparent/actual/suspected self-inflicted harm meeting SI criteria**	**Disruptive/aggressive/violent behaviour meeting SI criteria**	**Apparent/actual/ suspected homicide meeting SI criteria**	Total
Access & Assessment	3	1	1	5
Access & Assessment – Derwent Centre	1			1
Access & Assessment – The Lakes	5			5
Access & Assessment West	2			2
RAID	1			1
Rapid Assessment, Interface and Discharge (RAID)	2			2
Total	14	1	1	16

Reporting incidents and learning from when things go wrong

Staff knew what to and how to report incidents using the trust's electronic system for incident reporting. They understood the Duty of candour requirements and explained how they would inform patients when required.

Staff received feedback on incidents in their business meetings. We saw examples of the minutes of these meetings. Learning was shared in these meetings also.

Staff received a debrief following any serious incident and support was available when needed.

Is the service effective?

Assessment of needs and planning of care

We reviewed 42 records for this service. Most were thorough, holistic and up to date. However, in the Linden centre of the six records we reviewed two had no care plan, one had no risk assessment and two had no updated risk assessment. Three had no physical health information and one had no consent and capacity recorded. One record showed physical health problems but the record did not show what had been done, however, when this was raised with staff they confirmed the patient had been booked in to the physical health clinic that week.

Staff completed a comprehensive assessment of patients. Except for above physical health was assessed and recorded. In the Linden team staff held a weekly physical health clinic for new patients where patients' blood pressure, weight and height, and blood tests were carried out.

The majority of care plans were holistic and person centred and staff updated as necessary. Staff used the modified early warning system in the south or the track and trigger system in the north to monitor physical health.

Best practice in treatment and care

This core service participated in no specific clinical audits as part of their clinical audit programme 2017.

The managers in each team or a designated member of staff carried out weekly audits of records and took appropriate action when needed. The Linden team were about to start this in May 2018 and we saw the audit tool which would be used.

Staff facilitated patients seeing their GP when needed to deal with any physical health problems that could not be dealt with within the team. They referred patients to the community teams, or counselling service when needed. The occupational therapy staff provided anxiety management in the Linden team. There was also a brief intervention service to which staff referred patients who needed it.

Skilled staff to deliver care

The multidisciplinary team consisted of nurses, support workers, occupational therapists, psychiatrists, psychologists and social workers. Managers were recruiting the vacancies in psychology, occupational therapy and social work.

The team each had two 0.5 wte consultants and one full time post. They provided face to face medical reviews, and consultation to staff and GPs seeking medication advice. Psychiatrists provided advice via email following assessment and discussion with clinicians, and discussed with GPs over the phone. There was one trainee and a speciality doctor.

Staff were experienced and could access specific training if required. Some staff had completed dialectical behavioural therapy training. One of the consultants had provided additional training in the Mental Health Act, Mental Capacity Act, brief interventions and mindfulness. Others had attended conferences and seminar in subjects related to the service.

New staff received a trust induction and a local induction where they shadowed an experienced member of staff for a period of time prior to taking on the role fully.

Managers held monthly team meetings where incidents, complaints, performance and training were discussed as well as any ad hoc business that was needed. Except for the Linden team we saw minutes of these meeting for the period between July 2017 and February 2018. The Linden team has recently split into access and assessment and home treatment, so there were only minutes from April 2018 available.

The trust's target rate for appraisal compliance is 90%. As at 31 January 2018, the overall appraisal rates for non-medical staff within this core service was 87%.

The two teams who failed to achieve the trust's appraisal target were RAID East with an appraisal rate of 57% and CRHT East at 86%.

No appraisal data was submitted by the trust for medical staff in this core service during this period.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Liaison Services	1	1	100%
RAID-Liaison Psychology East	1	1	100%
Street Triage	3	3	100%
CRHT West	20	19	95%
CRHT East	22	19	86%
RAID East	7	4	57%
Core service total	**54**	**47**	**87%**
Trust wide	**4121**	**3386**	**82%**

As stated previously some staff were on long term leave and not available for this.

Managers provided supervision on four to six weekly basis. Staff also attended reflective practice sessions and a therapist offered supervision for a person development.

Between 1 April 2017 and 31 January 2018, the average clinical supervision rate across all six teams in this core service was 84% against the trust's 90% target. Adult Home Treatment had the lowest clinical supervision rate with 35% while Street Triage is the only team to have a rate of 100%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Street Triage	33	33	100%
CRHT East	220	213	97%
CRHT West	210	200	95%

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Raid West	70	63	90%
RAID East	60	51	85%
Adult Home Treatment	120	42	35%
Core service total	**713**	**602**	84%
Trust Total	**24,386**	**21,061**	**86%**

Multidisciplinary and interagency team work

Staff held weekly (sometimes twice weekly) multidisciplinary meetings. The daily handovers were also multidisciplinary and we found these to be thorough and effective. The teams used either a white board or an electronic board to discuss each patient.

Crisis staff provided in reach to the health based place of safety, to the assessment unit and the wards. We could see that staff communicated with other teams in the trust when patient was being transferred. Crisis staff completed the seven day follow up visits when required, after a patient had been discharged from an inpatient area.

There were monthly meetings with other agencies, including police, acute staff and ambulance staff to discuss any issues and staff described these as very effective.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

As of 31 December 2017, 77% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for all staff and renewed every three years. Some staff were on long term leave so had not been able to complete this training.

Staff worked with approved mental health professional (AMHP) when appropriate in the health based place of safety or when visiting a patient at home for a Mental Health Act assessment. AMHPs were based near the teams and were available for advice is needed.

The trust's policies were up to date. The section 136 (health based place of safety) policy had been updated to comply with the Policing and Crime Act 2017.

Staff explained a patient's rights to them under the Act when they were detained in the health based place of safety.

Care records referred to section 117 aftercare where applicable.

Good practice in applying the Mental Capacity Act

As of 31 December 2017, 95% of the workforce had received training in the Mental Capacity Act level two. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

Staff demonstrated an understanding of capacity and could seek advice if needed. Staff discussed and recorded capacity at initial assessment and at handover meetings. Records detailed capacity had been considered.

In the records we reviewed there had been no-one who lacked capacity.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff were respectful when discussing patients and patients told us they had been treated appropriately and with respect. Staff had explained to them what was going to happen and supported them to access other services if needed.

Staff said they would be able to raise any concerns about staff behaviour without fear of consequences. They said that the team would challenge any unwanted behaviour.

Involvement in care

Involvement of patients

Staff said and records showed that they involved patients in discussions about their care. Staff provided patients with a copy of their care plan unless they declined, and this was documented. We spoke with 17 patients and all said they had received a good service and had been involved in their care. Most said they had received information about their medication and the service. One patient said they had not.

The trust had a contract with an advocacy service. However, staff said patients rarely used it in this service. With one exception patients had all said they were very pleased with the service they received and had no complaints.

Staff requested feedback from patients at their final session and used the friends and family test process. The majority of responses (over 90%) were positive. Some patients said they did not like that they were seen by different staff and had to repeat themselves but understood the reasons for this.

We observed excellent staff patient interactions at the health based place of safety at Rochford.

Involvement of families and carers

With the patient's consent staff involved family and carers. They always asked permission before sharing information about the patient with family or carers.

Staff arranged for a carer's assessment when required to help identify what support they might need.

Teams in the south of the county held monthly carer groups to discuss with carers how they had experienced the service and if there were any issues.

Is the service responsive?

Access and waiting times

Targets for seeing patients within four hours of referral were met consistently. There had been no breaches of the 24-hour assessment target for the health based places of safety. The crisis service provided in reach to the health based places of safety and to the wards. Staff used a capacity tracker to determine if a bed was available in a health based place of safety. This was used to monitor the time of admission and planned discharge. Services in London used the health based places of safety with the agreement of the trust staff.

Access to an approved mental health professional (AMHP) out of hours could be delayed. The AMHP lead was monitoring and encouraging more staff to train to fill the gap. Staff told us the delay was never more than one or two days.

Staff completed the seven day follow up contact for some patients when required. The Colchester team employed a discharge co-ordinator to facilitate discharge or transition to other services.

There was a difference in commissioning arrangements leading to a different service in the north and south of the county. The service was provided for different hours in different teams. If a patient was not known to the crisis service they were seen out of hours in A&E or by the rapid assessment, interface and discharge (RAID) service in the south or by the access and assessment team in the north who triaged a referral and transferred to a crisis team the following morning. At the Lakes the wards picked up any calls for the crisis service out of hours. Staff at the health based place of safety at the Lakes told us, and we saw the record, when they had used A&E on one occasion in March 2018 when the bed in the health based place of safety was already in use.

In the north of the county:

Access and Assessment - The mid access and assessment service operated from 07.00 – 21.00 providing a single point of access for all referrals seven days per week. The team accepted referrals from GPs and other agencies. The team provided a response to urgent and crisis assessment seven days per week during operating hours, and a response to routine referrals 9-5 Monday to Friday. The team managed the 24hr crisis line between 08.00-18.00, with the bleep holder from the Linden Centre assisting with calls outside these hours if the access team clinician was unavailable. Following assessment, the team offered signposting, advice, brief intervention, medical review, referral to specialist community teams, and referral to home treatment for acute care. The team also provided input into the burns unit in the acute hospital during office hours Monday to Friday.

Brief Intervention - a number of staff provided individual and group based intervention for solution focused short term follow up. The team aimed to offer up to six contacts for individual work, whilst group work may last six weeks or longer.

A&E Liaison - 24hr cover was in place, provided by dedicated members of the team.

In the south of the County

In south Essex, the CRHTs served four clinical commissioning groups (CCG) catchment areas. The service was based on the original Policy Implementation Guidance (2000). The team operated 24 hours, being on site from 08.00 to 20.00hrs and after 20.00hrs provided on-call facilities for patients who were under the care of the crisis service. Since February 2016, the CCGs commissioned the rapid assessment, interface and discharge (RAID) services to provide the liaison mental health services to both Southend and Basildon General Hospitals, this replaced the service provided by the crisis teams. The trust had plans to transform the approach across both crisis teams in the south as part of the wider transformation programme. The crisis services will be separated from home treatment and there are plans to extend the hours of operation as well as move to a self-referral approach. The approach across the organisation will be harmonised as part of the wider transformation work.

There was a street triage team working in the Chelmsford, which had successfully reduced the use of the health based places of safety and was able to direct a patient to the most appropriate service.

The trust had a policy for failed visits and staff followed this and took appropriate action if a patient had not been contactable. Staff supported patients during their transition to other services.

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'. The core service met the referral to assessment target in two of the targets listed. Some of these services were not inspected this time.

Name of hospital site or location	Name of team	Service Type	Days from referral to initial assessment		Days from assessment to treatment	
			Target	Actual (mean)	Target	Actual (mean)
Linden Centre	BROOMFIELD LIAISON SERVICE (Access & Assessment Service Broomfield Hospital Chelmsford)	Adult MH Service	Not provided	0	Not provided	2
Derwent Centre	LIAISON WEST ESSEX	Adult MH Service	Not provided	0	Not provided	1
Basildon Hosp	Crisis Home Treat - Basildon	Crisis	1 day	0	Not provided	2
Rochford Hosp	Crisis Home Treat - Rochford	Crisis	1 day	1 day	Not provided	2

Facilities that promote comfort, dignity and privacy

At the health based place of safety in the Lakes and Linden Centre there was closed circuit television in place with no signs telling people this was the case, the monitors included a view of the toilet area. There was capability to turn this monitor off and only use it on a risk assessed basis. However, the monitor at the Lakes seemed to be kept turned on and could be viewed by any staff in the office next to the room.

Whilst the window to the outside in the health based place of safety at the Lakes had privacy etching to obscure views in it did not prevent sunlight entering so this could prevent a patient from having a sleep in the day because of the light.

The entrance to the health based place of safety at Basildon was from the car park in full view of people visiting the mental health unit. This was identified in the previous inspection. The health based places of safety at Rochford and the Lakes had televisions in the room but Basildon and Linden did not. Staff provided books and magazines for patients when appropriate.

Patients' engagement with the wider community

Staff in the health based place of safety at Rochford had facilitated a relative to visit a patient who was detained.

Meeting the needs of all people who use the service

Staff provided leaflets on services available and these could be in other languages if the patient's first language was not English. Staff could access interpretation services when needed. Staff offered flexibility for times and places of appointments. There were no crisis houses commissioned as a least restrictive option for patients.

Listening to and learning from concerns and complaints

All staff were aware of the complaints process and patients and carers told us they knew how to complain of they had needed to. Feedback from investigations into complaints was discussed at the team meetings.

This core service received seven complaints between 1 April and 31 December 2017. No complaints were referred to the Ombudsman during this period. Three of the complaints were regarding clinical practice and two each for staff attitude and systems and procedures.

Team	Clinical Practice	Staff Attitude	Systems & Procedures	Total
Access & Assessment	2	2	1	5
Early Intervention - East (Essex)	1			1
Section 136 Suite			1	1
Total	**3**	**2**	**2**	**7**

We received two complaints at the time of inspection relating to poor communication and having to wait for an appointment.

This core service received seven compliments during the last nine months from 1 April to 31 December 2017 which accounted for 1% of all compliments received by the trust.

Is the service well-led?

Leadership

Leadership was strong and staff said they felt supported and could raise any concerns if needed. Managers received monthly reports which they used to monitor the service and staff performance. They acted when required to deal with any issues.

Managers were supportive and staff felt able to raise any concerns they had. We saw posters on display that detailed what improvements were needed and what staff did well.

The trust provided leadership development and supported managers to complete further training if required.

Vision and strategy

Staff knew about the trust's values and said they could have been involved as much or as little as they wanted to be.

Whilst overall staff reported no major impact of the merging of the two trusts in April 2017, some teams were unsure of the plans for teams across the patch. They were unsure what the plans were for changing the assessment process, home treatment and whether it would be standardised across the trust. There was little evidence of working across the north and south of the patch within the teams. However, there was a crisis response and home treatment steering group which staff from the north had only recently started attending.

Culture

Staff told us they could raise any concerns and did not worry about consequences. Managers were supportive of open and transparent discussion. All staff said their team was supportive and good at their job.

Staff sickness had been 5% from April 2017 to December 2017, and for January 2018 was 1%. Managers were actively recruiting to vacant posts. Managers said they had support to manage poor performance when needed and had not had cause to do this over the last few years.

The trust recognised staff success within the service.

Governance

The governance processes enabled monitoring of key performance indicators, finance, training and appraisals and were discussed in the monthly team meetings. Managers had access to a balanced score or dashboard with key information. There were trackers to monitor supervision and appraisals.

The crisis resolution and home treatment standard operating procedure only covered the service in the south of the county and was signed off in December 2017. The North Essex Access and Assessment Single Point of Access operating procedure covered the north of the county and was signed of in July 2017.

Staff worked with other agencies to ensure continuity of patient care.

Management of risk, issues and performance

Staff knew about the risk register but there were no local risks identified for this service. The trust had business continuity plans for any adverse events.

Information management

We identified no issue with data from wards being too cumbersome for staff to use. Staff had access to lap tops and tablets for mobile working. However, some staff reported connectivity issues when away from base and said that sometimes the systems were slow.

Staff maintained confidentiality of records.

Staff made notifications to external bodies when appropriate.

Engagement

Staff were kept informed via team meetings, newsletters and emails. The trust website provided information for patients and public. However, the website was difficult to navigate and did not seem to include the service in the north of the county for crisis and home treatment services.

Patients and carers could give feedback on the services they received.

Senior managers met with commissioners and other agencies on a regular basis.

Learning, continuous improvement and innovation

All teams had active national accreditation, (Home Treatment Accreditation Scheme) which was due for review in September 2018.

We also saw a plan for these services across the county for the development of a 24/7 mental health crisis response and care service to deliver the crisis concordat mandate and implementing their five years forward view for mental health strategy.

Community-based mental health services for older people

Facts and data about this service

Location site name	Team name	Address	Number of clinics	Patient group (male, female, mixed)
Trust Head Office	Dementia Services Basildon (South West) - Memory Assessment Service	Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	N/A	Mixed

Location site name	Team name	Address	Number of clinics	Patient group (male, female, mixed)
	- Community Dementia Nurse			
Trust Head Office	Dementia Service - Memory Assessment Service - Community Dementia Nurse	Brentwood Resource Centre, Greenwich Avenue, Brentwood	N/A	Mixed
Trust Head Office	Older Adult OT Community and Memory Service Services - Brentwood	Brentwood Resource Centre, Greenwich Avenue, Brentwood	N/A	Mixed
Trust Head Office	Older Adult Psychology Service	Brentwood Resource Centre, Greenwich Avenue, Brentwood	N/A	Mixed
Trust Head Office	Brentwood Older People's CMHT	Brentwood Resource Centre, Greenwich Avenue, Brentwood	N/A	Mixed
Trust Head Office	Memory Assessment / Monitoring	Cherry Trees, Maldon & District Hospital, Spital Road Maldon	16	Mixed
Trust Head Office	Specialist Dementia Team (Mid)	Puddings Wood Drive Broomfield Chelmsford Essex		Mixed
Trust Head Office	Basildon Older People's CMHT	Ely House, Churchill Avenue, Basildon, Essex	N/A	Mixed
Trust Head Office	Specialist Dementia Team (North East)	The Emerald Centre, The King's Wood Centre, Colchester		Mixed
Trust Head Office	Memory Assessment / Monitoring	The Emerald Centre, The King's Wood Centre, Colchester	36	Mixed
Trust Head Office	Medical Older People	Brentwood Resource Centre, Greenwich Avenue, Brentwood	N/A	Mixed
Trust Head Office	Adult Community OT (Southend)	Harland Centre, Balmoral Road, Westcliff-on-Sea, Essex	N/A	Mixed
Trust Head Office	Dementia Service - Memory Assessment Service - Community Dementia Nurse	Harland Centre, Balmoral Road, Westcliff-on-Sea, Essex		Mixed
Trust Head Office	Older Adult Psychology Service	Harland Centre, Balmoral Road, Westcliff-on-Sea, Essex	N/A	Mixed
Trust Head Office	Southend Older People's CMHT	Harland Centre, Balmoral Road, Westcliff-on-Sea, Essex	8	Mixed

Location site name	Team name	Address	Number of clinics	Patient group (male, female, mixed)
Trust Head Office	Medical Older People	Grays Hall, Orsett Road, Grays, Essex	N/A	Mixed
Trust Head Office	Dementia & Frailty Service	The Lakes Turner Road Colchester Essex		Mixed
Trust Head Office	Dementia Support Team	Tower Road Clacton On Sea Essex		Mixed
Trust Head Office	Memory Assessment / Monitoring	Tower Road Clacton On Sea Essex	40	Mixed
Trust Head Office	Harlow Specialist Dementia / Frailty Team	Latton Bush, Latton Bush, Southern Way, Harlow,		Mixed
Trust Head Office	Memory Assessment / Monitoring	Latton Bush, Latton Bush, Southern Way, Harlow,	12	Mixed
Trust Head Office	Older Adult Psychology Service	240 Mountnessing Road Billericay Essex	N/A	Mixed
Trust Head Office	Older People Day Team	240 Mountnessing Road Billericay Essex	N/A	Mixed
Trust Head Office	OT OP Community and Memory Service – Rochford, Rayleigh, Castle Point and Southend	Union Lane Rochford Essex	N/A	Mixed
Trust Head Office	Specialist Dementia Team (West)	The Plain Epping Essex	28	Mixed
Trust Head Office	Dementia Service (South East)	Sydervelt Centre, Sydervelt Road, Canvey Island, Essex		Mixed
Trust Head Office	Older Adult Psychology Service	Sydervelt Centre, Sydervelt Road, Canvey Island, Essex	N/A	Mixed
Trust Head Office	Older People's CMHT	Sydervelt Centre, Sydervelt Road, Canvey Island, Essex	16	Mixed
Trust Head Office	Thurrock Older People's CMHT	Civic Offices, New Rd, Grays	N/A	Mixed
Trust Head Office	Dementia Service Thurrock (South West) - Memory Assessment Service - Community Dementia Nurse	Thurrock Community Hospital Long Lane Grays Essex	N/A	Mixed
Trust Head Office	Medical Older People	Union Lane Rochford Essex	N/A	Mixed

Location site name	Team name	Address	Number of clinics	Patient group (male, female, mixed)
Trust Head Office	Medical Older People	Thurrock Community Hospital Long Lane Grays Essex	N/A	Mixed
Trust Head Office	Older Adult Psychology Service	Thurrock Community Hospital Long Lane Grays Essex	N/A	Mixed
Trust Head Office	Older People's Day Team	Thurrock Community Hospital Long Lane Grays Essex		Mixed
Trust Head Office	opt MH Long Term Conditions	Thurrock Community Hospital Long Lane Grays Essex	4	Mixed
Trust Head Office	OT Older People's Community and Memory Service – Basildon, Billericay and Wickford	Thurrock Community Hospital Long Lane Grays Essex	N/A	Mixed
Trust Head Office	Medical Older People	Warrior House, 42-82 Southchurch Road, Southend-on-Sea, Essex	N/A	Mixed
Trust Head Office	Medical Older People	Basildon Resource Centre, Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	N/A	Mixed
Trust Head Office	Medical Older People	Harland Centre, Balmoral Road, Westcliff-on-Sea, Essex	N/A	Mixed
Trust Head Office	Medical Older People	240 Mountnessing Road Billericay Essex	N/A	Mixed
Trust Head Office	Memory Assessment / Monitoring	Western House, Chapel Hill, Stansted	4	Mixed
Trust Head Office	Memory Assessment / Monitoring	St Margaret's Community Hospital Saffron Walden	8	Mixed
Trust Head Office	Memory Assessment / Monitoring	Community Hospital, Radwinter Road, Saffron Walden	2	Mixed
Trust Head Office	Memory Assessment / Monitoring	Main Road, Harwich	8	Mixed
Trust Head Office	Memory Assessment / Monitoring	Trinity Street, Halstead	8	Mixed

Location site name	Team name	Address	Number of clinics	Patient group (male, female, mixed)
Trust Head Office	Memory Assessment / Monitoring	Broomfield Hospital Court Road Chelmsford CM1 7ET	32	Mixed

Is the service safe?

Safe and clean environment

Managers had completed environmental risk assessments, including ligature risk assessments, at eight of the locations visited. Staff did not leave patients unattended in any of the rooms at all services. However, Brentwood resource centre team did not have a ligature assessment audit available for staff to refer to.

Interview rooms were either fitted with alarms or staff took personal alarms in with them, when seeing patients. Staff were on site to respond to alarms.

The trust had not ensured that all clinic rooms were maintained to a high standard and were equipped to carry out physical examinations of patients. For example, at Harland team, the clinic room had some dust and a broken drawer. We found electrocardiogram pads with an expiry date of 2008 and non-clinical items in the clinical waste bin. At Thurrock older people's community team, staff had a physical health equipment bag and the blood pressure cuff and thermometer had expired October 2017, although staff had a replacement thermometer. Blood glucose strips were out of date and the blood glucometer had no date of calibration.

The buildings that accommodated the teams were clean, except one for one area that was dusty. They had good furnishings and were generally well maintained throughout. Across the sites the trust had systems for cleaning, and adhered to control of substances hazardous to health.

Staff followed infection control principles, including hand washing. The trust displayed hand washing signs at wash basins.

Safe staffing

This core service has reported a vacancy rate for all staff of 10% as of 31 January 2018.

This core service reported an overall vacancy rate of 7% for registered nurses at 31 January 2018 and 12% for registered nursing assistants.

	Registered nurses			Health care assistants			Overall staff figures		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Comm Dementia Nurse East	1.00	4	25%				1.00	4	25%
Comm Dementia Nurse West	-1.00	3	-33%				-1.00	3	-33%

	Registered nurses			Health care assistants			Overall staff figures		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Dementia East	0.00	6	0%	1.00	4	25%	1.00	10	10%
Dementia Psychology							0.00	5	0%
Dementia Service							-0.24	3.4	-7%
Dementia Service (South East)	1.00	3	33%	-0.60	3	-20%	0.40	6	7%
Dementia Service (South West)	0.00	2	0%	0.00	1.5	0%	0.00	3.5	0%
Dementia West	0.00	6	0%	0.27	6.87	4%	0.27	12.87	2%
E-Specialist Dementia	0.00	17	0%	3.20	22	15%	5.92	52	11%
M - Specialist Dementia	-0.10	15.42	-1%	0.87	19.02	5%	1.76	45.13	4%
M-Dementia Intensive Support	6.00	7	86%	3.00	3	100%	11.00	12	92%
Memory Clinic	1.00	1	100%				1.00	1	100%
Older People Cmht Basildon	1.00	4	25%	0.00	2.13	0%	1.00	6.13	16%
Older People Cmht Brentwood	0.19	2.19	9%	0.00	2	0%	0.19	4.19	5%
Older People Cmht Cpr	0.40	6.2	6%	1.00	2	50%	1.40	8.2	17%
Older People Cmht Southend	1.00	6	17%	0.00	1.8	0%	1.00	7.8	13%
Older People Cmht Thurrock	0.00	3	0%	0.00	1.33	0%	0.00	4.33	0%

	Registered nurses			Health care assistants			Overall staff figures		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Older People Day Services	0.00	1.8	0%				2.20	7	31%
Older People Home Treatment Team	0.60	6	10%	-0.40	3	-13%	0.20	10	2%
Older People Psychology Serv							-0.90	4.8	-19%
Ot Adult Community							2.17	20.76	10%
Ot Older People Community							-0.13	8.42	-2%
Ot Recharges							0.00	3	0%
Specialist Dementia Team (Mid)							0.80	0.8	100%
W-Specialist Dementia Frailty	-2.60	20	-13%	2.21	15	15%	1.48	47.73	3%
Core service total	**8.49**	**113.61**	7%	**10.55**	**86.65**	12%	**30.52**	**291.06**	10%
Trust total	**87.02**	**1106.10**	**7.9%**						

NB: All figures displayed are whole-time equivalents

Between 1 April 2017 and 31 January 2018, bank staff filled 61% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 39% of shifts for qualified nurses. Zero per cent of shifts were unable to be filled by either bank or agency staff.

The trust determined staffing levels across the service, including the number and grade of members of the multi-disciplinary team required at each service. Overall, staffing levels were sufficient to meet the needs of the patients.

There were two whole time equivalent qualified vacancies at the Kingswood Centre and 0.8 vacancies for a health care support worker at the Crystal Centre The manager had interview dates arranged to fill these posts.

Managers assessed and monitored risk of staff members caseloads. Managers used a ‘zoning’ tool with red amber and green risk ratings for patients as part of case management when

allocating to staff. There was an average of 25 to 30 patients per member of staff across the services we visited. This was slightly higher at Ely House and the manager was aware and was looking at how best to manage this. Managers allocated cover for any short-term staff absence and annual leave. Managers booked regular bank or agency staff to cover long term sickness within each service. This ensured that they were familiar with the service and patients.

Staff could get access to psychiatrists for patients if urgently required., patients and carers confirmed this. We observed an example of this when a patient requested on site to see a doctor during our visit at Basildon.

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Community Dementia Nurse East	4	4	0	0
Dementia East	28	28	0	0
Dementia West	1	1	0	0
East Adult Older Home Treatment	98	97	1	0
East Specialist Dementia	311	311	0	0
Mid Dementia Instance Support Service	65	10	55	0
Mid Specialist Dementia	10	5	5	0
N - Specialist Dementia Frailty	6	0	6	0
NE Dementia Service Long Term Team	29	29	0	0
Older People CMHT Basildon	7	0	7	0
Older People CMHT Brentwood	8	0	8	0
Older People CMHT Southend	33	33	0	0
Older People CMHT Thurrock	246	0	246	0
Core service total	**846**	**518 (61%)**	328 (39%*)	0 (0%*)
Trust Total	**102,629**	**31,709 (31%)**	**12,577 (12%)**	**795 (<1%)**

***Percentage of total shifts

Between 1 April 2017 and 31 January 2018, 20 shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants. In the same time period, agency staff covered no shifts. No shifts were left unfilled by either bank or agency staff.

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Dementia Services Long Term	4	4	0	0
Dementia West	53	53	0	0
Mid Dementia Instance Support Service	1	1	0	0
Older Adult Home Treatment	42	42	0	0
Older People CMHT Basildon	104	104	0	0
Specialist Dementia	20	20	0	0
Core service total	**224**	**224**	0	0
Trust Total	**144,009**	**60,464**	**5,916**	**804**

This core service had 28 (7%) staff leavers between 1 April 2017 and 31 January 2018.

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
364 EE706 Older People Cmht Thurrock team	2.62	1.60	61%
300 E-Older Adult Home Treatment	9.91	2.00	20%
364 EE808 Dementia Psychology	5.26	1.00	19%
364 EE800 Dementia Service	3.74	0.60	16%
364 EE804 Comm Dementia Nurse East team	6.40	1.00	16%
300 E- Specialist Dementia	50.14	6.00	12%
300 M- Specialist Dementia team	50.26	4.50	9%
300 M-Access/Assess & Home Treat team	46.46	3.60	8%
300 E- Access/Assess&Treatment	41.98	2.55	6%
300 W-Specialist Dementia Frailty	47.47	2.90	6%

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
300 W- Access/Assess & Home Treat	41.04	2.64	6%
300 M- Dementia Intensive Support DISSteam	1.00	0.00	0%
300 Memory Clinic	1.00	0.00	0%
364 EE806 Dementia West	14.85	0.00	0%
364 EE802 Dist West	3.50	0.00	0%
364 EF428 Ot Older People Community	8.15	0.00	0%
364 EF895 Stroke Community Service	2.38	0.00	0%
364 EF896 Stroke Southend Hospital Ft	2.92	0.00	0%
364 EE801 Comm Dementia Nurse West	5.00	0.00	0%
364 EF780 Older People Psychology Serv	5.74	0.00	0%
364 EE506 Older People Day Services	7.00	0.00	0%
364 EE807 Dementia East	10.40	0.00	0%
364 EE708 Older People Cmht Brentwood	4.00	0.00	0%
364 EE705 Older People Cmht Basildon	4.80	0.00	0%
364 EE333 Older People Cmht Cpr	6.80	0.00	0%
364 EE332 Older People Cmht Southend	7.10	0.00	0%
364 EE803 Dist East	6.80	0.00	0%
Core service total	396.72	28	7%
Trust Total	3127.64	253	7%

The sickness rate for this core service was 3% between 1 April 2017 and 31 January 2018. The most recent month's data showed a sickness rate of 3%. At the time of inspection, the staff sickness rates remained at 3%.

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
364 EE806 Dementia Services (West Essex)	0%	0%

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
364 EE708 Older People Cmht Brentwood	0%	10%
364 EE802 Dist West	0%	0%
364 EE803 Dist East	0%	0%
364 EE806 Dementia West	1%	1%
364 EF428 Ot Older People Community	1%	1%
364 EE800 Dementia Service	0%	0%
364 EE808 Older Adult Psychology Service	0%	1%
364 EE706 Older People Cmht Thurrock	2%	0%
364 EE801 Comm Dementia Nurse West	49%	9%
364 EE807 Dementia East	1%	1%
364 EF780 Older People Psychology Serv	3%	2%
364 EE506 Older People Day Services	3%	2%
364 EE808 Dementia Psychology	0%	0%
364 EE705 Older People Cmht Basildon	22%	10%
364 EF896 Community Stroke Psychology	-	11%
364 EE333 Older People Cmht Cpr	0%	3%
364 EE332 Older People Cmht Southend	2%	5%
364 EE804 Comm Dementia Nurse East	2%	0%
300 Memory Assessment / Monitoring	-	0%
300 W-Specialist Dementia Frailty	3%	2%
300 M- Specialist Dementia	3%	4%
300 E- Specialist Dementia	4%	5%
300 Older People Home Treatment Team	0%	1%
300 Medical Psychotherapy Epping	0%	0%
Core service total	**3%**	**3%**

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Trust Total	**4%**	**4%**

Between 1 April 2017 and 31 January 2018, none of the shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same time period, agency staff covered 301 shifts. All shifts could be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
DISS team	30		30	
Elderly Psychiatry	55		55	
Old Age Community ST	513			
Older Adult ST	86			
Specialist Dementia	37		216	
Core service total	**721**	**0**	**301**	**0**
Trust Total	**6744**	**258**	**3406**	**3080**

Mandatory training

The compliance for mandatory and statutory training courses at 31 December 2017 was 73%. Of the training courses listed 27 failed to achieve the trust target and of those, 18 failed to score above 75%.

The trust has a rolling month on month compliance rate for mandatory training.

Managers kept a local training matrix as the trust training data was not accurate. This was due to an error in the IT system following the trust merger on 1 April 2017. Brentwood older people's community team training matrix showed mandatory training figures at 50%, long term staff sickness affected this. This was the lowest example of compliance; all others were above 75%.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	This core service %	Trust target %
Conflict Resolution	100%	85%
Dementia Awareness (inc Privacy & Dignity standards)	100%	85%
Consent	100%	85%
Care Certificate	100%	85%
Safeguarding Children (Level 3)	100%	85%
Cascade Fire Trainer	100%	85%
Health and Safety (Slips, Trips and Falls)	100%	85%
Mental Capacity Act Level 2	98%	85%

Training course	This core service %	Trust target %
Dual Diagnosis	95%	85%
Induction E-Learning	94%	85%
PREVENT (WRAP) Training	94%	85%
Corporate Induction	93%	85%
Care Programme Approach	92%	85%
Safeguarding Adults (Level 3)	91%	90%
Safeguarding Adults (Level 1)	91%	90%
Duty of Candour (Overview Version)	90%	85%
Equality and Diversity	89%	85%
Harassment & Bullying	87%	85%
Safeguarding Adults (Level 2)	84%	90%
Medication Management (MH)	84%	85%
Complaints Handling	84%	85%
Clinical Risk Assessment	84%	85%
First Aid Trained	83%	85%
Food Hygiene	83%	85%
Duty of Candour (Detailed Version)	83%	85%
Fit for Work	79%	85%
Information Governance	78%	85%
Basic Life Support & AED	71%	85%
Fire Safety 2 years	68%	90%
Mental Health Act	67%	85%
Mental Capacity Act Level 1	65%	85%
Personal Safety Breakaway - Level 1	58%	85%
Infection Prevention, Control & Hand Hygiene	57%	85%
Diabetes Training	54%	85%
Personal Safety - MVA	30%	85%
Fire Safety 3 years	21%	90%
MERT (Enhanced Emergency Skills)	17%	85%
Observation of Service User	13%	85%
Hoisting	11%	85%
Manual Handling - People	11%	85%
Medicines Management (community)	5%	85%
TASI Trained	0%	90%
Security Training (eLearning)	0%	85%
Anaphylaxis	0%	85%
Security Training	0%	85%
Total	**73%**	85%

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 35 care records in total. Staff completed a risk assessment of patients at initial triage/assessment, in 33 records. Risk assessments were updated to reflect change. Staff had not completed risk assessments for two patients at Thurrock older people's community mental health service.

Staff used the recognised risk assessment tool on the trust's electronic patient record system. There were two different systems in operation one in the north and one in the south.

Staff created crisis plans for patients to use in times of crisis and supported patients to make advance decisions when required. Staff shared patient crisis plans with their family to ensure everyone involved with supporting the patient knew how best to support them. We found a detailed example of crisis and relapse planning.

Management of patient risk

Staff responded promptly if they identified deterioration in a patient's health. Staff referred patients to dementia review support teams, dementia intensive support teams and crisis teams in a prompt way. Staff monitored patients on waiting lists to detect and respond to increased levels of risk. Staff used the red amber and green traffic light system to identify patient's risk.

The trust had developed good personal safety protocols for staff, including lone working practices. We attended home visits with staff and saw evidence of the protocols being followed. All staff from the services carried alarms. Staff ensured colleagues knew of the appointments they would be attending, and could arrange for two workers to go out on visits to reduce risks. Teams had developed systems for staff on home visits to check in with colleagues at the end of the day.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust have provided details of the total number of safeguarding referrals made between 1 April 2017 and 31 December 2017 with 802 referrals made for adults and 180 for children. However this is for the whole trust and has not been broken down to core service level.

Safeguarding training Data provided by the trust for the service evidenced 91%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. We reviewed ten safeguarding referrals which showed teams working in partnership with other agencies and good joint working with the local authority. Staff were aware of who the trust safeguarding leads and champions were for them to speak to for advice and guidance. Staff told us the trust safeguarding lead had attended team meetings delivering training and support to staff at older people mental health community services.

Staff could give examples of how to protect patients from harassment and discrimination. This included patients with protected characteristics under the Equality Act.

The trust told us that there were no serious case reviews commenced or published in the last 12 months that related to this core service.

Staff access to essential information

The staff used electronic records systems for patient records. There were two different systems in place across the trust. Some staff said they could not access both systems. However, the trust had a portal called the Health Information Exchange (HIE) which had recently been introduced. There was a unified staff intranet system across the trust which had a tools section for staff to

access for policies and procedures and other information for their work. This was categorised into clinical, corporate and administration.

At Thurrock older people's team, social workers had access to the local authority electronic record system for patients.

Medicines management

Staff did not manage medicines consistently across the service. Some sites shared the use of a clinic room, some sites had medicine cupboards to store medication. Medication was dispensed at the patient's homes. Staff at the Basildon team had not checked and disposed of out of date medication. We found that four types of medication stored for the Ely service had expired, including four depot injections. The issues raised were dealt with immediately. Staff at Ely house also had no secure bag they could use to transport medication to the patients in the community.

Staff regularly reviewed the effects of medications on patients' physical health. Staff recorded reviews in patient records. Staff monitored dementia medication monthly for three months whilst patients titrated. Staff monitored patients prescribed antipsychotic meds or lithium and ensured patients had access to electrocardiograms and blood tests as required. Staff at Brentwood and Ely House teams used a physical health monitoring tool for patients on psychotropic medication. However, this was not used at other sites as not all staff were aware of the tool.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 January 2018 there was one STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was *apparent/actual/suspected self-inflicted harm meeting SI criteria* with one.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

	Number of incidents reported	
Type of incident reported on SIRI	Specialist Dementia – The Kingswood Centre	Total
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1	1
Total	**1**	**1**

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff reported incidents on the trusts electronic system and we saw examples of this.

Staff understood the duty of candour. They told us they explained things to patients when things went wrong. We saw evidence of a carer spoken to by the manager of the service following an incident.

Staff received feedback from investigation of incidents both internal and external to the service. We saw evidence of this and lessons learnt in team meeting minutes sent to staff. The trust cascaded a learning portfolio newsletter monthly to all staff of incidents that had occurred throughout the trust. For example, staff monitoring patients with diabetes. The Kingswood centre manager had an additional system for sharing learning from incidents with staff. For example, following an incident they sent guidance to staff regarding risks relating to patients with hoarding behaviour.

An example of changes made following an incident was at The Kingswood centre; where staff had worked with the pharmacy team to improve their medicines management practice and improve liaison with patients GP's. Managers held debrief meetings and supported staff and patients after incidents.

Is the service effective?

Assessment of needs and planning of care

We reviewed 35 care records. Staff had completed and regularly reviewed care plans for 30 of the patient records checked. However, care plans were limited in information and detail. Two patients reviewed had no risk assessments. Three patient records reviewed had no care plan. Those care records with care plans were updated.

Staff in the memory service teams we visited had a comprehensive assessment process in place as part of the referral and diagnosis of patients. Staff used nationally recognised tools such as the Generic Depression Scales; Lawton's Activities of Daily Living and Addenbrooke's Cognitive Examinations'. Staff discussed with the patient their psychiatric history and medical history given by the GP at the initial assessment. Staff completed a cardiac symptom checklist and recorded an overview of the patient's mental state. The multi-disciplinary team meeting then reviewed this information and determined the patients level of needs and care required.

The trust had undertaken care plan audits throughout the services we visited and these had highlighted some need for improvement where care plans or risk assessments were missing. These were available and accessible to staff and managers at each service to action.

Best practice in treatment and care

This core service participated in no specific clinical audits as part of their clinical audit programme in 2017.

Staff provided a range of care and treatments to patients. Staff followed National Institute for Health and Care Excellence guidance when delivering occupational therapy interventions, for example, cognitive stimulation therapy, occupational therapist assessments, psychologist based interventions, psychology led cognitive behaviour therapy for carers, and wellbeing groups held for carers and patients.

The Kingswood centre team held a weekly dementia café in the community for patients, carers and members of the public interested to learn more about dementia. This was open to other staff from the trust and representatives from voluntary agencies also attended. Patients and carers said this was well attended and met their needs. Staff provided leaflets and information.

Another example of staff responding to patients' need was that Kingswood centre staff supported a patient and employer to help understand dementia, with the aim of keeping the individual employed.

Staff from Ely house delivered a home treatment service and did not deliver any therapies to patients. Staff referred to other agencies if patients required this support. The local hospital provided therapies for patients at Latton Bush. Transport was provided for this.

The older people's mental health community services visited provided Information and support for patients with employment, housing, benefits and interventions that enabled patients to acquire living skills.

Thirty-two of the 35 care records that we reviewed showed evidence of staff recording the physical health conditions and needs of those patients. However, three records viewed had no record of physical health. Staff completed and recorded physical observations and falls assessments. Staff across teams did not have a consistent approach for completing physical health annual reviews and used different recording systems. Thurrock staff 's spreadsheet for monitoring staff's six monthly checks of patients' physical health was not up to date as it showed 39 of 52 patients had not received a physical health check in the last year. Staff completed annual health checks for patients referred to the dementia intensive support teams. GP's completed annual physical health checks for patients working with memory assessment services.

Staff displayed leaflets and information for smoking cessation, and advice on nutrition and healthier lives at team offices or had access to them to give to patients. The Crystal centre Alzheimer's workers gave support and advice on weight and smoking cessation. The Kingswood centre had an occupational health team who would provide advice on healthier living and had a referral system to a nutritional advisor. However, this was not consistent across all other sites visited.

Staff used recognised rating scales such as Health of the Nation Outcome Scales (HoNOS).

Staff completed clinical audits. We saw evidence of this at Latton Bush and The Crystal centre where staff had conducted audits on care programme approach, risk assessment, case notes, and medicines audits. The trust had carried out an audit of patients care plans across teams, highlighting areas for improvements required.

Skilled staff to deliver care

The teams had access to the full range of specialists required to meet the needs of the patients which included consultant psychiatrist, psychologists, occupational therapists, care home liaison, qualified nurses and support workers. Social workers were integrated with some teams such as Thurrock.

Staff were skilled and experienced and able to meet the needs of the patient group.

Managers provided new staff with a six-week induction period. This was a trust wide induction process. Kingswood centre had a local induction package produced for new staff on induction with relevant information to that specific service.

Managers provided staff with supervision meetings to discuss case management and to reflect on and learn from practice. These were held monthly across the sites we visited. In addition to this group supervision sessions were held for staff in the Kingswood centre, Thurrock and Brentwood. All sites visited used a supervision tree so managers could track staff that required supervision. Managers appraised staff performance annually. Managers ensured that staff had access to regular team meetings throughout all teams.

The trust's target rate for appraisal compliance is 90%. As at 31 January 2018, the overall appraisal rates for non-medical staff within this core service was 83%.

Eight teams failed to achieve the trust's appraisal target, the lowest appraisal compliance rates were the Dementia service with an appraisal rate of 0% and Comm Dementia Nurse East at 33%.

No appraisal data was submitted by the trust for medical staff in this core service during this period.

Not all sites visited could provide up to date percentages of appraisals for staff. However, we saw evidence Brentwood had increased to 94% and Basildon had increased to 100% appraisals for staff completed.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Comm Dementia Nurse West	2	2	100%
Dementia East	9	9	100%
Dementia Psychology	2	2	100%
Dist East	6	6	100%
Dist West	5	5	100%
Older People CMHT Brentwood	2	2	100%
Older People CMHT CPR	7	7	100%
Older People CMHT Southend	8	8	100%
Older People CMHT Thurrock	2	2	100%
Older People Day Services	5	5	100%
Older People Psychology Serv	4	4	100%
Dementia West	14	13	93%
Specialist Dementia	43	37	86%
Specialist Dementia Frailty	42	34	81%
Older People CMHT Basildon	5	4	80%
Home Treatment Older Adults	4	3	75%
Ot Older People Community	12	9	75%
Specialist Dementia	43	29	67%
Comm Dementia Nurse East	3	1	33%
Dementia Service	1	0	0%
Core service total	**219**	**182**	83%
Trust wide	4121	3386	82%

Between 1 April 2017 to 31 January 2018 the average rate across all eighteen teams in this core service was 87% of the trust's target. 'Older People Psychology service' had a rate of 0% although only one member of staff was reported as requiring clinical supervision.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Not all sites visited could provide up to date percentages of supervision for staff. However, Brentwood supervision figures had increased to 100%.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Castle Point & Rochford Older People's CMHT	70	70	100%
Comm Dementia Nurse East	30	29	97%
Comm Dementia Nurse West	20	19	95%
Dementia East	100	96	96%
Dementia Service (South East)	41	41	100%
Dementia Service (South West)	40	40	100%
Dementia West	130	120	92%
Home Treatment Older Adults	64	51	80%
Older Adult Psychology	15	15	100%
Older People CMHT Basildon	50	50	100%
Older People CMHT Brentwood	40	40	100%
Older People CMHT Southend	80	76	95%
Older People CMHT Thurrock	34	33	97%
Older People Day Services	40	37	93%
Older People Psychology Serv	1	0	0%
Ot Older People Community	10	10	100%
Specialist Dementia	586	446	76%
Specialist Dementia Frailty	287	259	90%
Core service total	**1,638**	**1,432**	**87%**
Trust Total	**24,386**	**21,061**	**86%**

Managers identified the learning needs of staff and provided opportunities for their skills and knowledge to be developed. Managers delivered further training to staff at meetings. The crystal centre had introduced lunch and learn which staff attended. Guest speakers were invited to attend group supervision on a quarterly basis at the Kingswood centre. One member of staff was supported by managers and had secured a course for eye movement desensitisation and reprocessing (EMDR) recommended by The National Institute for Health and Care Excellence. A support worker had started nurse training supported by the trust.

Manager's ensured staff received necessary specialist training for their role such as older people's mental health dementia training and virtual dementia tour training. Staff across all sites stated the trust provided a variety of training opportunities for staff.

Managers dealt with poor performance promptly. We reviewed two records relating to staff that had undergone performance management. The manager at Kingswood had produced a local matrix for the staff he managed which included actions, relevant information and support given.

Managers recruited volunteers, and supported them in their roles. Three student nurses in older people's mental health community told us they felt supported and part of the teams they worked with, and were provided with further training.

Multidisciplinary and interagency team work

All teams held regular multi-disciplinary team meetings on a weekly basis. All members of the multi-disciplinary team attended and had good working relationships. New referrals, risk and cases of concern were discussed. Staff shared information about patient risk and communicated these issues to the on-duty team. We saw evidence of this in the meetings that we attended.

We observed effective working relationships, with other teams in the organisation. This included the intensive support team crisis service, inpatient services and care homes. This was delivered though a newly funded role in the older people's mental health community services for a care liaison. This role looked to diagnose patients in care homes with dementia, and to support hospitals in preventing unnecessary admission to inpatient wards.

The service had good working relationships, including handovers, with primary care, social services and other teams external to the organisation. Staff had developed strong working relationships with the local authority safeguarding teams. In older people's mental health community teams there were joint meetings taking place with these outside organisations.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

As of 31 December 2017, 67% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for staff and renewed every three years.

Staff demonstrated a good understanding of the Mental Health Act, the code of practise and guiding principles. Staff understood their responsibilities for Patients on a community treatment order.

Staff had access to the Mental Health Act administrators for support and legal advice on the Mental Health Act and its Code of Practice. Staff knew who the Mental Health Act administrators were and how to contact them.

Staff could access the trust Mental Health Act policy on the intranet.

The team worked with patients in the community on community treatment orders (CTO's). Staff could explain the process to be followed with this. However, we received conflicting information from team and central trust staff about why one patient's order was discontinued. Staff told us there had been a delay in getting an approved mental health practitioner review. Central trust staff informed us a multi-disciplinary team review had taken place and it had been agreed not to continue the order. Records were not available for one patient to show that staff had explained their legal rights under S132 of the Act.

Staff supported patients discharged from detention under S117 of the Act and care plans referenced this and patients were reviewed annually. However, staff did not complete one patient's care plan at the Crystal Centre until 14 months after their discharge. We checked further on this and the patient's care needs were met as they were in a care home.

Good practice in applying the Mental Capacity Act

As of 31 December 2017, 65% of the workforce had received training in the Mental Capacity Act level one and 98% in Mental Capacity Act level two. The trust stated that this training is mandatory for all staff and renewed every three years.

The trust had a policy on the Mental Capacity Act. Staff were aware of the policy and how to access it. Staff knew where to get advice from within the trust regarding the Mental Capacity Act. The trust had arrangements to monitor adherence to the Mental Capacity Act.

Staff were trained in and understood the Mental Capacity Act 2005, and the five statutory principles, and were aware of their responsibilities.

For patients who had impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis. This was considered at the referral stage and at multi-disciplinary team meetings. However, one record had no capacity assessment recorded, when staff had identified concerns about their memory. Staff provided support and assistance in supporting patients to make decisions for themselves before they assumed that the patient lacked capacity to make it. We saw evidence of this on home visits we attended, for example, a patient did not want to consent to a memory assessment and staff assessed they had capacity, and discharged the patient back to their GP's care.

When patients were assessed as lacking capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. We saw staff engaging with a patient's relative regarding their preferences on a home visit.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We observed staff attitudes and behaviours when interacting with patients; staff were respectful and responsive to patient's needs. We saw staff taking time to explain important aspects of their treatment such as medication and side effects.

Staff directed patients to other services when appropriate for example to social workers for carers' assessments.

We spoke with 36 patients who told us that staff were extremely caring and compassionate, they were supportive to family members, they responded to their needs and explained things clearly.

Patients told us staff understood their individual needs and staff knew them well. Patients said that staff would contact them and communicate with them regularly. Staff understood and had a good knowledge of the patients in their care. This included patient's personal, cultural social and religious needs. For example, we observed staff showing genuine concern for the wellbeing of the whole family on a home visit. Four of the care plans we viewed had carers involvement recorded.

All staff spoken with said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes and behaviour towards patients without fear of the consequences. Staff could explain what signs they would look out for. One example we saw was when staff went into a care home to see a patient they reported safeguarding issues to the local authority.

Staff maintained the confidentiality of information about patients.

Involvement in care

Involvement of patients

Staff involved patients in care planning and risk assessment. At Brentwood and Basildon teams staff used 'My Care, My Recovery' plans with patients to gain the patient's view of their needs and saw evidence of this in five care plans we viewed. We saw evidence of patient and carer involvement across the services. Staff invited patients and carers to care plan approach reviews

as required. Staff knew patients' needs and responded in a timely way. One patient stated the psychologists work given to them regarding anger management was excellent.

Staff used a variety of methods to communicate with patients so they understood their care and treatment. We saw staff explaining treatment options using 'easy read' leaflets. Staff took time to explore options and answer questions for patients with communication difficulties.

Patients were given the opportunity to give feedback of the service via surveys conducted across the trust. The older people's community services also conducted specific surveys in individual services so the trust could make changes to improve the service.

Staff enabled patients to make advance decisions when appropriate. Staff also sign posted patients to support groups where this was discussed. However, this was not consistent across all sites.

Advocacy services were in place to provide independent support to patients. Patients and carers were aware of this service and could access this easily. Leaflets about the service were provided at all sites.

However, one patient said that some staff did not treat patients as an individual and example of this was referral to a mindfulness group. This was not appropriate as the need was for bereavement. One patient said staff did not give them appointment dates when they would next be visiting them, instead contacted them the day of their visit.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. There were regular carers groups and meetings offered at the services we visited except for Brentwood who stated they would be starting these again soon. Carers were offered cognitive behaviour therapy courses and were directed to groups in local centres. The Kingswood centre ran a gardening group for carers and patients on a weekly basis, we observed this on our visit this was a very positive experience and enjoyed by all who attended.

We spoke with 19 carers who said that they were satisfied with the care provided. Carers felt their views were valued by the staff. Carers told us that their workers were approachable, caring and supportive and they could contact them whenever they needed to.

Carers could give feedback on the service via surveys questionnaires and meetings with staff we saw evidence of this on sites we visited.

Staff provided information on how to access a carer's assessment. Staff referred carers to the local authority for these.

Is the service responsive?

Access and waiting times

The trust has identified the below services in the table as measured on 'referral to initial assessment'. The trust provided targets for 'days from referral to initial assessment' for six out of 18 teams listed below. All six teams met their target.

The trust did not provide any data regarding targets for assessment to treatment.

Name of hospital site or location	Name of team	Service Type	Days from referral to initial assessment		Days from assessment to treatment	
			Target	Actual (mean)	Target	Actual (mean)
Crystal Centre	Dementia Intensive Support Service (DISS)	Adult MH Service	Not provided	4	Not provided	6
Crystal Centre	Memory Assessment / Monitoring	Adult MH Service	Not provided	19	Not provided	63
Kingswood Centre	OLDER ADULT HOME TREATMENT	OP MH Service	Not provided	1	Not provided	1
Derwent Centre	MEMORY ASSESSMENT	OP MH Service	Not provided	34	Not provided	35
Derwent Centre	MEMORY MONITORING	OP MH Service	Not provided	12.5	Not provided	38
Thurrock Hosp	Day Treatment - Older - South Essex	Day Treatment	Not provided	91	Not provided	17
Various	Medical - Older MH	OP MH Service	Not provided	36	Not provided	94
Ely House	Memory Service Team - Basildon	OP MH Service	6 weeks for dementia diagnosis assessment	26	Not provided	76
Brentwood Hosp	Memory Service Team - Brentwood	OP MH Service	6 weeks for dementia diagnosis assessment	29	Not provided	27
Sydervelt Clinic	Memory Service Team - Castle Point Rochford	OP MH Service	6 weeks for dementia diagnosis assessment	31	Not provided	27
Harland Centre	Memory Service Team - Southend	OP MH Service	6 weeks for dementia diagnosis assessment	32	Not provided	56
Integration House Grays	Memory Service Team - Thurrock	OP MH Service	6 weeks for dementia diagnosis assessment	20	Not provided	66
Ely House	Older People MH Team - Basildon	OP MH Service	Not provided	6	Not provided	41
Brentwood Hosp	Older People MH Team - Brentwood	OP MH Service	Not provided	29	Not provided	25
Sydervelt Clinic	Older People MH Team - Castle Point Rochford	OP MH Service	Not provided	9	Not provided	15
Harland Centre	Older People MH Team - Southend	OP MH Service	Not provided	12	Not provided	16
Civic Offices Grays	Older People MH Team - Thurrock	OP MH Service	Not provided	12	Not provided	32
Health Close	Speech Therapy - Mem Svce - South Essex	OP MH Service	Not provided	43	Not provided	43

The older people's mental health service had clear criteria for which patients would be offered a service. The trust's timescale was set at 18 weeks from referral to treatment, for older people's mental health services which teams were meeting.

Brentwood had a two week wait for patients from referral to assessment; it then took an average of six weeks from assessment to treatment. The waiting period varied for memory assessment centres, this was due to the waiting time for magnetic resonance imaging (MRI) results to be returned to the service for diagnosis of treatment needs. The Harland Centre did not have any patients waiting to be assessed. However, patients were waiting up to eight weeks for their first appointment after assessment. At the Harland centre on average patients were seen within 14 weeks of the 18-week timescale. Basildon patients waited up to six weeks for assessment with a total of 12 weeks to treatment.

A central trust team received referrals and appropriate referrals were directed to the older adult mental health team. Urgent referrals to teams were seen quickly usually within 24 hours and managers had screening systems for checking that appropriate referrals were made.

The Kingswood centre, the Crystal centre, Basildon, Brentwood and Thurrock had a crisis team. All the other services could refer patients to the crisis team to be seen immediately. Staff gave patients information on how to contact the trust's 24-hour helpline if they were in crisis out of hours.

The teams responded promptly and adequately when patients telephoned the service, for example in an emergency, staff saw patients within two hours, patients with an urgent referral were seen the same day and staff saw patients with routine enquiries within seven days; currently services were meeting this within 48 hours.

Staff tried to engage with people who found it difficult or were reluctant to engage with the service. Staff said they would visit and try to engage patents. If necessary they would look to refer other services to provide more suitable support, and would be flexible with appointment times to encourage engagement. Where possible, staff offered flexibility in appointment times; for example, appointments running until six o'clock and some arranged on weekends for patients who still worked.

Teams followed up on those who did not attend appointments by calling the patient and offering alternative timings. If there was no response staff would contact GP's and carers to check on the patient's welfare and encourage attendance. Staff told us often the reason for non-attendance was because the patient was in an acute hospital.

Staff cancelled appointments only when necessary and when they did, they explained why and arranged another appointment as an alternative. Staff and patients spoken with at all services said this was rare.

All older people mental health community services we visited staff and patients told us appointments usually ran on time. Patients were kept informed when they did not.

Staff supported patients during referral and transfers between services. There was close working with other older people community services, care homes and hospital inpatient wards to prevent unnecessary admissions and support those that needed admission to hospital for treatment.

Facilities that promote comfort, dignity and privacy

The services we visited had a range of rooms and equipment to support treatment and care, soundproofed rooms were available.

Patients' engagement with the wider community

Kingswood Centre staff gave an example of supporting patients in accessing work opportunities and worked closely with the Alzheimer's society at all older people community services to aid this.

Staff encouraged patients to maintain relationships with people that mattered to them, and some patients had objectives in their care plan of how they could seek support from their family and engage them in treatment.

Meeting the needs of all people who use the service

Team offices were accessible for patients or others with mobility difficulties, for example they had designated disabled car parking areas and accessible meeting rooms and toilets. However, staff mostly conducted home visits.

The service made adjustments to meet patients' specific communication needs. The information provided was in a form accessible to the patient group. For example, we saw dementia friendly prompt cards and 'easy read' or large print font information. Alternatively, staff read information to patients with impaired vision.

Staff provided patients with information on the local treatments and service available, relevant to the older people's mental health pathway.

The trust had information leaflets available in a variety of languages, if a patient's first language was not English. Staff could access interpreting services when needed.

Staff assessed patient's ethnicity and religious or cultural needs. However, staff were unable to give specific information about how they supported lesbian gay, bisexual or transgender patients' needs, other than stating they assessed patients individually and developed care plans to meet any diverse needs.

Listening to and learning from concerns and complaints

This core service received 10 complaints between 1 April and 31 December 2017. No complaints were referred to the Ombudsman during this period. Complaints relating to clinical practice received the most complaints with six.

Team	Clinical Practice	Systems & Procedures	Communication	Total
Home Treatment Service	1		1	2
Southend East & Central CRHT			1	1
Basildon Older Peoples CMHT	1			1
Brentwood Older Peoples CMHT		1		1
Outpatients	1			1
Castle Point & Rochford Older Peoples CMHT	1			1
Specialist Dementia		1		1
Dementia Intensive Support Team	1			1
Harlow Specialist Dementia / Frailty Team	1			1
Total	**6**	**2**	**2**	**10**

This core service received 30 compliments during the last nine months from 1 April to 31 December 2017 which accounted for 5% of all compliments received by the trust as a whole.

Patients told us they knew how to complain and raise concerns if they wanted to.

There had been 11 complaints in the last 12 months up to the date of this inspection at the older people's mental health community sites. Those complaints we reviewed were timely and included details of any investigations. Further information was provided if the patient or carer wished to

complain further. Information regarding the patient and liaison services (PALS) and leaflets on how to make a complaint were available in the team reception areas.

Staff knew how to deal with and respond to complaints in line with the trust wide policy.

Staff advised that they received feedback on the outcome of investigation of complaints. This was via team and governance meetings. We found evidence of learning and that staff had acted on the outcome of complaints.

Is the service well-led?

Leadership

Managers had the skills and knowledge to perform their roles. We found the leadership was strong across sites and managers told us they were given regular leadership and development opportunities by the trust.

Team managers had a good understanding of the services they managed. They could explain clearly how the teams were working to provide care in the community.

Managers were visible in the service, staff and patients knew who they were and told us they were approachable. Staff knew who senior managers were in the trust and they were accessible to them.

Staff were given leadership and development opportunities by the trust and through staff appraisals. Staff felt encouraged and supported to do so. For example, staff told us they felt the trust was in the forefront of continuing professional development. Staff told us they were regularly offered external training.

Vision and strategy

Staff knew and understood the trust's vision and values and how these applied to their work. The sites we visited displayed these, and staff were aware they were on the trust's intranet site. We observed staff across the service displaying these in the interactions with patients and carers.

Staff had the opportunity to contribute to discussions about the strategy for their service through business team meetings held throughout the service.

Staff could explain how they were working to deliver high quality care within the budgets available. They told us how services worked together to ensure that needs identified were met.

Culture

Staff said they felt respected, supported and valued by their managers. They felt they had good direction from managers and were positive about working for the trust. Staff felt able to raise concerns without fear of retribution. Staff knew how to use the trust's whistle-blowing process, they could email concerns via the trust's 'I'm concerned about' initiative and were aware of the role of the Freedom to Speak Up Guardian and how to access this.

Managers dealt with poor staff performance when needed. We reviewed a sample of staff files and saw evidence of managers appropriately managing staff's performance. We saw that managers supported staff to reach required trust performance targets.

Staff spoke very highly of the teams they worked in. They felt well supported by their peers. Student nurses commented on their placement team staff being hard working and open. Teams worked well together and where there were difficulties managers dealt with them appropriately.

The trust had systems for monitoring compliance with annual appraisal of staff. Staff had received an appraisal. This included conversations about career development. Managers discussed with staff how they could be supported to undertake such development. New staff on induction told us they received an appraisal after their first three months in their role and felt supported by managers and the team.

Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. The trust had implemented monthly meetings for Black Asian and Minority Ethnic groups (BAME) However, one member of staff spoken with said they felt there was some unfairness with recruitment regarding culture, however was still happy within their role and still felt these concerns could be raised without fear of reprisal.

The service's staff sickness and absence rates were similar to the average for the provider.

Staff had access to support for their own physical and emotional health needs through an occupational health service. All staff spoken with were aware of this service and how to access it.

The trust recognised staff success within the service through staff awards. A member of reception staff had been given an 'our people' award. The Kingswood centre team had a locally won an award for efficiency of referrals of patients. Another member of staff had been given an award following the feedback of a trust survey for friends and family.

Governance

The service had governance systems in place which managers were familiar with. There were systems and procedure in place to ensure patient areas were safe and clean. Staff were trained and received regular supervision and appraisal. Staff carried out assessments of patients and treated them well. Services adhered to the Mental Health Act and the Mental Capacity Act. Managers monitored referral to treatment times. Manager's ensured staff reported incidents and ensured lessons learnt from investigations were shared. Staff had implemented recommendations from incidents, complaints and safeguarding at service level.

The trust had a clear governance framework in place. The service managers had a performance dashboard to monitor staff training compliance and other key indicators.

Team managers facilitated weekly business meeting with their teams. The meetings included standard agenda items set to ensure managers discussed and shared relevant information, such as incidents, complaints and lessons learnt from these.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. Staff understood arrangements for working with other teams, both within the trust and externally, to meet the needs of the patients.

Managers and the wider trust did not have robust oversight of the management of medicines and equipment in the older people's mental health community services.

Management of risk, issues and performance

Staff maintained and had access to the risk register at a team level and could escalate concerns when required. Staff concerns matched those on the risk register. The service had plans for emergencies – for example, adverse weather or a flu outbreak.

Where cost improvements were taking place, they did not compromise patient care. We saw evidence of new role introduced funded by commissioning groups. This role was in addition to the current staffing.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked and helped to improve the quality of care.

Information governance systems included confidentiality of patient records. Team managers had access to information to support them with their management role. This included information on the performance of the service, such as staffing and patient care. Information was in an accessible format and identified areas of improvement.

Staff made notifications to external bodies as needed

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, newsletters and local community resources information provided at individual services.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs, such as the friend and family test questionnaire for the trust. The trust provided family and carer questionnaires to give carers an opportunity to feedback regarding local services provided. Managers and staff used this to make improvements.

Patients and carers were involved in decision-making about changes to the service. Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback. Directorate leaders engaged with external stakeholders – such as commissioners.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. Staff had opportunities to participate in research and Innovations taking place in the service. For example, a member of staff at the Kingswood centre had researched and set up a young dementia onset group with joint working of other agencies.

There was a virtual dementia tour dedicated training room which was made available to carers to experience. This had a positive impact on carers understanding living with dementia. Brentwood were setting up formulation groups and medicines groups for carers. Latton Bush and the Crystal centre were researching and looking to implement end of life care champions.

Staff used quality improvement methods and knew how to apply them. Staff participated in national audits relevant to the service and learned from them. Older people mental health community services participated in accreditation schemes relevant to the service such as Memory Services National Accreditation Programme (MSNAP). However, we found the Crystal Centre had previously started this accreditation had not completed it. The manager told us the service would be participating for accreditation in the future.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
Memory Services National Accreditation Programme (MSNAP)	North Essex Memory Pathway	(October 2016)

Community mental health services for people with a learning disability or autism

Facts and data about this service

Location site name	Team name	Address	Number of clinics	Patient group (male, female, mixed)
Trust Head Office	Asperger's Service	Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	N/A	Mixed
Trust Head Office	OT Asperger's	Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	N/A	Mixed
Trust Head Office	Health Facilitation Service (Castle Point & Rochford Area)	Coombewood Centre, 1 Websters Way, Rayleigh, Essex	N/A	Mixed
Trust Head Office	Intensive Support Team (Castle Point & Rochford Area)	Coombewood Centre, 1 Websters Way, Rayleigh, Essex	N/A	Mixed
Trust Head Office	Adult LD Psychology Services	Pride House, Christy Close, Laindon, Essex	N/A	Mixed
Trust Head Office	Health Facilitation Service (Basildon Area)	Ely House, Churchill Avenue, Basildon, Essex	N/A	Mixed
Trust Head Office	OT LD Basildon	Ely House, Churchill Avenue, Basildon, Essex	31	Mixed
Trust Head Office	LD Medical	Grays Hall, Orsett Road, Grays, Essex	N/A	Mixed
Trust Head Office	Adult LD Psychology Services	Unit 2-5 Heath Close Billericay Essex	N/A	Mixed
Trust Head Office	LD Medical	Unit 2-5 Heath Close Billericay Essex	N/A	Mixed
Trust Head Office	LD Physiotherapy	Unit 2-5 Heath Close Billericay Essex	4	Mixed
Trust Head Office	Occupational Therapy (Learning Disabilities)	Unit 2-5 Heath Close Billericay Essex	N/A	Mixed
Trust Head Office	Speech & Language Therapy (Learning Disabilities)	Unit 2-5 Heath Close Billericay Essex	8	Mixed
Trust Head Office	Children's Learning Disability Service	Holmer Court, Essex Street, Colchester	0	Mixed
Trust Head Office	Learning Disabilities (Speech & Language Therapy, Occupational Therapy, Physiotherapy)	Pride House, Christy Close, Laindon, Essex	SLT 1:1 sessions daily Clinics monthly	Mixed
Trust Head Office	LD Medical	Union Lane Rochford Essex	N/A	Mixed
Trust Head Office	Intensive Support Team (Southend Area)	Southend Civic Centre, Civic Centre (Southend Borough Council), Victoria Avenue	N/A	Mixed

Location site name	Team name	Address	Number of clinics	Patient group (male, female, mixed)
Trust Head Office	Occupational Therapy Health & Wellbeing	Pride House, Christy Close, Laindon, Essex	35	Mixed
Trust Head Office	Speech & Language Therapy (Learning Disability) Communication Team	Southend Civic Centre, Civic Centre (Southend Borough Council), Victoria Avenue	N/A	Mixed
Trust Head Office	Intensive Support Team (Thurrock Area)	Thurrock Community Hospital Long Lane Grays Essex	N/A	Mixed
Trust Head Office	OT LD Health & Wellbeing	Pride House, Christy Close, Laindon, Essex	31	Mixed
Trust Head Office	LD Medical	Warrior House, 42-82 Southchurch Road, Southend-on-Sea, Essex	N/A	Mixed
Trust Head Office	Asperger's Service	Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	N/A	Mixed
Trust Head Office	OT Asperger's	Basildon Mental, Health Unit, Nethermayne, Basildon, Essex	N/A	Mixed
Trust Head Office	Health Facilitation Service (Castle Point & Rochford Area)	Coombewood Centre, 1 Websters Way, Rayleigh, Essex	N/A	Mixed
Trust Head Office	Intensive Support Team (Castle Point & Rochford Area)	Coombewood Centre, 1 Websters Way, Rayleigh, Essex	N/A	Mixed
Trust Head Office	Adult LD Psychology Services	Pride House, Christy Close, Laindon, Essex	N/A	Mixed

Is the service safe?

Safe and clean environment

Staff completed regular risk assessments of the care environment. Staff did not have access to clinic rooms within teams. Patient's medication was prescribed under consultation from the psychiatrists by their GP and stored in their own homes.

Most appointments happened in the patient's own home or in community facilities. All patient areas visited were clean and well maintained. Interview rooms had good soundproofing. Staff carried personal alarms, and there were staff on site to respond to alarms.

Cleaning records were up to date and demonstrated that the premises were cleaned regularly.

Staff adhered to infection control principles, including handwashing. We saw that the trust had displayed posters reminding staff to wash their hands.

Equipment was well maintained and kept clean. Appliance testing stickers were visible and in date.

Safe staffing

This core service has reported a vacancy rate for all staff of 18% as of 31 January 2018.

This core service reported an overall vacancy rate of 21% for registered nurses at 31 January 2018 and 33% for registered nursing assistants.

This core service has reported a vacancy rate for all staff of 18% as of 31 January 2018.

	Registered nurses			Health care assistants			Overall staff figures		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Asperger's & Asd Service							0.34	2.83	12%
Child Learning Disabilities Tm	1.69	4.41	38%	1.00	2	50%	4.69	9.61	49%
Health and Well-Being Ot Ld							0.32	7.53	4%
Ld Health Facilitation Team	1.60	6.92	23%	-0.16	1.77	-9%	1.44	8.69	17%
Ld Intensive Support Team	0.90	8.89	10%	1.81	4.34	42%	2.71	13.23	20%
Ld Physiotherapy							0.00	3.33	0%
Ld Psychology Services							1.61	3.12	52%
Ld Speech Therapy							0.22	7.27	3%
Occupational Therapy (Learning Disabilities)							-0.13	7.6	-2%
Core service total	**4.19**	**20.22**	**21%**	**2.64**	**8.11**	**33%**	**11.19**	**63.21**	**18%**
Trust total	**1655.28**	**11061.65**	**15.0%**	**1002.03**	**8846.71**	**11.3%**	**4284.55**	**30928.44**	**13.9%**

NB: All figures displayed are whole-time equivalents

Between 1 April 2017 and 31 January 2018, no bank or agency staff filled shifts to cover sickness, absence or vacancy for qualified nurses. During this period, no shifts were filled by bank or agency staff to cover sickness, absence or vacancy for nursing assistants. There were no shifts left unfilled.

This core service had four (5%) staff leavers between 1 April 2017 and 31 January 2018.

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
364 EF791 Ld Psychology Services	3.73	1.00	27%
300 Child Learning Disabilities Team	6.87	1.00	15%
364 EE501 Intensive Outreach Team	8.60	1.00	12%
364 EF590 Ld Speech Therapy	6.32	0.60	9%
336 EF899 L+D Psychology Team	6.97	0.20	3%
364 EB132 Ld Medical Essex Team	4.00	0.00	0%

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
364 EF329 Physiotherapy	4.10	0.00	0%
364 EF784 Adult Community Psychology	1.60	0.00	0%
364 EF889 Asperger's Service	2.45	0.00	0%
364 ED604 Ld Intensive Support Team	12.84	0.00	0%
364 ED605 Ld Health Facilitation Team	8.29	0.00	0%
364 EF425 Intensive Ot Ld	7.69	0.00	0%
364 EF429 Health and Well-Being Ot Ld team	7.96	0.00	0%
364 EF309 Ld Physiotherapy Team	2.85	0.00	0%
Core service total	84.26	4	5%
Trust Total	3127.64	253	7%

The sickness rate for this core service was 4% between 1 April 2017 and 31 January 2018. The most recent month's data (January 2018) showed a sickness rate of 5%.

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
364 EF425 Occupational Therapy (Learning Disabilities)	20%	3%
300 Child Learning Disabilities Team	11%	11%
364 EF429 Health and Well-Being Ot Ld	7%	3%
364 ED604 Intensive Support Team	5%	4%
364 EF889 Asperger's Service	2%	0%
364 EF590 Ld Speech Therapy	2%	4%
364 EF309 Ld Physiotherapy	2%	3%
364 EB132 Ld Medical Essex	1%	2%
364 EF329 Physiotherapy	0%	5%
364 ED605 Ld Health Facilitation Team	0%	1%
364 EF791 Ld Psychology Services	0%	0%
Core service total	**5%**	**4%**

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Trust Total	**4%**	**4%**

Medical staff

There was no data for this core service pertaining to medical locum usage between 1 April 2017 and 31 January 2018. At the time of inspection, all medical staff working at this service were substantively employed by the trust.

Mandatory training

The compliance for mandatory and statutory training courses at 31 December 2017 was 87%. Of the training courses listed nine failed to achieve the trust target and of those, eight failed to score above 75%.

The trust has a rolling month on month compliance rate for mandatory training.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	Compliance
Health and Safety (Slips, Trips and Falls)	100%
Cascade Fire Trainer	100%
Fire In-patient	100%
Observation of Service User	100%
TASI Trained	100%
Induction E-Learning	98%
Duty of Candour (Overview Version)	97%
Care Programme Approach	95%
Complaints Handling	95%
Equality and Diversity	95%
Harassment & Bullying	95%
Mental Health Act	94%
Safeguarding Children (Level 2)	93%
Fit for Work	93%
Food Hygiene	92%
Hoisting e-learning	92%
Duty of Candour (Detailed Version)	91%
Mental Capacity Act Level 1	91%
Corporate Induction	91%
Infection Prevention, Control & Hand Hygiene	91%
Other (Please specify in next column)	91%
Information Governance	89%
Care Certificate	88%
Personal Safety Breakaway - Level 1	86%
Clinical Risk Assessment	85%
Basic Life Support & AED	85%
Medication Management (MH)	77%

Safeguarding Adults (Level 3)	69%
Manual Handling - People	60%
Safeguarding Adults (Level 1)	60%
Fire Safety 3 years	59%
Hoisting	58%
PREVENT (WRAP) Training	57%
Fire Safety 2 years	49%
Safeguarding Children (Level 3)	40%
Total	87%

The number, profession and grade of staff in post matched the provider's staffing plan.

Managers assessed the size of the caseloads of individual staff regularly and helped staff manage the size of their caseloads.

Cover arrangements were in place amongst the team for sickness, leave, vacant posts and so ensured patient safety.

The service did not use locum/bank/agency staff.

The service had rapid access to a psychiatrist between the hours of 9am and 5pm. There were four psychiatrists within the team. Outside normal working hours patients accessed support via the police or accident and emergency and psychiatric liaison services.

Staff received, and were up to date with appropriate mandatory training. Overall, staff in this service had undertaken 91% of mandatory training against the trust target of 85%.

Assessing and managing risk to patients and staff

Assessment of patient risk

The trust had developed a comprehensive risk assessment tool. We saw evidence in care records that staff did a risk assessment of every patient at initial triage/assessment and updated it regularly, including after any incident.

In all 26 records we saw that staff created crisis plans with patients and staff had recorded whether patients had made advance decisions.

Management of patient risk

Staff responded promptly to sudden deterioration in a patient's health, including several examples of good multiagency working to support patients through crisis periods.

The trust had developed a comprehensive risk assessment tool. We saw evidence in care records that staff did a risk assessment of every patient at initial triage/assessment and updated it regularly, including after any incident. In all 26 records we saw that staff created crisis plans with patients and where appropriate advance decisions. Staff responded promptly to sudden deterioration in a patient's health, including several examples of good multiagency working to support patients through crisis periods.

Staff monitored patients on waiting lists to detect and respond to increases in level of risk. This was recorded in multi-disciplinary team meeting minutes.

The service had developed good personal safety protocols, including lone working practices. In the community staff had access to satellite badges that enabled staff to have a third party listen in to the conversation and track their whereabouts to send help. Staff also recorded their location in their electronic diary and operated a buddy system with colleagues whom they would call at the end of the day to let them know they were safe.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did so when appropriate. Staff we spoke with gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. That included working in partnership with other agencies. We saw evidence in care records that there had been good communication with local safeguarding authorities.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust provided details of the total number of safeguarding referrals made between 1 April 2017 and 31 December 2017 with 802 referrals made for adults and 180 for children. However, this is for the whole trust and has not been broken down to core service level.

The trust told us that there were no serious case reviews commenced or published in the last 12 months that related to this core service.

Staff access to essential information

Staff used electronic patient records. If paper documentation was used to complete assessments documentation would either be scanned into the electronic records system or the information transferred. This ensured that all information needed to deliver patient care was available to all relevant staff when they needed it and in an accessible form. That included when patients moved between teams.

Medicines management

Medicines were administered in patients' own homes. Staff followed good practice in medicines management and this was done in line with national guidance and Nursing and Midwifery Council code of conduct.

Staff did not have access to clinic rooms within teams. Patient's medication was prescribed under consultation from the psychiatrists by their GP and stored in their own homes, including long acting depot injections. Staff would visit to administer such medication and we saw that this was recorded appropriately in care records including patient consent to receive the medication.

Staff regularly reviewed the effects of medication on patients' physical health and documented this in records. This included reviews of patients who were prescribed antipsychotic medication or lithium. These reviews were line with guidance from the National Institute for Health and Care Excellence.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 January 2018 there were no STEIS incidents reported by this core service.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

Reporting incidents and learning from when things go wrong

All staff we spoke with knew what incidents to report and how to report them.

Staff we spoke with understood the duty of candour. They were open and transparent, and explained to patients and families when something went wrong. There was evidence in care records to demonstrate this.

Whilst there had been no recent serious incidents for this core service, it was evident in team meeting minutes and internal bulletins that staff received feedback from investigation of incidents elsewhere in the organisation, and were notified of changes that were made as a result of feedback from such incidents.

Is the service effective?

Assessment of needs and planning of care

The inspection team reviewed 26 care records; 18 from the adult's community learning disability team and six from the children's learning disability community service. All records reviewed demonstrated good practice. Records were holistic, with evidence of physical assessment, and were person centred and written in patient's own language.

Staff completed a comprehensive mental health assessment of each patient. Risk assessments took account of domestic risk, self-neglect, risk of suicide or deliberate self-harm, physical health, risk of exploitation and risk of falls. All risk assessments were comprehensive and completed in full.

Staff ensured that any necessary assessment of the patient's physical health had been undertaken. There was clear documentation of communication with patient's GP surgeries to ensure that all staff were aware of any physical health problems.

Staff developed care plans that met the needs identified during assessment. Care plans were holistic and written in easy read format. Care plans included positive behavioural support plans, care plans to address skills deficits, and monitoring of mental health and side effects of medication. Staff updated care plans regularly.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. Staff delivered interventions recommended by National Institute for Health and Care Excellence guidance. These included medication, specialist diagnostic assessment for Asperger's and other mental health conditions, and psychological therapies such as cognitive behaviour therapy.

In the adult's community learning disability intensive support team staff provided support for employment, housing and benefits, and interventions that enabled patients to acquire living skills. We spoke with a carer who told us that staff had gone the extra mile to support their relative who

was homeless and needed housing. Staff liaised with all the necessary agencies and supporting the patient and carer through the whole process.

Staff used specific professional assessments to enhance care; psychologists used the CORE psychological assessment designed to assess the severity of psychological symptoms and record outcomes of therapy. Speech and language therapists used the International Dysphagia Diet Standardisation Initiative. This included the recent update to this guidance for people who have difficulty swallowing.

In the children's learning disability service, staff provided parenting support groups for carers of children with learning disability. They also provided specialist autism diagnostic assessments and liaised with schools and colleges to help schools and colleges meet children's educational needs.

Staff in all teams ensured that patients' physical healthcare needs were being met, including their need for an annual health check. Where the patient's GP was responsible for that, the community health staff assured themselves that it was done. We saw correspondence in patient records that reflected this.

Staff supported patients to live healthier lives. We saw evidence in care records that staff had supported patients to manage their diabetes, and promoted healthy living groups within the community.

Staff used recognised rating scales and other approaches to rate severity and to monitor outcomes, such as Health of the Nation Outcome Scale and the CORE psychological assessment.

Staff used technology to support patients effectively. For example, online referral to therapies and other agencies, and timely access to blood test results.

Staff participated in clinical audit of care records.

This core service participated in no specific clinical audits as part of their clinical audit programme 2017.

Skilled staff to deliver care

The children's learning disability service included nurses, an occupational therapist, occupational therapy technician and an associate practitioner. There was no consultant psychiatrist for this team. Staff referred to child and adolescent mental health service consultants if required.

The adult's community learning disability service included nurses, consultant psychiatrists, occupational therapists, associate mental health practitioners, psychologists and community support workers.

All staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group.

We spoke to new staff in both the children's learning disability service and the adult community learning disability team. Staff told us that the trust provided new staff with appropriate induction

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. Managers ensured that staff had access to regular team meetings.

The percentage of staff that had had an appraisal in the last 12 months was 86%.

The percentage of staff that received regular supervision was 100%.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Staff told us they had opportunity to shadow colleagues and attend specialist training courses.

Managers dealt with poor staff performance promptly and effectively.

The trust's target rate for appraisal compliance is 90%. As at 31 January 2018, the overall appraisal rates for non-medical staff within this core service was 96%. LD Health Facilitation Team was the only team failing to achieve the trust's appraisal target with an appraisal rate of 88%.

No appraisal data was submitted by the trust for medical staff in this core service during this period.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Adult LD Wechs	3	3	100%
Asperger's Service	2	2	100%
LD Overheads1 - Heath Close	2	2	100%
LD Physiotherapy	3	3	100%
LD Psychology Services	3	3	100%
LD Speech Therapy	9	9	100%
Recovery Wellbeing Basildon	9	9	100%
LD Intensive Support Team	11	10	91%
LD Health Facilitation Team	8	7	88%
Core service total	**50**	**48**	**96%**
Trust wide	4121	3386	82%

Between 1 April 2017 and 31 January 2018, the average clinical supervision rate across all eight teams in this core service was 96% against the trust's 90% target.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Asperger's Service	3	3	100%
LD Physiotherapy	10	10	100%
LD Psychology Services	25	25	100%
LD Speech Therapy	24	24	100%
Pan Essex LD Service	8	8	100%
LD Health Facilitation Team	110	109	99%
LD Intensive Support Team	121	119	98%
Child Learning Disabilities Tm	31	22	71%
Core service total	**332**	**320**	**96%**

Trust Total	**24,386**	**21,061**	**86%**

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary team meetings. We observed a multidisciplinary meeting with the adult community learning disability team.

Staff shared information about patients at effective handover meetings within the team; for example, when staff went on holiday.

The community mental health teams had effective working relationships, including good handovers, with other teams within the organisation, for example; community to crisis team or inpatient services. We also observed both teams sharing appropriate information with professionals from external organisations to provide continuity of care.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

As of 31 December 2017, 92% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who the trust Mental Health Act administrators were.

The provider had relevant policies and procedures that reflected the most recent guidance on the Mental Health Act (1983).

Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

The adult's community learning disability team worked with patients who were subject to a community treatment order, and staff ensured that those people had easy access to information about independent mental health advocacy services. Staff did regular audits to ensure that the Act was being applied correctly and that patients had their rights explained to them regularly. Staff had completed Community Treatment Order paperwork correctly and it was up to date and stored appropriately.

Care plans referred to identified Section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment.

Good practice in applying the Mental Capacity Act

As of 31 December 2017, 100% of the workforce had received training in the Mental Capacity Act level two. The trust stated that this training is mandatory for all core services for staff and renewed every three years.

Staff were trained in and had a good understanding of the Mental Capacity Act 2005, particularly the five statutory principles.

The trust had a policy on the Mental Capacity Act. Staff we spoke with were aware of the policy and had access to it.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis regarding significant decisions.

Staff from the children's learning disability service were aware of Gillick competence and considered this when working with patients. Gillick competence is a test in medical law to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. Staff audited the application of the Mental Capacity Act and acted on any learning that resulted from it.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We observed nine episodes of care; two from the children's learning disability service, two from the adults Asperger's assessment team and five from the intensive support team within the adult's community learning disability team. All staff attitudes and behaviours when interacting with patients were discreet, respectful and responsive, providing patients with help, emotional support and advice in a way that they could understand. Staff regularly checked patients understanding of the interventions provided.

Staff supported patients and carers to understand and manage their care. We heard from 11 carers, everyone we spoke with could not speak highly enough of the level of care provided to them. We spoke to four carers from the children's learning disability service and six carers from adult community learning disability service.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. We observed patients from the adult's community learning disability service being supported to access a community group run by another agency.

Patients we spoke with said staff treated them very well and they valued the support they received.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Staff maintained the confidentiality of information about patients.

Involvement in care

Involvement of patients

All staff we spoke with and observed during episodes of care were fully committed to working in partnership with patients and carers who were active partners in their care.

All care plans we reviewed showed that staff involved patients in care planning and risk assessments. Care plans could be written in easy read format and patients were given copies.

People's emotional and social needs were highly valued by staff and are embedded in their care and treatment. We saw care plans which took account of patient's social needs and supported them to maintain relationships which were important to them.

Staff prioritised individual preferences and needs and reflected this in how they delivered care. Staff empowered patients to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care. Examples of this included employment and occupational activities where patients led community projects with support from different agencies.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties.

Staff involved patients in decisions about the service for example, in the recruitment of staff.

We saw in patient records that staff recorded if patients had to make advance decisions

Staff ensured that patients could access advocacy when required.

Involvement of families and carers

We heard from eleven carers whose feedback included that staff were always available to offer support and that they felt included and updated about the care of their relatives. Feedback from people who use the service, those who are close to them and stakeholders was continually positive about the way staff treat patients. Patients told us that staff went the extra mile and the care they receive exceeded their expectations.

Staff enabled families and carers to give feedback on the service they received at individual appointments with patients.

We saw evidence in care records that all carers were provided with information about how to access a carer's assessment.

Is the service responsive?

Access and waiting times

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

The trust has not provided targets 'for days from referral to initial assessment' or for 'days from assessment to treatment'.

Name of hospital site or location	Name of team	Service Type	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
			Target	Actual (mean)	Target	Actual (mean)	
Holmer Court	CAMHS LEARNING DISABILITY	CAMHS	Not Provided	**28**	Not Provided	**0**	Not Provided
Health Close	Learn Disab - Intensive Support - South Essex	Learning Disability	Not Provided	16	Not Provided	32	Not Provided
Various	Medical - Learn Dis	LD Medical	Not Provided	40	Not Provided	80	Not Provided
Basildon Hospital	Psychology - Learn Disab - South Essex	Learning Disability	Not Provided	134	Not Provided	25	Not Provided

The referral criteria for the children's learning disability service was for children aged up to 17 who had a learning disability or autism. The adult's community learning disability team accepted adults with learning disability and autism from the age of 18 and over.

The team responded promptly to urgent referrals, we saw examples in care records of three patients who had been seen on the same day as the referral was made due to them being in crisis. We also heard examples from two carers who said they valued the support offered to them whilst their relative was in crisis.

The average waiting time from referral to assessment for the children's learning disability team was 28 days. The trust did not provide their data for the time from assessment to treatment but staff told us that children usually waited up to two months. We heard from one carer who spoke highly of the care provided but complained that it had taken five months for their child to receive treatment the children's learning disability service.

Where possible, staff offered patients flexibility in the times of appointments. Staff cancelled appointments only when necessary and when they did, they explained why and helped patients to access treatment as soon as possible. Appointments usually ran on time and people were kept informed when they did not.

The psychology team leader regularly reviewed the waiting list for psychology referrals and informed us that they had made improvements to their waiting list by working with commissioners to increase their staffing. The waiting list had reduced from an average of two years wait to less than six months. There were however two patients who had waited eight and thirteen months respectively to begin therapy. In the Asperger's assessment team two patients had waited a year for assessment. All these patients were being seen by the multidisciplinary team which minimised the risk to patients.

Staff supported patients during referrals and transfers between services. For example, if they required temporary treatment in an acute hospital.

Facilities that promote comfort, dignity and privacy

The service had rooms at each location for meeting with patients and their carers, although many patients were seen in their own homes. Interview rooms had adequate soundproofing.

Patients' engagement with the wider community

Staff had good links with the local community and worked to promote opportunities for work and leisure activities for patients. We were shown a community project in Southend that was a horticulture centre with café run by patients and other volunteers.

Staff supported patients to maintain contact with their families and carers. Staff told us that carers were central to the care plan for patients and they were often actively involved in patient care.

Patients were encouraged to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients for example, by ensuring disabled people's access to premises and by meeting patients' specific communication needs.

There were leaflets displayed in waiting areas and staff ensured that patients could obtain information on treatments, local services, and patient's rights. Staff could provide this information in easy read format and in other languages.

Managers ensured that staff and patients had easy access to interpreters and signers.

Listening to and learning from concerns and complaints

This core service received one complaint between 1 April and 31 December 2017. This complaint related to the assessment and treatment received. The complaint was not referred to the Ombudsman.

This core service received 11 compliments during the last nine months from 1 April to 31 December 2017 which accounted for 2% of all compliments received by the trust as a whole.

Patients knew how to complain or raise concerns.

Staff provided feedback directly, and in writing, to patients who raised concerns.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to handle complaints appropriately; they directed the complaint to their manager in the first instance, whilst giving the patient details for the patient advice liaison service. Staff received feedback on the outcome of investigation of complaints and acted on the findings.

Is the service well-led?

Leadership

The term ‘leader’ refers to managers of community mental health teams, service directors and managers at directorate/service line level.

Leaders had the skills, knowledge and experience to perform their roles.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

Staff told us that leaders were visible in the service, approachable, and operated an open door policy. The leader of the adult learning disability team had made staff aware of specific time slots where staff could attend and discuss any concerns with her.

Leadership development opportunities were available such as staff leading projects or groups within the teams, including opportunities for staff below team manager level.

Vision and strategy

Staff knew and understood the provider’s vision and values and how they were applied in the work of their team. Staff we spoke with told us about the trust values of respect and dignity, commitment to quality of care, compassion, improving lives, working together for patients, and everyone counts. We saw staff demonstrate these values during observations of care.

The trust’s senior leadership team had successfully communicated the provider’s vision and values to the frontline staff in this service. The trust had posters displaying the values displayed in the community bases and online and staff told us their appraisals were based around these values.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff told us that they had been included in discussions about changes to the service including possible merging of services with a neighbouring NHS trust.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff told us they felt respected, supported and valued. Staff felt positive and proud about working for the trust and their team.

Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and about the role of the Freedom to Speak Up Guardian.

Managers dealt with poor staff performance when needed. Teams worked well together and where there were difficulties managers dealt with them appropriately.

Staff told us that appraisals included conversations about career development and how it could be supported.

Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression.

The service's staff sickness and absence rates were similar to the average for the provider. Staff had access to support for their own physical and emotional health needs through an occupational health service.

The trust recognised staff success within the service, through staff awards.

Governance

There were systems and procedures to ensure that the premises were safe and clean; staff were trained and supervised; patients were assessed and treated well; referrals and waiting times were managed well; incidents were reported, investigated and learned from.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Staff implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Staff undertook or participated in clinical audits for case notes and CPA reviews. The audits were sufficient to provide assurance and staff acted on the results when needed.

Staff understood arrangements for working with other teams, both within the trust and with external agencies, to meet the needs of the patients.

Management of risk, issues and performance

Staff maintained and had access to the risk register either at a team and directorate level and could escalate concerns when required from a team level. Staff escalated concerns through regular supervision and team meetings. We saw evidence of this in team meeting minutes.

However, the Asperger's assessment team had not been allocated more staff despite the large waiting list and an average waiting time of a year for assessment.

Information management

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Our inspectors found all information needed quickly and easily on the electronic recording system.

Information governance systems included confidentiality of patient records. Staff completed information governance training and 92% of staff were up to date with this.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information was in an accessible format, and was timely, accurate and identified areas for improvement. We were assured that staff made notifications to external bodies such as NHS England and the Care Quality Commission as required.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the trust and the services they used through the trust intranet, bulletins, and newsletters. Patients and carers had opportunities to give feedback on the service they received in a way that reflected their individual needs. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback. Directorate leaders engaged with external stakeholders such as commissioners and Healthwatch.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

None of the services within this core service had been awarded an accreditation.

Substance misuse services

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Trust Head Office	Essex STaRS Integrated Drug Treatment Service (IDTS)	N/A	Mixed
Trust Head Office	Essex StaRS (Mid)	N/A	Mixed
Trust Head Office	Essex StaRS (North East)	N/A	Mixed
Trust Head Office	Essex StaRS (Hub)	N/A	Mixed
Trust Head Office	Essex StaRS (South)	N/A	Mixed
Trust Head Office	Essex StaRS (West)	N/A	Mixed

Is the service safe?

Safe and clean environment

The service worked from premises that were owned by a partner agency. The trust had up to date environmental risk assessments in place for their patients and staff safety. Staff had identified all risks and acted to mitigate them where possible.

The service had a clinic room at each site where staff saw patients, which were clean and adequately furnished to facilitate physical examinations. Clinic rooms had up to date cleaning records and all equipment had ‘clean’ stickers with the correct date. Staff documented that equipment was regularly checked and calibrated.

Safe staffing

This core service has reported a vacancy rate for all staff of 16% as of 31 January 2018.

This core service reported an overall vacancy rate of -59% (over-established) for registered nurses at 31 January 2018 and 0% for registered nursing assistants.

	Registered nurses			Health care assistants			Overall staff figures		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Essex Stars-East	14.70	18.7	79%	0.49	1.4	35%	-3.52	10	-35%
Essex Stars-Hub	0.67	9	7%	1.50	5	30%	15.19	25.1	61%
Essex Stars-Idts	-2.60	3	-87%	0.50	4	13%	2.17	14	15%

	Registered nurses			Health care assistants			Overall staff figures		
Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Essex Stars-Mid	1.10	5	22%	1.20	4.7	26%	-2.10	7	-30%
Essex Stars-South	-2.00	3.5	-57%	0.00	3.5	0%	2.30	9.7	24%
Essex Stars-West	6.35	45.2	14%	2.69	22.6	12%	-2.00	7	-29%
Medical Drug and Alcohol South				-	-	-	1.00	1	100%
Medical Essex Stars				-	-	-	2.00	2	100%
Core service total	-3.52	6	-59%	0.00	4	0%	**12.04**	**75.8**	16%
Trust total	**250.46**	**1585.55**	**16%**	**147.04**	**1207.08**	**12%**	**709.54**	**4999.15**	**14%**

NB: All figures displayed are whole-time equivalents

Between 1 April 2017 and 31 January 2018, bank staff filled 350 shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 18 shifts for qualified nurses. No shifts were left unfilled by either bank or agency staff.

The service used a regular bank nurse to cover any vacant shifts to provide continuity of treatment for patients.

Team	**Available shifts**	**Shifts filled by bank staff**	**Shifts filled by agency staff**	**Shifts NOT filled by bank or agency staff**
IDTS	331	313	18	0
NE Stars	1	1	0	0
SE Stars	36	36	0	0
Core service total	368	350	18	0
Trust Total	**102629**	**31709**	**12577**	**1356**

Between 1 April 2017 and 31 January 2018, 43 shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, agency staff covered no shifts. No shifts were left unfilled by either bank or agency staff.

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
IDTS	17	17	0	0
WE Stars	26	26	0	0
Core service total	43	43	0	0
Trust Total	144009	60464	5916	4396

This core service had seven (11%) staff leavers between 1 April 2017 and 31 January 2018.

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
300 Substance Misuse - South Team	7.67	1.00	13%
300 Substance Misuse - NE Team	13.57	2.50	18%
300 Substance Misuse - Mid Team	9.55	0.00	0%
300 Substance Misuse - Management Team	8.17	0.37	5%
300 Substance Misuse - Dual Diagnosis	1.63	0.00	0%
300 Substance Misuse - IDTS	12.00	2.00	17%
300 Substance Misuse - West Team	7.25	1.00	14%
300 Substance Misuse Contacts	1.00	0.00	0%
364 EE505 Drugs + Alcohol Essex	3.00	0.00	0%
Core service total			
Trust Total	3127.64	253	7%

The sickness rate for this core service was 5% between 1 April 2014 and 31 January 2018. The most recent month's data (January 2018) showed a sickness rate of 6%.

'Substance Misuse – Management Team' had the highest annual sickness rate with 9% and had the highest sickness rate at the latest month, alongside 'Medical Drug and Alcohol' with 16%.

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
364 EB137 Medical Drug and Alcohol	16%	2%
364 EE505 Drugs + Alcohol Essex	2%	1%

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
300 Substance Misuse - South Team	14%	9%
300 Substance Misuse - NE Team	3%	4%
300 Substance Misuse - Mid Team	9%	3%
300 Substance Misuse - Management Team	16%	9%
300 Substance Misuse - Dual Diagnosis	0%	0%
300 Substance Misuse - IDTS	1%	1%
300 Drug Intervention Programme	-	0%
300 Substance Misuse - West Team	1%	6%
Core service total	**6%**	**5%**
Trust Total	**4%**	**4%**

Medical Staff

Between 1 April 2017 and 31 January 2018, no shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same period, agency staff covered no shifts. All 383 of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Substance Misuse	256	0	0	256
Substance Misuse ST	127	0	0	127
Core service total	383	0	0	383
Trust Total	**6744**	**258**	**3406**	**3080**

Managers described the service as being commissioned as nurse led with 2 funded consultant posts.

The two consultant posts within the service had both been vacant for over six months. Locum consultant cover was provided mainly by telephone support for the non-medical prescribers, if they requested advice. One locum consultant provided a clinic for patients presenting with complex needs once a week at the Colchester site.

Mandatory training

Nurses across the service did not have valid patient group direction (PGD)’s in place to evidence their competency to administer vaccinations. These had not been updated since the trust merger.

The compliance for mandatory and statutory training courses at 31 December 2017 was 75%. Of the training courses listed 20 failed to achieve the trust target and of those, 13 failed to score above 75%.

The trust has a rolling month on month compliance rate for mandatory training.

The trust provided updated training figures during the inspection. 27% of staff were up to date with medicines management training with none of the staff at Colchester having in date medicines management training. Basic life support training had increased to 72% by the time of the inspection, and personal safety and breakaway training had increased to 43%.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	**Compliance**
Manual Handling - People	100%
Cascade Fire Trainer	100%
Duty of Candour (Detailed Version)	98%
Corporate Induction	94%
Harassment & Bullying	94%
Equality and Diversity	93%
Safeguarding Children (Level 2)	91%
Mental Capacity Act Level 1	90%
Safeguarding Adults (Level 1)	90%
Safeguarding Adults (Level 3)	88%
Safeguarding Children (Level 3)	88%
Complaints Handling	87%
PREVENT (WRAP) Training	84%
Clinical Risk Assessment	84%
Basic Life Support & AED	76%
Information Governance	76%
Medicines Management (community)	75%
Fit for Work	74%
Fire Safety 2 years	72%
Infection Prevention, Control & Hand Hygiene	68%
Mental Health Act	67%
Duty of Candour (Overview Version)	57%
Personal Safety Breakaway - Level 1	45%
Induction E-Learning	40%
Fire Safety 3 years	20%
Medication Management (MH)	15%
Personal Safety - MVA	0%
Care Programme Approach	0%
Diabetes Training	0%
Dual Diagnosis	0%
Total	**75%**

Assessing and managing risk to patients and staff

A partner agency completed risk assessments for all patients, and these were available for trust staff to access on a shared electronic system.

The service did not operate waiting lists and so did not need to monitor patient risk during waiting times.

The trust supported the non-medical prescribers to increase their skills via a substance misuse competency framework. They were undertaking an in-house competency portfolio, whilst shadowing experienced clinicians to enable them to become competent non-medical prescribers in substance misuse. However, the non-medical prescribers were conducting initiation, titration and restarts on to substitute prescribing without the presence of an experienced substance misuse prescriber. This meant that although the clinical lead signed off any prescriptions the service could not be assured that patient risk was adequately assessed and monitored.

The service had good personal safety protocols including use of personal alarms so that staff could call for assistance in the event of an incident, and a lone working policy where all staff used personal safety devices that tracked their location.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust have provided details of the total number of safeguarding referrals made between 1 April 2017 and 31 December 2017 with 802 referrals made for adults and 180 for children. However, this for the whole trust and has not been broken down to core service level.

During the inspection, the service reported having made five safeguarding referrals in the last year.

The trust employed two family practitioners who worked with patients whose children had been identified as at risk by social services due to substance misuse. The family practitioners worked closely with social workers and families to encourage parents into substance misuse treatment, and patients fed back positively about the process.

The trust told us that there were no serious case reviews commenced or published in the last 12 months that related to this core service.

Staff access to essential information

The service used an electronic patient record system that was used by all agencies involved in delivering patient care. Staff had a laptop computer so that they could view patient information and record any changes during appointments. Staff reported that there were frequent problems accessing the online record system but that when it was accessible it worked well.

Medicines management

Patients receiving detoxification or maintenance substitute prescribing did not have regular medication reviews. The Department of Health guidelines on clinical management of drug misuse

and dependence recommend 12-week reviews with a prescriber. Non-medical prescribers did not review medication levels for over six months in most cases and in some cases over a year.

Staff printed prescriptions in advance and did not always record the prescription number on the tracker so staff were unable to always account for printed prescriptions.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 April 2017 and 31 January 2018 there was no STEIS incidents reported by this core service.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

The service reported 34 patient deaths over the past year. The trust policy was to not record patient deaths in substance misuse as a serious incident.

Reporting incidents and learning from when things go wrong

The trust policy was not to report the death of patients accessing substance misuse services as a serious incident. The trust reported that they planned to participate in a countywide review of deaths of patients accessing these services. At the time of inspection there had been no review of patient deaths. Managers had not identified any lessons learnt to reduce the risks for patients.

The service used an electronic reporting system for incidents, and staff were aware of what incidents should be reported.

Whilst teams discussed any local incidents and outcomes from their site, this was not shared with the other teams. Team meeting minutes did not evidence lessons learnt from incidents.

Is the service effective?

Assessment of needs and planning of care

A partner agency completed patient assessments of need and these were available for trust staff to access using the shared electronic system. Following the assessment patients were seen by healthcare assistants for urine drug screening to establish levels of drug use. Healthcare assistants also completed basic health checks including blood pressure, temperature and oxygen levels. Staff completed blood borne virus testing where consented to and reviewed any medication allergies.

Staff contacted the patients' GP for a patient summary and to arrange an appointment with the non-medical prescriber who would conduct a further urine drug screen and physical health check before commencing a prescribing regime.

Patients attended nurse led physical health clinics for support. The service offered monthly clinics with a liver specialist nurse. The service ended an agreement with a GP specialising in substance misuse in March 2018 where patients with complex health needs were seen. Staff from partner agencies wrote care plans with patients and saved them to the shared electronic record. Staff told us that they could input into patient care plans, however we reviewed 24 patient care plans and there was no record of staff adding goals relating to prescribing and clinical outcomes.

Best practice in treatment and care

We reviewed 36 patient records and found that staff prescribed medication doses in line with National Institute for Health and Care Excellence (NICE) guidance.

The service offered naloxone to all patients to reverse the effects of an opiate overdose.

Nurses held regular review appointments with patients, including physical health checks. This included routinely completing electrocardiogram (ECG) monitoring when a patient's methadone dose exceeded 100mg per day.

The service offered additional physical health clinics for patients with complex needs, including a monthly clinic with the regional liver nurse and a monthly clinic for pregnant patients.

This core service participated in no specific clinical audits as part of their clinical audit programme 2017.

Local managers conducted audits of their services, including medication review audits, naloxone audits and vaccinations; however, there was no trust wide audit system and findings were not shared across the teams.

Skilled staff to deliver care

The trust's target rate for appraisal compliance is 90%. As at 31 January 2018, the overall appraisal rates for non-medical staff within this core service was 55%. None of the teams achieved the trust's appraisal target.

No appraisal data was submitted by the trust for medical staff in this core service during this period.

During the inspection the trust provided updated appraisal figures that showed 87% of staff had received an appraisal during the last year.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Substance Misuse - South Team	8	7	88%
Substance Misuse - NE Team	14	9	64%
Substance Misuse - Mid Team	8	5	63%
Substance Misuse - West Team	5	3	60%
Drugs + Alcohol Essex	2	1	50%
Subst Misuse- Management Team	7	2	29%
Substance Misuse - IDTS	11	3	27%
Core service total	**55**	**30**	55%
Trust wide	4121	3386	82%

Between 1 April 2017 and 31 January 2018, the average clinical supervision rate across eight teams in this core service was 44% against the trust's 90% target.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Four teams had a clinical supervision rate below 50% and no teams reached the trust's target of 90%.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Subst Misuse- Management Team	30	22	73%
Substance Misuse - NE Team	120	68	57%
Substance Misuse - Mid Team	73	40	55%
Substance Misuse - South Team	77	40	52%
NORTH - CDAT Harlow	10	3	30%
Substance Misuse - West Team	73	20	27%
Substance Misuse - IDTS	107	28	26%
Drugs + Alcohol Essex	10	0	0%
Core service total	**500**	**221**	**44%**
Trust Total	**24,386**	**21,061**	**86%**

During the inspection we were provided with supervision figures for April 2018 which showed that 56% of staff received supervision for that month. The non-medical prescribers told us they held regular peer supervision but this was not recorded. They had received telephone supervision from a consultant bi-monthly since January 2018 but these did not include discussion of individual patients.

Multidisciplinary and interagency team work

The service attended meetings every morning with their partner organisations to discuss any patients of concern, any patients who had not attended appointments and any activities planned for the day. Staff worked closely with the partner organisations and transitions between the services was clear and collaborative.

The service had good liaison with patients' home GPs and sent detailed information about patients' treatment when they started substitute prescribing and when there were any changes in prescribing.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

As of 31 December 2017, 60% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for all staff and renewed every three years.

Good practice in applying the Mental Capacity Act

As of 31 December 2017, 92% of the workforce had received training in the Mental Capacity Act level two. The trust stated that this training is mandatory for all staff and renewed every three years.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff interactions with patients were caring, supportive and respectful. We spoke with nine patients who said that staff were always friendly and welcoming, and that there was always someone available to offer support and guidance when needed.

Staff showed a good understanding of the individual needs of patients.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. Patients told us that they felt more confident to access other health services after their positive experience with substance misuse services.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. Staff we spoke with were aware of the whistleblowing policy and felt confident they would use it if required.

Staff maintained the confidentiality of information about patients by storing all records on an electronic secure system, keeping all prescription charts in a locked cabinet and conducting all appointments in a private room.

Involvement in care

Involvement of patients

A partner organisation set patient care plans did not input directly into these care plans. We saw that patients were involved in setting their prescribing goals at their clinical assessment and during clinical reviews. Where patients disagreed with advice of staff, the non-medical prescribers gave advice on safe treatment but patients made the decision about whether to reduce or maintain their prescription.

The service held monthly service user forums where patients could feedback on the service. Evidence could not be provided of how the service had acted on this feedback.

Involvement of families and carers

The service offered patients the opportunity to invite family or friends to attend appointments and this was particularly encouraged when a physical health examination was taking place and patients might feel vulnerable.

Staff gave all patients a copy of the ‘friends and family test’ questionnaire at appointments and encouraged them to return this in the stamped addressed envelope. The service was unable to provide any results from these as the response level had been low.

Is the service responsive?

Access and discharge

There is no data available for referral to assessment and treatment times for this core service in the trust’s data submission.

The service ran an open access referral system so that anyone wishing to access substance misuse services could drop in to the service locations and be seen for an assessment without booking an appointment. Patients attending for the first time would be assessed by the partner organisation staff. They would then see a member of the clinical team on the same day and be offered an appointment with the non-medical prescriber within seven days.

In the period between April 2017 and December 2017, 97% of patients started pharmacological treatment within three weeks of initial assessment and only one patient waited for over six weeks to commence treatment.

The service offered flexibility in appointment times for patients, including running an evening clinic weekly at all the main sites. The service offered weekly satellite clinics so that patients did not have to travel long distances to attend reviews. Patients told us that they could change their

appointment time to suit their needs and that staff did not cancel or change appointments on a regular basis.

Staff informed the partner agency of any patients who did not attend an appointment in the following daily meeting for them to contact the patient.

The service recorded a total of 313 patients who had an unplanned exit from treatment during the first 12 weeks, with 20% of opiate using patients leaving treatment early compared to the national average of 16%.

The service recorded that 5% of patients who used opiates successfully completed treatment between January and December 2017, which was below the top quartile range nationally of 8-11%. Eighteen percent of patients who used opiates re-presented for treatment within six months of successful completion of treatment.

The average length of time in treatment was 4.2 years for patients who used opiates and six months for non-opiates, which were in line with national average.

The facilities promote comfort, dignity and privacy

The service had a range of rooms and equipment to support treatment and care including a clinic room to conduct physical examinations. Each location had a separate designated bathroom for conducting urine drug screening tests that maintained the privacy and dignity of people who used services.

All service locations had large, comfortable waiting rooms and provided hot and cold drinks for people waiting for appointments. The Colchester team had an agreement with a bakery to provide unsold sandwiches and snacks until lunchtime for anyone visiting the service.

Interview and group rooms had adequate soundproofing and privacy screens on doors to maintain confidentiality.

Patients' engagement with the wider community

A partner agency worked with patients to address their employment, accommodation and social needs.

Meeting the needs of all people who use the service

The service had some facilities for disabled people who used the service, although not all rooms were accessible to people with reduced mobility or wheelchair users. The service also offered satellite clinics at local community services that were easier to access for disabled people or those not able to travel to the main hub sites.

Staff ensured that patients could obtain information on treatments, local services and patients' rights and leaflets were available in all waiting rooms.

Listening to and learning from concerns and complaints

This core service received no formal complaints between 1 April and 31 December 2017.

This core service received one compliment during the last 12 months from 1 April 2017 to 31 December 2017, which accounted for less than 1% of all compliments received by the trust as a whole.

Staff told us that any patient who was unhappy with any aspect of their care would usually raise the issue informally during an appointment or via telephone. Patients we spoke with knew how to raise a formal complaint if needed.

Is the service well-led?

Leadership

Local leaders were visible within the service with regular visits to each team. Staff told us that they had monthly visits from the service manager and had received visits from the service director, who were open and approachable.

Leaders lacked a clear oversight of the performance of the service and risks to patient safety, despite being experienced in their roles.

Vision and strategy

Staff were all aware of the trust values of being open, compassionate and empowering and how they could demonstrate these values in working with patients.

Culture

Staff morale was high and staff all spoke positively about working within their team. Staff felt supported by local leaders and each other. Staff worked well together and although they had busy workloads felt they could ask each other for help and support when needed.

Staff felt distanced from the rest of the trust and that there was very little recognition or input from the trust and managers above local leadership.

Staff told us they could raise concerns without fear to their managers and knew how to use the whistleblowing process if needed. The service's sickness and absence rates were similar to the trust average.

Staff were aware of opportunities for career development and we saw examples where healthcare assistants had been able to train as assistant practitioners through the trust.

Governance

Managers had not addressed the poor levels of mandatory training, supervision and appraisal across the service. Staff told us there were issues with IT recording of training and supervision, but there was no plan in place to improve either recording or completion of training. Managers did not keep a local training database for their own assurance.

Managers did not have a clear oversight of staff performance as supervision was not taking place regularly. Appraisal rates had improved by the time of inspection but had been low prior to that.

Managers could not provide information regarding the service easily. This included information on staffing levels, training and serious incidents.

Managers did not have a clear overview of staff competencies. The trust implemented an in-house competency framework for non-medical prescribers with no experience or qualification in substance misuse. Managers and clinicians had different understandings of how the non-medical prescribers would work and what level of clinical responsibility they would hold whilst undertaking the portfolio. We were concerned that the non-medical prescribers were working outside of their scope of competency as managers had not ensured and recorded the appropriate levels of supervision and monitoring.

Senior managers had not conducted any service wide audits. Local managers completed some audits for their site but these were individual to their locations. Managers did not share results across the service. As a result, managers were not aware that medication reviews were not happening within recommended timelines or that non-medical prescribers were working outside of

their scope of competency. There was no effective system for identifying, capturing and managing issues and risks at team level.

Managers did not share lessons learned from incidents across all sites. Whilst teams discussed any local incidents and outcomes from their site, this was not shared with the other teams. There was minimal evidence of learning and reflective practice.

Management of risk, issues and performance

Staff could add items to the trust risk register through senior managers and we saw examples of items that staff had raised as a concern. This included patients using illegal substances on the property and arrangements to access blood testing.

The service had a 'major incident response plan' in place in case of emergency and a 'business continuity plan' for any incidents that might impact on service delivery.

Information management

The service used an electronic patient record system that was separate to the main trust electronic systems as it was shared with partner organisations. This system worked well for information sharing and joint working; however, we found that the system crashed regularly due to the number of staff accessing the same system at the same time. Staff told us that this was a frequent issue due to problems with the server and they had raised it repeatedly with the trust but no action had been taken to address this.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the trust and the services they used through the trust intranet and bulletins.

Patients and carers had opportunities to give feedback on the service they received via a 'Family and Friends test'. However, the service was unable to provide any results from these as the response level had been low. This meant the service could not use patient feedback to make changes or improvements.

Learning, continuous improvement and innovation

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

None of the services within this core service have been awarded an accreditation.