NHS
Essex Partnership University
NHS Foundation Trust

Council of Governors Meeting

Thursday 24 August 2023

EPUT

Essex Partnership University
NHS Foundation Trust

Meeting of the Council of Governors
Monday 24 August 2023 at 14:45
Microsoft Teams Meeting

Vision: To be the leading health and wellbeing service in the provision of mental health and community care

CEO Briefing – 14:00

PART ONE MEETING – HELD IN PUBLIC

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting	14:45
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting	14:46
3	**MINUTES OF THE MEETING (PART 1) HELD ON 22 MAY 2023**	SS	Attached	Approval	14:47
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting	14:50
	SOCIAL IMPACT STRATEGY **Nigel Leonard, Executive Director of Major Projects and Programmes**				14:52
5	**STANDING REPORTS**				
(a)	Report from the Chair	SS	Attached	Noting	15:07
(b)	Chief Executive Officer Report	PS	Attached	Noting	15:17
6	**ITEMS FOR DECISION**				
(a)	Auditor's Annual Report	MLe	Attached	Noting	15:27
(b)	Annual Review of External Audit Services	EL	Attached	Approval	15:32
(c)	Standing Orders for the Council of Governors	CJ	Attached	Approval	15:37
(d)	Council of Governors Relationship with the Board of Directors Policy & Procedure	CJ	Attached	Approval	15:42
(e)	Lead Governor Election	CJ	Attached	Approval	15:45
7	**ITEMS FOR NOTING**				
(a)	Membership / Your Voice	MD	Attached	Noting	15:50
(b)	CQC Report	NJ	Presentation	Noting	15:55
(c)	Changes to the Council of Governors and Membership of its Committees	CJ	Attached	Noting	16:10
(d)	Lead / Deputy Lead Governor Report	JJ / PM	Attached	Noting	16:13
8	**ANY OTHER BUSINESS**				16:16
9	**QUESTION & ANSWER SESSION FROM MEMBERS OF THE PUBLIC**				16:21
10	**RESOLUTION**				16:30

	Members of the public are excluded from Part 2 Council of Governors meeting having regard to commercial sensitivity and/or confidentiality and/or personal information and/or legal professional privilege in relation to the business to be discussed	
11	**DATE AND TIME OF NEXT MEETING** 13 December 2023 (14:00)	
12	**DATES OF FUTURE MEETINGS** TBC - 2024	

Professor Sheila Salmon
Chair

Minutes of the Council of Governors Meeting Held in Public
On Monday 22 May 2023
Microsoft Teams

Attendees:

Prof Sheila Salmon (SSa)	Chair of the Trust (Chair of the meeting)
Keith Bobbin (KB)	Public Governor Essex Mid & South
Lara Brooks (LB)	Staff Governor, Non-Clinical
Dianne Collins (DC)	Public Governor Essex Mid & South
Mark Dale (MDa)	Public Governor Essex Mid & South
Councillor Mark Durham (MDu)	Appointed Governor Essex County Council
Pippa Ecclestone (PE)	Public Governor West Essex & Hertfordshire
Paula Grayson (PG)	Public Governor Bedfordshire, Luton & Milton Keynes & ROE
Jason Gunn (JG)	Public Governor, West Essex & Hertfordshire
Sharon Green (SG)	Staff Governor, Clinical
Julia Hopper (JH)	Public Governor, Essex Mid & South
John Jones (JJ)	Public Governor Bedfordshire, Luton & Milton Keynes & ROE
Megan Leach (ML)	Public Governor, Essex Mid & South
Pam Madison (PM)	Public Governor, Essex Mid & South
Nicky Milner (NM)	Appointed Governor, Anglia Ruskin University
Stuart Scrivener (SSc)	Public Governor Essex Mid & South
David Short (DS)	Public Governor, North East Essex & Suffolk
Paul Walker (PW)	Staff Governor Non-Clinical
Cort Williamson (CW)	Public Governor, North East Essex & Suffolk

In attendance:

Dr. Rufus Helm (RH)	Non-Executive Director
Dr. Mateen Jiwani (MJ)	Non-Executive Director
Manny Lewis (ML)	Non-Executive Director
Loy Lobo (LL)	Non-Executive Director
Janet Wood (JW)	Non-Executive Director
Elena Lokteva (EL)	Associate Non-Executive Director
Paul Scott (PS)	Chief Executive Officer
Denver Greenhalgh (DG)	Senior Director of Corporate Governance
Professor Natalie Hammond (NH)	Executive Nurse
Nigel Leonard (NL)	Executive Director of Major Projects and Programmes
Trevor Smith (TS)	Executive Chief Finance & Resources Officer
Zephan Trent (ZT)	Executive Director of Digital, Strategy and Transformation
Martine Munby (MM)	
Chris Jennings (CJ)	Assistant Trust Secretary

024/23 APOLOGIES FOR ABSENCE

David Bamber	Public Governor, West Essex & Hertfordshire
Tracy Reed	Staff Governor, Clinical
Stephen Heppell	Non-Executive Director

Signed …… Date …….

In the Chair

SSa welcomed everyone to the meeting and welcomed JA and SH to their first Council meeting.

025/23 DECLARATIONS OF INTEREST

None

026/23 MINUTES OF THE MEETING (PART 1) HELD ON 15 FEBRUARY 2023

The minutes of the meeting held on the 15 February 2023 were agreed as an accurate record.

027/23 ACTION LOG AND MATTERS ARISING

The action log following the meeting held on the 15 February 2023 was reviewed. CJ advised the open actions had either been addressed as part of the CEO Briefing prior to the Council of Governors or were being incorporated into the annual report. CJ advised one action relating to holding a Governor session with Anglia Ruskin University had been extended until October 2023 to be incorporated into the next Joint Board Seminar Session.

PRESENTATION: COMMUNICATIONS

MM delivered a presentation regarding:

- Were communication is currently focused in EPUT
- How various audiences are reached.
- The gaps and challenges faced

MM advised the priority of Communications at EPUT is to engage and inform patients and staff. This included ensuring the community served understand what the Trust is doing and they feel they have a voice.

MM described the process for internal and external communication, including managing press relations, including horizon scanning in preparation for communicating when there are key reports or information being released. Internal communication included drop-in sessions, staff magazine etc. External communication included social media, press releases, public website etc.

MM advised there had been some gaps in resource in delivering some of the elements of communication, but was happy to confirm the appointment of a new Head of Public Affairs who would be driving communications and engagement and communications with MPs and other political stakeholders. MM explained the editorial planning process which covered shecduling of press releases, horizon scanning and planning of all internal and external communications.

LL asked what more can be done to develop more public engagement, which has been raised in conversations with Governors. For example, when information is published in the public domain is there a “call to action” asking people to get involved and help improve EPUT services. MM advised there was a structured programme of social posts and activity, including the public website, LinkedIn, Facebook, Instagram, Twitter etc. to try to engage with the local population.

LL asked how communication activity is monitored to ensure it is focusing on the important things and these are working well. MM advised there were metrics that were used to analyse communication campaigns which allows the impact to be measured. For example, the launch of the Sleep School where the lead will undertake a complete analysis of the number of people engaged in the app, the number of people that have attended events, viewed articles etc. This pulls together a picture of the level of engagement. This also is wider, with external campaign analysis, including engagement with social media posts etc.

MDa noted the low public attendance at the Council meeting and asked if Communications could help with raising the profile of the Council to encourage greater attendance. SSa suggested taking this forward as part of the upcoming elections, to see if other avenues of communication could be explored, including audio and video. MM agreed to take this forward. JJ agreed and noted the difficulty in engaging with members and asked whether the magazine mentioned by MM could also be sent out to Members. This was agreed.

DG advised the Membership Committee had been working on refreshing the Membership Strategy. DG advised there was active recruitment underway for recruiting a membership officer to help push messages, however, the recruitment undertaken so far has not identified the right candidates for the role.

PS thanked MM for bringing a calm experience to the Communications and engagement work, which is needed given the ongoing pressure. PS advised it had been a very busy 18-months and the development of the Communications Team has taken place during this busy period..

PS invited MM to speak more on the importance of communication with local communities, combined with gaining wider support and supporting efforts in raising the reputation of the organisation on a national level. PS also asked MM if she had any thoughts on the reference to the potential for a statutory inquiry in terms of communication.

MM agreed it had been a busy period. MM agreed there were opportunities to increase the profile of the organisation at a senior level, including speaking at national conferences and undertaking leadership pieces in key areas

PE commented on the earlier conversation regarding communication with members and raising the profile of Public Governors. SSa advised this could be picked-up as part of the wider discussion with the Membership Committee in terms of communication.

Action:

1. **Develop a Communication Plan with the Council of Governors Membership Committee for regularly communication with the Foundation Trust Membership. (MM)**

028/23 REPORT FROM THE CHAIR

SSa presented a report providing an update in support of Governors holding the Non-Executive Directors to account both individually and collectively for the performance of the Board and to provide an understanding of the work of the Non-Executive Directors. SSa advised the main focus on the report was NED activities and welcome d any questions.

PG thanked SSa for the report and noted it provided useful levels of detail for Governors to ask questions. PG noted references to Power BI which would help present data in a strategic way and allow NEDs to hold the Executive Directors to account and queried the progress of this as it was referred to as looking forward to implementation. ZT agreed the report was correct the Finance & Performance Committee would be receiving a new release of Power BI. The integrated performance report had been run through the Power BI tool, which will be presented to the Committee to demonstrate how the system works. ZT advised this is a major milestone in having a report produced in this way and is pleased the existing reporting has been recreated using Power BI. ZT advised the new system will give confidence in the accuracy of the data being presented to the Board of Directors and will allow greater user accessibility. However, it should be noted the data would not be available to everyone and there would be appropriate controls to ensure the right people had access to the right data.

ZT advised the Safety Dashboard was now going live and had been built using Power BI and this would be available to a limited sub-set of staff, to ensure access to sensitive data is controlled.

PG noted the Estates Strategy was not yet in place, but had been mentioned a number of months previously as in the progress being developed. ZT advised the EPUT Strategy had indicated a priority for the first year was to refresh the Estates Strategy as a key enabling strategy and therefore this was progressing. TS confirmed the Estates Strategy had been updated so it is line with the over-arching EPUT Strategy and work has been taken forward with the Care Units so the strategy is operationally and clinically-led. The strategy is also being informed by the new ways of working group as it is clear things have changed with hybrid working. There is also a need to ensure it considers system partners and collaborative working to work across the interdependencies in the different systems. TS summarised this as a key objective for completion by the end of the financial year. LL agreed and commented it was important for a sound strategy to be developed for the future. LL advised his report was optimistic about ensuring the different strategies (estates, workforce etc.) all come together at the right time.

PG noted a comment made by LL regarding getting it right first time when it came to data and was pleased to see this was in place.

PE agreed with comments made by PG regarding the detail of the report. PE noted in LL's section there was a reference to focusing therapeutic benefit. PE asked on what basis is this measured, is feedback received from GP surgeries in terms of preventative interventions? This would be a basic preventative interventions or preventing certain things from getting worse. PE queried whether the feedback received could justify staff being present in GP surgeries and would create a good news story.

PS advised the Trust had been implementing mental health specialists as part of primary care, to help support primary care networks. There had been recruitment undertaken over the last year and feedback has been mixed. PS gave an example in Basildon of receiving great feedback from the GP where they had worked with the Trust and have changed the way people are supported in primary care and how mental health support is received. However, conversely, there have been some GP networks that have found this difficult and further work / conversations is required. PS advised part of the next steps is to identify data which can provide feedback alongside the informal responses mentioned. PE thanked PS for the response and noted the potential for GP surgeries to be able to offer a wider service at primary care level.

PE commented she had attended a 15 Steps Visit to the Derwent Centre where there was a hub which was not being used and needed updating to ensure it is fit for use in the future. PE hoped there were plans in place to make use of the space going forward as it seemed an excellent location for patients on the two inpatient wards. SSa agreed she had visited the site with Paul Burstow and had noted the hub was not being used and had taken this forward with AG and can ensure this is followed-up.

The Council of Governors received and noted the report.

029/23 CHIEF EXECUTIVE OFFICER REPORT

PS presented a report providing a summary of key activities and information. PS highlighted the following items in his report:

- The EPUT Safety Conference which took place on the 15 June at Anglia Ruskin University, which included engaging with students. The conference focused on the key outcomes from the second-year of the strategy, celebrating the achievements, but acknowledging there is more to do.
- The Mental Health Urgent Care Department, including interest from regional colleagues and early positive feedback.
- Professor Natalie Hammond leaving the Trust, moving to a new role in the Integrated Care Board.

PG commented she had read reports, updates etc. written by NH over the years and had noted she had always put patients at the heart of everything EPUT does. PG commented she would miss NH but was assured her directorate was in a good position to continue in the same positive way.

JJ endorsed PG's comments and noted a conversation he had with NH a number of years previously when he had raised concerns about the use of prone restraint. NH had assured JJ work was underway to reduce the number of prone restraints and he was happy to see the numbers had fallen significantly. JJ noted the response to his concerns was appreciated.

NH said she had appreciated the Council of Governors in terms of the challenges which has helped focus in her in the role over the years. NH advised she was looking for the opportunity to influence the wider health and social care economy and hoped to retain the lessons learnt from Governor challenges in the new role.

LL commented in relation to the Urgent Care Centre there was sometimes a view any new service created increased demand. LL disagreed with this view and felt new services usually provide a service for a need which was already there, but was not being served. There would be an increase in admissions at first, but this would settle into a normal flow pattern as the service was established. This should provide encouragement for new innovative services to be introduced. PS agreed and noted part of the business case looked at moving capacity away from other services, but also to serve unmet demand. It would important going forward to monitor the patient flow, demand and who is attending the service.

CW commented he hoped the new service worked to meet high demand and noted this was a constant challenge for the NHS to meet the growing demand for different services.

JH commented there would be a high number of people using the Urgent Care Service who would be autistic and would like to know how the capacity would be able to assess and meet

the needs of autistic patients and whether clinicians are suitably trained in this area. SSa thanked JH and suggested PS reflect on this when developing outcome metrics for measuring the quality of the service.

MD commented there was an involvement group established to develop and design the new service, which included individuals from a wide range of backgrounds, which could include autism. The group would continue to meet and invited JH to attend. JH asked MD to contact her with information about the group.

The Council of Governors received and noted the report.

030/23 COMMITTEE CHAIRS REPORT

DG presented a report providing a summary of the work undertaken by the following standing committees of the Board of Directors:

- Quality Committee
- People, Equality and Culture (PECC) Committee
- Charitable Funds Committee

DG advised there were no significant issues to report and highlighted the following areas of the report:

- The chair of the Quality Committee would be monitoring the attendance at the Committee to ensure individuals remain for the whole meeting.
- The PECC Committee is a relatively new Committee and with ML's leadership the Committee was starting to become fully established.

The Council of Governors received and noted the report.

031/23 CODE OF GOVERNANCE FOR FOUNDATION TRUSTS

CJ presented a report providing an update and assurance on the Trust's compliance with the provisions of the *NHS Foundation Trust: Code of Governance (July 2014)* in preparation for the inclusion of the "comply/explain" principals and necessary disclosures as part of the Trust's Annual Report 2022/23 submission. CJ advised the Trust intended to declare full compliance and highlighted three provisions which were rated "yellow" which were ongoing processes due for completion.

CJ advised the review was scrutinised by the Council of Governors Governance Committee with a recommendation to the Council of Governors to accept the declaration of full compliance. The report will be presented to the Finance & Performance Committee and Board of Directors for further scrutiny and final approval.

PG commented there was excellent evidence, but was disappointed by the response rates to the Council of Governors Effectiveness reviews identified as a "yellow" rating. DG advised this would be taken forward during the year.

The Council of Governors received, noted and accept the assurance given as evidence the Trust complies with the provisions of the Code of Governance.

032/23 NHS ENGLAND / IMPROVEMENT SELF-CERTIFICATION FOR 2022/23: GOVERNOR TRAINING

PG presented a report providing the action taken to agree the statement detailing the learning and training completed by Governors in 2022/23 to support the Board of Directors self-certification.

The Council of Governors received, noted the report and agreed the requirements relating to Governor Training had been met.

033/23 TRUST CONSTITUTION

CJ presented a report confirming a review had been undertaken of the EPUT Constitution and proposed amendments for approval by the Council of Governors for onward presentation to the Board of Directors for ratification.

CJ advised the review was undertaken by Capsticks (legal firm) to ensure the Constitution was in line with the new Code of Governance for NHS Providers (April 2023). The recommendations from Capsticks were discussed by a Task and Finish Group and the CoG Governance Committee, with a recommendation to the Council of Governors to approve the revised Constitution. The agreed amendments were listed in the report. CJ advised one proposed amendment relating to restrictions on membership was agreed in principle, subject to a change of wording to reflect concerns raised about the initial wording recommended by Capsticks. DG added the legal review was also undertaken to ensure the Constitution was in line with the Health and Care Act 2022.

PE queried a section of the constitution regarding removal of a Governor who consistently and unjustifiably fails to attend Council of Governors meetings. PE asked for a definition of this and the process for taking this forward if a Governor fails to attend a number of Council meetings. PE felt there was a danger of Governors seeking re-election, whilst failing to attend a significant number of Council meetings. DG advised there is a way to remove a Governor for failing to attend multiple meetings, which is around constituting a group of the Council to review cases who have followed the right process and the individual has not stepped-down. DG noted this historically does not happen as either the individual resigns or attends meetings. DG advised part of the process is for JJ to contact the individual to offer support to attend meetings. The meeting was reassured that all cases would be take on an individual basis to take into account any extenuating circumstances.

CJ advised there is a procedure in place which is overseen by the Governance Committee which contains a number of stages. The first stage is for the Lead Governor to contact the individual, followed by the Trust Secretary's Office and finally by the Chair who would then ask the individual to step down. The process has been followed through on one occasion where the individual agreed to step-down. So, the process outlined in the Constitution had not yet been followed as individuals had either attended the next meeting or resigned. SSa noted the point of an individual able to re-stand having not attended multiple meetings and this may be something requiring exploration going forward.

MD commented he had raised previously the suggestion for volunteers to automatically be made members as an "opt-out". He had been advised there was an issue with requiring individuals to be checked and added to the Membership database, so an opt-out was not

possible. However, MD queried whether there could be a solution to resolve this. SSa agreed the Task and Finish Group had asked for this to be taken forward and the TSO would liaise with Patient Experience to identify a solution.

The Council of Governors received, noted the report and approved the amended Trust Constitution.

034/23 ELECTIONS TO THE COUNCIL OF GOVERNORS 2023

CJ presented a report providing details of the Governor Election programme and timetable for 2023.

The Council of Governors received and noted the report.

035/23 COUNCIL OF GOVERNORS EFFECTIVENESS REVIEW 2022-23

CJ presented a report providing details and key findings of the self-assessment undertaken by the Governors to assess the effectiveness of the Council of Governors and its sub-committees in the period April 2022 to March 2023. CJ advised this was an interim report as there had not been enough responses to the self-assessment to provide full assurance. CJ advised some sub-committees had reached the required number of responses and the results would be presented to each sub-committee for consideration. CJ advised the report would be re-presented to the Council of Governors if enough Governors complete the self-assessment prior to the next meeting.

PE commented the low response rate may be due to the Council only meeting virtually, which makes it difficult for individuals to feel part of the Council. SSa advised there were mixed opinions in the Council regarding virtual and face-to-face meetings and this would be taken forward to consider options for having virtual / face-to-face meetings.

The Council of Governors received and noted the report.

036/23 CHANGES TO THE COUNCIL OF GOVERNORS AND MEMBERSHIP OF ITS COMMITTEES

CJ presented a report providing details of any changes to composition, current sub-committee membership and attendance at the Council of Governors meetings.

The Committee received and noted the report.

037/23 LEAD / DEPUTY LEAD GOVERNOR REPORT

JJ presented a report providing an update on activities involving the Lead and Deputy Lead Governors.

PG commented she had heard of an ICB having a forum for Governors of all the different provider Trusts and felt this was a good step-forward. JW advised Suffolk and North East Essex (SNEE) Integrated Care Board were planning to have a session about Governors and lay members of local authorities. JW had sent the information to CJ for circulation to Governors.

The Council of Governors received and noted the report.

038/23 ANY OTHER BUSINESS

Your Voice

MD advised face-to-face Your Voice sessions were being held on the 6 – 8 June 2023 and encouraged Governors to attend.

039/23 QUESTIONS AND ANSWERS SESSION

None.

040/23 DATE AND TIME OF NEXT MEETING

The date and time of the next meeting is Thursday 24 August 2023 at 14:45 (CEO Briefing at 14:00)

Signed …….. Date …….

Agenda Item: 4
Council of Governors Part 1
24 August 2023

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Council of Governors Meeting
Action Log (following Part 1 meeting held on 22 May 2023)

Requires immediate attention /overdue for action	
Action in progress within agreed timescale	
Action Completed	
Future Actions	

Lead	Initials	Lead	Initials	Lead	Initials
Martine Munby	MM	Chris Jennings	CJ	Manny Lewis	ML
Loy Lobo	LL	Paul Scott	PS		

Minutes Ref	Action	Owner	Dead - line	Outcome	Status Comp/ Open	RAG rating
May Presentation	Develop a Communication Plan with the Council of Governors Membership Committee for regularly communication with the Foundation Trust Membership.	MM / CJ	Sep-23	This will be discussed at the next CoG Membership Committee.	Open	
February 005/23	Provide update on impact of International Recruitment, including figures on the number of international recruits to date.	ML/LL	Jun-23	This was included as part of the Annual Report for 2023/24	Closed	
	Provide an update on progress to improve the Lighthouse Child Development Centre	PS	Jun-23	This was included as part of the CEO Briefing with Governors.	Closed	
November 041/22	Develop a session with Governors to discuss the relationship between EPUT and Anglia Ruskin University.	CJ	~~Apr-23~~ Oct-23		Open	

		Agenda Item No: 5a
SUMMARY REPORT	**COUNCIL OF GOVERNORS PART 1**	**24 August 2023**

Report Title:	**Report from the Chair**					
Executive/ Non-Executive Lead:	Sheila Salmon, Chair					
Report Author(s):	Angela Laverick, PA to Chair, Chief Executive and NEDs					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides the Council of Governors an update report from the Chair of the Trust in support of Governors holding the Non-Executive Directors to account both individually and collectively for the performance of the Board and to provide an understanding of the work of the Non-Executive Directors.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Council of Governors is asked to:

1 Note the contents of the report

Summary of Key Issues

The report provides an overview of the Chair's, Non-Executive Directors' and Board related activities since the last report to the Council of Governors.

An update report from the Chair of the Trust will be provided at each general meeting of the Council of Governors.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	
Involvement of Service Users/Healthwatch	✓
Communication and consultation with stakeholders required	
Service impact/health improvement gains	

Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	CAMHS	Child and Adolescent Mental Health Services

Supporting Documents and/or Further Reading
Report from the Chair

Lead
Professor Sheila Salmon **Chair**

Agenda Item: 5a
Council of Governors Part 1
24 August 2023

REPORT FROM THE CHAIR

1.0 PURPOSE OF REPORT

This paper presents an update report from the Chair of the Trust in support of Governors holding the Non-Executive Directors (NEDs) to account both individually and collectively for the performance of the Board and to provide an understanding of the work of the Chair, NEDs and Board of Directors. This report covers the period since the last report to the Council of Governors.

2.0 ACTIVITY UPDATE FROM CHAIR AND NEDS

i) Professor Sheila Salmon

Board changes

As reported in my Board of Directors Chair report, colleagues will be aware that Professor Natalie Hammond, Executive Nurse left EPUT at the end of July to take up the role of Chief Nurse at Hertfordshire and West Essex ICB. Sean Leahy, Executive Director of People and Culture has also left EPUT to take up an exciting opportunity. An executive recruitment search is underway to appoint substantively to both roles. I was pleased to confirm in my most recent Board report that Frances Bolger was taking up the role of Interim Executive Nurse and Dr Ruth Jackson (Executive People Officer at Mid an South Essex ICB) was giving temporary strategic leadership to the People and Culture Directorate at EPUT whilst interim directorship was finalised. I am delighted to be able to update the Council of Governors that Susan Young has been confirmed as interim Chief People Officer and interim Executive Director of People and Culture. Susan comes with extensive experience having worked in the NHS and both central and local government. Susan is a Chartered Fellow of the Chartered Institute of Personnel and Development with over 20 years' experience in HR, organisational development and broader transformation in the public sector at Board level as both an Executive and Non-Executive. Susan joined us from 16 August on a part time basis and will commence full time in September 2023. Susan has been able to take up her role from 14th August 2023.

As advised previously, Elena Lokteva has now transitioned into the role of Non-Executive Director and has taken up the role of Audit Committee Chair. I welcome Elena to this role, to which she brings a wealth of experience. I would like to extend sincere heartfelt thanks to Janet Wood for her outstanding service in that role since the inception of EPUT. Janet's final term of office at EPUT concludes on 30th September 2023.

I am pleased to report that the NEDs and I have continued to be proactive in our connection and visibility with services – these are outlined below in the individual summary NED reports. I have visited Rochford Community Hospital and Brockfield House where I met a range of staff and leaders of the services, being able to observe caring in action.

I have had the privilege to chair a number of consultant appointment panels and have continued to be both impressed and encouraged by the quality of applicants and the appointments made. Committed to forging ever-stronger partnerships, I have acted as external assessor to system executive director appointments.

I was delighted to co-host with the CEO, a drop in session in Westminster for the Essex MPs, which was positively received.

I would also like to commend the most recent in-person Your Voice public meetings held in Colchester, Basildon and Harlow. The two that I was personally able to attend (Basildon and Harlow), were both well attended and with lively debate.

The regional network events for Chairs and CEOs have resumed in person and I am valuing being able to engage face to face with peers and colleagues.

The Lead Governor and I met with the Lead Governor and Chair of MSE Acute FT, to discuss the potential value of organising a joint session with governors from the two FTs in Mid and South Essex. It was agreed to take this forward and I am thankful to the Trust Secretariat who are liaising to secure a mutually agreeable diary date in the autumn.

ii) Janet Wood

The annual work cycle of the Audit Committee completed in June. The Annual Report and Accounts have been audited and received and approved by both the Audit Committee and Board. They were also laid before parliament ahead of the summer recess. These will be shared with Governors in due course, together with the Annual Audit Report from External Audit. Elena Lokteva has now taken over as Chair of the Audit Committee – I wish her all the very best in the role.

I have been out and about quite a lot over the last few weeks connecting with staff, patients and partners. This included a visit to Clifton Lodge, one of our nursing homes, and Your Voice meetings in Colchester and Harlow – where it was wonderful to engage with the public in person. I also attended system events in Harlow and Ipswich, meeting up with system partners. At the Ipswich event there was a session on system governance for NEDs and governors which EPUT was represented at. I also attended the NHS Providers Governance Conference in London where the theme was systems and governing under pressure.

This is my last update to Governors, my 6 year tenure as a Non-Executive Director at EPUT is compete at the end of September. I would like to thank all governors (past and present) for your contributions, support and challenge over the years.

iii) Loy Lobo

It has been a busy period since my May report with a wide spectrum of engagement. This year, I am prioritising visits to community-based services and considering options for virtual visits to smaller service units spread around EPUT's vast service footprint. I also attended all the Your Voice meetings held in June and the RISE Graduation Day in July.

1. **Mental Health Emergency Department (MHED):** The Mental Health Emergency Department will be seen as one of the outstanding achievements of the past 12 months. It is an exemplar of how innovation needs to be done – co-produced with the experts with lived experience. I visited the MHED and met the staff, consultant on duty, and operational leads, and received good feedback on the initial response from patients. It would be good to visit again during a busy period to observe the flow and feel the vibe.

2. **Community services**: Visited Herrick House (Colchester) and Kingswood Centre Dementia Services (Colchester) on separate days. It is becoming increasingly apparent to me that the long-term solution to creating time to care in our in-patient units could be found in providing earlier/preventative services in a community setting, augmented by digital services where appropriate.

3. **Finance & Performance Committee:** It was a moderately busy period for F&P. The Integrated Performance Report (IPR) developed with the PowerBI reporting platform continues to evolve. The tool is helping the committee focus on the issues and metrics that matter, and dig into hotspots by care unit. Functionality that enables tracking by CQC action items will be available soon. I have implemented such tools in other industries (Pharmaceutical, Financial Services, Consumer Products) and can testify to their power to transform executive decision making processes.

4. **Research & Innovation Strategy**: I was pleased to participate in two workshops to help shape the R&I strategy which generated energetic discussion. I am looking forward to receiving the outputs from the workshops.

5. **Electronic Patient Records (EPR) System:** I was delighted with the news of the EPR Outline Business Case being approved by the NHS England Joint Investment Committee. It was a huge effort, led for EPUT by Zephan Trent and in collaboration with colleagues at MSE-FT. I have been privileged to support this effort and will continue to be involved via the Joint EPR Programme Board which has just been set up. This transformational project will implement the first common EPR system in England that will work across the Acute, Community, and Mental Health settings.

6. **Mid & South Essex Integrated Care Board Finance & Investment Committee:** I continue to represent EPUT on the Finance & Investment Committee. Although EPUT is on target to achieving its financial objectives, the system as a whole faces a challenging year due to the efficiencies that still need to be found at the FT. There are early signs that a collaborative mind-set between the system partners and a rapid implementation of identified efficiencies could go a long away to helping the system come closer to achieving financial balance in the mid to long term.

7. **RISE**: Finally, I was delighted to attend the RISE Graduation Day celebrations along with Manny Lewis and Mateen Jiwani. The energy in the room was uplifting and it raised the optimism level further in a person prone to optimism bias, on seeing the talent coming through the ranks of EPUT and the passion they were bringing to their work.

iv) Manny Lewis

In the period since the last update to Council, apart from attendance at Board, Board seminars, Finance & Performance Committee, Herts & West Essex Chairs, NED Discussion Group, Education Board, Constituency meetings, Remuneration & Nomination Committee and People, Equality & Culture Committee, my other contributions have been:

1 A service visit to the Lakes and also Henneage ward in Colchester. This was a very positive experience which showed a highly professional ward and service management team on site which provided for a good caring environment. Some need for investment in the estate was identified which I have followed up with estates management.
2 Attendance at the Trust's Safety First conference at ARU where I joined the Q&A panel at the end of the conference – I think it was a successful event that engaged the students well, not so much of a focus on stakeholders.
3 I chaired interviews for a consultant post for Adult Community which was successfully appointed to.
4 I also opened the RISE graduation event at Stockbrook Manor where the morale, energy and potential of the participants was really impressive
5 I also interviewed for the interim Executive Director for People & Culture with Sheila Salmon and look forward to working with Susan Young, the successful candidate.

v) Dr Mateen Jiwani

These last few months have been mixed with strategic and oversight meetings. I have now chaired the Charitable Funds Committee and settled into the role of Senior Independent Director which, has allowed a successful transition into my first appraisal of the chair which we have submitted regionally into the national framework. This is a voluntary exercise for this organisation but demonstrates our commitment to exemplary working, openness, and reflective approaches.

The People and Culture committee has challenges with the workforce and we maintain a level of watchfulness that we will innovate and support delivery on as a wider team. The new Executive Director will allow us to continually build on the new ways of working, managing the scrutiny of portfolio delivery, and also ensuring we focus on the success of recruitment and retention. I was also present at the RISE ceremony helping to present awards to staff who have achieved great successes. I have been close to the Digital Strategy landing with a keen eye for scrutiny and also ensuring digital transformation has a clear vision for implementation and offers challenges circling training and feasibility. I have equally been offering this for the EPR business case and implementation, I am pleased this was approved for progress.

I continue chairing in circular with ARU Vice chancellors the second Joint conference to help settle the deepening strategic partnership between the two organizations. I have attended board seminars, NED discussion groups, Consultant interviews, Audit Committee, People, Equality & Culture Committee, and Charitable funds committees. I have also managed to represent EPUT at a roundtable discussion with other MH trusts for the national rapid review into MH inpatient care which, was chaired by the chair of the independent inquiry. I also attended and was on the Panel for the Organisations Safety First conference. This was a very memorable experience showcasing how involved staff are in the safety agenda of the Trust.

I have managed visits to some more sites including Latton Bush and also Ruby Ward to see some of the work being done by colleagues including international recruits. This was eye-opening and we need to be celebrating the good work. Conversely, I've been taking away learning as per my colleague governor from our dementia services which, need estates utilization and some long-term planning, I've subsequently highlighted this to our estates managing team.

I have been reviewing the complaints audit as part of my NED role and plan to continue this work in a more leading capacity alongside one of the other NED to continue the good work and build on the new processes.

vi) Elena Lokteva

It has been a particularly busy period for the Audit Committee in connection with the completion of the annual report and financial statements, and for me personally as I took on the role of the Chair of that committee. I would like to take this opportunity to thank Janet Wood for leading the Committee through the difficult years of the pandemic and independent investigation.

In my capacity as NED, I actively participated in the May and June Board meetings, the Board Workshop, the Remuneration & Nomination Committee, and the Board Safety Oversight Group.

I continue to dedicate time to learning about our patients and staff experiences to ensure that we foster a culture of care, empowerment and continuous learning. During the reporting period, I visited Meadowview Ward, Thurrock Hospital; Colchester Specialist Community Team, Herrick House; Robin Pinto Ward in Luton; participated in North East Essex & Suffolk Your Voice Meeting, Windrush Day celebration organised by Ethnic Minority Race Equality Staff Network, Safeguarding Champions Event and Breakfast with the Lessons Team.

To keep abreast of both the dynamics of integrated care and governance best practices, I have attended NHS Providers Annual Governance Conference and participated in Performance Management and Quality training for NHS NEDs. This helped me to learn best practices and better understand a Board role in ensuring collaboration in times of change.

vii) Dr Rufus Helm

I continue working with IT and the Patient Experience Team to improve engagement with IWantGreatCare. One key issue is that the Trust does not have a service directory that reflects how our services are structured so patients find it difficult to locate the correct service in IWGC, so service leads have been asked to provide the Patient Experience with an up-to-date structure. This will have benefits beyond recording patients' experiences.

I attended a Research and Innovation Strategy Workshop led by Dr David Ho and Anna Bokobza - key messages included ensuring there is an opportunity for "bottom-up" innovation from our staff and service users and dedicated funding to be made available to support innovation.

I also attended Suffolk and NE Essex's Health and Care Expo in the beautiful grounds of Wherstead Park – it was great to see such a large display of health and care organisations showing what they are doing to support the local population

3.0 RECOMMENDATIONS AND ACTION REQUIRED

The Council of Governors is asked to:

1. Note the content of this report.

Report prepared by
Angela Laverick
PA to Chair, Chief Executive and NEDs

On behalf of
Professor Sheila Salmon
Chair

SUMMARY REPORT	COUNCIL OF GOVERNORS PART 1	Agenda Item: 5b
		24 August 2023

Report Title:	**Chief Executive Officer Report**					
Executive/ Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Paul Scott, Chief Executive Officer					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides a summary of key activities and information to be shared with the Council of Governors.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Council of Governors is asked to:

1. Note the contents of the report

Summary of Key Issues

The report attached provides information on behalf of the CEO in respect of performance, strategic developments and operational initiatives.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	

Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Impact on Statutory Duties and Responsibilities of Council of Governors	
Holding the NEDs to account for the performance of the Trust	✓
Representing the interests of Members and of the public	✓
Appointing and, if appropriate, removing the Chair	
Appointing and, if appropriate, removing the other NEDs	
Deciding the remuneration and allowances and other terms of conditions of office of the Chair and the other NEDs	
Approving (or not) any new appointment of a CEO	
Appointing and, if appropriate, removing the Trust's auditor	
Receiving Trust's annual accounts, any report of the auditor on them, and annual report	
Approving "significant transactions"	
Approving applications by the Trust to enter into a merger, acquisition, separation, dissolution	
Deciding whether the Trust's non-NHS work would significantly interfere with its principal purpose or performing its other functions	
Approving amendments to the Trust's Constitution	
Another non-statutory responsibility of the Council of Governors (please detail):	

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main Report

Lead
Paul Scott **Chief Executive Officer**

Agenda Item: 5b
Council of Governors Part 1
24 August 2023

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CHIEF EXECUTIVE OFFICER REPORT

1. Statutory Inquiry Update

On 28 June 2023, the Secretary of State for Health and Social Care announced that the Essex Mental Health Independent Inquiry would be granted statutory status, under the Inquiries Act 2005. We are awaiting further information around the terms of reference, implications for the Trust and next steps.

This announcement and the uncertainty around next steps will of course cause concern. However, as a Trust our position remains the same, in that we are committed to supporting the Inquiry and ensuring families, carers and service users receive the answers they rightly deserve. We will continue to engage with openness, honesty and transparency, and work with the Inquiry to encourage staff, service users and families to come forward. Patient safety remains our absolute priority, and we welcome this inquiry as an opportunity to learn lessons to ensure the best and safest care possible for our patients.

It is important to recognise that while there is more to do to improve our services every day we see compassionate care across the Trust and there have huge achievements and transformation that has and continues to take place. Everything we have achieved so far gives us solid foundations to continue building on giving our patients the very best care. Just this year we have seen the opening of the Mental Health Urgent Care Department – providing those experiencing mental health crisis the support they need to access services and avoiding the need for a visit to an acute A&E. We have also worked with the East of England Ambulance service to launch mental health ambulance cars and we've extended the Ops Courage service for veterans and their families. Looking forward we are speaking to commissioners about funding for our Time to Care programme which will focus on allowing clinical staff more time to care for their patients away from administrative and other tasks. We are also continuing to work with MSEFT on the creation of a shared Electronic Patient Record (EPR) - patients and those who use our services see no boundary in their health care and our systems need to reflect this.

2. CQC Update

The CQC published its report on the 12 July following our well-led inspection back in January. As expected, the report contains areas for improvement and the CQC rated the overall Trust as requires improvement. Although this is disappointing, it is important we do not lose sight of the positives in the report and the significant progress we have made in the six months since the inspection.

For context, 30 core domains were inspected by the CQC – 53% of those saw no change to their rating, 7% saw an improved rating and only three core services saw a decrease in overall rating. Some of the issues identified by the CQC include storage of medicine, monitoring of fridge temperatures, being up to date with mandatory training, colleagues remaining alert during observations and staffing levels.

Much of the change that has taken place in recent months goes a long way to address the issues raised by the CQC. Patients say they feel safe, valued and respected and their loved ones describe the care they witness as compassionate. The rating for our substance misuse services has improved to good, the CQC recognised the action we are taking to develop a learning culture, new reporting, and support systems in place for colleagues who experience racial abuse and the vital role we played to ensure everyone can access COVID-19 vaccinations.

We are taking great strides on our journey of improvement and our work with patients, service users and their families to transform the care we provide is resulting in positive change on a wide scale. We will keep you updated on the actions we are taking and the progress we continue to make.

3. Quality and Excellence Awards

On Wednesday 5 July, the Trust held its annual Quality and Excellence Awards at Three Rivers Golf and Country Club in Cold Norton. Fittingly taking place on the NHS' 75th birthday, the evening was a celebration of all that the NHS and the Trust stands for, showcasing inspirational stories and examples of outstanding compassionate care, innovation and commitment to public service. We received nearly 300 nominations this year, all of whom deserve recognition for their amazing achievements, and the judges had a difficult job choosing the shortlist for the 19 categories. I would like to extend my congratulations to everyone who was a winner, highly commended, or shortlisted. I could not be more proud of what our staff do every day to care for people and transform lives and I look forward to seeing what we will achieve over the coming months and years ahead. We are already starting planning for this years' scheme and are looking to launch the call for nominations in the autumn so please look out for communications.

4. RISE Graduation

Last month we held our second RISE graduation event. The scheme, developed for colleagues from black, Asian and minority ethnic backgrounds and designed to help nurture rising stars working in any role within EPUT, sees participants attend a number of sessions across multiple topics including change management, effective leadership and cultural and emotional intelligence. The successful event celebrated the 47 colleagues, who graduated from the programme. I would like to congratulate all graduates for their exciting achievements, and I look forward to seeing their careers progress further throughout the organisation. We are now seeking nominations for our next cohort and look forward to future career success for those involved.

5. National Award Nominations

Our new Mental Health Urgent Care Department, which opened in March this year, has been shortlisted for four national awards. The first of its kind in Essex, providing urgent mental health support for anyone over 18 in mid and south Essex. The department is open 24 hours a day, seven days a week, and has been shortlisted in three categories of The Nursing Times Awards for Critical and Emergency Care Nursing, HRH the Prince of Wales Award for Integrated Approaches to Care, and Nursing in Mental Health. It is also a finalist in the Royal College of Nursing Awards for the Mental Health Nursing category. Since the department opened, we have seen a reduction in the number of people in mental health crisis being admitted to emergency departments at Basildon, Southend and Broomfield hospitals. The winners for both awards will be announced later this year, and I wish the Team all the best and would like to congratulate all on the huge achievement.

6. EPUT International Recruitment programme receives national award for high-quality pastoral support

I am delighted to share that last month; EPUT's International Recruitment (IR) programme received an NHS Pastoral Care Quality Award. This award recognises that the support we offer colleagues who joined the Trust through our IR programme meets best practice standards.

All members of our IR programme team, supported by our nursing managers and directors, have worked tirelessly to ensure our international colleagues receive enhanced support as they join our Trust and start their NHS career. Over the last 18 months, they have personally welcomed more than 220 nurses, allied health professionals (AHPs), and helped them start their lives in the UK. Within the wider programme team, the dedicated IR pastoral care team have played an integral role in championing international colleagues' wellbeing.

A recent survey of international colleagues showed 99% felt safe and welcomed upon their arrival to the UK, and 94% said their experience of pastoral care met their expectations.

This award is an incredible achievement, recognising the tremendous effort we have made to best support our internationally educated colleagues, and would like to congratulate the Team on their achievement.

7. Industrial Action

As you will be aware, junior doctors took industrial action between Friday 11 August and Tuesday 15 August. The Trust respects the right of junior doctors to take action and contingency plans continue to be in place to ensure we maintain urgent care and preserve patient safety throughout strike days.

8. Oliver McGowan Training

The training aims to save lives by ensuring colleagues have the right skill and knowledge to provide, safe, compassionate and informed care to autistic people and people with a learning disability. It was developed in partnership with Paula McGowan after the death of her son Oliver in 2016 shone a light on the need for better training.

All staff are required to complete two modules – an online element and a subsequent live element of which details will be shared across the Trust shortly.

9. Couth Asian Heritage Month

Next week our Ethnic Minority Equality Network (EMREN) will be hosting an event to celebrate South Asian Heritage month, at the Broomfield Village Hall, 158 Main Road, CM1 7AH from 1pm to 3.30pm. You are welcome to drop in.

This forms part of a wider celebration of the importance of Asian heritage across the UK and within the Trust – with communications and activities throughout the month.

10. Refurbishment

As part of our continued commitment to upgrading our buildings the Hadleigh Unit at the Basildon Mental Health Unit is currently undergoing a12 week refurbishment programme. We will keep you updated on the progress.

11. Planned for the Autumn:

We continue to focus on our relationship with key external stakeholders and have arranged a virtual MP drop in session in September as part of our ongoing communications with MPs and their offices (we also share a monthly email update).

We are working on the autumn edition of EPUT news Magazine that is printed for colleagues on clinical sites and widely shared in digital format as well. Governors will receive a copy.

The communications team are working on plans to mark World Mental Health Day in October as a celebration of the work that goes on across the Trust. We are aiming to link this to a relaunch of fundraising for the EPUT charity so that we can raise funds to benefit patients and staff across our services.

Essex Partnership University NHS Foundation Trust

Auditor's Annual Report

Year ended 31 March 2023

Contents

Introduction

Purpose

The purpose of the Auditor's Annual Report is to bring together all of the auditor's work over the year. A core element of the report is the commentary on value for money (VFM) arrangements, which aims to draw to the attention of the Trust or the wider public relevant issues, recommendations arising from the audit and follow-up of recommendations issued previously, along with the auditor's view as to whether they have been implemented satisfactorily.

Responsibilities of the appointed auditor

We have undertaken our 2022/23 audit work in accordance with the Audit Plan that we issued in March 2023. We have complied with the National Audit Office's (NAO) 2020 Code of Audit Practice, other guidance issued by the NAO and International Standards on Auditing (UK).

As auditors we are responsible for:

Expressing an opinion on:

- The 2022/23 financial statements;
- The parts of the remuneration and staff report to be audited;
- The consistency of other information published with the financial statements, including the annual report; and
- Whether the consolidation schedules are consistent with the Trust's financial statements for the relevant reporting period.

Reporting by exception:

- If the governance statement does not comply with relevant guidance or is not consistent with our understanding of the Trust;
- To the Secretary of State for Health and Social Care and NHS England if we have concerns about the legality of transactions of decisions taken by the Trust;
- If we identify a significant weakness in the Trust's arrangements in place to secure economy, efficiency and effectiveness in its use of resources;
- Any significant matters that are in the public interest; and
- Any significant issues or outstanding matters arising from our work which are relevant to the NAO as group auditor.

Responsibilities of the Trust

The Trust is responsible for preparing and publishing its financial statements, annual report and governance statement. It is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Introduction (continued)

2022/23 Conclusions - Draft	
Financial statements	Unqualified – the financial statements give a true and fair view of the financial position of the Trust as at 31 March 2023 and of its expenditure and income for the year then ended. We issued our auditor's report on 30 June 2023.
Parts of the remuneration report and staff report subject to audit	We had no matters to report.
Consistency of the other information published with the financial statement	Financial information in the annual report and published with the financial statements was consistent with the audited accounts.
Value for money (VFM)	We had no matters to report by exception on the Trust's VFM arrangements. We have included our VFM commentary in Section 03.
Consistency of the annual governance statement	We were satisfied that the Annual Governance Statement was consistent with our understanding of the Trust.
Referrals to the Secretary of State and NHS England	We made no such referrals.
Public interest report and other auditor powers	We had no reason to use our auditor powers.
Reporting to the Trust on its consolidation schedules	We concluded that the Trust's consolidation schedules agreed, within a £300,000 tolerance, to the audited financial statements.
Reporting to the National Audit Office (NAO) in line with group instructions	We had no matters to report to the NAO.
Certificate	We issued our certificate on 5 July 2023.

Audit of the financial statements

Key findings

The Annual Report and Accounts is an important tool for the Trust to show how it has used public money and how it can demonstrate its financial management and financial health. The financial statements have been prepared properly in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023 and the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

On 30 June 2023, we issued an unqualified opinion on the financial statements. We reported our detailed findings to the 27 June 2023 Audit Committee meeting, and provided an updated report on 29 June 2023 in advance of the issue of our audit report. We outline below the key issues identified as part of our audit, reported against the significant risks and other areas of audit focus we included in our Audit Plan.

Significant/Fraud risk	Conclusion
Management override: Misstatements due to fraud or error	We did not identify any evidence that management has overridden controls in order to prepare fraudulent financial statement balances or postings within the financial statements.
Risk of fraud in revenue and expenditure recognition	We did not identify any evidence of manipulation of revenue and expenditure through improper revenue and expenditure to inflate income or understate expenditure,
Inappropriate capitalisation of revenue expenditure	We did not identify any evidence of manipulation of expenditure through incorrect capitalisation of revenue expenditure.
National cyber incident	Our work on NHS and non-NHS income and expenditure between 1 July 2022 and 31 October 2022 has not identified any material misstatements or instances of incorrect accounting treatment.

Area of Audit Focus	Conclusion
Agreement of balances with commissioners	We investigated differences from the agreement of balances exercise and did not identify any issues.
Valuation of land and buildings	We are satisfied that the value of assets is materially accurate and that accounting entries have been correctly posted. We identified a factual audit difference, which management has chosen not to adjust. The valuations of land and buildings in the Trust's external valuer's report were different to those recorded in the fixed asset register and the financial statements. As a result, within the financial statements, land is understated by £1.0 million and buildings are overstated by £0.4 million. This treatment was in line with the Trust's agreed approach that if the movement resulting from the 31 March 2023 valuation was not material the Trust would not reflect these updated balances in the Accounts. For 2022/23 the valuation was a desktop valuation and follows a full valuation of all the Trust's assets undertaken in 2021/22 and therefore movements were not expected to be material.
New accounting standard – IFRS 16	Our work on leases did not identify any material misstatements or instances of incorrect accounting treatment. The total net book value of Right of Use assets in the accounts is £41.3 million and the Trust completed all submission required to NHS England and submitted them to required deadlines.

Audit of the financial statements

Key findings (continued)	
Area of Audit Focus	**Conclusion**
Independent inquiry	We have not identified any material misstatements in relation to the provision for the response to the inquiry and disclosures in the Annual Report and accounts accurately reflect the current position. The Trust revisited the basis of the provisions in the accounts following the issue of the open letter by the Chair of the Inquiry which indicated it may move to a statutory basis. The expected change in status of the inquiry was confirmed when The Secretary of State for Health and Social Care made a statement in Parliament on the 28 June 2023 indicating intention to give the inquiry statutory powers. As the Trust had already calculated the provision in the accounts on the basis that the inquiry would move to a statutory basis, there is no impact on the provision already included in the accounts.
Local Government Pension Scheme (LGPS)	To gain assurance over the material accuracy of the balances related to the LGPS, we liaised with the administering authority (Essex Pension Fund) to obtain information and supporting evidence over the investment asset values and assessed the work of the Pension Fund actuary including the assumptions they used. We also undertook additional procedures using our own pensions specialists to gain assurance over this material estimate. We did not identify any matters arising from the work completed and are satisfied that the Trust's valuation of pension assets, liabilities and disclosures are not materially misstated. As a result of the fact that the Trust's IAS19 report on pension liabilities includes a asset ceiling, we undertook further work in relation to this matter. An asset ceiling is the present value of any economic benefit available to the Trust in the form of refunds or reduced future employer contributions. The value of this in 2022/23 was £5.796 million (£2.121 million in 2021/22), with the cumulate impact at 31 March 2023 being £7.917 million. This has the effect of reducing the plan assets along with the net defined benefits and other reserves recognised in the SOFP. Our key findings in relation to this were that: • Based on the proxy calculation by our own pensions specialist, the defined benefit obligation determined by the actuary was materially accurate; • In our view, although payment of exit credits (i.e. a refund on exiting the scheme, when the Trust is in a surplus position) is discretionary under the terms of the scheme, we would not conclude there is no unconditional right to such a payment. In our view, it is likely that such a payment would be made and therefore there should be no adjustment to the plan assets in relation to the asset ceiling. This is however a judgement and will depend on specific circumstances and individual facts. The Trust should give further consideration to this matter as part of the preparation of the 2023/23 financial statement and determine whether the asset ceiling should be included or not in line with IFRIC 14. Management have not amended the accounts for this change; and • On the basis that management were not amending to remove the asset ceiling adjustment, we identified that a change to the presentation of the asset ceiling in note 7.4 (employee retirement benefit obligation) was required. The value of this in 2022/23 was £5.796 million (£2.121 million in 2021/22). There is no impact on the overall defined benefit net asset reported in the statement of financial position as a result of these changes which are purely presentational. Management amended the accounts for this change;

Value for Money

We did not identify any risks of significant weaknesses in the Trust's VFM arrangements for 2022/23.

Our VFM commentary highlights relevant issues for the Trust and the wider public.

We had no matters to report by exception in the audit report.

Scope

We are required to report on whether the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in it use of resources. We have complied with the guidance issued to auditors in respect of their work on value for money arrangements (VFM) in the 2020 Code of Audit Practice (2020 Code) and Auditor Guidance Note 3 (AGN 03). We presented our preliminary VFM risk assessment to the Audit Committee members in March 2023 as part of our Audit Plan. We completed our risk assessment procedures during our audit, based on a combination of our cumulative audit knowledge and experience, our review of Trust Board and committee reports, meetings with the Executive Chief Financial Officer and Deputy Chief Executive, and evaluation of associated documentation through our regular engagement with Trust management and the finance team.

Reporting

We completed our risk assessment procedures in June 2023 and did not identify any significant weaknesses in the Trust's VFM arrangements. We have also not identified any significant risks during the course of our audit. As a result, we had no matters to report by exception in the audit report on the financial statements.

Our commentary for 2023/23 is set out on pages 8 to 13, The detailed arrangements underpinning the reporting criteria are set out in Appendix 1.

In accordance with the NAO's 2020 Code, we are required to report a commentary against three specified reporting criteria:

Reporting criteria	Risks of significant weaknesses in arrangements identified?	Actual significant weaknesses in arrangements identified?
Financial sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services	No significant risks identified	No significant weaknesses identified
Governance: How the Trust ensures that it makes informed decisions and properly manages its risks	No significant risks identified	No significant weaknesses identified
Improving economy, efficiency and effectiveness: How the Trust uses information about its costs and performance to improve the way it manages and delivers its services	No significant risks identified	No significant weaknesses identified

Value for Money (continued)

Financial Sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services

Essex Partnership University NHS Trust has continued to improve the management of financial resources over the financial year and has maintained both its governance and financial oversight arrangements. The management of the financial position has continued despite significant underlying financial pressures within all catchment ICS's and the ongoing financial impact of the Inquiry. Particular improvements during the year have included an increased level of substantial rated Internal Audit reports, including budget setting and monitoring, whilst reducing the number of limited report ratings, with only one limited assurance report in relation to operational effectiveness for the site visits review. There has also been a strengthened focus on income reporting, more concrete plans for reducing procurement waivers and enhanced financial reporting into the Accountability Framework meetings with Care Units. The Trust also received the highest score for budget setting in the HFMA financial sustainability assessment.

The Trust agreed its draft Operational Plan on 27 March 2023. This sets out the key commitments and priorities for the first year of delivery against their new strategic plan for 2023/24 to 2027/28 for the Trust as well as for each care unit. The Operational Plan also outlines the key risks that will be addressed in 2023/24. Key priorities include delivering high quality and safe integrated care services, which will include actions in response to the Essex Mental Health Independent Inquiry.

The Trust has also submitted its final Financial Plan for 2023/24 on the 31 May 2023 to the board of directors with initial plan approved in March 2023. The Financial Plan includes a breakeven position for 2023/24 but recognises that the financial challenges that it faces are greater than in 2022/23. The Integrated Care System (ICS) is expected to have a net deficit of £40 million, and there is an expectation to deliver efficiency savings while not compromising patient safety. One of the key risks identified for the Trust is escalating costs in response to the independent Inquiry, which is now expected to run past the planned deadline of Spring 2023 into 2024/25.

The Trust has continually monitored its short-term financial pressures throughout the year. Where pressures have been identified, they have been reported to EPUT's system partners and efficiency plans have been put in place to resolve the position. The Trust was initially reporting a planned deficit for 2023/24 of £9.8 million. This has been partially addressed through an increase to planned efficiency savings of £22.9 million (4.4% of operating expenditure) of which £3.8 million is currently unidentified, which is lower than the position of £10.9 million unidentified in prior year. The Trust has therefore set a balanced financial position for 2023/24 with the financial plan formally agreed by the Board.

The Trust submitted a breakeven plan for 2022/23 which included £17.3 million efficiency savings. They reported an overall surplus position of 96k (adjusted financial performance) for the 2022/23 year, after achieving savings of £13.6m against the planned savings of £17.3 million. The Trust has a consistent record of delivery of a high level of efficiency savings and is expected to do so for 2023/24. The Trust recognises delivery and development of recurrent efficiencies will be required to further improve this position as noted above with efficiency requirements much greater than previously delivered.

Conclusion
The Trust had the arrangements we would expect to see in 2022/23 to enable it to plan and manage its resources to ensure that it can continue to deliver its services.

Value for Money (continued)

Governance: How the Trust ensures that it makes informed decisions and properly manages its risks

The Trust has continued to improve its governance structures through constant review of its existing frameworks throughout the year.

During the year, the Trust has continued its governance oversight arrangements through the Accountability Framework Model which was implemented in 2021/22. Monthly meetings have taken place with the six Care Units which has enabled teams to meet internally to review their positions ahead of meeting the Executive Team representatives. It also provides a common structure to produce the supporting data packs. The development of the framework has been jointly led by the Chief Finance Officer and Chief Operating Officer , with the meetings having been used to encourage empowerment, transparency, accountability and dialogue.

The Trust has recently given more focus to managing procurement risks, with the aim of reducing waivers for 2023/24. Regular communication between the procurement team and operational colleagues have been planned through one-on-one meetings and Accountability Framework meetings. The Trust has also consolidated procurement activities and is also planning to recruit two new Procurement Business Partners and are migrating from Delta to a new procurement software called Atamis, which enables better benchmarking. Waivers are being reported to the weekly Executive Operational Committee and on to the Audit Committee.

The supply and recruitment of nurses continues to be a well-known and documented challenge for all NHS Trusts, and this was no different for 2022/23. This has been identified as a longstanding historic strategic risk. The risk for the Trust is that if it does not effectively address and manage staff supply and demand (including looking at staff competency), this could result in potential failure to provide optimal patient care and treatment, the resultant impact being on safety and quality of care. The Trust has undertaken significant activity to transform the workforce through investment, international recruitment and enhanced oversight during daily planning and busier periods. The 'Time to Care Programme' has redesigned the staffing model and activities to ensure better quality care, a more therapeutic inpatient stay and improve the overall experience for staff. The Trust is simultaneously trying to reduce temporary and agency staffing as part of their efficiency savings for 2023/24, with the target of savings of approximately £2 million to be achieved through successful recruitment to substantive nursing posts.

Cyber security

The Trust has a strong governance structure in place to identify, monitor and mitigate key cyber security risks. An Information Governance and Cyber Risk Log is used to capture and monitor information governance and cyber security risks and to log mitigating controls implemented or to be implemented. This is further strengthened by having a dedicated Data Security and Protection Toolkit (DSPT) & Risk Working Group, which provides a focal point for the discussion of information governance risks and issues. The Trust utilises a product called LANSweeper to monitor potential security exposures, such as device and server patching compliance, anti-virus updates and drive encryption status.

The Trust, along with other NHS organisations, was impacted in August 2023 by a national cyber-attack on Advanced. As a result of the attack, One Advanced (who provide the eFinancials and eProcurement system the Trust uses) shut down connection into HSCN (which impacted the Trust's ability to access eFinancials). Although eFinancials were not listed by One Advanced as one of the systems affected, when Advanced turned systems back on, the Trust, and other users of the system, took the decision to cut access to the system until further assurance could be obtained. The finance department initiated its business continuity plan (BCP) and established daily meetings with key staff across finance and undertook a risk assessment. This focussed on ensuring critical goods and services were able to be ordered and payments made to suppliers.

During this event, the Trust identified that its current business continuity plan did not explicitly cover actions to be taken in the event of complete lack of access to the system, and as such, this was developed as a live document. Trust staff were also regularly communicated with and this was escalated and monitored via the Trusts emergency command structure. The Trust also worked closely with other NHS organisations and NHSE to ensure the most up to date information was available and assuring that is was taking all necessary actions. The Trust established a 'walled garden' arrangement to enable controlled testing to be undertaken in a secure environment. A detailed testing plan was prepared and worked through before the system was released to all users. The Trust also asked its Internal Auditors to review their BCP to ensure it covered everything they would expect from a financial perspective. This review did not identify any concerns and provided a moderate assurance report.

Value for Money (continued)

Governance: How the Trust ensures that it makes informed decisions and properly manages its risks

Cyber security (continued)

Only moderate priority recommendations have been identified by Internal Audit for Cyber Security and Control Design and Operational Effectiveness have been given a moderate assurance rating. There were ten findings and recommendations made by the Internal Auditors, of which the most relevant one in light of the cyber security breach, was around the Trust's ability to adequately identify threats as well as the lack of procedures in place to prevent vulnerabilities being exploited. It was recommended that the Standard Operating Procedures that were drafted by the Cyber Security Operation Manager be developed further. Management have agreed to the recommendation and that it will form part of a new Cyber Governance Manager role.

Collaboration and joint working

The Trust is the lead for Adult Secure Services within the Provider Collaborative (PC). There are five other members within this collaborative structure with Cambridge and Peterborough NHS Foundation Trust acting as lead provider for Adult Eating Disorder Services and the host for the Transformation and Commissioning team. Hertfordshire Partnership University NHS Foundation Trust acts as lead provider for Child and Adolescent Mental Health Services. The six member organisations form part of the Collaborative Board reporting to NHS England.

The Trust is also in a Community Collaborative for Mid and South Essex, with North East London NHS Foundation Trust (NELFT) & Provide Community Interest Company (Provide CIC) forming the Mid and South Essex Community Collaborative (MSECC) which delivers community services.

CQC reports

The Trust has received a number of reports from the Care Quality Commission (CQC) as well as high levels of media interest over the last 12 months. Key inspection reports include:

July 22 Child and Adult Mental Health Services (CAMHS):

CQC carried out an unannounced focused inspection during March and April 2022 to follow up on the conditions placed on the Trust's registration after the previous inspection which was reported in September 2021. The conditions put in place from the previous inspection included restricting the service from admitting any new children and young people without the prior written agreement of the CQC and a condition to ensure all three wards are staffed with the required numbers of suitably skilled staff to meet the new children and young people's needs and to undertake children and young people's observations as prescribed.

During the inspection the Trust demonstrated that improvements have been made and as a result the service is no longer rated as inadequate overall, and the imposed conditions were removed, indicating that governance arrangements were operating effectively in relation to addressing the issues identified in the previous CQC inspection.

October 2022 Acute wards for adults of working age and psychiatric intensive care units:

CQC carried out an unannounced focused inspection following the Trust notifying them of concerns about the safety and quality of the services, that was to be included in a Channel 4 Dispatches programme.. CQC visited the two wards identified in the Channel 4 programme and following this suspended Trust's rating for acute wards for adults of working age and psychiatric intensive care units pending further inspection activity.

Value for Money (continued)

Governance: How the Trust ensures that it makes informed decisions and properly manages its risks

CQC reports (continued)

A Letter of Intent was sent to the Trust following this inspection and this was followed up with a Section 29 Warning Notice on 30 October 2022. This asked the Trust to make improvements by 18 November 2022 regarding: Patient observations; Sufficient numbers of regular staff; Patient consent; Blanket restrictions; Incident reporting; storage of Ligature cutters.

The Trust responded to this warning notice in the required timeframes and all actions arising from the warning notice have now been delivered, with the exception of roll out of e-observations, which is due to go live in June 2023. The current status of the service is a rating of 'inadequate', although the CQC has not imposed any conditions on the Trust's registration within the warning notice or in the subsequent report.

This indicates that the Trust has taken action to respond to the issues raised by the CQC inspection and is reporting these through its governance structures.

April 23 Overall inspection rating;

Despite the inspections noted above the CQC have not re-rated the overall Trust rating which remained as good... The Trust is anticipating a re-rating when the CQC core services report is published, and this is expected in late July.

Essex Mental Health Independent Inquiry

In addition to the CQC inspections, the Essex Mental Health Independent Inquiry was announced by the Government on 21 January 2021, with the aim of publishing a report in Spring 2023. It was established to investigate the circumstances of mental health inpatient deaths which occurred over a 20-year period between 1 January 2000 and 31 December 2020 at the former North Essex Partnership University NHS Foundation Trust, the former South Essex Partnership University Trust and the successor body, Essex Partnership University NHS Foundation Trust.

The Chair of the inquiry has sent an open letter to the Secretary of State on the 15 May 2023 requesting that the Essex Mental Health Independent Inquiry is converted to a statutory Inquiry under the 2005 Inquiries Act. This was on the basis that, in her view, she cannot effectively meet the Terms of Reference if the Inquiry remains on a non-statutory footing. The Chair noted in her letter that staff who have come forward at present are not representative: 75% are senior managers and 75% do not work directly with patients. Only a small number are patient-facing staff have come forward to date. In the Chair's view, the engagement of these staff, and in particular witnesses involved in deaths being investigated, is critical to the Inquiry and it is not possible to properly investigate matters with the current level of engagement.

It was previously expected that the Inquiry findings would be published in Spring 2023. However, due to the issues noted above it is now not expected to conclude until 2025. As a result, the Trust has recognised provisions future costs in its 2022/23 accounts and 2023/24 Financial plan.

We have considered the Trust's response to the inquiry as part of our 2022/23 audit. We have concluded that the Trust has put in place appropriate governance arrangements to manage and learn from the Inquiry. A Project Team has been established, and an Independent Director appointed, which provides regular updates to relevant Committees and the Board. The risk of not responding appropriately to the inquiry is also noted in the BAF as a strategic risk. The Trust have also made effective use of Internal Audit to assist in learning the lessons from the inquiry to date as well as reviewing issues that have been identified in relation to weaknesses and gaps in records held.

Value for Money (continued)

Governance: How the Trust ensures that it makes informed decisions and properly manages its risks

Essex Mental Health Independent Inquiry (continued)

Where there have been changes to the scope of the inquiry, the Trust has reviewed the implications and ensured that support has been provided in the form of legal representation, internal communications, back filling posts and re-aligning the financial provision. We noted in particular, that the Trust has been prudent in extending their provision for the inquiry to 2024/25 and increasing the legal costs on the basis of advice from their legal advisors in relation to the likelihood of the basis of the inquiry moving to a statutory basis. The expected change in status of the inquiry was confirmed when The Secretary of State for Health and Social Care made a statement in Parliament on the 28 June 2023 indicating intention to give the inquiry statutory powers. As the Trust had already calculated the provision in the accounts on the basis that the inquiry would move to a statutory basis, there is no impact on the provision already included in the accounts.

Based on the above and our review of the papers and minutes presented to Audit Committee, Board of Directors and supported by our discussions with the Senior Trust Officers and attendance at Audit Committee meetings, we are satisfied that, from a governance perspective, the Trust is responding appropriately to the inquiry and arrangements in place related to support this are adequate.

Conclusion: The Trust had the arrangements we would expect to see in 2022/23 to enable it to make informed decisions and properly manage its risks.

Value for Money (continued)

Improving economy, efficiency and effectiveness: How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

The Trust has a variety of ways of measuring its own performance across all aspects of its operations. It brings these together in the form of monthly reporting to the Board against national and local indicators. The Integrated Quality & Performance Report sets out the performance of the Trust against a range of key indicators. Where performance is below plan, these reports highlight the action being taken to seek the required improvement.

In terms of financial review, monthly finance reports are reported to the Finance and Performance Committee. A detailed summary of the finance position is provided in these reports covering the current surplus/deficit position along with a forecast to the year end and this is challenged regularly by the Committee. As at year end, the Trust had successfully achieved most of its saving efficiency targets with £13.6 million total savings against planned savings of £17.3 million. We note that £4.5 million of the savings was due to an unplanned non-recurrent receipt of income from non-patient care. The remaining variances to the planned budget related to procurement, which had a shortfall of £3.3 million, as well as £5 million for skill mix reviews. The savings have been monitored throughout the year by the Trust who have reported monthly to the Executive Operational Committee and Finance & Performance Committee, as well as to the Mid and South Essex (MSE) ICB and NHS England as part of the monthly monitoring return.

In addition to assurance services, the Trust's Internal Auditors also provide operational recommendations and controls reviews in areas highlighted by Trust Management. The outcome of these and any recommendations are tracked at Audit and Assurance Committees. This information is used in conjunction with financial and performance information to identify areas for improvement.

Internal Audit undertook various reviews requested by management during 2022/23 including site visits, reviewing patient safety and Cyber Security. The site visit reviews was rated as limited in effectiveness and moderate in design. The Cyber security received a moderate rating in design and effectiveness. Management is developing plans to address the Internal Audit recommendations from these reviews and these will be routinely followed up to establish compliance by the Audit Committee. Internal Audits on budget control and monitoring and costing both received substantial Assurance.

The Trust has an established Systems and Partnerships Committee which provides oversight of its active role within the local ICS. An executive director and non-executive director head up work in the three main ICSs that the Trust operates in: Mid and South Essex, Hertfordshire and West Essex and Suffolk and North East Essex. This has ensured a strong Trust presence at decision-making ICS meetings, ensuring mental health and community health services remain a high priority in all system-wide considerations. This has also enabled ongoing scrutiny of the equality of service delivery to different groups.

The progression of the ICS is one of the key areas to address for the Trust heading into 2023/24. The formation of Integrated Care Boards and Integrated Care Partnerships alongside place-based health and care partnerships, maintaining inclusive focus of West Essex within the Herts and West Essex ICS. The Trust recognise creating and forming these new organisational structures and new strategic ways of working will allow more opportunities for the Trust and for them to work in partnerships with others to achieve strategic objectives.

Conclusion: The Trust had the arrangements we would expect to see in 2022/23 to enable it to use information about its costs and performance to improve the way it manages and delivers services.

Appendices

Building a better working world

Appendix A – Summary of arrangements

Financial Sustainability

Reporting Sub-Criteria	Findings
How the body ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them	The Trust's Finance and Performance (F&P) Committee maintains and provides oversight over the financial performance of the Trust. They also have oversight over the Board Assurance Framework (BAF) to identify and evaluate any changes in financial performance related risks. F&P reports quarterly to the Trust Board (quarterly performance through outturn reports). The month end outturn position (and the associated report) is subject to review at a number of levels – reviewed by management accountants and their Senior Finance Manager, before further review by the Assistant DoF and Associate DoF throughout the outturn process. This is then reviewed by the ECFO at the draft position stage. The final position and annual report are reviewed by the CFO before the report is finalised. The finalised reports are presented at Board meeting regularly. Hot spots for overspend are identified at each Board meetings and corrective action are taken (e.g. high level of bank/ agency use, addressed by tight control over staffing level and recruitment to fill up vacant post).
How the body plans to bridge its funding gaps and identifies achievable savings	Management makes recommendations to the Board. Monthly reporting on financial performance and planning to a Finance and Investment Committee enable the Trust to identify gaps in funding and monitor progress on meeting savings targets. The Board then takes decisions, such as strategic initiatives and major transactions and probes for explanations of past results (e.g. budget variances/gaps), which appear to be constructively challenged by the Board and relevant subcommittees such as the Finance and Performance Committee and the Quality Committee.
How the body plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities	The Trust has a vision and a long-term strategic plan (5 years) which articulates how it will deliver its statutory responsibilities. The Trust translates this into an annual operating plan including the financial plans for enabling sustainable delivery of services. This forms the basis of monthly Trust Board reporting. EPUT has a Board Assurance Framework in place which identifies business risks, evaluates the significance of those risks and the likelihood of occurrence against strategic priority. The BAF is reviewed by Executive Operational Committee and Audit Committee regularly. The Trust has aligned its financial plans with its BAF which is a key enabler of delivering its strategic plan, operational plans and statutory duties.
How the body ensures that its financial plan is consistent with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system	The Trust reports to each Board meeting on key performance areas including Patients, Sustainability, People and Quality. The Trust's financial plans include reporting on these wider areas as part of the Trust's mechanisms for monitoring the achievement of targets for each of the key performance areas. Where the Trust identifies a risk to target achievement, it incorporates the resulting identified mitigating actions into the BAF, which enables it to identify the necessary financial resources required to implement the actions. The Trusts Board Assurance Framework (BAF) provides a mechanism for the Board to monitor the risks to delivery of the trust's strategic objectives as well as the effectiveness of the controls and assurance processes. The BAF is reviewed by Executive Operational Committee and Audit Committee regularly. The Quality Committee provide assurance to the Board and oversight of the Trust's active role within the local Integrated Care System.
How the body identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans	The Trust maintains an integrated performance report that is reported to the Board and F&P Committee. The report includes actual financial outturn as well as the expected/projected outturn position for the financial year. Within this report the Trust will identify if there are additional risks to financial resilience and required mitigations to deliver financial targets.

Appendix A – Summary of arrangements (continued)

Governance

Reporting Sub-Criteria	Findings
How the body monitors and assesses risk and how the body gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud	The Trust's BAF is refreshed annually to match its strategic aims and align to strategic priorities and risks. The BAF outlines the actions being undertaken by the Trust to provide assurance that risks are being mitigated to an acceptable level. This framework provides a comprehensive method for the effective management of the potential risks that may prevent the achievement of the key items (i.e. strategic priorities) agreed by the Board of Directors. The BAF is supported by corporate and service risk registers. The risks assessed are wider than just financial, due to the nature of the Trust's activities. The Trust assesses impact of risks on a matrix of likelihood and occurrence against a strategic priority, with a combined score produced to assess the importance of the risk. The Trust has a risk appetite statement that defines acceptable levels of risk for its activities. The BAF is reviewed regularly as the Executive Operational Standard Committee (EOSC) receive reports monthly and the Board every two months or as per the Board meeting schedule. Earlier in 2021, the CFO oversaw a complete refresh of the BAF to ensure work is run in parallel to the high-level governance and accountability framework projects. The Trust is currently working on ensuring BAF risks can consolidate where practical and that the Trust achieves regular Executive engagement on a monthly basis. The Trust has an internal audit service to help gain assurance over the effective operation of internal controls. It also has a Local Counter Fraud Specialist (LCFS) as part of its arrangements to prevent and detect fraud. The Trust's LCFS regularly reviews the Trust's policies and procedures and inputs into the Trust's counter fraud policy to ensure the Trust's internal processes are robust as possible. In addition to this, LCFS also run a series of counter fraud awareness sessions throughout the year and online surveys are undertaken and used to check staff awareness of counter fraud processes. The Chief Finance Officer (CFO) is responsible for the adequate provision of Internal audit with oversight from the Audit Committee. Trust management is responsible for responding to the internal audit findings appropriately and in a timely manner with appropriate challenge from the Audit Committee. The Audit Committee receives a copy of the counter fraud plan each year and approves the activities and proactive audits to be undertaken. LCFS attend all Audit Committee meetings and updates members on the progress of all investigations, proactive audits and awareness sessions.
How the body approaches and carries out its annual budget setting process	The Trust develops its financial plan and budget using dual processes: • Top down: where the Trust quantifies the core financial gap to assess the Trust's affordability envelope and inform the scale of the efficiency expectation for forthcoming year. This is developed through the application of national and local planning assumptions, as well as known commitments. • Bottom up: where the Trust develops a granular level of activity, income, expenditure, workforce, capacity and efficiency planning. The Trust then triangulates these plans with operational, performance and workforce leads. The financial plan is reviewed by the F&P Committee before being presented to the Board for approval prior to 1 April.

Appendix A – Summary of arrangements (continued)

Governance

Reporting Sub-Criteria	Findings
How the body ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information (including non-financial information where appropriate); supports its statutory financial reporting requirements; and ensures corrective action is taken where needed	The CFO oversees the adoption and operation of the Trust's Standing Financial Instructions including the rules relating to budgetary control, procurement, banking, losses and controls over income and expenditure transactions. The CFO reports to the F&P Committee that oversees and ensures that effective processes and systems are in place to ensure budgetary control. This is evident through the quarterly reporting by the F&P Committee to the Board to indicate the actual financial outturn compared to the budget/plan. Hot spots for overspend are identified at each Board meetings and corrective action are taken (e.g. high level of bank/ agency use, address by tight control over staffing level and recruitment to fill up vacant post). Reporting to the Board also includes the full range of non-financial management information on all the Trust's key performance areas. As the Trust deliver a wide range of services commissioned by different Clinical Commissioning Groups (CCGs) and specialist commissioners, there are a great number and wide variety of mandated, contractual and locally identified key performance indicators (KPIs) that are used to monitor the performance and quality of services delivered. Each year the Board of Directors approve a performance framework for the Trust that includes target levels of performance across the entire range of the organisation's activities; from front line customer care; to the efficiency of back office functions; to the well-being of staff. The targets that have been agreed by the Board are then monitored at inpatient ward, community team and individual consultant level. In addition to these targets, managers at the Trust monitor local trends and measure the other work that EPUT do to compare how well their services are performing. Activity is recorded and sent in a report to the CCGs. These monthly reports compare the levels of activity that have been planned to the actual activity that has taken place, and highlight any areas of concern. Performance against all KPIs are provided to the F&P Committee each month and any areas of significant under-achievement are advised to the Board of Directors as 'Inadequate indicators' each month. Updates on how the Trust address these 'inadequate indicators' are also reported on, these are evaluated and approved by the Board of Directors.
How the body ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency. This includes arrangements for effective challenge from those charged with governance/audit committee	The effective operation of the Board, supported with regular, clear and relevant information, is the Trust's key tool for ensuring that it makes properly informed decisions. Published Board papers and minutes evidence the challenge made by non-executive members and the transparency in decision making. The Audit Committee meets quarterly, is comprised of appropriately skilled and experienced members, has clear terms of reference which emphasises the Committee's role in providing effective challenge and has an annual work plan to help ensure that it focuses on the relevant aspects of governance, internal control and financial reporting. We attend all meetings of the Audit Committee and have directly observed the challenge given by non-executives in their role as the body charged with governance for the Trust.

Appendix A – Summary of arrangements (continued)

Governance

Reporting Sub-Criteria	Findings
How the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of officer or member behaviour (such as gifts and hospitality or declarations/conflicts of interests)	The Trust has policies and procedures in place to ensure that staff operate in accordance with relevant legislative and regulatory requirements. These policies and procedures are monitored and reviewed by the Audit Committee annually. The Trust has an appointed 'Principal Freedom to Speak Up' guardian as well as local guardians, which allow staff to raise any further concerns. The Trust has a comprehensive system of internal control; this includes Standing Orders (SOs), Standing Financial Instructions (SFIs), Standards of Business Conduct (SBC), and disciplinary procedures in relation to fraud. The SOs, SFIs and SBC are set out in the Scheme of Reservation & Delegation (SoRD) and Governance Manual approved by the Trust Board and circulated to all staff. The aim of the Standards of Business Conduct is to protect the Trust and its staff from any suggestion of corruption, partiality or dishonesty by providing a clear framework through which the Trust can provide assurance that staff conduct themselves with honesty, integrity and probity. The Trust has specific policies for staff and non-executive directors in respect of gifts and hospitality and conflicts of interest. Annually, all Senior Staff and non-executive directors as well the governors are required to make declarations. These declarations are recorded in a register and disclosed within the Annual Report.

Appendix A – Summary of arrangements (continued)

Improving economy, efficiency and effectiveness

Reporting Sub-Criteria	Findings
How financial and performance information has been used to assess performance to identify areas for improvement	The Chief Finance Officer produces a finance report which is considered by the F&P Committee and forms part of the Integrated Performance Report presented to every meeting of the Trust Board. This considers the current and forecast financial performance and position of the Trust, details of variations from plan, updates on funding arrangements which have changed throughout the year due to financial risks to the Trust and mitigating actions as appropriate. This is presented together with extensive reporting on performance, quality and workforce metrics so that a complete balanced scorecard for the whole Trust and its outputs can be considered by executives and non-executives. This is then used to identify areas that need to be improved and is also linked through to the BAF and wider risk management arrangements where areas needing improvement create corporate risks for the Trust. The Board receives reports on performance in its key areas, which includes Patients, Sustainability, People, Quality and Systems & Partnerships. The reports clearly outline performance against planned targets and outcomes. Depending on the performance area, a Board committee will have oversight of the actions being identified and taken to address areas where performance is below plan. Each committee has a process in place for monitoring agreed actions and these are then included in subsequent Board reports.
How the body evaluates the services it provides to assess performance and identify areas for improvement	The Trust has an array of ways of measuring its own performance across all aspects of its operations. It brings these together in the form of monthly reporting to the Board against national and local indicators. The Integrated Quality & Performance Report sets out at the performance of the Trust against a range of key indicators. Where performance is below plan these reports highlight the action being taken to seek the required improvement. The Finance and Performance Committee, People, Innovation and Transformation Committee, and Quality Committee have a responsibility to receive and scrutinise action plans that mitigate significant potential risks identified. The Trust publishes an annual Quality Report outlining the its performance against a wide range of quality measures. The Trust is regularly inspected by the Care Quality Commission (CQC), with the most recent overall report on how well the Trust uses its resources being in October 2019 and reporting a “good” overall rating. This included “outstanding” ratings for the ‘Caring domain’ and for ‘CAMHS’ and ‘End of Life Care.’ There have been further CQC inspections and reports and negative press coverage following a Health and Safety Executive fine in June 2022 related to historic deaths in the predecessor Trust (North Essex). Following this an Essex Mental Health Inquiry was initiated and there was a negative Channel 4 Dispatches programme in October 2022. Following these inspections the Trust has been served with a number of notices by CQC. Its overall CQC assessment however remains good and there is evidence of action being taken by the Trust in response to the issues identified in the CQC inspections.

Appendix A – Summary of arrangements (continued)

Improving economy, efficiency and effectiveness

Reporting Sub-Criteria	Findings
How the body ensures it delivers its role within significant partnerships, engages with stakeholders it has identified, monitors performance against expectations, and ensures action is taken where necessary to improve	The Trust has an established Systems and Partnerships Committee which provides oversight of its active role within the local Integrated Care System. An executive director and non-executive director head up our work in each of the three of the integrated care systems that EPUT operate in: Mid and South Essex Health and Care Partnership, Hertfordshire and West Essex and Suffolk and North East Essex. This has ensured a strong Trust presence at decision-making ICS meetings, ensuring mental health and community health services remain a high priority in all system-wide considerations. This has also enabled ongoing scrutiny of the equality of service delivery to different groups. An integral part of the Trust is the Council of Governors which brings the views and interests of the public, service users and patients, carers, our staff and other stakeholders into the heart of our governance. This group of committed individuals has an essential involvement with the Trust and contributes to its work and future developments in order to help improve the quality of services and care for all our service users and patients. The Trust believes that receiving and acting on feedback from its service users is crucial to maintaining the high quality standards it sets itself and work has continued to increase the feedback received and actions taken. The Trust uses a range of mechanisms to gather feedback from our service users, including; Organisational and national patient surveys; “Your Voice” meetings giving service users, carers, members of the Trust and Governors as well as the public a chance to speak directly to the Chief Executive about the services provided by EPUT; Patient Council set up to involve service users in transformation work within the Trust . During 2020/21 the Patient Experience Team finalised a project to engage with people with lived experience to co-produce the Trust’s new Patient Experience Framework for 2020-2023, which is available on the Trust’s website. The Trust also has a Membership Framework in place that recognises the need to put service users and the public at the heart of our engagement. It outlines the visions for membership and includes the priorities to build an effective, responsive and representative membership body that will assist in ensuring the Trust is fit for its future in the changing NHS environment. The Trust seeks to ensure it is inclusive in its approach in engaging the community, appreciating the wide social and cultural mix of its constituencies.

Appendix A – Summary of arrangements (continued)

Improving economy, efficiency and effectiveness

Reporting Sub-Criteria	Findings
How the body ensures that commissioning and procuring services is done in accordance with relevant legislation, professional standards and internal policies, and how the body assesses whether it is realising the expected benefits	The Trust use national contracts or agreements wherever possible, primarily through NHS Supply Chain, the Crown Commercial Service and NHS Commercial Alliance. Where it is not possible to use a national agreement, contracts are advertised in the public domain via the government portal Contracts Finder. Procurement of services is undertaken by the Trust's in-house Procurement team. The team has appropriately qualified staff and policies to ensure that procurement is undertaken in accordance to legislation. Where specialist knowledge is required, the Trust will obtain advice, legal advice relating to tender or routes to market. The Trust takes all reasonable steps to ensure laws and regulations are complied with. This includes ensuring appropriate knowledge and expertise of its own staff and, where required obtaining professional and specialist advice in certain areas e.g. VAT, employment, Health and Safety. The Trust receives a quarterly update from its legal advisors which identifies all recent legal cases or legislation potentially relating to Trust business. The Executive Operational Committee are provided with details of any material claims from the Executive Director for Corporate Governance. Public stakeholders, including Clinical Commissioning Groups, Sustainability and Transformation Partnerships (STPs) and Local Authorities are involved in managing key risks through well-established contract management and partnership committee structures that oversee the operational delivery of and potential threats to services delivered in partnership. In addition, the Trust imparts information to the Council of Governors on key risks that may have arisen or are likely to materialise, through regular meetings.

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ED None

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Agenda Item No: 6b

SUMMARY REPORT	COUNCIL OF GOVERNORS PART 1	24 August 2023

Report Title:	**Annual Review of External Audit Services**					
Report Lead:	Elena Lokteva, Non-Executive Director / Chair of Audit Committee					
Report Author(s):	Clare Barley, Head of Financial Accounts					
Report discussed previously at:	Audit Committee (13/07/2023)					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report provides the Council of Governors with the annual review of external audit services for the 2022/23 financial year.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Council of Governors is asked to:

1 Note the contents of the report
2 Confirm the reappointment of Ernst and Young as the Trusts external auditors for the 2023/24 financial statements
3 Request any further information or action.

Summary of Key Issues

In line with paragraph 23(2) of Schedule 7 to the National Health Service Act 2006, the Council of Governors are responsible for the appointment of the Trust's External Auditors. It is also considered good practice that within the term of the contract, the Audit Committee periodically report to the Council of Governors on the performance of the external auditors.

Under the contract, the external auditors will automatically be reappointed each year unless either party terminates the agreement. The annual review of performance by the Audit Committee serves to confirm that the reappointment of the external auditors is appropriate.

The last market testing exercise was undertaken in 2021/22, with the Council of Governors approving the award of a three year contract (with option to extend for a further two years) to Ernst and Young. The audit completed for 2022/23 was the first year of the contract.

The market for external audit services in the NHS remains challenging with many organisations still struggling to appoint auditors and / or experiencing difficulties in the ability to meet the national accounts deadlines. Ernst and Young have been supportive of the Trust with the delivery of accounts and audit to national timelines, including the laying of the combined Annual Report and Accounts to Parliament ahead of the summer recess.

There continues to be a collaborative approach to the audit, with regular communication and early engagement in the planning process. The Auditors had an on-site presence for 2022/23 which helped support the early resolution of audit queries. The Audit Committee did note however that some aspects of testing could have been planned earlier in the process especially where this necessitated the need for further engagement from third party advisors, including the Local Government Pension Scheme and District Valuer. This will be considered as part of the planning process for 2023/24.

Overall the Audit Committee was very satisfied with the provision of external audit services and their responsiveness and support during the annual accounts process. The Audit Committee recommend that the Council of Governors confirm the reappointment of Ernst and Young for a further year.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	
SO2: We will enable each other to be the best that we can	
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered	
1: We care	
2: We learn	✓
3: We empower	

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			n/a
Governance implications			
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Impact on Statutory Duties and Responsibilities of Council of Governors	
Holding the NEDs to account for the performance of the Trust	
Representing the interests of Members and of the public	
Appointing and, if appropriate, removing the Chair	
Appointing and, if appropriate, removing the other NEDs	
Deciding the remuneration and allowances and other terms of conditions of office of the Chair and the other NEDs	
Approving (or not) any new appointment of a CEO	
Appointing and, if appropriate, removing the Trust's auditor	✓
Receiving Trust's annual accounts, any report of the auditor on them, and annual report	
Approving "significant transactions"	
Approving applications by the Trust to enter into a merger, acquisition, separation, dissolution	
Deciding whether the Trust's non-NHS work would significantly interfere with its principal purpose or performing its other functions	
Approving amendments to the Trust's Constitution	
Another non-statutory responsibility of the Council of Governors (please detail):	

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead

Elena Lokteva,
Non-Executive Director / Chair of Audit Committee

		Agenda Item No: 6c
SUMMARY REPORT	**COUNCIL OF GOVERNORS PART 1**	**24 August 2023**

Report Title:	**Standing Orders for the Council of Governors**					
Report Lead:	Chris Jennings, Assistant Trust Secretary					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Council of Governors Governance Committee 9 August 2023					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides the Standing Orders For The Council Of Governors for the required annual review.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Council of Governors is asked to:

1 Note the contents of this report.
2 Approve the reviewed Standing Orders For The Council Of Governors

Summary of Key Issues

The Standing Orders (SOs) For The Council Of Governors are required to be reviewed annually. The Council of Governors is required to approve these SOs.

The review of the Standing Orders was completed by Capsticks (legal firm) in line with a similar review of the Trust Constitution, to ensure it is in line with the new Code of Governance for NHS Providers (April 2023) and the Health & Care Act 2022.

The review identified minor amendments associated with references to the new code. There were two queries raised by Capsticks / Governance Committee:

Section 1.1: Save as otherwise permitted by law, at any meeting of the Council of Governors the Chair of the Trust shall be the final authority on the interpretation of these standing orders (on which they should be advised by the Trust Secretary).
The Governance Committee suggested changing the wording “Save as otherwise permitted by law” to “Unless otherwise permitted by law” for more clarity. This has been amended in the document following confirmation from the Legal Team it did not inadvertently change the meaning.

Section 4.9: A Governor and/or a member of a committee of the Council and/ or any non-Governor shall not disclose a matter dealt with by, or brought before, the Council or a committee of the Council without the permission of the Council or such committee (as applicable) until such matter shall have been concluded or in the case of such committee, until the committee shall have reported to the Council.
Capsticks queried the reference to “non-Governor” as the sub-committees membership was made-up of Governors. The response provided was the sub-committees are supported by EPUT staff and can invite other non-Governors to attend to discuss specific topics. Therefore, no change was made.

The Council of Governors is asked to approve the Standing Orders For The Council of Governors. These will be presented to the Board of Directors in September for final approval.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered	
1: We care	
2: We learn	
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Impact on Statutory Duties and Responsibilities of Council of Governors	
Holding the NEDs to account for the performance of the Trust	
Representing the interests of Members and of the public	
Appointing and, if appropriate, removing the Chair	
Appointing and, if appropriate, removing the other NEDs	
Deciding the remuneration and allowances and other terms of conditions of office of the Chair and the other NEDs	
Approving (or not) any new appointment of a CEO	
Appointing and, if appropriate, removing the Trust's auditor	
Receiving Trust's annual accounts, any report of the auditor on them, and annual report	
Approving "significant transactions"	
Approving applications by the Trust to enter into a merger, acquisition, separation, dissolution	
Deciding whether the Trust's non-NHS work would significantly interfere with its principal purpose or performing its other functions	
Approving amendments to the Trust's Constitution	
Another non-statutory responsibility of the Council of Governors (please detail): • Standing Orders for the Council of Governors	✓

Acronyms/Terms Used in the Report			
CoG	Council of Governors		

Supporting Documents and/or Further Reading
Standing Orders For The Council Of Governors

Lead
Chris Jennings **Assistant Trust Secretary**

STANDING ORDERS FOR THE PRACTICE AND PROCEDURES OF THE COUNCIL OF GOVERNORS

POLICY REFERENCE NUMBER:	TB02
VERSION NUMBER:	7
KEY CHANGES FROM PREVIOUS VERSION	Minor amendments
AUTHOR:	Trust Secretary's Office
CONSULTATION GROUPS:	Board of Directors Council of Governors CoG Governance Committee
IMPLEMENTATION DATE	April 2017
AMENDMENT DATE(S)	September 2018, September 2019, November 2019, September 2020, September 2021, November 2022
LAST REVIEW DATE	September 2023
NEXT REVIEW DATE	September 2024
APPROVAL BY COUNCIL OF GOVERNORS	24 August 2023
RATIFIED BY BOARD OF DIRECTORS	27 September 2023
COPYRIGHT	

POLICY SUMMARY
The purpose of the Standing Orders for the Council of Governors is to set out the practice and procedures of the Council in order to maintain good standards of governance.
The Trust monitors the implementation of and compliance with this policy in the following ways:
Monitoring of implementation and compliance with the Standing Orders for the Council of Governors will be undertaken by the Trust Secretary.

Services	**Applicable**	**Comments**
Trustwide	✓	
Essex MH&LD		
CHS		

The Director responsible for monitoring and reviewing this policy is the Chief Executive Officer

CONTENTS

INTRODUCTION

Regulatory Framework

Essex Partnership University NHS Foundation Trust (the Trust) is a public benefit corporation. It was established on 1st April 2017, following the grant of an application pursuant to Section 56 of the National Health Service Act 2006 (the 2006 Act), by Monitor (now part of NHS England).

The functions of the Trust are conferred by this legislation and the Trust will exercise its functions in accordance with the terms of its provider licence (no: 120163) and all relevant legislation and guidance.

These standing orders add clarity and detail where appropriate. Nothing in these standing orders shall override the Trust's constitution, the National Health Service Act 2006, the Health & Social Care Act 2012 and the Health and Care Act 2022.

The Trust's standing orders and wider governance arrangements are further supported by various policies and procedures.

The principal place of business of the Trust is The Lodge, Lodge Approach, Wickford, Essex SS11 7XX.

1. INTERPRETATION

1.1 Unless otherwise permitted by law, at any meeting of the Council of Governors the Chair of the Trust shall be the final authority on the interpretation of these standing orders (on which they should be advised by the Trust Secretary).

1.2 Any expression to which a meaning is given in the National Health Service Act 2006 or regulations made under it shall have the same meaning in these standing orders and in addition:

1.2.1 **2006 Act** means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

1.2.2 **2012 Act** means the Health & Social Care Act 2012.

1.2.3 **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

1.2.4 **Board of Directors** or **Board** or **Board Member** or **Member of the Board** means the Chair, Executive and Non-Executive Directors of the Trust collectively as a body in accordance with the constitution. This term is used interchangeably with the term **Director**.

1.2.5 **Chair of the Board** or **Chair of the Trust** means the person appointed under paragraph 28 of the constitution by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from a meeting or is otherwise unavailable or such other Non Executive Director as may be appointed as acting Chair in accordance with these SO.

1.2.6 **Chief Executive** is the person appointed as the Chief Executive Officer (the Accounting Officer) of the Trust under paragraph 31 of the constitution.

1.2.7 **Committee** means a committee appointed by the Council of Governors.

1.2.8 **Committee members** means persons formally appointed by the Council of Governors to sit on or to chair specific committees.

1.2.9 **Constitution** means the Trust's constitution which has effect in accordance with Section 56(11) of the 2006 Act.

1.2.10 **Council of Governors** or **Council** means the Council of Governors of the Trust as described in paragraphs 14 and 18 of the constitution.

1.2.11 **Directors** means the Executive and Non-Executive members of the Board of Directors.

1.2.12 **Executive Director** means a member of the Board of Directors, including the Chief Executive, appointed under paragraph 31 of the constitution.

1.2.13 **Lead Governor** is the person appointed by the Council of Governors in accordance with the *NHS Foundation Trust Code of Governance* (July 2014).

1.2.14 **Licence** means the Trust's provider licence (no: 120163) issued by NHS England (Monitor) on 1st April 2017.

1.2.15 **Motion** means a formal proposition to be discussed and voted on during the course of a meeting.

1.2.16 **Non-Executive Director** means a member of the Board of Directors, including the Chair, appointed by the Council of Governors under paragraph 28 of the constitution.

1.2.17 **SOs** mean these Standing Orders (for the Council of Governors).

1.2.18 **Trust** means Essex Partnership University NHS Foundation Trust.

1.2.19 **Trust Secretary** means a person appointed by the Chair and Chief Executive as the Trust Secretary.

1.2.20 **Vice-Chair** means the Non-Executive Director appointed under paragraph 30 of the constitution.

1.2.21 **Working days** a day that is not a Saturday or Sunday, Christmas Day, Good Friday or any day that is a bank holiday.

1.3 Words importing the plural shall import the singular and vice-versa.

1.4 Any reference to an Act shall, where appropriate, include any Act amending or consolidating that Act and any regulation or order made under any such Act.

2. COUNCIL OF GOVERNORS ROLES AND RESPONSIBILITIES

2.1 The purpose of these SOs is to ensure that the highest standards of corporate governance and conduct are applied to all Council meetings and associated deliberations.

2.2 The roles and responsibilities of the Council which are to be carried out in accordance with the Trust's constitution, license and the *Code of Conduct for NHS Provider Trusts (February 2023)* (and any subsequent versions) are:

General Duties

2.2.1 To hold the Non-Executive Directors individually and collectively to account for the performance of the Board, including ensuring that the Board acts so that the Trust does not breach the terms of its licence. "Holding the Non-Executive Directors to account" includes scrutinising how well the Board is working, challenging the Board in respect of its effectiveness, and asking the Board to demonstrate that it has sufficient quality assurance in respect of the overall performance of the Trust, questioning Non-Executive Directors about the performance of the Board and of the Trust and making sure to represent the interests of the Trust's members and of the public in doing so.

2.2.2 To represent the interests of the members of the Trust and the interests of the public.

Chair and Non-Executive Directors

2.2.3 To approve the policies and procedures for the appointment and removal of the Chair and/or Non-Executive Directors in accordance with any guidance issued by NHS England and on the recommendation of the Council's Nominations Committee.

2.2.4 To appoint and remove the Chair and other Non-Executive Directors. The Council should only exercise its power to remove the Chair or any other Non-Executive Directors after exhausting all means of engagement with the Board.

2.2.5 To approve the policies and procedures for the appraisal of the Chair and Non-Executive Directors on the recommendation of the Council's Remuneration Committee. The performance of Non-Executive Directors should be subject to regular appraisal and review. All Non-Executive Directors should be submitted for re-appointment at regular intervals. The Council should ensure planned and progressive refreshing of the Non-Executive Directors.

2.2.6 To decide the remuneration, allowances and other terms of office for the Chair and Non-Executive Directors having regard to the recommendations of the Council's Remuneration Committee. Professional advisers should be consulted to market test the remuneration levels of the Chair and other Non-Executives Directors at least once every three years and when there is a material change to the remuneration of the Chair or another Non-Executive Director.

Chief Executive

2.2.7 To approve the appointment of the Chief Executive of the Trust.

Auditors

2.2.8 To approve the criteria for the appointment, removal and re-appointment of the auditor.

2.2.9 To appoint, remove and reappoint the auditor having regard to the recommendation of the Trust's Audit Committee.

Strategy Planning

2.2.10 To provide feedback to the Board on the development of the strategic direction of the Trust, as appropriate.

2.2.11 To collaborate with the Board in the development of the Trust's forward plan.

2.2.12 Where the forward plan contains a proposal that the Trust will carry out activities other than the provision of goods and services for the purpose of the NHS in England, to determine whether it is satisfied that the carrying out of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and notify its determination to the Board.

2.2.13 Where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purpose of the NHS in England, approve such a proposal.

2.2.14 To approve entering into any significant transactions (as defined under paragraph 49 and Annex 9 of the constitution) in accordance with the 2006 Act and the constitution.

2.2.15 When appropriate, to make recommendations for the revision of the constitution and approve any amendments to the constitution in accordance with the 2006 Act and the constitution.

2.2.16 To receive the Trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council.

Representing Members and the Public

2.2.17 To prepare and from time to time review the Trust's membership engagement strategy and policy.

2.2.18 To notify NHS England, via the Lead Governor, if the Council is concerned that the Trust is at risk of breaching the terms of its licence, and if these concerns cannot be resolved at local level.

2.2.19 To report to the members annually on the performance of the Council.

2.2.20 To promote membership of the Trust and contribute to opportunities to recruit and engage members in accordance with the membership strategy.

2.2.21 To seek the views of stakeholders and feedback to the Board.

2.3 All business shall be conducted in the name of the Trust.

3. THE COUNCIL OF GOVERNORS

3.1 Composition of the Council

The composition of the Council shall be in accordance with paragraph 14 of the constitution.

3.2 Appointment of the Chair

The Chair is appointed by the Council as set out in paragraph 28 of the constitution.

3.3 Terms of Office of the Chair

The provisions governing the period of tenure of office of the Chair are set out in Board of Directors SO 2.8.

3.4 Role of the Chair

3.4.1 The Chair is not a member of the Council. However, under the regulatory framework, they preside at meetings of the Council and holds a second or casting vote.

3.4.2 Where the Chair has died or has ceased to hold office, or where they are unable to perform their duties as Chair owing to illness or any other cause, and there will be an absence of a Chair for less than 3 months the Vice-Chair of the Board shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these SOs shall, so long as there is no Chair able to perform their duties, be taken to include references to the Vice-Chair.

3.4.3 Where an absence of the Chair has or will exceed a period of 3 months the Council at a general meeting shall appoint one of the Non-Executive Directors as the acting Chair. Before a resolution for such an appointment is passed, the Board shall be entitled to advise the Council of the Non-Executive Director (who may be the Vice-Chair) who is recommended by the Board of Directors for that appointment. This recommendation will not, however, be binding upon the Council of Governors; it will be presented to the Council of Governors at its meeting before it comes to its decision. The Vice Chair shall act as Chair until an appointment of an acting Chair is made by the Council.

3.5 Role of the Lead Governor

3.5.1 The Lead Governor shall be appointed by the Council.

3.5.2 The Lead Governor will facilitate communication between NHS England and the Council where Governors have concerns about the leadership provided to the Trust by the Board or in circumstances where it would be inappropriate for the Chair to contact NHS England, or vice versa (for example, regarding concerns about the appointment or removal of the Chair).

3.5.3 Having a Lead Governor does not prevent any other Governor from making contact with NHS England directly if they feel this is necessary. However, any Governor should consider contacting the Lead Governor prior to contact with NHS England. For the avoidance of doubt, a person holding the role of Lead Governor shall not assume greater power or responsibility than other Governors. Where the Trust chooses to broaden the Lead Governor's role, the Chair and the Council should agree what powers should be included.

3.6 Termination of Office and Removal of Governors

Paragraphs 16, 17 and Annex 6 paragraph 5 of the constitution sets out the period of tenure of office of Governors and provisions relating to the termination or suspension of office of Governors.

3.7 Vacancies amongst Governors

3.7.1 Where a vacancy arises amongst the appointed Governors, the Trust Secretary shall request that the appointing organisation appoints a replacement.

3.7.2 Where a vacancy arises amongst the elected Governors within the first 24-months of their term of office, the Trust Secretary shall offer the next highest polling candidate in the election for that post the opportunity to assume the vacant office for the unexpired balance of the retiring member's term of office. If that candidate does not wish to fill the vacancy, it will then be offered to the next highest polling candidate and so on until the vacancy is filled.

3.7.3 Where the vacancy cannot be filled, consideration will be given for holding a by-election, based on cost of the election and the proximity of any by-election to other elections to the Council of Governors.

3.8 Appointment and Powers of Vice-Chair

3.8.1 The Council at a general meeting shall appoint one of the Non-Executive Directors as a Vice-Chair in accordance with paragraph 30.1 of the constitution and, in similar manner, shall remove any person so appointed from that position and appoint another Non-Executive Director in their place.

3.8.2 In line with paragraph 30.2 of the constitution, before a resolution for any such appointment is passed, the Board may decide which of the Non-Executive Directors it recommends for that appointment; the Chair shall advise the Council of the recommendation from the Board which will not be binding upon the Council but will be presented to the Council at its meeting before it comes to a decision.

3.8.3 Subject to SO 3.4.2 and SO 3.4.4 in the absence of the Chair, the Vice-Chair shall be the acting Chair of the Trust.

3.8.4 Any Non-Executive Director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Council may then appoint another Vice-Chair in accordance with paragraph 30.1 of the constitution and SO 3.8.

4. MEETINGS OF THE COUNCIL

4.1 Subject to SOs 4.2.1 and 4.2.2 below and any other provisions of these SOs, the Council may only exercise any powers and make decisions when in formal session. The Council may be advised by committees appointed by the Council but may not devolve any decision making powers to these committees, which, for the avoidance of doubt, shall operate as working groups of the Council.

4.2 Admission of the Public and the Press

4.2.1 The meetings of the Council shall be open to members of the public and the press.

4.1.1 Members of the public and the press may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Council will resolve that:

"In accordance with paragraph 34.1 of the constitution and paragraph 13(2) of Schedule 7 of the 2006 Act, the Council of Governors resolves that there are special reasons to exclude members of the public from Part 2 of this meeting having regard to commercial sensitivity and/or confidentiality and/or personal information and/or legal professional privilege in relation to the business to be discussed."

4.1.2 The Chair may exclude any person from a meeting of the Council if that person is interfering with or preventing the proper conduct of the meeting.

4.1.3 Nothing in these SOs shall require the Council to allow members of the public to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council.

4.1.4 Matters discussed at a meeting following the exclusion of the public and representatives of the media shall be confidential to the Council and shall not be disclosed by any person attending the meeting without the consent of the Chair of the meeting.

4.1.5 All decisions taken in good faith at a meeting of the Council or of any committee shall be valid even if there is any vacancy in its membership or it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

4.3 Calling Meetings

4.1.6 Ordinary meetings of the Council shall be held at such times and places or via digital platforms as the Council may determine.

4.1.7 There shall be not less than four meetings in any year except in exceptional circumstances.

4.1.8 Meetings of the Council may be called by the Trust Secretary, or by the Chair. Not less than one-third of the Governors in office can requisition the Trust Secretary to call a meeting at any time by giving written notice to the Trust Secretary stating the business to be considered at the meeting.

4.4 Notice of Ordinary Meetings

4.1.9 The Trust Secretary shall give to all Governors at least 10 (ten) working days written notice of the date and place of every ordinary meeting of the Council.

4.1.10 Agendas will be sent to Governors not later than three (3) working days before the meeting and supporting papers, whenever possible, shall accompany the

agenda, save in the case of the need to conduct urgent business under a meeting called under paragraph 4.5.1.

4.1.11 A notice or other document(s) to be served upon a Governor under these SOs shall be delivered by hand or sent by post to the Governor at the place of residence which he shall have last notified to the Trust, or where sent by email, to the address which he shall have last notified to the Trust as the address to which a notice or other document may be sent by electronic means.

4.1.12 A notice or other document(s) where delivered by hand or sent by post shall be presumed to have been served on the next working day following the day it was sent and where it was sent by email at the time at which the email is sent.

4.1.13 Failure to serve notice and supporting papers on any Governor shall not affect the validity of an ordinary meeting.

4.4.6 Save in the case of urgent meetings, for each meeting of the Council a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's office and on the Trust's internet site for general access at least three working days before the meeting.

4.5 Notice of Urgent/Extraordinary Meetings

4.1.14 At the request of the Chair or not less than one-third of Governors, the Trust Secretary shall send written notice of a meeting to all Governors as soon as possible after receipt of such a request. The Trust Secretary shall give Governors as much notice of the meeting as is practicable in light of the urgency of the request.

4.1.15 If the Trust Secretary does not call a meeting of the Council of Governors within ten (10) working days of receiving a requisition from Governors pursuant to SO 4.3.3, the Governors who made the requisition may convene the meeting themselves by giving written notice to all Governors; this notice must be signed by all of the Governors who signed the requisition. A meeting called under this SO may only consider the business set out in the requisition.

4.1.16 In the case of a meeting called under SO 4.4.2, 4.4.3 or 4.5.1, the notice shall be signed by the Chair or by at least one-third of Governors in office.

4.1.17 No business at a meeting called under SO 4.4.2, 4.4.3 or 4.5.1 shall be transacted at that meeting other than that specified in the notice. Agendas will be sent to Council members three (3) working days before the meeting and supporting papers, shall accompany the agenda, save in the case of urgent meetings.

4.1.18 In the case of a meeting called under SOs 4.4.2, 4.4.3 and 4.5.1 failure to serve such a notice on more than three (3) Governors will invalidate the meeting.

4.6 Setting the Agenda

4.1.19 The Council may determine that certain matters shall appear on every agenda for an ordinary meeting and shall be addressed prior to any other business being conducted.

4.1.20 A Governor desiring a matter to be included on an agenda shall make his request in writing to the Chair at least seven (7) working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 (ten) working days before a meeting may be included on the agenda at the discretion of the Chair.

4.7 Motions

4.1.21 **Notices of motion:** A Governor desiring to move or amend a motion shall send a written notice thereof at least seven (7) working days before the meeting to the Chair who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This SO shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

4.1.22 **Withdrawal of motion or amendment:** A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.1.23 **Motion to Rescind a Resolution:** Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governor who gives it and also the signature of four other Governors. Such notice shall be sent to the Chair at least 10 (ten) working days before the meeting, who shall insert it in the agenda for the meeting. When any such motion has been disposed of by the Council, no Governor may propose a motion to the same effect within six months. However, the Chair may do so if they consider it appropriate.

4.1.24 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.1.25 When a motion is under discussion or immediately prior to discussion, it shall be open to a Governor to move one of the following motions:

(a) an amendment to the motion
(b) the adjournment of the discussion or the meeting
(c) that the meeting proceed to the next business*
(d) the appointment of an ad hoc committee to deal with a specific item of business; or
(e) that the motion be now put*

provided that in the case of sub-paragraphs denoted by * above and to ensure objectivity, motions may only be put by a Governor who has not previously taken part in the debate.

4.1.26 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

4.8 Petitions

Where a petition has been received by the Trust not less than 10 (ten) working days before a meeting of the Council, the Chair of the Council shall include the petition as an item for the agenda of the next meeting of the Council.

4.9 Chair of Meeting

4.1.27 At any meeting of the Council the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair or another Non-Executive Director, if there is one present, shall preside.

4.1.28 If the Chair, Vice-Chair and all Non-Executive Directors are absent, the Lead Governor, if present, shall preside. If the Lead Governor is not present, such Governor to be appointed from amongst the Council present shall preside.

4.10 Chair's Ruling

Statements of Governors made at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

4.11 Record of Attendance

4.1.29 The names of the Chair and Governors present at a meeting shall be recorded in the minutes. Board Directors who attend a meeting will be recorded in the minutes as 'in attendance'.

4.1.30 Governors who are unable to attend a Council meeting should advise the Trust Secretary in advance of the meeting so that their apologies may be submitted.

4.1.31 A meeting of the Council refers to officers being physically present or officers being present via the use of technology, as defined in SO 4.12.6.

4.12 Quorum

4.1.32 The quorum for every meeting of the Council shall be one-third of the total number of Governors in office on the date of the meeting, a majority of whom must be Public Governors.

4.1.33 If at the time of the meeting no quorum is present:

(a) The Chair shall announce a 30 minute delay
(b) If after the delay a quorum is present, the meeting shall proceed
(c) If a quorum is not present after the delay, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such a time and place as the Chair shall determine and a notice of the adjourned meeting shall be circulated to Council members. When the meeting reconvenes, if a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of Governors present during the meeting is to be a quorum

4.1.34 Where during a meeting of Council a quorum is no longer present:

(a) The Chair shall announce a five (5) minute delay
(b) If after the delay there remains no quorum, the Council meeting shall be adjourned

4.1.35 Where the Council is adjourned under SO 4.12.3(b), the Trust Secretary shall list the uncompleted business from the meeting as the first items for consideration at the next following meeting of Council.

4.1.36 If a Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest, they shall no longer count towards the quorum. If a

quorum is then not available for the discussion and/or passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.1.37 Governors may participate (and vote) in its meetings by telephone, teleconference, video or computer link in accordance with SO 4.19 below. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

4.13 Voting and Decisions

4.1.38 At the end of a discussion on business not subject to a decision, the Chair may summarise the view of the Council for recording in the minutes.

4.1.39 On any matter requiring a decision, Council shall determine its position by voting.

4.1.40 Subject to statutory or constitutional requirements, a decision of the Council is reached by a majority of Governors present and voting. Votes in abstention shall not be counted in determining a majority. In the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote. No resolution can be passed if it is opposed by all of the Public Governors present and voting.

4.1.41 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

4.1.42 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands.

4.1.43 On the request of the one-third of the Governors present, a recorded vote shall be taken:

(a) The Trust Secretary will call the names of all Governors
(b) Each Governor shall declare their vote as 'In Favour', 'Against' or 'Abstain'
(c) The vote of each Governor shall be recorded in the minutes accordingly

4.1.44 On the request of the majority of Governors present at the meeting, a vote may be taken by secret ballot:

(a) Each Governor shall be issued with a ballot paper allowing a vote of 'In Favour', 'Against' or 'Abstain'
(b) Each Governor shall have the opportunity to vote in secret
(c) The Trust Secretary shall count the ballots, and record the number of votes cast for each option on the minutes
(d) Governors may not record their vote in the minutes if a secret ballot is taken.

4.14 Voting by Paper Ballot

4.1.45 If the Chair of the Trust calls an extraordinary meeting of the Council under SOs 4.4.2, 4.4.3 and 4.5.1 they may, subject to SO 4.14.2 below, determine that any Governor may cast their vote on the matter(s) to be dealt with at the meeting by paper ballot in accordance with the process set out at SOs 4.14.3 - 4.14.5 (inclusive) below.

4.1.46 The Chair may only determine that Governors may cast their vote by paper ballot on any matter where this is compatible with the 2006 Act.

4.1.47 Where the Chair makes a determination pursuant to SO 4.14.1 in respect of any extraordinary meeting of the Council, the Trust Secretary shall circulate a ballot paper to all of the Governors together with the papers for the meeting.

4.1.48 Any Governor may cast their vote at the meeting or by:

(a) marking the ballot paper, in accordance with the instructions on the ballot paper, to show how he wishes to vote
(b) subject to SO 4.14.6, signing the ballot paper
(c) returning the ballot paper to the Trust Secretary so that it arrives before the date and time stipulated on the ballot paper.

4.1.49 Governors must return the ballot paper by hand, by email or by post. Any ballot paper received on or after the date and time stipulated shall be rejected.

4.1.50 If a Governor returns a ballot paper to the Trust Secretary by email, the ballot paper does not have to be signed by the relevant Governor provided that it is returned from an email address that the Governor has previously notified to the Trust Secretary.

4.1.51 Any votes duly cast by paper ballot shall be added to the votes cast by Governors voting in person at the meeting. Unless otherwise provided by the Trust's constitution or by law, every matter shall be determined by a majority of votes cast and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote. No resolution can be passed if it is opposed by all of the Public Governors voting, whether at the meeting or by paper ballot.

4.1.52 The Trust Secretary shall ensure that the Trust keeps a record, in writing, of all ballot papers for at least twelve (12) months from the date of the meeting in respect of which the votes were cast. The votes (whether in person or by ballot) shall recorded in the minutes in accordance with SO 4.13.

4.15 Prevention of Disorder at a Meeting

If there is disorder in the public gallery (including members of the public attending in a virtual capacity) at a meeting of the Council:

4.1.53 The Chair may direct those causing the disorder to leave the meeting, and they shall thereupon leave and not return to the meeting.

4.1.54 The Chair may suspend the meeting to a stated time (not longer than 30 minutes from the time of the suspension) to allow order to be restored

.

4.1.55 If those causing disorder refuse to comply with the Chair's direction, the Chair may move *that the public gallery be cleared to allow the Council to proceed in proper order.*

4.1.56 A motion under SO 4.15.3 shall be voted on immediately and without debate.

4.1.57 If Council agrees to a motion under SO 4.15.3, the Chair shall suspend proceedings until the public gallery is cleared; the gallery shall remain

cleared for the remainder of the meeting, unless the Council shall otherwise decide.

4.16 Written Resolution Process

4.1.58 Subject to SO 4.16.2, the Council may use the process for adopting a written resolution set out in this SO 4.16 to enable it to transact business between meetings of the Council. The process for adopting a written resolution shall not be used to replace meetings of the Council.

4.1.59 The Council may only use a written resolution for transacting business where this is compatible with the 2006 Act.

Proposing written resolutions

4.1.60 At the Chair's request, the Trust Secretary shall propose a written resolution to the Governors**.**

4.1.61 A written resolution is proposed by giving notice of the proposed resolution to the Governors. Such notice shall stipulate:

(a) the proposed resolution; and
(b) the long-stop date by which the written resolution is to be adopted, which shall be not less than ten (10) days from the date the written resolution is dispatched by the Trust Secretary
(c) Notice of a proposed written resolution must be given in writing to each Governor. Notice by email or post is permitted.

Adopting written resolutions

4.1.62 Unless otherwise provided by the Trust's constitution or by law and subject to SO 4.16.7 below, a proposed written resolution shall be adopted when it has been signed and returned to the Trust Secretary by hand, by email or by post by a majority of the Governors.

4.1.63 If a Governor returns a written resolution to the Trust Secretary by email, the written resolution does not have to be signed by the relevant Governor provided that it is returned from an email address that the Governor has previously notified to the Trust Secretary.

4.1.64 For the avoidance of doubt, the proposed written resolution shall lapse if it has not been returned by the requisite number of Governors pursuant to SO 4.16.6 above, by the longstop date.

4.1.65 Once a written resolution has been adopted, it shall be treated as if it had been a decision taken at a Council of Governors' meeting in accordance with these SOs.

4.1.66 The Trust Secretary shall ensure that the Trust keeps a record, in writing, of all written resolutions for at least six (6) years from the date of their adoption.

4.17 Meetings: Electronic Communication

4.1.67 In this SO, 'communication' and 'electronic communication' shall have the meanings as set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

4.1.68 A Governor in electronic communication with the Chair and all other parties to a meeting of the Council or of a committee of the Council shall be regarded for all purposes as being present and personally attending such a

meeting provided that, and only for so long as, at such a meeting they have the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

4.1.69 A meeting at which one or more of the Governors attends by way of electronic communication shall be deemed to be held at such place at which the Chair is physically present. If the meeting takes places by way of electronic communication entirely, the meeting shall deemed to have been held via the electronic communication platform and will be recorded in the minutes as such.

4.1.70 Meetings held in accordance with this SO are subject to SO 4.12. For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

4.1.71 The minutes of a meeting held in this way must state that it was held (whether wholly or partly) by electronic communication and that the Governors were all able to hear each other and were present throughout the meeting.

4.18 Minutes

4.1.72 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting where they will be signed by the person presiding at it, including electronically.

4.1.73 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.1.74 Minutes shall be retained in the Trust Secretary's office.

4.1.75 Minutes shall be circulated in accordance with Governors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

4.19 Additional Powers

4.1.76 The Council may require one or more of the Directors to attend a Council meeting to obtain information about the Trust's performance of its functions or the directors' performance of their duties, and to help the Council to decide whether to propose a vote on the Trust's or Directors' performance.

4.1.77 The Trust may choose to involve Governors in hospital/service visits or volunteering. However, Governors acknowledge that they do not have a right to inspect Trust property or services and they are not under a duty to meet patients and conduct quality reviews.

4.1.78 Governors may refer a question concerning whether the Trust has failed, or is failing, to act in accordance with its constitution, or Chapter 5 of the 2006 Act to the Panel for Advising Governors appointed by NHS England under the 2006 Act.

4.20 Variation and Amendment of Standing Orders

4.1.79 Any variation of these SOs shall not constitute a variation of the constitution. These SOs shall be amended only if:

(a) unless proposed by the Chair, a notice of motion under SO 4.7 has been given; and

(b) not fewer than half of the Trust's Governors vote in favour of amendment; and
(c) at least half of the Governors are present at the meeting at which the amendment is considered; and
(d) the variation proposed does not contravene a statutory provision or requirement, condition or notice issued by NHS England; and
(e) the amendment is approved by the Council.

5. ARRANGEMENTS FOR THE EXERCISE OF COUNCIL FUNCTIONS

4.2 The Council may not delegate its functions to any committee of the Council. Subject to the constitution and any requirements of NHS England, the Council may appoint committees to assist the Council in the proper performance of its functions under the constitution and the regulatory framework, consisting wholly of the Chair and members of the Council.

4.3 A committee appointed under this SO 5 may, subject to such requirements, conditions or notices as may be given by NHS England or such directions as may be issued by the Council, appoint sub-committees consisting wholly of members of the committee.

4.4 The SOs of the Council, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council. In which case the term "Chair" is to be read as a reference to the chair of the committee as the context permits, and the terms "member of the Council" or "Governor" is to be read as a reference to a member of the committee also as the context permits.

4.5 There is no requirement to hold meetings of committees established by the Council in public.

4.6 Each such committee shall have such terms of reference and be subject to such conditions (as to reporting back to the Council), as the Council shall decide and shall be in accordance with the regulatory framework and any requirement, condition, notice or guidance issued by NHS England. Such terms of reference shall have effect as if incorporated into the SOs.

4.7 The Council shall approve the terms of reference and appointments to each of the committees which it has formally constituted.

4.8 The committees established by the Council shall be such committees as are required to assist the Council in discharging its responsibilities.

4.9 A Governor and/or a member of a committee of the Council and/ or any non-Governor shall not disclose a matter dealt with by, or brought before, the Council or a committee of the Council without the permission of the Council or such committee (as applicable) until such matter shall have been concluded or in the case of such committee, until the committee shall have reported to the Council.

4.10 A Governor or a non-Governor in attendance at a committee or of a meeting of the Council shall not disclose any matter dealt with by the committee or the Council, notwithstanding that the matter has been reported or concluded, if the Council or committee resolves that it is confidential.

4.11 The Trust Secretary or their deputy or assistant will attend all meetings of the committees in support of them.

4.12 Notwithstanding anything in these SOs, the Chair and Governors may meet informally or as a committee of the Council at any time and from time to time, and shall not be required to admit any member of the public or any representative of the media to any such meeting or to send a copy of the agenda for that meeting or any draft minutes of that meeting to any other person or organisation. For the avoidance of doubt, no business shall be conducted at such meetings.

6. PREVENTION OF CONFLICTS OF INTEREST

6.1 Declaration of Interests

4.12.1 The Trust recognises that, as volunteers, Governors may have private interests that could conflict with those of the Trust. It is the responsibility of Governors to ensure that any potential conflicts of interest are registered and declared at meetings in accordance with this SO and paragraph 22 of the constitution.

4.12.2 The Trust policy for Conflicts of Interest, Gifts and Hospitality (CP80) defines a conflict of interest as "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold".

4.12.3 A conflict of interest may be

- **Actual:** There is a material conflict between one or more interests.
- **Potential:** There is the possibility of a material conflict between one or more interests in the future.

6.1.4 Governors may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see if different and perceived conflicts of interests can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

6.1.5. Interests fall into the following categories:

(a) Financial interests: Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.

(b) Non-financial professional interests: Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

(c) Non-financial personal interests: Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

(d) Indirect interests: Where an individual has a close association[2] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

[1] This may be a financial gain, or avoidance of a loss.

[2] A common sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

4.12.4 Governors must declare interests which are relevant and material to the Council. All existing Governors should declare such interests. Any Governors appointed subsequently should do so on appointment

4.12.5 At the time Governor's interests are declared they should be recorded in the Council register of interests and in the minutes of the relevant meeting at which the declaration is made. Any changes in interests should be declared at the next meeting following the change occurring.

4.12.6 Governors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the annual report. The information should be kept up to date for inclusion in succeeding annual reports.

4.12.7 During the course of a meeting of the Council, if a conflict of interest is established, the Governor concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

4.12.8 There are a number of common situations which can give rise to risk of conflicts of interest, as follows:

- Gifts
- Hospitality
- Outside employment
- Shareholdings and other ownership issues
- Patents
- Loyalty interests
- Donations
- Sponsored events
- Sponsored research
- Sponsored posts
- Clinical private practice

4.12.9 The interests of Governors' spouses or partners if living together, in contracts are to be declared. If Governors have any doubt about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.2 Register of Interests

6.2.1 The Trust Secretary will ensure that a register of interests is established to record formally declarations of interests of Governors. In particular the register will include details of all directorships and other actual and potential interests which have been declared by Governors, as defined in paragraphs 22 of the constitution and SO 6.1.3.

6.2.2 The Trust Secretary shall keep these details up to date by means of an annual review of the register, for which Governors will be required to complete a further declaration via an Annual Declaration of Interest Form. It is the responsibility of each Governor to provide an update to the Trust Secretary of their register entry if their interests change. The form will also

require Governors to provide consent to process and publish this information as per GDPR or equivalent requirements.

6.2.3 The register will be available to the public and the Trust Secretary will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

6.2.4 In establishing, maintaining, updating and publicising the register, the Trust shall comply with all guidance issued from time to time by the NHSE/I.

6.3 Interests of Relatives, Spouses and Partners

6.3.1 A Governor is required to declare, as if it was their own interest, interests owned or otherwise held by:

4.12.9.1 Their spouse or civil partner
4.12.9.2 Any person with whom they have a long-term relationship as a couple on a domestic basis
4.12.9.3 Their children, step-children or other minors living in the same household as them
4.12.9.4 Any parent, grandparent, uncle or aunt living in the same household as them

4.12.10 Where a declaration is made under SO 6.3, the Governor shall declare and the Trust Secretary shall note on the Register:

4.12.10.1 The name of the individual having the interest
4.12.10.2 Their relationship to the Governor making the declaration.

6.4 Interest of Governors in Contracts

4.12.11 If it comes to the knowledge of a Governor that a contract in which they have any pecuniary interest not being a contract to which they are themselves a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Trust Secretary of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

4.12.12 A Governor should also declare to the Trust Secretary any other employment or business or other relationship of theirs, or of a cohabiting spouse, civil partner or person living together with them as partner, that conflicts or might reasonably be predicted could conflict with the interests of the Trust. Interests, employment or relationships declared, are to be entered in a register of Governor's interests.

4.12.13 Further details are included in the Conflict of Interest, Gifts and Hospitality policy & procedure.

7. STANDARDS OF BUSINESS CONDUCT

7.1 Standards of Conduct

4.12.14 The Council shall agree, from time to time, codes of conduct for the proper execution of the office of Governor.

4.12.15 Governors must comply with the Council's *Code of Conduct,* the requirements of the regulatory framework, the constitution and any guidance, requirement condition or notice issued by NHS England.

7.2 Canvassing of, and Recommendations by, Members of the Council of Governors in Relation to Appointments

7.2.1 Except in relation to the appointment of a person as a member of the Trust, a Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this SO shall not preclude a Governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.2.2 This SO does not prevent a Governor from contributing to the appointment of a Non-Executive Director to the Trust or the Chief Executive in accordance with the statutory requirements.

7.2.3 Informal discussions outside appointment panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8. MISCELLANEOUS

8.1 Standing Orders to be given to all Governors

It is the duty of the Trust Secretary to ensure that existing Governors and all new appointees are notified of and understand their responsibilities within these SOs.

8.2 Review of Standing Orders

The SOs shall be reviewed annually by the Council. The requirement for review extends to all documents having the effect as if incorporated in the SO.

8.3 Potential Inconsistency

In the event of any conflict or inconsistency between these SOs and any of the legislation and guidance listed in these SOs, the legislation shall prevail. In the event of any conflict or inconsistency between these SOs and the licence and/or the constitution, the licence and/or the constitution shall prevail.

9. DISPUTE RESOLUTION

8.1 Where there is a dispute between the Council of Governors and the Board of Directors, Governors shall follow the procedure set out in the current *Council of Governors Policy for Engagement with the Board of Directors where there is disagreement and/or concerns regarding performance.*

8.2 Where a dispute arises out of or in connection with the constitution, including the interpretation of these SOs and the procedure to be followed at meetings of the Board, the Trust and the parties to that dispute shall use all reasonable endeavours to resolve the dispute as quickly as possible.

8.3 Where a dispute arises that involves the Chair, the dispute shall be referred to the Senior Independent Director who will use all reasonable efforts to mediate a settlement to the dispute.

8.4 For the avoidance of doubt, the Trust Secretary shall deal with any membership queries and other similar questions in the first place including any voting or legislation issues and shall otherwise follow a process for resolving such matters in accordance with any procedures agreed by the Board.

10. RELATIONSHIP BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

10.1 Governors should discuss and agree with the Board how they will undertake their statutory roles and responsibilities, and any other additional roles, giving due consideration to the circumstances of the Trust and the needs of the local community and emerging good practice.

10.2 Governors should work closely with the Board and must be presented with, for consideration, the annual report and accounts (including any report of the auditor on them) and the annual plan at a general meeting. The Governors must be consulted on the development of forward plans for the Trust and any significant changes to the delivery of the Trust's business plan.

10.3 The annual report should state how performance evaluation of the Board, its committees, and its Directors, including the Chairman is conducted and the reason why the Trust adopted a particular method of performance evaluation.

10.4 The annual report should identify the members of the Council, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the appointed Lead Governor. A record should be kept of the number of meetings of the Council and the attendance of individual Governors and Directors and it should be made available to members on request.

10.5 The Council should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors. The Council will need to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the Trust's Audit Committee, which provides information to the Governors on the external auditor's performance as well as overseeing the Trust's internal financial reporting and internal auditing.

10.6 If the Council does not accept the Audit Committee's recommendations, the Board should include in the annual report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council has taken a different position.

10.7 The annual report should describe the process followed by the Council in relation to appointments of the Chair and Non-Executive Directors.

END

		Agenda Item No: 6d
SUMMARY REPORT	**COUNCIL OF GOVERNORS PART 1**	**24 August 2023**

Report Title:	**Council of Governors Policy & Procedure for Engagement with the Board of Directors**					
Report Lead:	Chris Jennings, Assistant Trust Secretary					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides the Council of Governors Policy & Procedure for Engagement with the Board of Directors.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Council of Governors is asked to:

1 Note the contents of this report.
2 Approve the reviewed Policy & Procedure.

Summary of Key Issues

The Council of Governors Policy and Procedure for Engagement with the Board of Directors provides the mechanisms in place for the Council to routinely engage with the Board of Directors and the action to be taken should here be a dispute. The policy and procedure are subject to three-yearly review.

The Assistant Trust Secretary has completed a review of the Policy and Procedure with minor amendments made in relation to language and references to the new Code of Governance for NHS Providers. The Council of Governors Governance Committee considered the policy and procedure and agreed to recommend it for approval by the Council of Governors.

The Council of Governors is asked to approve the policy and procedure.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered	
1: We care	
2: We learn	
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	

Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Impact on Statutory Duties and Responsibilities of Council of Governors	
Holding the NEDs to account for the performance of the Trust	✓
Representing the interests of Members and of the public	✓
Appointing and, if appropriate, removing the Chair	
Appointing and, if appropriate, removing the other NEDs	
Deciding the remuneration and allowances and other terms of conditions of office of the Chair and the other NEDs	
Approving (or not) any new appointment of a CEO	
Appointing and, if appropriate, removing the Trust's auditor	
Receiving Trust's annual accounts, any report of the auditor on them, and annual report	
Approving "significant transactions"	
Approving applications by the Trust to enter into a merger, acquisition, separation, dissolution	
Deciding whether the Trust's non-NHS work would significantly interfere with its principal purpose or performing its other functions	
Approving amendments to the Trust's Constitution	
Another non-statutory responsibility of the Council of Governors (please detail):	

Acronyms/Terms Used in the Report			
CoG	Council of Governors		

Supporting Documents and/or Further Reading
Council of Governors Policy for Engagement with the Board of Directors Council of Governors Procedure for Engagement with the Board of Directors

Lead
Chris Jennings **Assistant Trust Secretary**

THE COUNCIL OF GOVERNORS POLICY FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

POLICY REFERENCE NUMBER:	CP56
VERSION NUMBER:	002
KEY CHANGES FROM PREVIOUS VERSION	n/a
AUTHOR:	Trust Secretary's Office
CONSULTATION GROUPS:	Council of Governors Governance Committee, Council of Governors, Board of Directors
IMPLEMENTATION DATE:	September 2020
AMENDMENT DATE(S):	n/a
LAST REVIEW DATE:	September 2023
NEXT REVIEW DATE:	September 2026
APPROVAL BY COUNCIL OF GOVERNORS	24 August 2023
APPROVAL BY BOARD OF DIRECTORS	27 September 2023
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POLICY SUMMARY
This Policy and associated Procedure outlines the mechanisms by which Governors and Directors will interact and communicate with each other to support their role in holding the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and describes the methods by which Governors may engage with the Board when they have concerns about the performance of the Board of Directors, compliance with the Trust's provider licence, or the welfare of the Trust.
The Trust monitors the implementation of and compliance with this Policy in the following ways:
This Policy will be subject to a three year review and implementation will be monitored by the Trust Secretary's Officer.

Services	**Applicable**	**Comments**
Trustwide	✓	

The Director responsible for monitoring and reviewing this Policy is the Senior Director of Governance

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS POLICY FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS POLICY & PROCEDURE FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

Assurance Statement

The purpose of this Policy and associated Procedure is to ensure a process is in place for engagement between the Council of Governors and the Board of Directors as well as when the Council of Governors need to engage with the Board of Directors for those circumstances when they have concerns about the performance of the Board of Directors, compliance with the Trust's provider licence or the welfare of the Trust in line with the requirement Appendix B, 2.6 of the *Code of Governance for NHS Providers (April 2023)*

1.0 INTRODUCTION

1.1. This Policy has been developed by the Council of Governors to take account of the recommendations in Appendix B, 2.6 of the *Code of Governance for NHS Providers (April 2023)*to address engagement between the Council of Governors (Council) and the Board of Directors (Board)

1.2. The principles in this Policy may also be applied to engagement between the Council and committees and working groups of the Council and the Board

1.3. The Council of Governors (Council) is responsible for representing the interests of Trust members as a whole and the interests of the public

1.4. The Council is required to hold the Non-Executive Directors (NEDs) individually and collectively to account for the performance of the Board. This includes ensuring the Board does not act in a way which results in the Trust breaching the terms of its provider licence

1.5. Governors are required to act in the best interests of the Trust and should adhere to its values and the Code of Conduct for the Council of Governors

1.6. Governors are required to discuss and agree with the Board how they will undertake these duties and any other additional roles, giving due consideration to the circumstances of the Trust, the needs of the local community and emerging best practice. It is envisaged that the process used to exercise their responsibility will be one of mutual agreement between the Council and the Board

1.7. This Policy and associated Procedure outlines the mechanisms by which the Council and the Board will interact and communicate with each other to support ongoing interaction and engagement, ensure compliance with the regulatory framework and specifically provide for those circumstances where the Council has concerns about:

1.7.1. the performance of the Board of Directors
1.7.2. compliance with the Trust's provider licence

1.7.3. other matters related to the overall wellbeing of the Trust

1.8. The resolution of disputes between the Council and the Board is also covered in SO 9 of the Council's Standing Orders and SO 14.4 of the Board's Standing Orders

1.9. The relationship between the Council and the Board is also covered under SO 10 of the Council's Standing Orders and SO 15 of the Board's Standing Orders.

1.10. All new and / or revised Council of Governor procedures will include a section detailing action to be taken where the Council disagrees with a recommendation made by the Board in any decisions requiring Council approval.

2.0 DEFINITIONS

In this Policy the following definitions apply:

2.1 **Board of Directors (Board):** means the Board of Directors as constituted in accordance with the Trust's Constitution

2.2 **Chair:** means the person appointed in accordance with the Constitution to that position. The expression 'Chair' shall be deemed to include the Vice-Chair / Acting Chair if the Chair is absent from a meeting or otherwise unavailable

2.3 **Chief Executive (CEO):** means the CEO appointed in accordance with the Constitution

2.4 **Constitution:** means the Constitution of the Trust

2.5 **Council of Governors (Council):** means the Council of Governors as constituted in accordance with the Constitution

2.6 **Director:** means a person appointed as a Director (whether an Executive Director or a Non-Executive Director) in accordance with the Constitution

2.7 **Governor:** means a member of the Council of Governors

2.8 **Independent Regulator:** is the regulator of Foundation Trusts as NHS England, following its incorporation of NHS Improvement.

2.9 **Lead Governor:** is the Governor appointed by the Council of Governors in accordance with the Constitution

2.10 **Provider Licence:** means the Trust's provider licence granted by the Independent Regulator under section 87 of the NHS Act 2006

2.11 **Regulatory Framework:** means the NHS Act 2006, Health & Social Care Act 2012, the Trust's Provider Licence, and any directions or guidance issued by the independent regulator (NHS Improvement)

2.12 **Standing Orders:** means the Standing Orders of either the Council of Governors or Board of Directors

2.13 **Trust:** means Essex Partnership University NHS Foundation Trust

2.14 **Trust Secretary:** means the secretary/company secretary of the Trust or any other person or body corporate appointed to perform the duties of the secretary of the Trust, including a joint/assistant or deputy secretary

3.0 KEY PRINCIPLES

3.1 Informal, formal and frequent communication between the Council and the Board are an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides

3.2 Directors and Governors are expected to act in such a manner as to comply with this Policy

3.3 Chair:

3.3.1 The Chair acts as the principal link between the Council and the Board and has the main role in dealing with issues raised by Governors, involving the Chief Executive and/or other Executive or Non-Executive Directors as necessary

3.3.2 The Chair ensures that the Board and Council work together effectively and enjoy constructive working relationships (including the resolution of any disagreements)

3.3.3 The Chair ensures good information flow from and between the Board, committees, Council and members

3.3.4 The Chair ensures that the Council and Board receive accurate, timely and clear information that is appropriate for their respective duties

3.3.5 The Chair constructs the agendas for both the Board and Council (with the input of others as appropriate)

3.3.6 The Chair has the most formal contact with Governors and should supplement this with informal contact where possible

3.3.7 The Chair shall:

(a) Operate an open door Policy

(b) Support informal meetings outside of formal Council meetings with the CEO and/or any Director (via the Trust Secretary Office) to answer questions or confirm decisions taken by the Board (where appropriate)

(c) Encourage the participation of Directors in induction and training of Governors

3.4 Chief Executive:

3.4.1 The CEO ensures the provision of information and support to the Board and Council and ensures that Board decisions are implemented

3.4.2 The CEO facilitates and supports effective joint working between the Board and Council

3.4.3 The CEO supports the Chair in his/her task of facilitating effective contributions and sustaining constructive relations between Executive and Non-Executive Directors, elected and appointed members of the Council, and between the Board and Council

3.4.4 The CEO with the Chair ensures that the Council and Board receive accurate, timely and clear information that is appropriate for their respective duties

3.4.5 The CEO with the Chair constructs the agendas for both the Board and Council (with the input of others as appropriate)

3.5 Senior Independent Director (SID)

3.5.1 The SID acts as an alternative source of advice to Governors

3.5.2 The SID is available to Governors and members if they have concerns which contact through the normal channels of Chair, CEO and Executive Chief Finance officer has failed to resolve or for which such contact is appropriate

3.6 Lead Governor and Governors

3.6.1 Individual Governors have a responsibility to raise concerns (as defined in this Policy) and to assure themselves that issues have been resolved

3.6.2 The Lead Governor shall make themselves available to provide informal advice to any Governor who may seek it in advance of a concern being raised

3.6.3 The Lead Governor will be the conduit for direct communication between NHS England and the Council. This would be in exceptional circumstances where every attempt has been made to resolve any concerns locally either through the Chair or any other Board member

3.6.4 The Council as a body has a duty to inform NHS England if the Trust is at risk of breaching the terms of its provider licence.

3.7 Directors

Directors shall cooperate with any requests from the Chair (via the Trust Secretary Office) to attend informal meetings outside of formal Council meetings to answer questions from Governors and confirm decisions taken by the Board (where appropriate)

3.8 Trust Secretary

3.8.1 The Trust Secretary will be the first point of contact for any Governor or group of Governors who wish to raise a concern covered by this Policy

3.8.2 The Trust Secretary will, where possible, resolve the matter informally and/or advise as to whether it is appropriate to take the concerns to the Chair

3.8.3 The Trust Secretary will arrange informal meetings between Governors and Directors outside of formal Council meetings to answer questions and confirm decisions taken by the Board (where appropriate) where requested by the Chair.

4.0 SCOPE

4.1 This Policy applies to the Council of Governors and Board of Directors.

5.0 MONITORING AND REVIEW

5.1 The Senior Director of Governance has the overarching responsibility for this Policy

5.2 The Trust Secretary is responsible for ensuring the Policy follows the appropriate Trust format and complies with the recognised development, consultation, approval and ratification process

5.3 This Policy will be kept under review and revised in accordance with any regulatory and/or statutory changes and emerging best practice and guidance

5.4 Awareness of this Policy will be raised at Governor and Board induction

5.5 In addition to the monitoring arrangements described above, the Trust may undertake additional monitoring of this Policy and procedure in response to the identification of any gaps or as a result of the identification of risks arising from the Policy prompted by incident review, external reviews or other sources of information and advice including but not limited to commissioned audits and reviews, detailed data analysis, etc.

5.6 This Policy will be reviewed at least every three years; changes to legislation, guidance or the outcomes of any investigations or reviews may result in the Policy being reviewed earlier.

6.0 POLICY REFERENCES/ASSOCIATED DOCUMENTATION

- Code of Governance for NHS Providers (April 2023)
- Trust Constitution including Board of Directors and Council of Governors Standing Orders
- Code of Conduct for the Council of Governors
- Lead Governor Role Description
- NHS Providers *Foundations of good governance: a compendium of best practice* (3rd edition)
- (Monitor) NHSE/I *Your statutory duties: a reference guide for NHS FT governors*

END

THE COUNCIL OF GOVERNORS PROCEDURE FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

PROCEDURE REFERENCE NUMBER:	CPG56
VERSION NUMBER:	002
KEY CHANGES FROM PREVIOUS VERSION	n/a
AUTHOR:	Trust Secretary's Office
CONSULTATION GROUPS:	Council of Governors Governance Committee, Council of Governors, Board of Directors
IMPLEMENTATION DATE:	September 2020
AMENDMENT DATE(S):	n/a
LAST REVIEW DATE:	September 2023
NEXT REVIEW DATE:	September 2026
APPROVAL BY COUNCIL OF GOVERNORS	24 August 2023
APPROVAL BY BOARD OF DIRECTORS	27 September 2023
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PROCEDURE SUMMARY
This Procedure and associated Policy outlines the mechanisms by which Governors and Directors will interact and communicate with each other to support their role in holding the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and describes the methods by which Governors may engage with the Board when they have concerns about the performance of the Board of Directors, compliance with the Trust's provider licence, or the welfare of the Trust.
The Trust monitors the implementation of and compliance with this Policy in the following ways:
This Procedure will be subject to a three year review and implementation will be monitored by the Trust Secretary.

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this Procedure is the Senior Director of Governance

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS PROCEDURE FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

CONTENTS

THIS IS AN INTERACTIVE CONTENTS PAGE, BY CLICKING ON THE TITLES BELOW YOU WILL BE TAKEN TO THE SECTION THAT YOU WANT.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS PROCEDURE FOR ENGAGEMENT WITH THE BOARD OF DIRECTORS

Assurance Statement

The purpose of this Procedure is to ensure a process is in place for engagement between the Council of Governors and the Board of Directors as well as when the Council of Governors need to engage with the Board of Directors for those circumstances when they have concerns about the performance of the Board of Directors, compliance with the Trust's provider licence or the welfare of the Trust in line with the requirement Appendix B, 2.6 of the *Code of Governance for NHS Providers (April 2023)*

1.0 INTRODUCTION

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1.2. This Procedure outlines the mechanisms by which the Council and the Board will interact and communicate with each other to support ongoing interaction and engagement, ensure compliance with the regulatory framework and specifically provide for those circumstances where the Council has concerns about:

1.2.1. the performance of the Board of Directors
1.2.2. compliance with the Trust's provider licence
1.2.3. other matters related to the overall wellbeing of the Trust

1.3. The resolution of disputes between the Council and the Board is also covered in SO 9 of the Council's Standing Orders and SO 14.4 of the Board's Standing Orders

1.4. The relationship between the Council and the Board is also covered under SO 10 of the Council's Standing Orders and SO 15 of the Board's Standing Orders.

2 SCOPE

2.1 Informal, formal and frequent communication between the Council and the Board are an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides

2.2 Directors and Governors are expected to act in such a manner as to comply with this Procedure

3.0 ENGAGEMENT

3.1 A duty of the Council is to hold the NEDs individually and collectively to account for the performance of the Board

3.2 Governors and Board Directors should have the opportunity to meet at regular intervals with Governors feeling comfortable in asking questions regarding the management of the Trust and Directors should keep Governors appropriately

informed, particularly about key Board decisions and how they affect the Trust and the wider community

3.3 The relationship between the Council and Board is critical and should be based on the Trust's values (We Care, We Learn, We Empower) as well as respect, candour and trust. There are a number of ways an open and constructive relationship can be achieved between the two; these are not limited to the examples below:

- Receiving the agenda and minutes of Board meetings and requesting any specific papers.
- Minutes of Part 1 Board of Director meetings and a summary of discussions for Part 2 Board of Director meetings.
- Governors are invited to attend Board meetings and have the opportunity to ask questions of the Board on the agenda items
- Receiving quarterly finance, quality and performance update reports at Council meetings and asking questions on and/or challenging their content
- The attendance of the CEO, other Executive and Non-Executive Directors at Council meetings and using these opportunities to ask them questions as required.
- Confidential briefing session by the CEO prior to the quarterly Council meeting with opportunity to ask questions
- Attending Annual Members Meeting
- NEDs/Governors informal meetings and local constituency meetings.
- Involvement of Governors at Quality visits with Executive and Non-Executive Directors
- Establishment of joint working groups, e.g. Membership Framework Task & Finish Group; Appointment of Auditors Working Group
- Briefing session by the ECFO on the annual accounts
- Receiving the annual report and accounts and asking questions on their content
- Receiving performance appraisal information for the Chair and other NEDs (through the Council's Remuneration Committee)
- Receiving information/being kept up to date on issues or concerns likely to generate adverse media (or in response to media coverage) and providing Governors with the opportunity to raise questions or seek information or assurances
- Receiving information on proposed significant transactions, mergers, acquisitions, separations or dissolutions, and questioning Directors on these (in the first instance through the Governors Significant Transactions Group)
- Receiving relevant development sessions/workshops/briefings by Board Directors as appropriate ensuring that Governors are equipped with the skills and knowledge they require to fulfil their role
- Involvement of Governors in the Trust's strategy and planning process through attendance at the Trust's stakeholder planning event and also through a meeting of the Governors Strategic Planning Working Group
- Chair's report on the activities of the NEDs at each Council meeting
- Reports from the chairs of Board standing committees highlighting the work and key issues reviewed by the committee on an annual rolling basis
- Views of Governors on the performance of the Chair are fed through the Senior Independent Director
- Your Voice meetings for members and the public in each of the Trust's constituencies.

4.0 RAISING CONCERNS

4.1 Governors should raise concerns through existing channels as outlined in section 3,0 of this procedure. Any concerns raised will be recorded and monitored via the relevant committee (when raised formally) or via a Governor Requested Action Log (when raised informally).

4.2 Governor(s) should not raise concerns that are not supported by evidence. In raising their concerns, Governors will need to demonstrate the following:

4.2.1 any written statement must be from an identifiable person(s) who must sign the statement and indicate that they are willing to be interviewed about its content

4.2.2 other documentation must originate from a bona fide organisation and the source must be clearly identifiable.

Newspaper or other media articles will not be accepted as prima facie evidence but may be accepted as supporting evidence.

4.3. The CEO as the Accounting Officer will routinely present reports on performance, finance and compliance at Board and Council public meetings. Any Governor or member of the public in attendance may also raise any concerns relating to the performance, finance and/or compliance through the Chair at these meetings at the time, so that issues can be addressed without delay

4.4 If the above does not address the concerns of the Governor(s), para 19.3 of the Trust's Constitution may be invoked. The clause states that the Council may require one or more of the Directors to attend a meeting of the Council for the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties.

4.5 While recognising the key role of the Chair in providing the link between the Council and the Board, if concerns are identified and persist, any Governor(s) who have concerns covered by this Policy should:

4.5.1 in the first instance, consult the Trust Secretary for advice and guidance and who will seek to resolve the matter informally. The Trust Secretary will advise the Governor(s) on the issues raised and whether it is appropriate to take their concerns to the Chair

4.5.2 the advice of the Trust Secretary, however, is not binding upon the Governor(s) concerned who retain at all times the right to raise the matter with the Chair directly

4,5.3 if the above steps fail to resolve the matter or contacting the Trust Secretary or Chair (in the case of his/her own performance) was felt inappropriate, the Governor(s) should contact the SID to address the concerns

4.6 The Chair will investigate all concerns brought to them by Governors involving the Chief Executive and/or other Board members. The investigation will include a review of the evidence offered and discussions with Trust officers as appropriate.

4.7 As soon as practicable after the conclusion of the investigation, the Chair and Trust Secretary (or SID) will meet with the Governor(s) to discuss the findings. This meeting has three possible outcomes:

4.7.1 Governor(s) are satisfied their concerns were unjustified and withdraw them unreservedly; in this case no further action is required

4.7.2 Governor(s) are satisfied their concerns have been resolved during the course of the investigation. The Chair will write a report on the concerns and the actions taken and present this at a closed session of the next scheduled meeting of the Council. If the majority of those Governors present at the meeting agree that the matter is resolved, then no further action is required. However, should a majority of the Council in attendance disagree, the process for escalation described in section 5 will be initiated

4.7.3 The matter is not resolved to the satisfaction of the Governors. The Chair will call a closed extraordinary meeting of the Council as soon as possible in accordance with the Trust's Constitution to consider the matter further. The meeting may choose either to take no further action or, if the majority of those Governors present and voting agree, to initiate the escalation process described in Section 5. The Council may require one or more of the Directors to attend a meeting of the Council for the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties

4.8 The minutes of the meeting(s) shall record the outcome of the discussions.

5.0 ESCALATING CONCERNS

5.1 Where the matter is not resolved following the completion of steps outlined in section 4 then the following actions will be taken.

5.2 The SID takes over the lead role from the Chair. Should the SID be unavailable or prevented from participating because of a conflict of interest, then the Council may choose any other Non-Executive Director to fulfil the role

5.3. The first duty of the SID is to establish the facts of the concern. This will be accomplished by reviewing the evidence offered by Governors, the process of the investigation and any documentation produced, and also by meetings/interviews with Governors and any Trust officers involved. In carrying out this process the SID will seek the agreement of all interested parties and will have the authority to commission whatever legal or other advice is required following internal protocols

5.4 Once the facts are established to the SID's satisfaction, the SID will make a decision on the course of action to be followed in the best interests of the Trust and will describe the reasons for that decision in a written report. In the first instance, the SID will present the decision and the report to Governors and to interested parties within the organisation.

5.5 The Chair will the, at the SID's request, call a closed extraordinary meeting of the Council as soon as possible in accordance with the Trust's Constitution. The purpose of this meeting, and the sole item on the agenda, will be for the SID to present their report and decision, and for the Council to give its response. Three outcomes are possible:

5.5.1 The Council accepts the SID's decision. No further action is necessary

5.5.2 The Council does not accept the SID's decision but chooses not to escalate the matter further. No action is prescribed by this Policy but the Council may choose to keep the matter under review at future meetings

5.5.3 The Council votes to make a formal notification to NHS England through the Lead Governor under the terms of guidance from NHSE

5.6 The timescale for completion of this process from raising the concern to receipt of the response should be no more than 14 calendar days unless there are exception circumstances resulting in agreement to an extension which is acceptable to all parties.

6.0 DISAGREEMENTS BETWEEN THE BOARD OF DIRECTORS AND COUNCIL OF GOVERNORS

6.1 It is important that the Council of Governors discusses and agrees with the Board how it will undertake its statutory roles and responsibilities, and any other additional roles, giving due consideration to the circumstances of the Trust and the needs of the local community and emerging good practice, as set-out in section 10.1 of the Standing Orders.

6.2 The Board of Directors must ensure the Council of Governors is provided with all information and involvement where a statutory decision is required by the Council is required.

6.3. For any statutory decisions to be made by the Council of Governors, a report will be presented establishing the context and process followed and make a recommendation to the Council of Governors.

6.4 The Council of Governors should consider and discuss any recommendation made prior to approving or not approving the recommendation.

6.5 If the Council of Governors does not approve the recommendation, the Trust Secretary must ask the Council to provide a rationale and record this in the minutes of the Council of Governors.

6.6. The Trust Secretary will report to the Board of Directors that the recommendation has not been approved by the Council of Governors and provide the rationale provided.

6.7. The Board of Directors will determine if the non-approval of the recommendation creates a significant risk to the Trust and if so, request the Senior Independent Director (SID) to undertake mediation.

6.8. The SID will meet with Governors who did not approve the recommendation to understand the rationale and try to find a way forward.

6.9 Following mediation by the SID, the Board of Directors will decide the next steps to be taken, including re-presenting the resolution to the Council of Governors.

7.0 DISPUTES

7.1 Where a Governor is declared ineligible or disqualified from office or his term of office as a Governor has been terminated (other than a consequence of his own resignation) and that person disputes the decision, he shall as soon as reasonably practicable be entitled to attend a meeting with the Chair and Chief Executive. The Chair and Chief Executive shall use their best endeavours to facilitate such a meeting, to discuss the decision with a view to resolving any dispute which may have arisen but the Chair and Chief Executive shall not be entitled to rescind or vary the decision which has already been taken.

END

		Agenda Item No: 6e
SUMMARY REPORT	**COUNCIL OF GOVERNORS PART 1**	**24 August 2023**

Report Title:	**Lead Governor Election**					
Report Lead:	Chris Jennings, Assistant Trust Secretary					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report sets out the role description, process and timetable for the appointment of the Deputy Lead Governor.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Council of Governors is asked to:

1 Note the contents of this report.

2 Approve the process and timetable for the election of the Lead Governor to the Council of Governors.

Summary of Key Issues

Foundation Trusts are required by NHS England to have in place a nominated Lead Governor who can be a point of contact for and can liaise with NHS England on behalf of Governors, in circumstances where it would be inappropriate for NHS England to contact the Chair and vice versa. The Trust has the position of Lead Governor undertakes this role, alongside other roles as defined by an internal procedure.

The Council of Governors previously considered and approved the role description, process and timetable in September 2021 for the appointment of the Lead Governor for a period of two years ending in October 2023.

The role description for the Lead Governor and Deputy Lead Governor has been reviewed and attached to this report as Appendix 1. The process for appointing the Lead / Deputy Lead Governor has been reviewed and attached as Appendix 2. The timetable for the process of appointing the Deputy Lead Governor has been developed and attached as Appendix 3.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered	
1: We care	
2: We learn	
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Impact on Statutory Duties and Responsibilities of Council of Governors	
Holding the NEDs to account for the performance of the Trust	
Representing the interests of Members and of the public	
Appointing and, if appropriate, removing the Chair	
Appointing and, if appropriate, removing the other NEDs	
Deciding the remuneration and allowances and other terms of conditions of office of the Chair and the other NEDs	
Approving (or not) any new appointment of a CEO	
Appointing and, if appropriate, removing the Trust's auditor	
Receiving Trust's annual accounts, any report of the auditor on them, and annual report	
Approving "significant transactions"	
Approving applications by the Trust to enter into a merger, acquisition, separation, dissolution	
Deciding whether the Trust's non-NHS work would significantly interfere with its principal purpose or performing its other functions	
Approving amendments to the Trust's Constitution	
Another non-statutory responsibility of the Council of Governors (please detail): • Election of the Lead Governor.	✓

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
Appendix 1 – Lead Governor and Deputy Lead Governor Role Description Appendix 2 – Process for Appointing the Lead Governor Appendix 3 – Timetable for Appointing the Lead Governor

Lead
Chris Jennings **Assistant Trust Secretary**

COUNCIL OF GOVERNORS

Lead Governor and Deputy Lead Governor

1 Introduction

1.1. Foundation Trusts (FTs) are required by NHS England (NHSE) to have in place a nominated Lead Governor who can be a point of contact for NHSE and can liaise with NHSE, on behalf of Governors, in circumstances where it would be inappropriate for NHSE to contact the Chair and vice versa

1.2. NHSE is clear in its expectation that such direct contact between itself and a Council will be rare. The main circumstances in which NHSE will contact a Lead Governor are when NHSE has concerns about the Board of Directors' leadership which could potentially lead to NHSE using its formal powers to remove the Chair and/or Non-Executive Directors (NEDs). Given that the Council is responsible for appointing the Chair and NEDs, then NHSE is likely to want to discuss such action with the Governors

1.3. NHSE does not expect direct communication with Governors until such time as there is a real risk that the FT may be in significant breach of its provider licence. Should individual Governors wish to contact NHSE with such concerns, then NHSE expects this to be through the Lead Governor

1.4. The other circumstances where NHSE may wish to contact a Lead Governor is where NHSE is aware that the process for the appointment of the Chair or other members of the Board, elections for Governors or other material decisions may have not complied with the FT's constitution or, alternatively, while complying with the constitution, may be inappropriate. In such circumstances, the Lead Governor may be a point of contact for NHSE if the Chair, other Board members or the Trust Secretary have been involved in the process by which these appointments or other decisions were made

1.5. In summary, the role of the Lead Governor is to therefore act as a clearly identified point of contact between NHSE and the wider Council should particular issues in respect of the Trust's governance arise. In the normal course of a well governed Trust, contact between NHSE and the Lead Governor is unlikely to be required

1.6. NHSE requires only that the Lead Governor act as a point of contact between NHSE and the Council when needed. Directors and Governors should always remember that the Council of Governors as a whole has responsibilities and powers in statute and not individual Governors

1.7. It is recognised that the duties may evolve and the role descriptions will be kept under review by the Council of Governors Governance Committee in line with its terms of reference and work plan as advised by the Trust Secretary and liaising with the Chair of the Trust. Any changes to the role requirements will be with the approval of the Council.

2 Lead Governor Role

The main duties of the Lead Governor at EPUT will be to:

2.1. Act as the point of contact between NHSE and the Council in the event that NHSE wishes to contact the Council directly, or the Council decides to exercise its powers to contact NHSE, on an issue for which the normal channels of communication are not appropriate. Before contacting NHSE, the Lead Governor will first discuss the issues with the Trust's Senior Independent Director (SID) as set out in Monitor's *Code of Governance for FTs (July 2014) Annex 1 or any amendments*

2.2. Chair such parts of meetings of the Council which cannot be chaired by the Trust Chair or Vice-Chair or Non-Executive Directors due to a conflict of interest in relation to the business being discussed

2.3. Act as a point of contact for the SID

2.4. Meet with the Chair, Vice-Chair, SID, Trust Secretary and Deputy Lead Governor on a regular basis, e.g. to plan the agenda for Council meetings

2.5. Work collaboratively with the Chair and Trust Secretary liaising with Governors to seek their views and feedback, and to encourage engagement

2.6. Act as a point of contact for any Governor wishing to raise matters with the Trust Chair in the event that a Governor may not wish to do so directly

2.7. Organise and chair informal Governor only meetings and provide feedback (where appropriate) to the Chair and Trust Secretary

2.8. Act as a coordinator of Governors' responses to formal consultations

2.9. Coordinate Council contributions to regulatory reports including Quality Account, Annual Report, etc.

2.10. Report on the activities and work of the Council at the Annual Members Meeting

2.11. Contribute to the Chair's annual appraisal including seeking the views of other Governors in relation to this and feeding back to the SID on behalf of the Council

2.12. Undertake a coordination role within the Council and act as a conduit for communication with the Council of Governors from other Trusts and official Governor groups.

3 Deputy Lead Governor Role

The main duties of the Deputy Lead Governor will be to:

3.1. Support to the Lead Governor in fulfilling their role (as detailed in 2 above)

3.2. Carry out the role of the Lead Governor in their absence

3.3. Provide continuity.

The division of responsibilities will be decided by the Lead Governor and Deputy Lead Governor once elected and in post.

4 The Person

To be able to fulfil either role effectively, the person will:

4.1. Be an elected Public Governor who is not employed by the NHS or another healthcare or healthcare-related organisation

4.2. Have the confidence of fellow Governors and the Board of Directors

4.3. Have the ability to influence and negotiate, and present well-reasoned argument but ensuring that individual issues are not taken forward as the Council view

4.4. Have a willingness to challenge constructively

4.5. Be able to demonstrate experience of chairing large and small meetings effectively

4.6. Understand the role of NHSE, the basis on which NHSI may take regulatory action and the Trust's relationship with NHSE.

4.7. Be committed to the success of the Trust

4.8. Be able to commit the time necessary to fulfil the role.

5 Terms of Office

5.1. The Lead Governor and Deputy Lead Governor will be elected by the Council of Governors

5.2. Both the Lead and Deputy Lead Governor will serve terms of a two-year duration with nominations taking place in alternative years

5.3. If the Lead or Deputy Lead Governor terminates his/her tenure or is removed from office, a new nominations process will take place to appoint to the vacant position for the remainder of the term

5.4. The Lead and Deputy Lead Governor will undertake development and training that is deemed relevant to the posts

5.5. The Council of Governors reserves the right to remove the Lead and/or Deputy Lead Governor in line with the provisions set out in the constitution (Annex 6 paragraph 5 Termination of Office and Removal of Governors) and in the Governors Misconduct Procedure.

COUNCIL OF GOVERNORS
Lead Governor and Deputy Lead Governor

1 Process for the Appointment of the Lead Governor and Deputy Lead Governor

The Council will elect the Lead Governor and Deputy Lead Governor in line with the following process which will be managed by the Trust Secretary who will ensure timely and successful management of the process:

Stage 1

- Details of the Lead Governor and/or Deputy Lead Governor roles will be circulated to all Governors together with the timetable

Stage 2

- Public Governors may self-nominate for the Lead Governor and/or Deputy Lead Governor role(s) by submitting the relevant Nomination Form to the Trust Secretary's Office by the stated date. A short statement on what they would bring to the role is required. Two separate forms will be required if applying for both roles
- A nomination must be seconded and signed by another Governor who believes the nominee has the required values, qualities and ability to become or continue as the Lead Governor and/or Deputy Lead Governor (whichever post is vacant). In this instance, a statement from the seconder can be emailed to the Trust Secretary provided the email address used is one the Governor has previously notified to the Trust Secretary and/or used
- Governors will be asked to forward their nominations in writing or by email to the Trust Secretary by a stated date

Stage 3

- A list of Governor nominations will be circulated to all Governor nominees who have the opportunity of withdrawing their nomination within 24 hours of receipt
- A list of final Governor nominations together with their nomination statement and ballot paper will be circulated by the Trust Secretary's Office to all Governors for consideration
- Where there is a single nomination, seconded and received within the correct timescale, that nominee will be elected unopposed
- Where there are two or more nominations, seconded and received within the correct timescale, a paper ballot will be conducted (in line with Council of Governors standing orders paragraph 14):
  - Any Governor can cast a vote by marking the ballot paper in accordance with the instructions included on the ballot paper
  - Governors must return the ballot paper by hand, by email or by post; any ballot paper received after the date and time stipulated will be rejected
  - A ballot paper does not need to be signed by the Governor if it is returned by email (provided that it is returned from an email address that the Governor has previously notified to the Trust Secretary and/or used)
  - A ballot paper returned by hand or by post must be signed by the Governor
- All Governors will be entitled to vote for both the Lead Governor and Deputy Lead Governor

- The roles will be appointed on a 'first past the post' approach and the Governor with the highest number of votes will be appointed for each role
- In the event of an equality of votes, the Chair of the Trust will have a second or casting vote
- In the event of no nomination or no valid nomination having been received for either or both positions, the process will commence again with respect to the vacant position(s)

Stage 4

- All nominees will be advised of the outcome of the ballot within 48 hours of the deadline date

Stage 5

- The Council of Governors will be advised of the outcome of the ballot within 48 hours of confirmation being provided to the nominees

Stage 6

- The Council of Governors will formally confirm the appointment of the Lead Governor and/or Deputy Lead Governor at the next general meeting of the Council.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

Lead Governor Election Timetable

Stage	Action	Lead	Deadline
1	**Role and timetable:** Details of the Lead Governor role and timetable circulated	Trust Secretary	24 Aug
2	**Nominations:** Governors to self-nominate for the Lead Governor role by submitting the relevant Nomination Form in writing or by email to the Trust Secretary's Office	Public Governors	2 Oct
	Seconding: Nominations must be seconded and signed by another Governor (in this instance, a statement from the seconder can be emailed to the Trust Secretary's Office provided the email address used is one the Governor has previously notified to the Trust Secretary and/or used)	Governors	
3	**Withdrawal:** Opportunity for Governor nominees to withdraw their nominations	Governor nominees	9 Oct
	Ballot papers: List of Governor nominees together with their nomination statement and ballot paper will be circulated to all Governors	Trust Secretary	10 Oct
	Voting closes: Governors can vote by hand, by email or by post	All Governors	27 Oct
4	**Results outcome:** All nominated Governors will be advised of the outcome of the ballot	Trust Secretary	30 Oct
5	**Results declared:** Results will be advised to all Governors by email	Trust Secretary	30 Oct
	Appointment effective	Lead Governor	31 Oct

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 7a
SUMMARY REPORT	**COUNCIL OF GOVERNORS PART 1**	**24 August 2023**

Report Title:	**Membership Metrics / Your Voice**					
Report Lead:	**Mark Dale, Public Governor**					
Report Author(s):	**Chris Jennings, Assistant Trust Secretary**					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	✓

Purpose of the Report		
This report provides information on the current Membership of the Trust as at June 2023. The report also provides feedback following Your Voice meetings held on the 6 – 8 June 2023	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Council of Governors is asked to:

1 Note the contents of the report

2 Request any further information or action.

Summary of Key Issues

This report provides information on the current Membership of the Trust as at June 2023. The report also provides feedback following Your Voice meetings held on the 6 – 8 June 2023.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	
SO2: We will enable each other to be the best that we can	
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Impact on Statutory Duties and Responsibilities of Council of Governors	
Holding the NEDs to account for the performance of the Trust	
Representing the interests of Members and of the public	✓
Appointing and, if appropriate, removing the Chair	
Appointing and, if appropriate, removing the other NEDs	
Deciding the remuneration and allowances and other terms of conditions of office of the Chair and the other NEDs	
Approving (or not) any new appointment of a CEO	
Appointing and, if appropriate, removing the Trust's auditor	
Receiving Trust's annual accounts, any report of the auditor on them, and annual report	
Approving "significant transactions"	
Approving applications by the Trust to enter into a merger, acquisition, separation, dissolution	
Deciding whether the Trust's non-NHS work would significantly interfere with its principal purpose or performing its other functions	
Approving amendments to the Trust's Constitution	
Another non-statutory responsibility of the Council of Governors (please detail):	

Acronyms/Terms Used in the Report			
CoG	Council of Governors	Comms	Communication Team
BoD	Board of Directors		

Supporting Documents and/or Further Reading
Main Report

Lead
Mark Dale, Public Governor **Chair of the Council of Governors Membership Committee**

Agenda Item: 7a
Council of Governors Part 1
24 August 2023

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

MEMBERSHIP METRICS / YOUR VOICE

1.0 PURPOSE OF REPORT

This report provides information on the current Membership of the Trust as at June 2023. The report also provides feedback following Your Voice meetings held on the 6 – 8 June 2023.

2.0 MEMBERSHIP METRICS

2.1 Membership Composition

According to the Civica Membership Database, the following is the current membership:

Member Type	No. Members as at April 2023	No. members as at June 2023	Difference
Public Members	4,901	4,894	-7
Staff Members	9,537*	8,931	-606
Total Members	**14,438**	**13,825**	**-613**

*as at November 2022

Reasons for Leaving

The Trust Secretary's Office have started a process of recording reasons for leaving the Public Membership for any direct requests to be removed from the database. The following provides reasons for leaving since this was established after the previous meeting:

Health Reasons	2
Did not recall joining / no longer interested	2
Deceased	1

The additional two Public Members who have left since the last report were likely included in the regular review conducted by Civica.

By Public Constituency

The following table provides a breakdown of public members by Constituency:

Constituency	No. Members as at April 2023	No. members as at June 2023	Difference
Essex Mid & South	1,926	1,924	-2

Constituency	No. Members as at April 2023	No. members as at June 2023	Difference
Milton Keynes, Bedfordshire, Luton & Rest of England	1,689	1,686	-3
West Essex & Hertfordshire	696	696	-
North East Essex & Suffolk	590	588	-2
Total Members	**4,901**	**4,894**	**-7**

2.2 Demographics Groups

The following information provides a breakdown of demographics available on the Civica database system. Please note, members themselves populate the information and there may be gaps if not fully completed.

By Gender

Gender	No. Members as at April 2023	No. members as at June 2023	Percentage
Public Members			
Female	2,907	2,896	59%
Male	1,866	1,869	38%
Not Stated	128	129	3%

By Age

Age	No. Members as at April 2023	No. members as at June 2023	Percentage
Public Members			
60-74	1,043	1,047	21%
30-39	991	996	20%
50-59	819	810	17%
40-49	643	667	13%
Not Stated	571	571	12%
75+	504	508	10%
22-29	330	295	7%
0-16	0	0	0%
17-21	0	0	0%

It should be noted that whilst the figures in the above table have changed, the percentages of the overall membership have not.

By Ethnicity

Ethnicity	No. Members as at April 2023	No. members as at June 2023	Percentage
Public Members			

Ethnicity	No. Members as at April 2023	No. members as at June 2023	Percentage
White Scottish, Welsh, Northern Ireland British	3,483	3,476	71%
Not Stated	410	410	8%
Black or Black British African	182	182	4%
Asian or Asian British Indian	158	159	3%
Asian or Asian British Pakistani	124	124	3%
White - Other	117	117	2%
Black or Black British Caribbean	80	80	2%
White Irish	78	77	2%
Asian or Asian British Bangladeshi	78	78	2%
Mixed White - Black Caribbean	42	42	<1%
Asian or Asian British Other Asian	33	33	<1%
Mixed - Other	30	30	<1%
Asian or Asian British Chinese	24	24	<1%
Other Ethnic Group	17	17	<1%
Black or Black British Other Black	16	16	<1%
Mixed White - Asian	14	14	<1%
Mixed White - Black African	13	13	<1%
Other Ethnic Group Arab	0	0	0%
White-Irish Gypsy Irish Traveller	0	0	0%

2.3 Membership Communication

The following table provides information on any communication circulated by the Trust to members electronically using the membership database:

Electronic Communication	Members Emailed	Percentage Opened	Bounces
Prospective Governor Workshops (16/06/2023)	3,533	31%	200
Your Voice (West Essex) (24/05/2023)	497	34%	29
Your Voice (North Essex) (24/05/2023)	363	35%	49
Your Voice (Mid & South Essex) (24/05/2023)	1,357	35%	78
Your Voice 2023 (19/05/2023)	8,467	23%	388
Your Voice (West Essex) (19/05/2023)	498	33%	30
Your Voice (North Essex) (19/05/2023)	364	34%	50
Your Voice (Mid & South Essex) (19/05/2023)	1,380	37%	87

Postal Communication	Members Posted	Cost
Prospective Governor Workshops (Mid & South Essex) (16/06/2023)	466	£572.60
Prospective Governor Workshops (West Essex) (16/06/2023)	169	£207.34
Prospective Governor Workshops (North Essex) (16/06/2023)	171	£210.31
Your Voice (West Essex) (30/05/2023)	169	£207.34
Your Voice (North Essex) (26/05/2023)	177	£218.08
Your Voice (Mid & South Essex) (24/05/2023)	475	£583.63

3.0 YOUR VOICE

3.1. North East Essex & Suffolk

The Trust held a public Your Voice meeting on the 7 June 2023 at the Colchester Town Hall, Colchester. The meeting was chaired by Jason Gunn, Public Governor, West Essex & Hertfordshire. The subject of the meeting was Feel Well: Working Together in Partnership. The session was facilitated by:

- Emma Strivens, Director of Community Partnerships, EPUT
- Laura Taylor-Green, Director for North East Essex Alliance
- George Davidson, Associate Director of Mental Health and Feel Well Domain Lead

Individuals attended the meeting as follows:

Attendance Breakdown

Attendee Group	No. of Attendees
Staff Member	6
Public Member	4
Governor	4
Non-Executive Director	3
Executive Director	1
Total	**18**

Feedback forms were received from six attendees:

Scale: 1 Strongly Disagree 2 Disagree 3 Neutral 4 Agree 5 Strongly Agree						
	N/A	**1**	**2**	**3**	**4**	**5**
Feel Well: Working Together in Partnership Was the presentation useful and easy to understand?	1				3	2

What did you think about the meeting?	Engaging	4
	Worthwhile	4
	Useful	6
	Inspiring	1
	Good Venue	6
	Welcoming	6
	Good Location	6
	Enjoyable	3

Question:	Feedback Provided
What interests do you have in Mental Health?	• Community services options for support and navigation. • I am a Public Governor for North East Essex and South Suffolk for EPUT. • As a staff member and member of public who lives in North Essex.
What was your main reason for attending today?	• Understanding how the services are evolving. • Interested in keeping our NHS working. • Public Governor – presenter. • I was invited by EPUT. • Listening to service users and staff. • To hear public views and priorities.

Question:	Feedback Provided
What topics would you like to see covered at future meetings?	• Peer-led contributions. • For people in long-term care, I would like to know how the level of involvement of mental health services in the long-term.
Where did you find out about this meeting?	• Email list. • See above. • Email • Public website.
Any other comments?	• More of the same with proactive engagement with partners to involve members of the public. • Thank you.

3.2. West Essex & Hertfordshire

The Trust held a public Your Voice meeting on the 8 June 2023 at the Great Parndon Community Association, Harlow. The meeting was chaired by Paul Walker, Staff Governor. The subjects covered at the meeting were:

- Virtual Hospital, Out of Hospital Care, Falls Care (Dan Gray)
- Primary Care Transformation (Stephanie Rea, EPUT)

Individuals attended the meeting as follows:

Attendance Breakdown

Attendee Group	No. of Attendees
Staff Member	9
Public Member	6
Governor	5
Non-Executive Director	2
Executive Director	1
Total	**23**

Feedback forms were received from five attendees:

Scale: 1 Strongly Disagree 2 Disagree 3 Neutral 4 Agree 5 Strongly Agree						
	N/A	1	2	3	4	5
Virtual Hospital, Out of Hospital Care, Falls Care Was the presentation useful and easy to understand?				1	1	3
Primary Care Transformation Was the presentation useful and easy to understand?			1		1	3

What did you think about the meeting?	Engaging	3
	Worthwhile	2
	Useful	3

	Inspiring	2
	Good Venue	2
	Welcoming	2
	Good Location	2
	Enjoyable	4

Question:	Feedback Provided
What interests do you have in Mental Health / Healthcare?	• First hand as my son has severe problems. • Mainly stopping people falling through gaps in service. • We support 29 faith [illegible] and community groups. • I currently work in the EPUT back office, but previously worked with the West Essex IAPT service.
What was your main reason for attending today?	• To communicate some of [my son's] experiences and to make myself more aware of facilities and services in the NHS. • Interesting listening to FT members and members of the public. • Gathering information. • To gain a greater understanding of EPUT as my current employer, especially in terms of the clinical side, which I only indirectly support within the digital programme.
What topics would you like to see covered at future meetings?	• Preventative Health Education. • Support for social care in the community. • Any relevant – as aiming to understand the EPUT landscape.
Where did you find out about this meeting?	• I am an EPUT member. • Email • An Internal EPUT communication.
Any other comments?	• Thank you • Brilliant.

3.3. Essex Mid & South

The Trust held a public Your Voice meeting on the 6 June 2023 at the Towngate Theatre, Basildon. The meeting was chaired by Professor Sheila Salmon, Chair. The subject covered at the meeting was Conversations on Imagining New Ways of Working in Partnership with Healthcare. The meeting was facilitated by:

- Jo Debenham
- Jeff Banks
- Rita Thakaria.

Individuals attended the meeting as follows:

Attendance Breakdown

Attendee Group	No. of Attendees
Public Member	9
Staff Member	8
Non-Executive Director	3
Governor	1
Executive Director	0
Total	**21**

Feedback forms were received from ten attendees:

Scale: 1 Strongly Disagree 2 Disagree 3 Neutral 4 Agree 5 Strongly Agree						
	N/A	**1**	**2**	**3**	**4**	**5**
Conversation on Imagining New Ways of Working in Partnership with Healthcare Was the presentation useful and easy to understand?			1	2	2	4

What did you think about the meeting?	Engaging	8
	Worthwhile	8
	Useful	7
	Inspiring	4
	Good Venue	5
	Welcoming	9
	Good Location	6
	Enjoyable	5

Question:	Feedback Provided
What interests do you have in Mental Health / Healthcare?	• It is my line of work. • Autistic daughter – main carer. Mother with suspected dementia – carer. • Expert-by-experience (EbE), volunteer, interest in future services. • Working with the education (schools). • I am a carer for my husband who is bi-polar and hoarding issues. • As a therapist and a carer of someone with mental and physical needs. • Service lead of three primary care MH services for Vita Health Group. • Psychotic Disorders, Autism Spectrum. • A son with mental health issues.

Question:	Feedback Provided
What was your main reason for attending today?	• To see what is being done about collaboration / integration. • To see if things have moved forward from last-time pre-covid. • In-person meeting (makes a welcome change). • Update on what is going on with the health service and co-operation with other agencies. • It was in a location I could attend in person after many years – could not manage zoom meetings. I also came on public transport. • To catch-up with how things are moving on. • Seeking more information. • To learn more about the future integration plans and networking. • To explain more on patient relationships. • Interest. • To get to experience of Your Voice meetings.
What topics would you like to see covered at future meetings?	• How MH services can collaborate with one another in a way that is helpful to patients. • Autism awareness. • How to be an active partner, how to challenge, what to say. • Volunteer's impact. • Detail on how technology improves service provision. (e.g. oxevision) • More on ICS / Integrated Health Systems. • Partnerships which the education area. • Support for patients with bi-polar and especially hoarding issues and for their families who live with them and try to support them. Ongoing support, not just short term. • New therapies and ideas being explored. • Detailed process map of how the integration will work, including inclusion of all key NHS providers and [illegible]. • Patient integrated systems with other parties. • Addiction & mental health joined up service. • Engagement and promotion of mental health services.
Where did you find out about this meeting?	• Member – via email • Email / social channels. • As a Public Governor. • A letter inviting me as a member to attend. • Email. • Through EPUT partners. • NHS Mail. • Received a letter. • From my colleague.
Any other comments?	• Keep up the vision. • Was ok as an introduction to ICS / ICB's but arguably not the detail needed.

Question:	Feedback Provided
	• ICB's / ICS need to open channels (i.e. co-production). CCG's were reluctant at times, hope history doesn't repeat itself. • Good meeting – hope to have more face-to-face locally. • Very informative meetings. • It was eye opening meeting, bringing changes and offering holistic care to service users.

Report prepared by
Chris Jennings**,**
Assistant Trust Secretary

on behalf of
Mark Dale
Public Governor
Chair of the Council of Governors Membership Committee

NHS
Essex Partnership University
NHS Foundation Trust

CQC Core Service Inspection

Published 12th July 2023

EPUT

NHS
Essex Partnership University
NHS Foundation Trust

CONTENTS

1. Summary

NHS
Essex Partnership University
NHS Foundation Trust

The purpose of this report is to share the findings from the CQC Core Services Inspection (Report published 12 July 2023) and processes followed to develop robust action plan in preparation for submission to the CQC.

It was recognised that over the last year EPUT teams have undergone a number of high profile and challenging reviews which have led to a number of action plans being developed. The latest CQC report has provided opportunity to seek wider engagement and deeper understanding of the causes of the findings and a way of bringing together all of the great work that has been done or is in progress.

To achieve this EPUT has invested time and effort into developing a new approach to responding to CQC reports. The purpose was to drive up levels of engagement at service/ ward level, define clear lines of responsibility and ensure the actions are sustainable. This approach has set the foundations for continuously improving the process to ensure future CQC reports are responded to in an equally, if not, better way.

Over the course of a few months, EPUT has designed and implemented new documents, new processes and is currently encouraging new behaviours to address the 72 findings raised in the July 2023 CQC report; the feedback from the teams affected has been excellent.

Throughout the process we have seen:

- Really high levels of engagement with the process

- Teams and individuals sharing good practices to scale up

- Pockets of excellence in continuous improvement capability

- Honesty and openness

- High levels of ownership and responsibility for the actions developed

- Open-mindedness to embrace a new process and the supporting standard work

2.1 CQC Inspection

NHS
Essex Partnership University
NHS Foundation Trust

On 12 July 2023, the Trust received the final version of the CQC report following their Core Services Inspection undertaken in November 2022 and January 2023. This included inspection of 6 EPUT core services and a well led inspection.

Overall EPUT provides 15 core services with 75 Core Domains (excluding our nursing homes). This inspection covered 30 (40%) of the core domains, and six services of which:

- 53% there was no change to domain rating
- 7% has an improved domain rating
- 40% moved down in domain rating (this is inclusive of the inadequate rating for our Acute wards for adults of working age and psychiatric intensive care service from the April 2023 report)

Three services saw a deterioration of overall core service rating
- Wards for people with a learning disability or autism
- Acute wards for adults of working age and psychiatric intensive care service (note marked as remains the same in the CQC report but noted here in recognition of the outcome of the April 2023 report)
- Community-based mental health services of adults of working age

Two services remained static in overall core service rating
- Wards for older people with mental health problems
- Mental health crisis services and health-based places of safety

One services saw an improvement in overall core service rating
- Substance misuse service

Within the report the CQC list areas for improvement within two categories:
- 45 Must Do actions - necessary to comply with our legal obligations under registration
- 26 Should Do actions - to prevent failing to comply with legal requirements, or to improve services

2.2 Action Themes

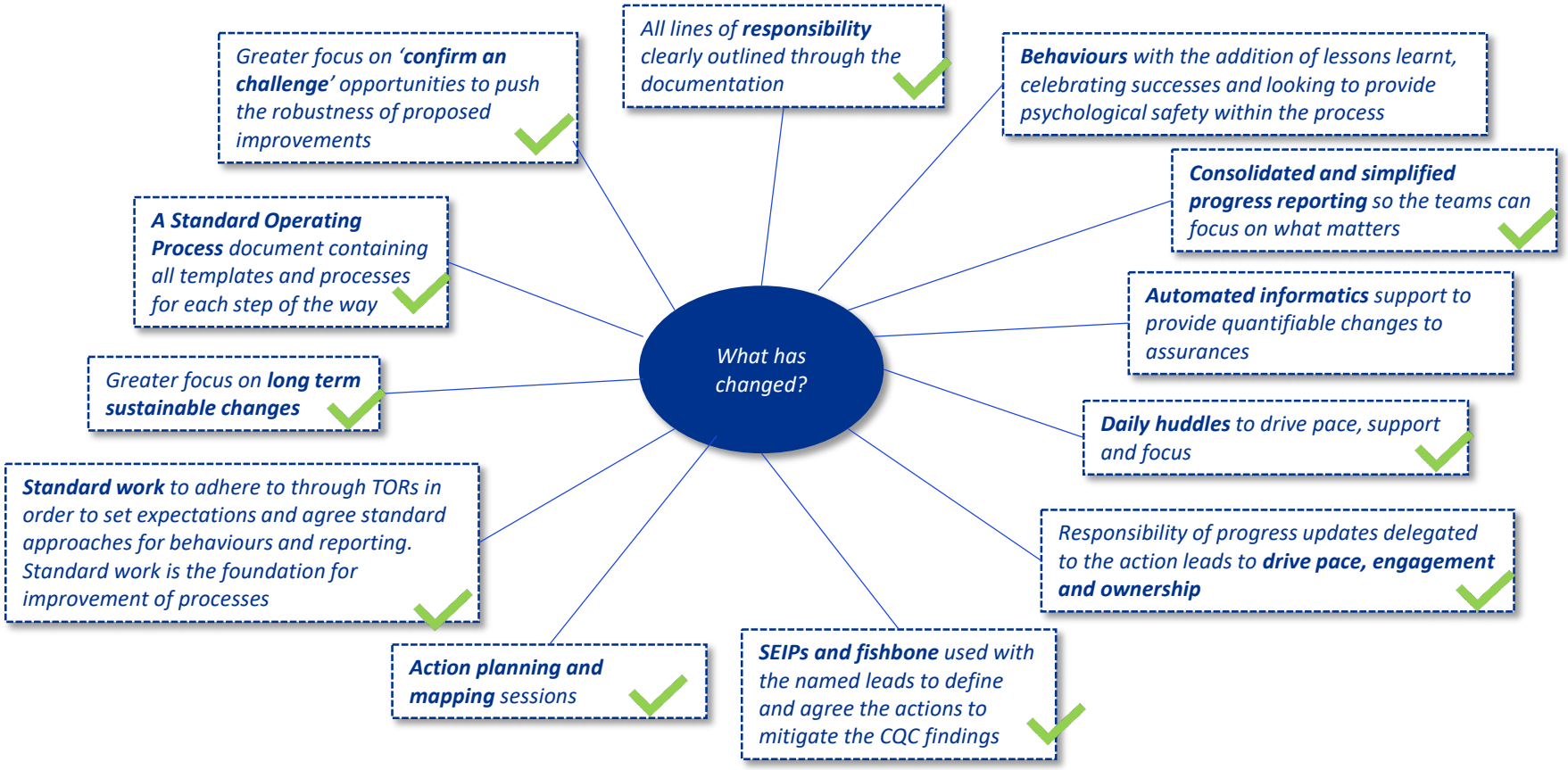
NHS Essex Partnership University NHS Foundation Trust

A thematic grouping of the identified areas for improvement is provided in the table below (full action plan attached as appendix 1):

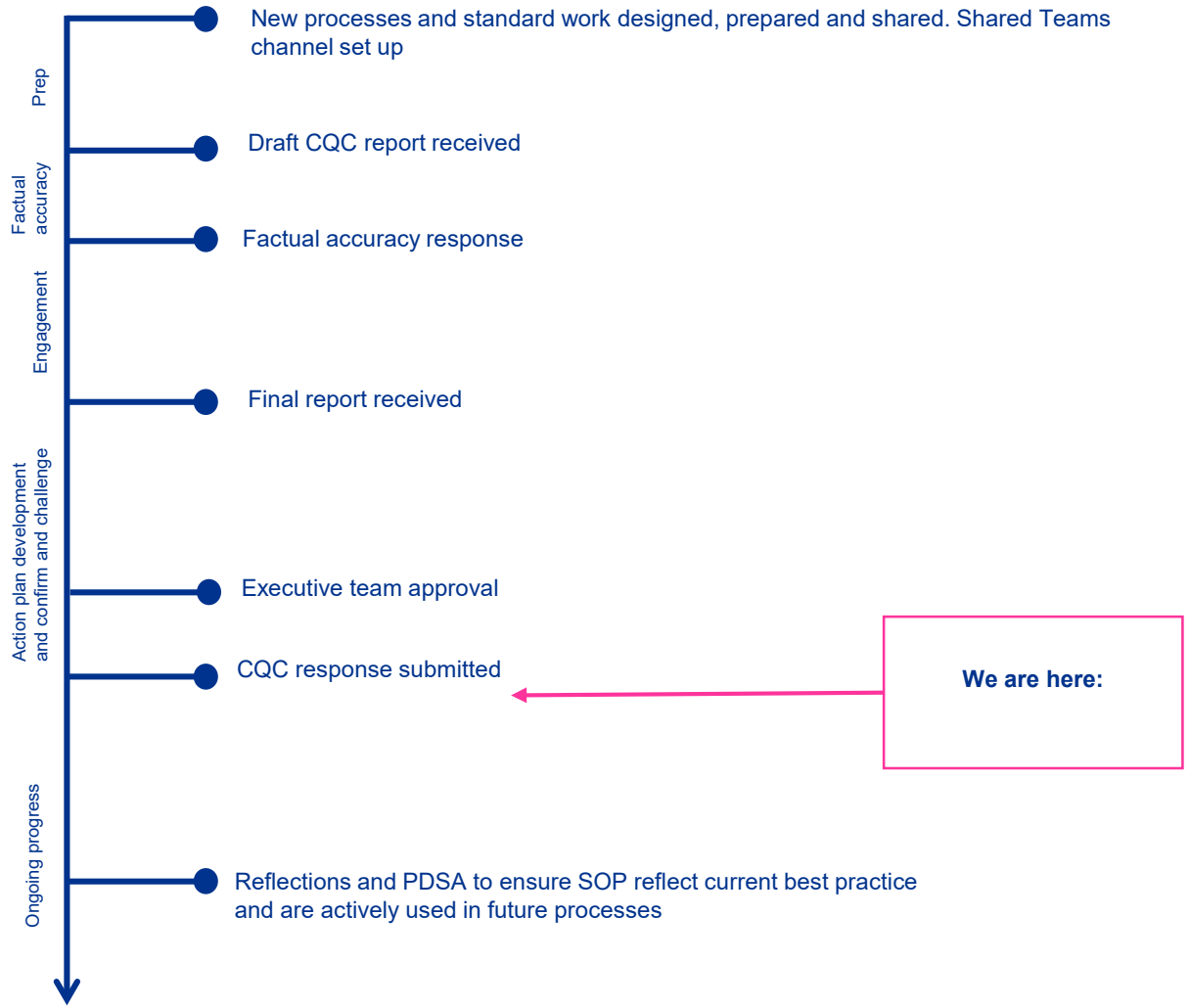
Governance and Culture of Learning	Clinical Care	Environment and Equipment	Technology and Data	Staffing
• Ensuring breaches identified by CQC are addressed in a timely and effective way • Ensuring robust governance systems which enable identification of issues affecting quality of care are embedded • Embedding QI methodologies • Incident recording and reporting including racial abuse • Ensuring audit processes are effective • Ensuring new vision and values are understood by staff	• Ensure robust observation and engagement processes including tackling sleeping on duty • Reduction of blanket restrictions • Ensure patients treated with dignity and respect with comprehensive care plans • Ensuring robust assessment and management of patient risks • Ensuring effective medicines management • Ensuring timely discharge planning from community MH services • Ensuring accurate record keeping • Monitoring of meaningful activities on wards	• Ensuring maintenance work is completed • Ensuring well maintained, clean and well-furnished including nurse call alarms • Ensuring medical equipment is managed in line with policy	• Ensuring robust data quality and accuracy of data • Plan for implementation of a consistent patient record • Ensuring patients are aware of Oxevision and how this is used	• Ensuring sufficient numbers of regular staff and reduce vacancy rates • Ensuring sufficient numbers of qualified psychology staff • Ensuring all staff remain up to date with training, supervision and appraisal • Ensuring staff have access to specialist LD and autism training • Case load management

3.1 What has changed in the EPUT CQC response process?

Over the last few months we have been developing a new processes for responding to CQC that incorporates the best of what EPUT do, combined with wider team feedback to improve our processes in order to developed long term sustained change and improvement for our staff, patients and families



3.2 Timeline of events and where we are now



3.3 CQC response process documentation

NHS Essex Partnership University NHS Foundation Trust

New CQC response documentation:

- Standard Operating Process (SOP) for the CQC response inclusive of lines of responsibility
- Action leads meeting standard work to ensure brevity, consistency, agreed behaviours and ownership of action progress
- Action plan to hold all of the information on a shared Teams channel for all action leads to use as routine

Here are 2 examples to show the new documentation in use and continuing using throughout the process until the activities and behaviours become the new way of working

Weekly meeting standard work

NHS Essex Partnership University NHS Foundation Trust

CQC ACTION LEADS MEETING TERMS OF REFERENCE May 2023

TERMS OF REFERENCE FOR:	**CQC Action Leads Meeting**	**TERMS OF REFERENCE AUTHORISED BY:**			
CHAIRED BY:	**Chair:** Denver Greenhalgh - ... **Co-Chair**: Director of Care Unit **Deputy Chair**: Nicola Jones	**SECRETARIAT:**	Compliance Team	**FREQUENCY:**	Weekly (Wednesday am)
PURPOSE:	The group is responsible for development, monitoring and testing of CQC action plans			**REPORTING TO:**	Executive Oversight Team
ATTENDANCE:	**Care Unit Leadership Team** Director of Care Unit DDQS Deputy Medical Director **Care Unit Action Leads** DDQS - Katy Stafford, Keri McKay and Vijay Chutto AD's - Tendai Ruwona / Cindy Weaver Director – Lizzy Wells Service Managers	**Corporate service action leads** Emergency Preparedness and Resilience Team - Lara Brooks VAPR – Lara Brooks, Eliot Judge Employee Engagement - Lorraine Hammond Nursing and Quality - Angela Wade Patient Safety and Learning - Moriam Adekunle, Georgia Warne Quality Improvement - Steve Yarnold Safeguarding - Tendayi Musundire Contracts - Trevor Smith / Liz Brogan Estates - Linda Martin / Fiona Benson Capacity and Flow - Sarah Braizer Pharmacy - Hilary Scott IM&T - Jan Leonard HR - Debbie Prentice, Paul Taylor Clinical Audit - Roshni Patel Ligature - Comfort Sithole		**Compliance Facilitation** Nicola Jones Comfort Sithole Alison Buckland **Performance Facilitation** Rob Thornton Other members to be invited as and when needed	
QUORACY:	60% of membership, including a representative from the following: 1. Chair 2. Operational Representative Inpatient Services 3. Risk and Compliance Representative	**INPUTS:**	Action update reports from all Action Leads Updated Action Plans for information from Compliance Team	**OUTPUTS:**	Updated Action & Decision log Assurance Report to ET (Weekly) Metrics Report to ET (Monthly) Update comms to inpatient clinical support group/ similar for other care units.
	Pre meeting 1. By 4pm on every Tuesday all progress updates are to be completed by the action owners and RAG ratings assigned to prevent the need for in-meeting updating (Microsoft teams) 2. All progress updates are to be submitted to Alison Buckland or added to the shared document (include link MS teams) 3. If you are unable to complete it please delegate the task so it is completed 4. Ensure someone with your delegated authority can attend in your place if you are unable to 5. Chair to gather information or any escalations/ decision answers from connected governance meetings to feed information into this meeting as required **Meeting:** (To include TOR here) 6. The chair will ask for any urgent escalations or decision to be made to go first 7. Action owner to state clearly and succinctly the action reference and requirement from the chair (decision/ escalation)		**9. Action updates:** Each action owner to state activities completed this week and activities planned for next week– this should be succinct and quick especially if RAG rated as green 10. Action owner to describe any delays experienced or anticipated with planned mitigations and to seek approval from the chair or support from the group 11. Only delays and escalation will be captured in the meeting by X **Meeting behaviours:** • All participants to proactivity participate and offer support or constructive challenge as required • Provide succinct updates in the format requested • Adherence to the process including the update format **Post meeting:** • Chair to use the contents of the progress updates to inform the ensuing governance structure • Any escalations or decisions required beyond this meeting to be taken to the appropriate next level meeting		

SOP for CQC response

Compliance and Assurance Standard Operating Procedure (C&A SOP 03)

SOP Title: Receipt of CQC Inspection Report

Date Implemented	Version number	Date(s) reviewed	Approved by:	Next review date:	Author:
May 2023 (TBC)	V0.7 (draft)	N/A			Nicola Jones Director of Risk and Compliance

SOP		
1.0 Purpose	To set out the process including roles and responsibilities to be followed when a CQC inspection report is received by the Trust.	
2.0 Scope	All Staff	
3.0 Deliverables	**Factual Accuracy** Factual Accuracy check completed and returned to CQC within timescale Daily Stand ups established	**Inspection Report** Clear lead nominated for each CQC must do / should do action Analysis undertaken to understand the root cause of the CQC concern Problem solving undertaken to address root cause of the CQC concern Action plan developed to address CQC concerns approved by executive team and returned to the CQC within timescales Group nominated to take forward monitoring of implementation and of effectiveness of action plan
4.0 Responsibilities	**Chief Executive Officer** • Relationship holder with the CQC • On receipt of draft or final version of a CQC inspection report CEO office, on behalf of CEO, to circulate this immediately (on same working day) to Senior Director of Corporate Governance, Director of Risk and Compliance and Executive Team **Chief Nurse:** Responsible for • Relationship holder with the ICB Chief Nurses and ICB Quality forums • Relationship with the CQC **Chief Operating Officer:** Responsible for • Chairing the factual accuracy process • Leading the Care Unit Leadership Team in development of an action plan to address all concerns and holding leads to account for implementation and change through the accountability framework meetings. **Care Unit Leadership Team:** Responsible for • Providing factual accuracy challenge with evidence • Supporting the RCA process • Ownership of CQC action plans including testing • Embedding change across all services **Senior Director of Corporate Governance / Director of Risk and Compliance:** Responsible for	

3.4 The process and principles used to develop the actions

NHS
Essex Partnership University
NHS Foundation Trust

Principles:

The action plan was created using some of the core principles of continuous improvement, namely:

- Understanding the **cause** of the concern and defining the actions to mitigate it
- **Standard practices** for process and behaviours
- **Engagement** with the people within the processes

Process:

All of the CQC findings were categorised according to how they were going to be worked with to develop mitigating actions. These were determined based on whether they needed:

1. A 2 step approach to:
    a. Understand the likely cause of the findings (SEIPS sessions)
    b. Develop a set of actions to mitigate those causes (solutions sessions)
2. Discussion to cross reference and build on work already in progress or agree actions to mitigate a finding that had a clear objective within it – 'just do its' (action planning sessions)

The CQC findings were grouped based on the content within them to enable wider discussions with the right people present in order to reduce the time commitment required without reducing their opportunity for engaging with the process.

- There were 30 findings grouped as 'Just Do It' actions (or already underway) that did not need an analysis/ SEIPS session.
- The were 42 CQC findings grouped for 'Solution sessions' which were preceded by an analysis/ SEIPs session

A large group of stakeholders were met with **(>100 individuals**) over a 12 days period and encouraged to share the 'truth and reality' behind the findings which has led to a detailed and specific set of actions developed with a high level of engagement and therefore ownership of responsibility.

3.5 SEIPS Sessions

Essex Partnership University NHS Foundation Trust

What is SEIPS: System Engineering Initiative for Patient Safety

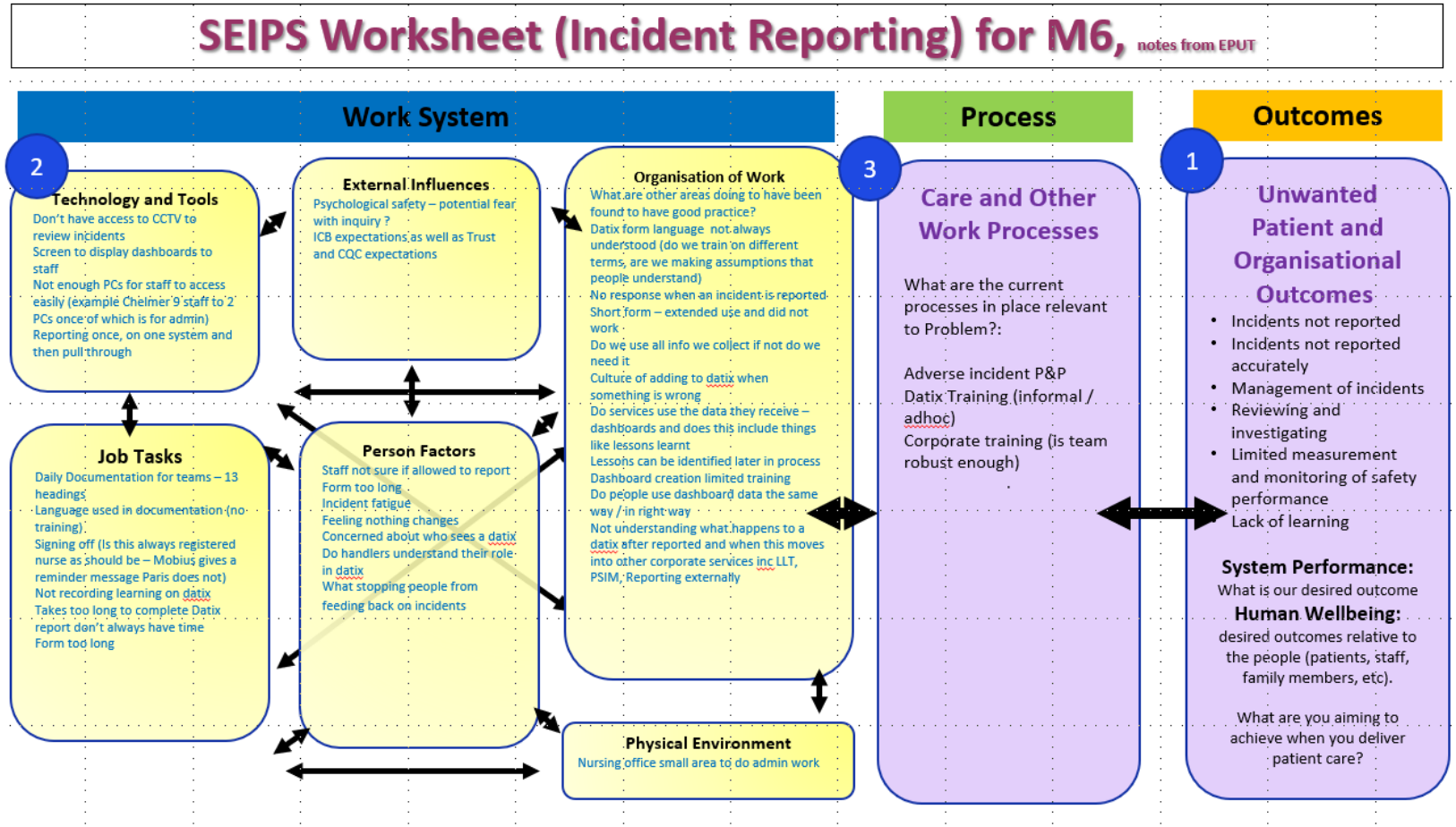
Purpose: The purpose of these sessions was to:

1. Engage a broad audience that are closest to the issues that led to the CQC findings and
2. Ensure causes and process challenges were understood in order to develop actions to mitigate them

Outputs:

- Sessions were run with leaders and those closest to the process (ward managers, etc where relevant).
- Engagement was strong for all participants across all the sessions.
- Participants were very honest and forward with their thinking and shared that they enjoyed using the SEIPS to structure their thinking.
- The findings were used to facilitate a 'solutions' conversations at a later date

SEIPS Example



3.6 SEIPS Outputs into effective actions

Essex Partnership University NHS Foundation Trust

- Following the SEIPS session, action leads and other leaders responsible for implementing the actions were facilitated to develop mitigating actions, define the action owner, and set out realistic and achievable timescales.
- Additionally, the actions were designed to be corrective, remedial, and preventative to ensure not only were each of the findings addressed immediately but actions were put in place to prevent recurrence somewhere else in the Trust
    - Action types were defined as:
        - **Remedial** – an urgent change made to a non conforming process, service or person
        - **Corrective** – taking the appropriate steps to identify the root cause of a problem and implementing a solution that corrects the root cause as to prevent its recurrence
        - **Preventative** - a preventive action aims to correct a potential problem in areas outside of or relating to the cause
- Metrics were also developed, one to show implementation progress and another to show improvement against the finding
- Each action underwent a challenge to assess sustainability and amended if it did not meet the requirement

Example to show the outputs from a solutions sessions see next slides

M6 Incident Reporting Action plan

Improvement Metrics
Reporting in line with Benchmarking.
Auditing of records showing all incidents reported on Datix

Cause / Contributing factor	Action to be taken (Sub-Actions)	Sub-Action Lead	Action Type (Corrective, Remedial or Preventive)	Action Implementation metric	Target Date to complete Action	Action Sustainable (Y/N)	Compliance Check and Challenge	
Link between Datix and EPR not working properly.	Temporary fix to be put in place	Jan Leonard	Corrective	System link	30/04/2023	NO	3	Automated process
	Fix to be completed for Datix to link into Paris	Jan Leonard	Corrective	System link	30/07/2023	YES	3	Automated process
Job Tasks – Datix form takes too long to complete, using complex language and times out Organisation of Work - Culture of adding to Datix, not all information collected used	Review causes and survey feedback relating to completion of incident form and shorten incident reporting form both Dif1 and Dif2 to go back to pure function and purpose of Datix	Phil Stevens	Preventative	Shortened form	30/11/2023	YES	3	Reduces time taken. Potential to increase quality
Do not currently use BWV footage	Recommendation for BAU process for using BWV and CCTV for training / learning re incidents to be presented to Executive Team for approval	Lara Brooks	Corrective	Staff accessing footage (BWV)	15/05/2023	YES	3	Better senior oversight
	Launch of new BWV BAU process	Lara Brooks	Corrective	as above	30/05/2023	YES	3	as above
	Full roll out of BWV access and use for learning to all service managers and matrons (new action 23.05.23)	Lara Brooks	Corrective	as above	30/07/2023	YES	3	as above
	Recommendation for BAU process for using BWV and CCTV for training / learning re incidents to be presented to Executive Team for approval	Lara Brooks	Corrective	as above	16/05/2023	YES	3	as above
Do not currently use CCTV footage	Identify solution to current technical barriers which prevent wide access to CCTV (action added 23.05.23)	Linda Martin	Corrective	Staff accessing footage (CCTV)		YES	3	as above
Staff don't remember to updated risk assessment	Service Managers to share information with staff reminding why is important to review a patients risk assessment following an incident	Service Managers	Preventive	% of risk assessments reviewed following an incident	30/05/2023	YES	1	Reminder
	Exploring if the Datix system can give a prompt to staff when completing an incident reminding them to review the patients risk assessment	Lara Brooks	Preventive	system change	16/05/2023	YES	3	Automated process
	Develop alert and launch	Lara Brooks	Preventive	system change	30/05/2023	YES	3	as above
Tec/Tools -No screen to display Datix dashboards for staff discussion	Project to put up screens on wards which will enable display of Datix dashboards to Staff	TBC - Comms / IM&T	Preventative	Screens on wards	30/07/2023	YES	2	Enhanced comms
	Work with wards on best utilisation of screens for Datix dashboards	Phil Stevens	Preventative	see above	30/07/2023	YES	2	Enhanced comms

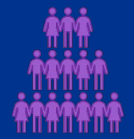
M6 Incident Reporting Action plan ..Cont'd

Cause / Contributing factor	Action to be taken (Sub-Actions)	Sub-Action Lead	Action Type (Corrective, Remedial or Preventive)	Action Implementation metric	Target Date to complete Action	Action Sustainable (Y/N)	Compliance Check and Challenge	
Tec/Tools -Not enough PCs for staff to access easily (example Chelmer 9 staff to 2 PCs one of which is for admin)	Review number of equipment available on each ward and increase based on analysis of need	Adam Whiting	Corrective	Equipment review	TBC	YES	2	Enhanced equipment
	Consider Datix upgrade to DCIQ (QI action long term) which brings ability to report on mobile devices	Phil Stevens/ Adam Whiting	Preventative	New Tech	30/03/2024	YES	3	New system
Person Factors Differing views when something should be reported	Undertake analysis of staff survey results	Diana Luckie (TBC)	Preventative	Analysis complete	30/09/2023		1	fact finding
Range of Factors: Nothing changes, fatigue, psychological safety, don't know what happens when a Datix is reported	Develop and implement process for advertising changes made following incidents	Phil Stevens/ Didier Stephen (TBC)	Preventative	Advertising material available	30/10/2023	YES	2	Enhanced comms
	Explore automatic feedback from Datix to reporters, rather than current system where staff have to tick a box	Phil Stevens	Preventative	Automatic process	30/10/2023	YES	2	Enhanced comms
Person Factors Do handlers understand their role in Datix What stopping people from feeding back on incidents	Ward Managers to develop and implement process for saying thank you to their staff and giving feedback	Tendai Ruwona (Matrons)	Preventative	Ward Manager Assurance	30/10/2023	YES	2	Enhanced comms
Organisation of Work No response when an incident is reported	Awareness raising for handlers of importance of completing key fields so staff get feedback	Tendai Ruwona (Matrons)	Preventative	Comms	30/10/2023	NO	1	Reminder
Organisation of Work What are other areas doing to have been found to have good practice?	Speak with high reporting organisations and EPUT services to understand processes they use and feedback to incident project group	Phil Stevens	Preventative	Discussion Held	30/09/2023	NO	1	fact finding
Job Tasks Not recording learning on Datix Organisation of Work Lessons can be identified later in process	Review of learning sections on Datix as part of Datix form review (see action 6.3)	Didier Stephen	Preventative	see above		YES	3	see above
Job Tasks - Signing off incidents This is always registered nurse	Review process for identifying handlers to ensure considers the whole MTD	Phil Stevens	Preventative	New handlers	30/09/2023	YES	2	Enhanced involvement
Mobius gives a reminder message Paris does not	Review if it is possible for Paris to give reminders to sign off	TBC – IM&T Adam Whiting	Preventative	System change	30/09/2023	YES	3	Automated process

3.7 EPUT CQC response

We have embraced a new way of responding to CQC reports that involves a wide range of teams and individuals who know the services and how best to make valuable, long term, sustained change. This will support higher quality of care and better outcomes for our patients, alongside improved well being for our staff. This page highlights the level of engagement and commitment EPUT have put in to developing a comprehensive, forward looking action plan to mitigate the 72 CQC findings from the **draft** report received June 2023

>100 clinical, managerial, senior leaders and front line staff engaged and consulted with in the process



66% Of the people engaged and consulted with in the process so far are clinicians (from front line to senior leaders)

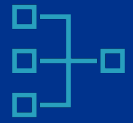
11 SEIPS* and causal review sessions held

12 days to complete the action plan in response to the draft CQC report

13 action and solution planning sessions held

New processes designed and in place:

- NEW CQC response process
- Action plan template
- Factual accuracy
- CQC response governance



>300 Actions signed up to with agreed owners with a significant proportion being preventative.

Full confirm and challenge process initiated to ensure all actions address the findings and are robust and sustainable

'I am confident we are not putting plasters on things and this new process will sustain change'

'People who were involved in SEIPs now understand the issues better and own it'

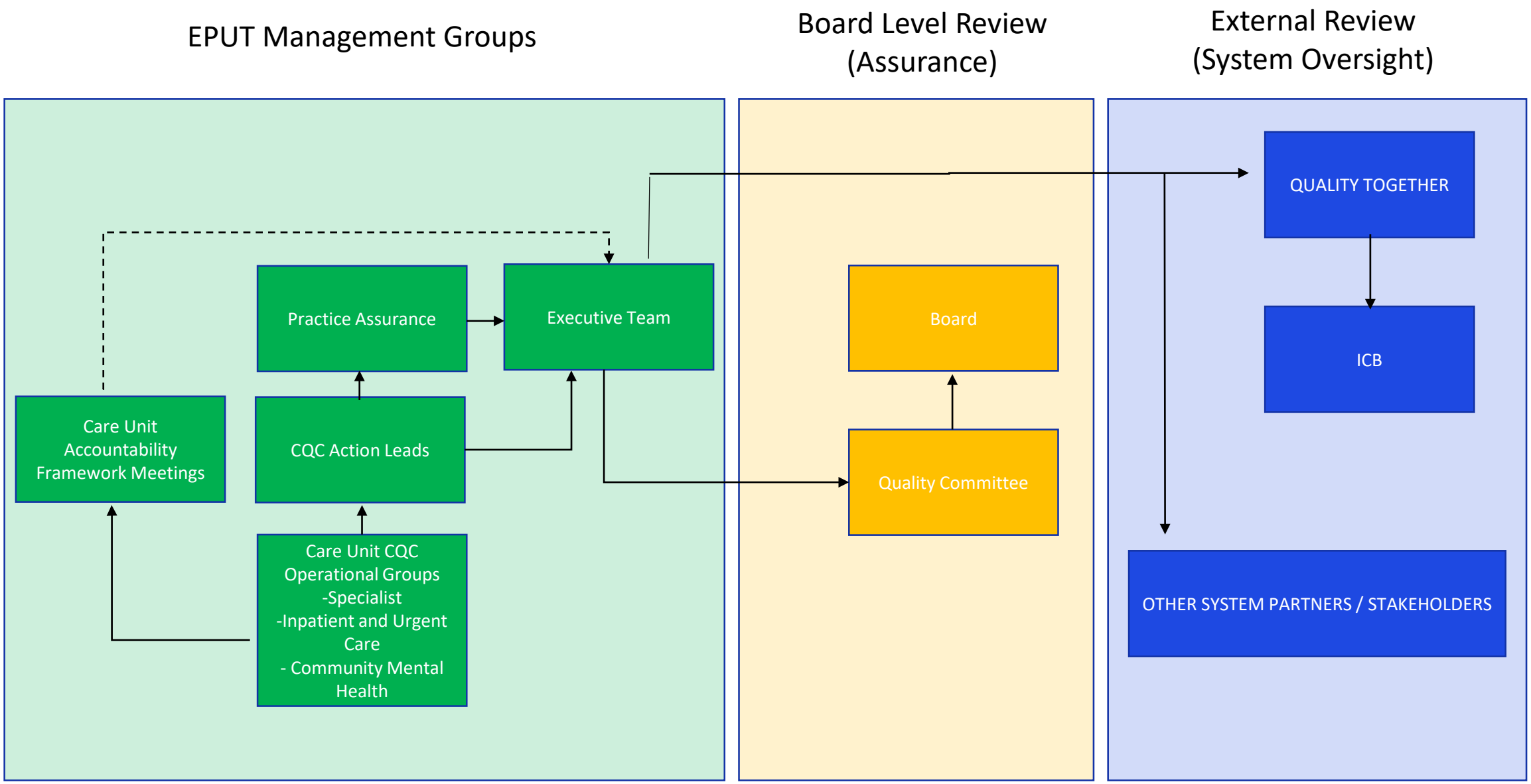
Staff feedback on developing the action plans:

'I feel my voice is being heard'

Using this new approach 'We have been able to provide realistic actions'

** SEIPs – Systems Engineering Initiative for Patient Safety*

4. Governance



5. Next Steps

NHS Essex Partnership University NHS Foundation Trust

Areas of focus for the next month

Implementation of quality improvement plan by operational groups and performance oversight by the action leads meeting – reporting to Executive Team. Focus on:

- Delivery of the "Quick Wins"
- Early identification of barriers/ risks
- Piloting Ward/Service Level Assurance Methodology (3 wards and then roll out)
- Further development of metrics to provide assurance that actions are making a difference

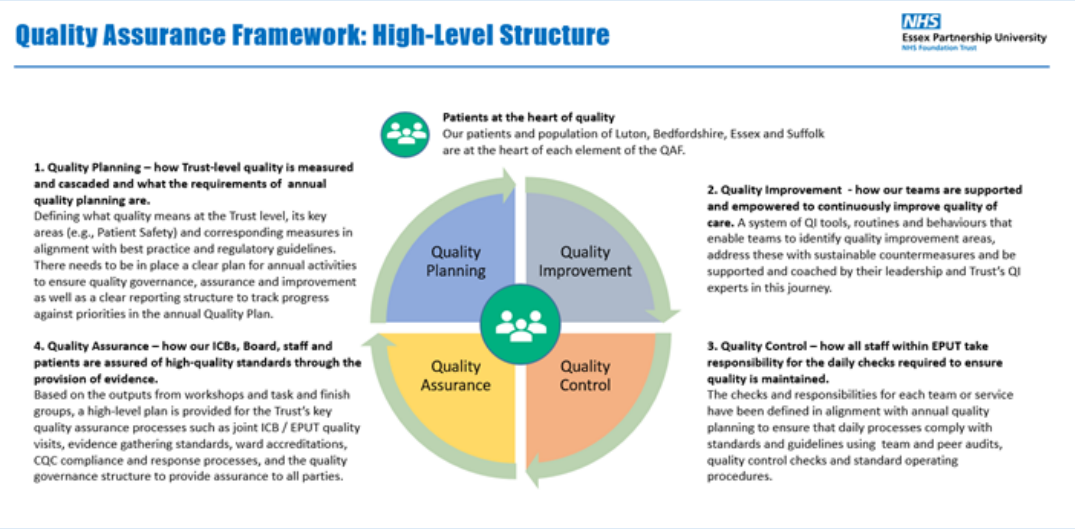
Reporting

Monthly reporting to Executive Team, Quality Committee and Partners on progress against actions to include:

- Sit rep
- Progress in last month
- Risks identified and mitigations
- Assurance Metrics

Linkages

Links to development of Quality Assurance Framework – 4 quadrants being:



Essex Partnership University NHS Foundation Trust

Inspection report

Trust Head Office, The Lodge
Lodge Approach
Wickford
SS11 7XX
Tel: 03001230808
www.eput.nhs.uk

Date of inspection visit: 22 November 2022, 23 November 2022, 24 November 2022, 4 January 2023, 5 January 2023, 6 January 2023, 17 January 2023, 18 January 2023, 19 January 2023
Date of publication: N/A (DRAFT)

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

We inspected Essex Partnership University NHS Foundation Trust (EPUT) because we received information and had concerns about the safety and quality of services.

We carried out an unannounced comprehensive inspection of 6 core services:

- Wards for people with a learning disability or autism
- Acute wards for adults of working age and psychiatric intensive care units
- Mental health crisis services and health-based places of safety
- Wards for older people with mental health problems
- Substance misuse services
- Community-based mental health services for adults of working age

We also inspected the well-led key question for the trust overall.

We chose to inspect acute wards for adults of working age and psychiatric intensive care units to see how many improvements had been made following our inspection in October 2022 where we rated the safe domain as inadequate and issued a warning notice. We chose to inspect 3 core services based on their ratings at comprehensive inspections in 2018 and 2019 to see if the trust had made improvements to quality and safety. We chose 2 core services that were rated as good in 2018 to check if the trust had sustained the quality of care delivered.

The trust provides the following mental health services, which we did not inspect this time:

- Child and adolescent mental health wards
- Community mental health services for people with learning disabilities or autism

Our findings

- Community-based mental health services for older people
- Forensic / secure wards
- Long stay/rehabilitation mental health wards for working age adults
- The trust provides community health services, which we did not inspect this time:
- The trust delivers the following community health services:
- End of life care
- Children and young people's services
- Inpatient services
- Adult services

Our rating of services went down. We rated them as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement. We reduced the overall rating for caring from outstanding to good because this is a more accurate reflection of how the trust are currently performing overall. Our overall rating considered the current ratings of the 5 mental health core services and 4 community health core services we did not inspect at this time.
- The governance and safety culture of the trust did not always support the delivery of high quality, person centred care. Issues with timeliness in responding to lessons and inaccurate data impacted staff's ability to support people appropriately. Three core services had declined in their quality. Wards for people with a learning disability or autism and community based mental health services for adults of working age went from good to requires improvement and acute wards for adults of working age and psychiatric intensive care units went from requires improvement to inadequate. Two core services – wards for older people with mental health problems and mental health crisis services and health based places of safety had remained requires improvement overall. One of the 6 core services we inspected had improved from requires improvement to good overall: substance misuse services. The trust had plans or had recently launched new strategies to address key safety concerns for example around staffing vacancies and patient safety observation, but many were very new and not yet embedded.
- Across the 6 core services we rated 30 domains associated with the key questions. In 9 examples there was an overall reduction from good to requires improvement. In one example there was a reduction from requires improvement to inadequate. In 1 examples ratings remained the same. In 3 examples domains had improved from requires improvement to good and in 1 example the safe domain improved from inadequate to requires improvement.
- The most concerning ratings were for acute wards of adults of working age and psychiatric intensive care units. We rated safe and well led as inadequate, the other domains as requires improvement which means this service is still inadequate overall. The trust failed to ensure that all the concerns highlighted in the warning notice issued in October 2022 had been achieved consistently across all wards. For example, on some wards staff still applied blanket restrictions. Examples included searching all patients returning to wards and preventing patients from accessing fresh air freely.
- There remained ongoing challenges with staffing wards consistently and we identified problems with staff completing patient observations safely and in line with trust policies. The rating for safe had remained inadequate, the same rating applied during the inspection in October 2022. CQC recognised Trust wide plans to address issues such as staffing. However, several aspects of these plans were not fully implemented embedded to impact care on all the wards yet.

Our findings

- We also saw a reduction in the quality of care staff provided in wards for people with a learning disability or autism and community based mental health services for adults of working age. Both services overall ratings had reduced from good to requires improvement.
- Whilst there were still improvements required across a number of core services and leadership did not always support the delivery of improvement at pace, the trust recognised this and were in the early stages of implementing various programmes and processes which would drive the quality of care up. The leadership team had been increased to support executives in driving quality improvement. The CQC reflected the need to ensure pace and priority for this work and the trust agreed and committed to this.

Our inspection identified the following areas where further improvement was needed:

- The arrangements for governance, assurance and performance management did not operate effectively. The CQC recognised the timing of the inspection meant there were multiple examples of new strategies, systems, roles and approaches that were in the early stages of implementation. Examples included the trust safety strategy, the appointment of directors of quality and safety and the implementation of 'Time to Care' and safety dashboards. All of these required further embedding to directly impact the quality of care people received. The pace of change remained a concern along with ongoing and repeated breaches of regulation identified in services that had been highlighted to the trust during previous inspections dating back to 2019.
- The approach to service delivery and improvement was reactive and the trust were in the early stages of implementing more robust assurance arrangements to support a proactive response to improvement. There remained work to be done to ensure quality improvement initiatives were present in services and making an impact on the services people received.
- Staffing remained a challenge. Bank and agency use was higher than the trust targets. Managers described ways they attempted to book staff familiar with the wards and patients, but staff and patients told us unfamiliar staff were an issue, especially during evenings and weekends. Sickness was rated as 'amber' on the trust risk register at 6%. There were challenges in recruiting to roles, vacancy rates for qualified staff were 21%. We continued to find issues with how staff observed patients, with examples of staff sleeping and not interacting in a therapeutic way. However, it was recognised there were some early programmes of work which may have a positive impact in the future, such as the recruitment programme for internationally trained nurses.
- Data quality affected the trust's ability to monitor and mitigate against poor performance, risk and poor quality. Data provided about key elements of service performance from executive level did not match with information we found at ward level. An example that supports this can be found in the report for acute wards for adults of working age and psychiatric intensive care units relating to supervision and appraisal data. There was a lack of pace relating to over 10 items reflected on the board assurance framework. From October 2022 – January 2023 there were 7 strategic and 8 corporate risk items that had shown no movement is their score. We identified issues with quality audits not highlighting gaps in the quality of care being provided, an example of this related to governance systems providing false assurance to the board about the quality of patient observations being delivered on wards. There were issues with inpatient services having low bed occupancy despite community teams having increased caseloads and waiting lists. An example of this was seen in acute wards for adults of working age and psychiatric intensive care units and community home treatment teams, this had not been robustly addressed by the trust.
- The trust were due to launch their new data strategy following the inspection to build on their digital strategy. This would provide focus on how best to utilise data to provide robust intelligence and information to improve patient outcomes. Electronic systems and data quality required attention and pace. The trust have been using 7 different

Our findings

electronic patient record systems since the merger in 2017 and 6 years later are in a position of having funding approved to develop and implement a single system for the trust. In August 2019 we highlighted to the trust issues with training data, performance data and staff difficulties with multiple electronic recording systems. However, the health information exchange (HIE) remained in place to support record sharing between teams.

- Medicines optimisation and management across the trust required improvement. Pharmacy workforce challenges affected the quality and sustainability of medicines services. Pharmacy teams operated with a 45% vacancy rate overall. Organisational restructures and reporting lines meant Pharmacy teams felt removed from operational decision making. There were issues with medicines management on wards and the capacity of Pharmacy teams to audit and offer support was compromised by staffing challenges. The trust continued to advertise Pharmacy roles but had trouble in recruiting.
- Leaders did not always support staff effectively. Supervision and appraisal rates did not consistently achieve the trusts target meaning not all staff had regular access to this support. Meetings and opportunities to share learning did not take place consistently and regularly. This applied at all levels in the trust and minimised lessons and learning influencing strategy and practice. Feedback from staff about their engagement with the trust varied greatly, some staffing groups felt disconnected and that leaders did not listen to or recognise their concerns, whilst other groups were mainly positive. Forty two percent of the focus groups expressed some level of concern regarding their ability to express concerns and engagement with the organisation.
- Long standing complaints required attention to ensure complainants received responses in good time and knew what was happening with their case. One example showed a complaint being made in August 2021, not resolved and the most recent contact recorded as April 2022. Whilst recognising the very recent implementation of a new complaints process, we were not assured that there was enough focus on resolving long standing complaints.

Our inspection identified a number of areas where improvements had taken place:

- There was a full recognition by the trust of the need to continually improve the culture of the organisation. The freedom to speak up guardian, although in an interim post, had worked hard to increase their visibility and share the importance of speaking up. Many of the staff we met during the inspection talked about the improvements in the workforce culture, although there were still pockets of poor morale, mainly due to staffing challenges and some issues identified via an internal inquiry following a television broadcast. The trust board displayed positive role modelling behaviours which they demonstrated throughout the well led review. The trust made sure learning featured at different levels in the organisation from the executive level learning sub- committee group through to learning newsletters displayed on wards and in services. Executives made themselves available to staff via 'grills' where staff could directly challenge leaders about their concerns or any issues. The trust appointed 500 engagement champions who could access the CEO directly, however there remained challenges with capturing the voice of staff working on inpatient wards. The trust set expectations about staff behaviour and developed a behaviour framework to outline clear boundaries about unacceptable behaviour and consequences for those behaviours. This was initially driven by the need to support staff who experienced racial abuse (identified at the CQC inspection in November 2022) but was not limited to this issue.
- The trust was actively involved work across the systems relevant to Essex. Three members of the executive team served 3 integrated care boards (ICB's) relevant to the trust's portfolio. The trust was part of four integrated care systems and were involved in 6 place based alliances. The trust also engaged with 3 local authorities which served different areas to those associated with the ICB's. Trust leaders understood the need to design, plan and develop effective services to meet the needs of the local population. A priority for the board was to ensure that the trust faced outwards and developed a reputation of transparency and openness. The trust opened their committees to governors to increase challenge and accountability and support the work of the non-executive directors. Feedback from people was integral to planning and reviewing services. The patient experience team developed multiple ways for people to

Our findings

provide feedback on their experiences by working with local teams to understand what fitted their demographic. This included the use of text messages, quick response (QR) codes, paper ballot boxes and forms. The work on creating a variety of feedback methods contributed to an 800% increase in feedback from August 2022 – January 2023. Work was ongoing to ensure that patients and people who use service featured as a key stakeholder. The 'your voice' community provided challenge and feedback to the board and the trust launched 'I want great care' in January 2022. The patient experience annual review from November 2022 demonstrated positive results for involvement including 92% growth in the recruitment of volunteers (from 126 in 2021 to 243 in 2022) and a 720% growth in recruitment to the lived experience team (from 10 in 2021 to 82 in 2022).

- The trust participated in the early adoption of the patient safety incident response framework (PSIRF). This sets out the NHS's approach to developing and maintain effective systems and processes for responding to patient safety incidents. The purpose is to develop a culture of learning to improve patient safety. The patient safety team engaged regularly with the national team to support the re-design of materials to improve their quality. The trust made a commitment to PSIRF despite the fact it was promoted as a cost neutral programme but has needed investment. Responses to patient safety incidents demonstrated compassion and answered all questions and concerns put forward by families and carers.
- The trust was the lead provider for the COVID-19 vaccination programme and was integral to ensuring people of Essex had access to this. They set up multiple vaccination sites quickly, delivered 1.6 million vaccinations and worked with local systems and partners to offer vaccinations to hard to reach and marginalised groups. The trust used creative ways to increase vaccination uptake such as vaccination busses and home visits.

How we carried out the inspection

Before the inspection visit, we reviewed information that we held about each of the core services.

During the inspection visits, we:

- Visited 29 wards, 17 teams and 4 health based places of safety
- Spoke to 224 staff performing a wide range of roles
- Spoke to 104 patients and 17 relatives or carers
- Looked at 182 individual patient records
- Looked at over 116 medication records
- Attended 29 meetings including staff handovers, multidisciplinary meetings and patient community meetings. We observed 5 examples of patient care by sitting and watching from patient areas.
- Attended 4 home visits
- Held 12 focus groups with staff of all grades on a variety of topics
- Looked at records, policies and procedures involved in the day to day operation of the services.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

Our findings

We spoke to 104 patients and 17 relatives and carers across the services we inspected. Patients and carers gave largely positive feedback about the way staff treated them and the support they offered. Patients and carers gave examples of staff treating them as individuals and involving them in their care.

On acute wards for adults of working age and psychiatric intensive care units, most patients told us staff working day shifts treated them with kindness and helped them to be independent. Patients liked the choice of food and the fact they could have snacks and drinks throughout the day. On wards for people with a learning disabilities and/or autism people told us staff treated them with kindness and that staff provided activities that they enjoyed such as cycling and colouring. Staff supported carers to attend the ward for visits and clinical meetings and involved them in planning the care and discharge of their loved one. On the wards for older people with mental health problems patients told us that staff listened and helped them to understand their care. Patients felt safe, valued and respected.

In the community-based mental health services for adults of working age, patients and carers praised the staff for making sure everyone was involved in care decisions and that staff looked at physical and social needs alongside their mental health. They felt the service responded to their needs quickly and involved other services which could help. Patients liked the frequency of their appointments and the fact that there was a team approach so they could be seen by others if their worker was on leave or absent and didn't have to repeat their care story. In the mental health crisis services and health-based places of safety, patients said staff treated them kindly and offered flexible appointments to meet their needs. Patients felt staff offered them opportunities to be involved in their care and did everything they could to provide care in the community and help people stay out of hospital. In substance misuse services, people felt staff had an excellent knowledge of substance misuse and this helped them feel supported. They described staff as being available when they needed them and making every effort to involve people in their care.

There were however some areas for improvement identified by people who used the services. On the acute wards for adults of working age and psychiatric intensive care units' patients and carers described issues with staff working nights. This included 5 patients describing staff falling asleep at night, 3 patients told us that staff talked in different languages during night shifts and were 'uncaring'. Four patients told us that staff observing them did not engage with them. One patient described issues with the food portions and 11 patients told us that the coffee was decaffeinated so staff could support them with good sleep hygiene. On wards for people with a learning disabilities and/or autism there had been an issue with a walk being cancelled due to staffing shortages and not all carers had a copy of their relative's care plan.

In the community-based mental health services for adults of working age, some people told us they would like more definite goals and to see the Doctor more often for reviews.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Trust wide

Our findings

- The trust must ensure they have a robust process for implementing and monitoring improvement processes. Such as breaches identified in core service reports in a timely and effective way. (Regulation 17(1)).
- The trust must ensure that the governance systems are further embedded and reviewed to enable the identification of issues affecting the quality of care being delivered. (Regulation 17(1)).
- The trust must ensure they improve the quality of their data, the effectiveness of their systems and the accuracy of the assurance they receive about the quality of care being delivered. (Regulation 17(1)).
- The trust must ensure they embed quality improvement methodologies across services to encourage ongoing improvements for people who use them. (Regulation 17(1)).
- The trust must ensure that they have a robust and timely plan for the implementation of a consistent patient record in line with their current strategic aim. (Regulation 17(1)).

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

- The trust must ensure that systems and processes are in place to assess, monitor and ensure staff follow the trusts 'policies and procedures for the recording and reporting of incidents. (Regulation 12 (1).
- The trust must ensure staff follow the provider's policy and procedures on the use of enhanced support when observing patients who have been assessed as being at higher risk harm to themselves or others and observe patients in a way that maintains the patients' safety. (Regulation 12(1)).
- The trust must ensure staff fully engage with patients when undertaking enhanced observations (Regulation 12(1)). The trust must ensure that staff do not fall asleep when undertaking patient observations. (Regulation 12 (2).
- The trust must take immediate steps to review and reduce all blanket restrictions on the wards, where it is safe to do so. (Regulation 12 (1).
- The trust must ensure there are sufficient numbers of regular staff working on the wards who are familiar with individual service user needs. (Regulation 12 (1).
- The trust must ensure that maintenance work is completed to address the inability of staff to observe patients from all areas (blind spots). (Regulation 12 (1).
- The trust must ensure patients understand the use of the contact-free patient monitoring and management system, including why it is used and how information will be stored and accessed. (Regulation 12 (1).
- The trust must ensure that all patients have access to nurse call alarms. (Regulation 12 (1).
- The trust must always treat all patients with dignity and respect. (Regulation 10. (1))
- The trust must support the autonomy of the patients in line with their needs and stated preferences. Patients admitted informally must be fully informed of their rights and able to leave the ward safely. (Regulation 10. (2) (b))
- The trust must ensure patients are always treated with respect and dignity whilst they receive care and treatment. Care plans must be fully complete, personalised, holistic, reviewed regularly and consider the full range of patient's needs. (Regulation 10. (1))
- The trust must review the current prohibited items lists as these varied from ward to ward. (Regulation 12 (1).
- The trust must ensure care and treatment is provided with the consent of the patient around the contact-free patient monitoring and management system. (Regulation 12 (2)).
- The trust must assess risks to the health and safety of patients receiving care and treatment, including patient's sexual safety; doing all that is reasonably practicable to mitigate such risks. (Regulation 12. (1) (2) (a) (b)).

Our findings

- The trust must ensure that any episode of abuse is reported, and appropriate actions taken, including incidents of racial abuse to staff; doing all that is reasonably practicable to mitigate such risks (Regulation 12. (1) (2) (a) (b))
- The trust must ensure staff used systems and processes to safely prescribe, administer, record and store medicines. The trust must ensure that staff regularly review the effects of medications on each patient's mental and physical health. (Regulation 12 (2))
- The trust must ensure all ward areas are clean, well maintained and well-furnished. This includes the seclusion room at Ardleigh ward. The trust must ensure that ward doors are robust. (Regulation 15. (1))
- The trust must ensure the premises are suitable for the purpose for which they are being used including patient search rooms for Willow, Cedar and Hadleigh wards. (Regulation 15. (1))
- The trust must ensure systems and processes established and operate effectively to ensure compliance with inspection requirements. Audit processes effective, pick up and effectively address gaps in care (Regulation 17 (1))
- The trust should ensure they have effective systems and process to identify, and where risk allows, mitigate and review restrictive practice. (Regulation 17 (1))
- The trust must ensure sufficient numbers of suitably qualified psychology staff deliver care at Willows and Cedar ward. (Regulation 18. (1))
- The trust must ensure that staff are made aware of the need for professional boundaries. (Regulation 18. (1))
- The trust must ensure staff receive regular mandatory training. This includes Fire compliance, prevention management of violence and aggression, Safeguarding adults and Children, Mental Capacity Act training (Regulation 18. (2))
- The trust must ensure staff receive regular supervision and appraisals. (Regulation 18. (2))

Mental Health crisis and health-based places of safety

- The trust must ensure that staff in the home treatment team east manage, store and monitor controlled drugs in line with trust policy. (Regulation 12 (2))

Community Mental Health services for Adults of Working Age

- The trust must ensure that they are compliant with all aspects of medicines management including. That there are no gaps in clinic room fridge and room temperature records. that there is always a robust system in place to ensure the security of all doctors FP10 prescription pads. That all out of date medicines are disposed of immediately. (Regulation 12(2)(g))
- The trust must ensure that all patients have fully completed discharge plans and that there are systems and processes in place to secure timely discharge for patients using the recovery and wellbeing part of the service as part of their recovery. (Regulation 17(2)(b))
- The trust must ensure that managers at Colchester EIP and Colchester wellbeing and recovery teams use effective systems for auditing patients' care records when they transfer between care co-ordinators. (Regulation 17(2)(b)).
- The trust must ensure that their electronic recording system/s can link up historical and current patient information. To ensure that staff can easily access all this information and ensure that no patient information is lost when transferring from one system to another. (Regulation 17(2)(f))

Wards for older people with mental health problems

Our findings

- The trust must ensure that emergency equipment is managed in line with trust policy (Regulation 12(2)(b)).
- The trust must ensure all Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) information and recording is correct (Regulation 12(2)(b)).
- The trust must ensure staff on Henneage Ward maintain trust standards when observing and interacting with patients (Regulation 12(2)(b)).
- The trust must ensure that medicines are managed in line with trust policy, in particular medicines reconciliation and covert medicines administration (Regulation 12(2)(g)).
- The trust must continue its work to recruit psychologists as part of the multidisciplinary team. (Regulation 18(1)).

Wards for People with a learning disability and autistic people

- The service must ensure it has enough permanent regular nursing and support staff to keep patients safe (Regulation 18(1)).
- The service must ensure that blood glucose machines are fully calibrated (Regulation 12(2) (e)).
- The provider must ensure that all care and treatment records are complete and accessible (Regulation 17(2)(c)).
- The service must ensure that staff accurately record administration of medications, and that consent to treatment forms are easily accessible (Regulation 12(2) (g)).
- The service must ensure that staff record patient vital signs on the physical health observation charts, in line with trust policy. (Regulation 12(2)(a)).
- The service must ensure that staff have access to specialist learning disability and autism training. (Regulation 12(2) (c)).

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure they continue to work on the organisational culture, including addressing the recommendations made from the inquiry linked to recent television broadcasts.

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

- The trust should ensure the new vison and values are reviewed across wards to ensure staff understand their role and contribution to providing high quality care.
- The trust should ensure that staff are provided with clear guidance regarding how to hold patient forums.

Mental Health crisis and health-based places of safety

- The trust should ensure that the Home First West, Home First Mid, and Home First East teams are up to date with their mandatory training.
- The trust should ensure that teams do not have excessively high caseloads.
- The trust should ensure teams monitor physical health where necessary.
- The trust should ensure that care plans are personalised and individualised and demonstrate patient involvement.

Our findings

- The trust should ensure the Home First East team manage and store medication in line with the trust's medication management policy.
- The trust should ensure that vacancy rates are reduced so that teams are adequately staffed.
- The trust should ensure that the Home First West, Home First East and Crisis Resolution and Home Treatment west teams are up to date with staff supervision.
- The trust should ensure that doctors in the Home First Team East keep prescription pads stored securely.
- The trust should ensure the Home First East team complete audits to monitor the effectiveness of the service.

Community Mental Health services for Adults of Working Age

- The trust should ensure that all patient care plans are individualised and holistic.
- The trust should ensure that they address the waiting lists for psychological therapy.

Wards for older people with mental health problems

- The trust should ensure that work continues to recruit permanent staff to reduce vacancy levels.
- The trust should consider arrangements for formally monitoring meaningful activities for patients on each ward.
- The trust should ensure that staff on Tower ward meet its targets for compliance with mandatory training, in particular grab bag training.
- The trust should ensure the service adheres to the Mental Health Act and the Mental Health Act Code of Practice, in particular that patients' medicines are prescribed in line with consent to treatment documents.
- The trust should ensure that care plans are easy to use and understand.
- The trust should continue its work to recruit psychologists as part of the multidisciplinary team.
- The trust should ensure that staff meet its targets for compliance with staff appraisals and staff supervision.
- The trust should ensure all wards follow its governance systems and processes to maintain patient safety, in particular for clinical equipment monitoring, assessment and management of patient risk, and medicines management.
- The trust should ensure that it develops structured quality improvement models to help facilitate improvements and service developments.

Wards for People with a learning disability and autistic people

- The service should ensure that staff follow trust policy on body worn cameras
- The service should ensure that the contents of the first aid box are checked regularly, and items replaced.
- The service should ensure that governance systems and process are fully embedded to ensure that action is taken.

Is this organisation well-led?

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Our findings

Since our previous inspection in July and August 2019, changes had taken place to the board to increase accountability, strengthen clinical leadership and increase capacity. The board appointed the current chief executive officer in October 2020. Alongside this, the trust recruited a new chief operating officer, a new executive director of strategy, transformation and digital and a new chief financial officer.

The EPUT board of directors consisted of 8 executive directors (EDs) and 8 non-executive directors, with no current vacancies. The trust planned to refresh the chair of the audit committee later in 2023.

The executive board had 1 (7%) person from an ethnic minority group member and 2 (25%) women. The non-executive board had 3 (50%) members from ethnic minority groups and 3 (50%) women.

The trust leadership team had a comprehensive knowledge of current priorities and challenges. However, we were concerned by the lack of pace that leaders applied to make improvements in some services. Acute wards for adults of working age and psychiatric intensive care units' inspections from 2019 to current have identified ongoing and repeated breaches of regulation that are yet to be fully addressed. Further to this, examples of poor practice which have been highlighted in the core service report were still being used and evidence of trust policies not being followed. The trust leadership team recognised the need for further work to embed and evaluate policies and procedures, particularly relating to patient safety. Leaders demonstrated commitment and drive to improving the care delivered in underperforming services.

The leadership team created new roles to drive improvement. The trust recruited deputy directors for quality and safety and deputy medical directors. The trust intended to devolve leadership and empower leaders to drive improvements in their care units. The accountability framework implemented in January 2022 supported this approach. Leaders aimed to outline, through the framework, ways in which the care units were held to account on their ability to achieve the trusts strategic objectives and key performance indicators. Leaders held monthly accountability framework review meetings to ensure joined up discussions took place with care units to understand local challenges and successes. The agenda for the meetings monitored performance and challenged under performance.

Leaders planned time to ensure visibility in services. From June 2022 to December 2022 board members completed 130 visits to services across the trust portfolio. During visits leaders spoke with staff about any concerns, observed how staff delivered care and spoke with patients about their experiences of services. Leaders reported to board on visit outcomes. Staff across services spoke positively about visibility of senior leaders. The CEO held 'L50' events with 50 leaders in the trust where they updated colleagues about key messages, challenges, priorities and achievements. There were further opportunities for staff to engage via all staff briefings and 'engagement champion grills'.

Recruitment files demonstrated all appointments to the board had been completed in line with fit and proper person guidelines. More recent appointments demonstrated the involvement of governors and people who use services in the recruitment process.

The trust invested in developing leaders for the future. The RISE programme provided opportunities for staff from ethnic minority groups to develop a range of skills and competencies to support them in advancing their careers. It was open from bands 2 to 8b and provided opportunities from 1 day line manager modules to longer courses offering 5 modules, a quality improvement project and a graduation event. The programme used a blended learning approach and offered a range of development tools from self paced learning to mentoring. The first cohort had completed the programme and an evaluation was complete. Twenty seven percent of the first cohort experienced promotion during their time on the course. The trust recognised that staff not from a ethnic minority groups had requested access to the programme and planned to design further options to promote inclusivity.

Our findings

People appointed to positions of senior leadership had the appropriate skills, knowledge and experience to perform their roles. The members of the executive leadership team had clearly defined roles as leads for delivering the strategic improvement priorities and were actively working on translating this into practice. Members of the executive leadership team spoke about this work with confidence.

The non-executive directors had well defined areas of responsibility and brought a wide range of skills, experience and connections with external bodies. They were able to describe their roles with clarity.

Clinical leadership had been strengthened. The medical director had support from 5 deputy medical directors, having previously having 1. This was the same for the executive nurse. This increased medical leadership's ability to meet with medics working in services and offer increased support. The medical director met with inpatient consultants on a weekly basis to keep informed about the pressure's services faced. The guardian of safe working met with junior doctors regularly and medical staff had access to supervision and external supervisors. Medicines safety and Pharmacy sat under the portfolio of the executive nurse. Medical education sat under the portfolio of the medical director. There were 145 trainee Doctors and 180 students involved with the trust. Once a month the medical director and a deputy medical director held a reflective podcast which engaged 300-400 staff.

Vision and Strategy

In 2021, the trust agreed a new vision and set out "to be the leading health and wellbeing service in the provision of mental health and community care. The executive team presented their 2023 – 2028 strategic plan at public board on 25 January 2023. The strategy sets out the commitment to put service users, families and carers at the centre of everything the trust does and was designed in line with national policies such as the NHS long term plan and the NHS mental health implementation plan. The trust set values of "we CARE, we LEARN, we EMPOWER. The strategic objectives set by the board aim to "deliver safe, high quality, integrated care services, we will enable each other to be the best that we can, we will work together with our partners to make our services better, we will help our communities thrive." The trust vision aimed to "be the leading health and wellbeing service in the provision of mental health and community care".

The trust had four strategic objectives:

We will deliver safe, high quality, integrated care services

We will enable each other to be the best we can be

We will work together with partners to make services better

We will support our communities to thrive

The trust sought feedback from patients, carers, families and system partners during the development of the strategic plan to ensure it captured the needs of the population and they system. The trust engaged with 680 people over 83 engagement events during the development phase.

Our findings

The strategy laid out the priorities for each objective, the trusts commitments to achieving the objectives and ways in which leaders would monitor outcomes. Under the strategy sat local strategies for the 5 'care units': Mid and South Essex Community, North east Essex, Specialist services, Urgent care and Inpatient and West Essex Community. These described local visions and commitments that supported the objectives of the overall trust strategic plan. Care units formed a new operating model for the trust led by multi disciplinary and professional teams.

Wider organisational plans supported the delivery of the strategic plan. Some of these included the 'safety first, safety always strategy' which aimed to consistently deliver safe, individualised care with patients and family at the centre. The trust viewed this strategy as a 'golden thread' throughout the organisation supported by the accountability framework and the cultural work happening in the trust. The digital and data strategy aimed to maximise inclusion and support transformation and improvement programmes and focused on meeting national and system requirements including the requirements set out by the NHS transformation directorate relating to shared care record requirements. The trust also had strategies 'under construction' such as the clinical quality strategy, the working with people and communities strategy and the people and culture strategy, all of which required embedding following their sign off. Executives chaired the strategy steering group which reviewed progress against the delivery outcomes of the strategy.

The trust developed strong working relationships with system partners. The population served by the trust required engagement with 4 integrated care boards (ICB's), 4 integrated care systems (ICS's), 3 local authorities and 6 place based alliances. The trust had also established specific arrangements with other providers of NHS services to work towards their strategic objectives. In North East Essex the community collaborative brought together services providing community health services. This also occurred in Mid and South Essex. In East of England, the regional specialist mental health collaborative brought together specialist mental health services and and the CEO attended to represent the trust.

In Southend, Essex and Thurrock the trust worked with multiple partners and stakeholders from NHS colleagues to the Police to refresh the all age mental health strategy for the area. This required collaborative working arrangements to support its design and implementation.

The trust maintained relationships with local universities to support education and training for students and worked with services in their geographical area such as general practitioners, acute hospitals and community services.

Culture

The trust recognised the need to continually improve the culture of the organisation. Throughout various interviews leaders described the work to ensure staff worked in a culture of learning and not blame. Many of the staff we spoke with during the inspection described work encouraging people to speak up and recent work about challenging racist behaviour.

Following a recent undercover television programme broadcast the trust instigated an internal inquiry to investigate and review concerns raised. Culture featured as a concern for two acute wards for adults of working age. Whilst the inquiry team approached 61 members of staff only 20% of staff engaged with the process. Recommendations from the inquiry included the need for further development of local learning cultures, time to be protected to support developments of team culture and was critical of the 'cultural grip' that failed to assure that behaviours were in line with trust values. The inquiry made primary recommendations that the trust review induction guidance for temporary staff to promote consistency of positive culture, that the trust should review how a culture of psychological safety could be

embedded to encourage staff to speak out and that local teams featured in the broadcast build relationships with the lessons team to develop their culture of learning. The inquiry team made longer term recommendations for the trust to develop strategic plans to address organisation culture and develop staff confidence in the trusts ability to be open, honest and responsive. The inquiry team presented their findings to board in January 2023.

The trust had an interim freedom to speak up guardian (the permanent post was being recruited to). The role of a freedom to speak up guardian is a person who supports staff to speak up about concerns without the fear of negative consequences. Data collected from the freedom to speak up guardian showed an increase in people raising concerns. In 2022/2023 quarter 1 (April – June) staff reported 44 concerns, quarter 2 (July – September) staff reported 54 concerns and in quarter 3 staff reported 129 concerns. Themes of concerns included bullying and harassment, patient safety, staff safety and inappropriate restraints. The trust also had 10 freedom to speak up champions whose role was to support the guardian in raising the profile of their work. The guardian and champions prioritised visibility and spent time of wards, including attending handovers and night shifts. The guardian delivered themed workshops to staff which linked to themes from reported concerns and had also delivered sessions to staff following the broadcast of an undercover television programme. During December 2022 the guardian purposely reduced their visits to wards to measure visibility versus reported concerns. Reported concerns dropped when visibility decreased. The guardian had direct access to the chief executive office and provided reports to board. The trust employed administrative support for the guardian to support the workload of 129 reports of concerns requiring review and action.

The trust had an equality, diversity and inclusion plan outlined for 2022 – 2023. The plan outlined four strategic pillars: culture and leadership, talent management and acquisition, recruitment and retention and data. Work identified in the plan included 'embed the just culture – civility and respect principles across the trust', 'ensure process for career progression plans are in place for black and minority ethnic staff', 'all leavers will have a "stay" and/or "exit" interview and 'campaign to encourage staff to share their protected characteristics for use within the trust'. The trust outlined ways in which progress against the work would be measured such as: 80% of staff with complete demographic data, 100% of staff leavers to have a recorded exit interview, 5% uptake in career progression initiatives and a reduction of 5% in recorded formal concerns. The plan outlined the goal of improved staff wellbeing making a positive impact on patient safety.

Twenty three percent of staff in the trust were from ethnic minority groups. The workforce race equality standards (WRES) requires NHS employers to take action to ensure that staff from ethnic minority groups have equal access to career opportunities and receive fair treatment in the workplace. Whilst the trust made some improvements in 2022 across 6 WRES indicators, 3 showed a decline in staff experience. Indicators showing improvement included staff from ethnic minority groups in clinical workforce leadership positions (NHS Band 7, 8a and 8d) increasing by 1.5%, as well as staff from ethnic minority groups being more likely to access mandatory training and continual professional development. This was a specific achievement for the trust after being identified as one of the lowest performing trusts in the country for this previously. Although board representation for staff from ethnic minority groups had declined from 2021, at 25%, this remained above the national average of 7.5%. However, indicators which had worsened included the number of staff from ethnic minority groups experiencing bullying and harassment from patients, relatives and staff in the last 12 months and the likelihood of staff from ethnic minority groups entering disciplinary proceedings. The trust refreshed their WRES action plan for 2022/23 based on the required areas for improvement and consulted with stakeholders and the ethnic minority and race equality staff network in September 2022 with a view to develop the plan further and present to board for approval.

The declaration rate for disabled staff had increased by 0.7% from 2021 to 2022, standing at 4%. The workforce disability equality standards (WDES) supports organisations to compare the workplace and career experiences of disabled and non-disabled staff. In 2022, the trust saw an improvement in 11 out of 13 WDES metrics. Disabled applicants were more

likely to be approved during trust shortlisting processes for roles than non-disabled applicants. This indicator was supported by the work completed by the trust around hiring practices as a disability confident employer and their guaranteed interview scheme. However, the prevalence of disabled staff experience of bullying and harassment was the main area of focus for the trust, having seen a decline in the 2022 results compared to 2021. As with the WRES, the trust refreshed their WDES action plan in consultation with stakeholders and the disability and mental health network for in September 2022, with an updated version to be presented for board sign off.

The equality and inclusion sub committee was in place to steer and guide work required to make progress on the trust's general equality duties. The committee was responsible for monitoring and developing the equality delivery system (EDS2). The EDS2 was designed to support employers embed equality principles into day to day work and improve equality performance. The most recent EDS2 from 2021/2022 recorded the trust as 'achieving' 12 outcomes and 'excelling' in 6 outcomes. The trust excelled in areas such as staff taking up training and development opportunities and having fair recruitment and selection processes contributing to a more representative workforce. However, it was noted that the trust also 'excelled' in staff feeling free from abuse and harassment, bullying and violence, which conflicts with the findings of the WRES and WDES. The trust had 350 staff engagement and equality champions whose role it was to spread the message about equality inclusion. They received training and support for this role and were sponsored by the Executive Director for People and Culture. The trust trained staff in understanding the accessible information standards to ensure that anyone using services with a disability, impairment or sensory loss could get the information they needed in a way they understood. Leaders expected staff to identify and record information relating to communication needs at the earliest opportunity and to review them throughout treatment.

Staff networks existed for staff from ethnic minority groups, disabled staff, LGBT+ staff and staff with caring responsibilities. Executive sponsors supported each network. Staff networks planned and delivered events throughout the year to draw attention to specific topics such as Black History Month and LGBT+ history month.

Recruitment and retention of staff posed a challenge to the trust. Staffing data showed trust wide vacancy rates for registered nurses to be at 21% (1544 full time equivalent out of an establishment of 1958). The vacancy rate for health care assistants was 12% (745 full time equivalents out of an establishment of 850). The trust workforce improvement planning for 2023 – 2024 set out three key workforce priorities: recruitment and retention, temporary staffing and culture. Recruitment and retention was underpinned by 9 actions, examples of which included: clear recruitment processes, job description standardisation, the implementation of 'Time to care' and school/college/university in-reach across the trust geography. Temporary staffing actions included example such as 6 month contracting with agencies and a preferred supplier list and the introduction of an agency to bank policy. Finally, culture actions included examples such as equality, diversity and inclusion educational sessions, leadership development for band 7 and 8a and a rota of employee experience managers on wards. The trust set a deadline of 7 February 2023 for all care units to design action plans to support workforce improvement. The HR director took responsibility for owning the plan, with progress tracked via fortnightly delivery review meetings and assurance gained from the accountability frameworks. The trust were in the early implementation stage of 'Time to care' (TTC) following it commission in June 2022. The program supports frontline staff to identify challenges and implement solutions at the ward level in order to increase time available for direct patient care. This was not yet fully embedded in all services.

The trust recruited 185 internationally trained nurses from a variety of different countries to improve vacancy rates. At the time of inspection 65 were working on wards and the remaining 120 were in progress. The trust offered 3 months pastoral care to internationally recruited nurses in comparison to most other trusts with similar programmes who offered 1 month.

Our findings

Staff sickness was above target for the trust (5%). Figures report for January board showed 6% sickness levels across the trust. Although long term absence was less concerning at 3%. The trust reported that 5% of staff sickness related to anxiety, stress or depression. Staff turnover sat at 11% against a national benchmark of 12% for mental health services and 12% for community health services.

The trust recognised staff through staff recognition awards which members of the public could access via their website. There were 5 categories available: hero award – beyond the call of duty, peer to peer recognition, team recognition, leadership award and research, innovation and improvement. The trust put forward any winners of recognition awards into the staff recognition of the year award at the annual quality awards event.

The trust supported staff wellbeing in a variety of ways. The 'here for you' service, delivered in partnership with another NHS trust was award winning and was established in response to the challenges staff faced during and post the COVID-19 pandemic. It provided support for mental health issues, financial issues and practical issues. This was additional support available to staff alongside the employee assistance programme.

Forty two percent of staff engaged in the most recent staff survey, despite the trust arranging access for bank staff. Highlights of the survey showed 89% of staff felt the organisation was compassionate and inclusive. Staff felt trusted to do their job (92%), staff felt they could discuss flexible working (78%) and that leaders took a positive interest in their career (77%). Forty nine percent of staff felt they could meet the demands of their job which was 5% above the average scores nationally. Twenty one percent of staff felt they would probably look for a new job in the next 12 months.

Duty of Candour continued to be upheld appropriately. Complaint and investigation responses included apologies, where appropriate, and demonstrated compassion and transparency.

Governance

Governance processes did not always support the delivery of high quality person centred care. It is recognised that many of the governance process were new and had recently implemented by the trust. The year 2 progress report for the safety strategy was due for board sign off in January 2023 and required embedding across the organisation. The use of live safety dashboards to capture risk and performance issues was a new concept and was still under development. The trust recognised that their pace at implementing new structures and processes needed to increase and it would take time for them to see the benefits reflected in the quality of their services. A full review of governance and leadership was due to take place by the end of the 2023/24 financial year by an external facilitator. The trust did use data that compared current performance to previous months performance to look at how services performed over time, and this was included on the new safety dashboards.

We remained concerned about the trusts ability to use previous inspection findings to drive improvements to patient safety and experience. In acute wards for adults of working age and psychiatric intensive care unit's leaders had not ensured all breaches from 2019 and 2022 inspections had been fully addressed. We reviewed all six breaches during the services inspection and identified ongoing issues with 5. How staff safely and effectively observed patients also remained an issue across services. In continuing to identify these issues, we not only remain concerned about the safety of patients in services, but also question how robust and effective the trusts governance and monitoring systems are when they are not identifying and addressing these issues in between CQC inspection activity.

We asked the trust how they would ensure that they would resolve historical and repeated issues raised by previous inspections across their portfolio of services. Changes made to structures and culture were given as examples. One being the newly appointed deputy directors of quality and safety who oversaw each care unit (5 in total). The people in

those roles played a significant part in ensuring that quality and governance was consistent across the care units. They chaired the quality and safety meetings which enabled them to take lessons and feedback to trust sub committees such as the quality and governance sub-committee. The roles were new and required time to embed with the most recent recruitment having been appointed in December 2022. Whilst it is recognised the trust are making changes to address issues of quality and safety, we remain concerned about pace when some of these issues came to light from the inspection in 2019.

The structures, systems and processes in place to support the delivery of trust strategy included sub-board committees, care unit meetings and local governance meetings. The director of corporate governance reviewed the governance structures on their appointment and implemented a system framework approach. This enabled the trust to ensure there were programmes of work identified to address any problems identified from assurance processes. Governance leads had defined portfolios and described their priorities.

Papers provided for board meetings contained appropriate information and were of a good standard. Minutes reflected the link between wards and the board. Staff at service level communicated how governance processes worked and gave examples of how change had occurred.

The new accountability framework provided the structures for team, care unit and senior governance meetings. It enabled leaders to share essential information such as learning from complaints and incidents to ensure action could be taken. Although the trust could access a wide variety of data, we could not be assured this was always accurate. Without accurate data we were not assured the trust would always be able to recognise where support may be needed in services to improve the quality of care delivered by staff.

There were arrangements in place to ensure that the trust discharged its powers and duties under the provisions of the Mental Health Act 1983 (MHA) and Mental Capacity Act 2005 (MCA).

The audit committee 7 times in 2022/23 and was supported by 3 NEDs. In November 2022 the committee noted that despite policy review staff still did not always adhere to policies and procedures required by the trust. This information came from a ‘site visit’ report. It was decided that to address this issue executives must take ownership of policy and they must be enforced. This was due to be raised at executive team meeting and an update provided to the committee in January 2023. We were not assured that this action was robust to address the issue of staff not following policy. The trust clinical audit team were responsible for oversight and management of audit across the services. They provided bi-monthly reports on progress of their audit schedule to the clinical governance group and a monthly report to the learning collaborative partnership.

The trust used a quality assurance and quality control IT system. The aim is to take data from ward to board. The areas for quality assurance and quality control are infection, prevention and control, Mental Health Act, medicines management and clinic room care. Information is transferred to a portal where information could be filtered into dashboards and performance reports.

There were discrepancies in information provided to board as assurance via this system compared with data provided at ward level during our inspection. Therefore, we were not assured that the board received accurate assurance all the time. Examples of this includes data around the observation of patients

Following our focused inspection in October 2022 of acute wards for adults of working age, there was a recognition that the process for accessing closed circuit television (CCTV) for assurance was difficult. This process was being updated and needed continued development.

Our findings

Management of risk, issues and performance

In January 2021 the trust launched their safety first, safety always strategy following the Health and Safety Executives prosecution. The prosecution related to the North Essex Partnership NHS Foundation Trusts failings to adequately manage ligature risks between 2004 and 2015. The strategy sets out how the trust will focus on seven themes of improvement: leadership, culture, continuous learning, wellbeing, innovation, enhancing environments and governance and information. The trust engaged with medical and corporate staff across the organisation through 1 to 1 meetings, workshops and focus groups in creating the strategy. The strategy year 2 progress report was due to be reviewed with further consultation and brought back to board in March 2023.

Since the launch of the strategy the trust have invested £20 million in their inpatient services addressing environments and safety. This included reducing ligature risks across the estate. In 2022 fixed ligature point incidents reduced by 32%. Alongside the physical changes to environments the trust offered opportunities to staff where they could receive payment for completing training outside of working hours, including the completion of required patient safety training. Six thousand staff members had completed part one of this training. Staff had access to suicide prevention training which worked alongside physical changes to environments with an aim to reduce harm to patients. As of January 2023, 95% of staff had completed dedicated suicide prevention training. Whilst the implementation of the suicide prevention strategy remained on the board assurance framework (BAF) as an 'amber; risk the trust had made key progress including at 19% downward trend n instances of self harm, 95% of patients had a personal safety plan and further trainers for suicide prevention training had been recruited.

The board had a BAF in place which identified key strategic and corporate risks which they scored by priority. In January 2023 the board reported 4 risks rated as 'red' relating to safety, people, demand and capacity and capital. These related to demand for services, national challenges relating to recruitment and retention, COVID-19 long term planning and enough capital being made available to maintain modernisation and essential works. The board rated 4 strategic risks as 'amber'. Corporate risks rated 'red' included issues with staff observing patients (as found by CQC). 'Amber' corporate risks related to training frequencies post COVID-19, suicide prevention, patient safety incidents, medical devices, staff experience and COVID-19 vaccination focus. We were concerned about the pace of issues being addressed on the BAF as many had been present for the last 3 months with minimal movement. NEDs also expressed this concern. The board had been unable to remove any risks in January 2023 and had made an additional entry relating to Pharmacy. Services completed local risk registers which detailed specific risks that applied to their services, however none of the services described how local risks informed what risks the board included in the trust wide risk register. We identified issues with the quality of risk assessments across the services. The quality and frequency of completion varied. These issues had not been addressed by the trust via quality audits and spot checks.

The trust participated in the early adoption of the patient safety incident response framework (PSIRF). This sets out the NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents. The purpose is to develop a culture of learning to improve patient safety. PSIRF does not make a distinction between patient safety incidents and serious incidents, instead it promotes a proportionate approach where a response to incidents should have resources allocated to learning. There was a specific patient safety team dedicated to reviewing safety incidents in the trust. On report of a safety incident the executive assurance group reviewed the information and made decisions about how to progress it. The most reported incident types relevant to patient safety incidents were recorded as patient disengagement, record keeping and documentation and communication. Actions could include a full patient safety incident investigation (PSII), a clinical review, the requirement for a safety improvement plan (SIP) or an after action review. Reviews provided an opportunity for the trust to look at any gaps and share this with local teams to promote a culture of learning. At the time of the inspection there were 10 PSII investigations underway, 3 of which were 'paused' due to ongoing Police involvement. Forty five examples did not meet the criteria for investigation and

would be directed down other learning avenues depending on decisions by the executive assurance group. We reviewed 5 PSII reports and found that the trust had compassionately involved family members and sensitively addressed all their questions and queries. Family liaison officers supported this process. Staff completed thorough and detailed investigations and the staff leading them had the right qualifications and experience and applied objectivity as they did not work in the service the investigation related to. Investigators sent completed PSII reports back to the executive assurance group for final review and sign off and family liaison officer supported families on receipt of final reports.

The trust invested heavily in PSIRF and maintained significant involvement in the national programme. Initially it was expected that adopting PSIRF would be a 'cost neutral' (meaning no impact on the trusts finances) exercise, despite this not being the case the trust progressed with implementation and made appropriate financial investments into the patient safety team and the resources required. The trust contributed to the design of new safety improvement plans to be used nationally following a review of the practicality and effectiveness of the original template.

The trust invested and implemented a contact free vision based patient monitoring system and an electronic observation platform. This aimed to support clinicians intervene earlier when there were issues with vital signs, risk and cardio-respiratory issues. During previous CQC inspection in October 2022, we identified problems with the trust gaining consent from patients for this system to be used. In response the trust immediately met with all patients on the wards this related to and discussed the system and its use. They reviewed the standard procedure for the use of the system to strengthen guidance for staff about gaining consent. Despite the changes made by the trust there remained issues with observations which we have highlighted in the core service reports. We found reported incidents of staff falling asleep on duty and we observed staff not completing observations in a therapeutic way as required by trust policy. Closed circuit television was available on wards but leader did not have easy access to this to prove or disprove allegations of sleeping on duty. During the well led inspection the trust recognised that this was an ongoing issue to monitor and improve and there had been some more recent changes that required embedding. Examples included reviews of CCTV and the development of 'key point' learning for night staff. The trust were also reviewing the idea of increasing the volume of senior night staff available to provide increased leadership, but all of these changes were in their infancy and newly introduced, despite these issues being highlighted at previous inspections.

The trust had played a significant role in the roll out of the COVID-19 vaccination programme. As of January 2023, the trust delivered over 1.6 million vaccinations and were the only provider in the region to do so. The autumn 2022 booster programme delivered 161,000 vaccinations. At the peak of the pandemic the trust ran up to 16 vaccination centres. They also provided vaccination busses, a wellbeing team that delivered vaccines to hard to reach groups, a team to deliver vaccines to housebound patients. The trust intended to retain their vaccination staff in preparation for any future surge and had plans to support stepping up closed vaccination centres if need required.

There remained issues with restrictive practices across the organisation. Staff restricted patients access to fresh air on some acute wards for adults of working age. We identified this at our inspection in October and November 2022 and some remained in place in January 2023 when we returned. Staff did not base these restrictions based on individual risk assessment and we heard some concerning responses when we asked why they were in place (we raised this to the trust for them to action). The approach to restrictions was inconsistent, some wards restricted patients on a risk basis, some worked in a more restrictive way. Restricted items lists were at a level expected in secure wards on wards that did not require that level of security. We were concerned about how the trust supported and educated staff about restrictive practices based on these findings and it brought into question the audit of restrictive practice that the trust were not aware of the inconsistencies. The trust did have global restrictive practices guidelines in place which required staff to monitor and review global restrictions to ensure they were in place for the shortest amount of time; however, this was not something staff described to us at ward level.

Our findings

The trust had made progress in reducing the use of prone restraint, which was an issue identified at their last well led inspection. The trust reduced prone restraints by 27% at the end of 2022. One of the deputy directors for quality and safety led work around reducing restrictive practice. They had been in post for 3 months. Immediately they ensured that those staff who led on restraint became certified and became members of the national restrain reduction network. This will ensure that the trust meet national standards for staff training in restraint along with interventions that should be tried before restraint, such as de-escalation. As of November 2022, 91% were up to date with TASI (therapeutic and safe interventions) training against a target of 95%. The trust experienced challenges with restraint training during the COVID-19 pandemic but were working towards pulling training back from an 18 month renewal (which was agreed nationally) to a 12 month renewal. The trust had arranged multiple training events throughout the coming year to produce enough capacity for staff to attend. If monitoring of restraint increased the TASI team based themselves on wards to observe staff teams' practice and provide support. This had a notable impact in reducing the use of restraint. In January 2023 staff successfully de-escalated 61% of reported incidents avoiding the use of restraint.

Improvements were in progress to increase the safety of patients in relation to sexual safety. The trust required all services to work with patients to produce a sexual safety charter for each service. This provided the opportunity for staff to explain what sexual safety meant to patients and come up with ways they could feel safe and protected in their services. Staff displayed sexual safety charters across the services. Staff used the opportunity to encourage patients to speak up if they had concerns and ensured patients knew how to make a complaint.

Medicines optimisation and management across the trust required improvement. Pharmacy workforce challenges affected the quality and sustainability of medicines across the services. Pharmacy teams operated with a 45% vacancy rate overall. Of 25 vacancies, 14 remained as open adverts with no applicants. Organisational restructures and reporting lines meant that Pharmacy teams felt removed from operational decision making and morale was low. We identified issues with medicines management on wards and the capacity of the Pharmacy teams impacted their ability to audit and support teams with compliance. The trust continued to advertise their vacancies but had trouble recruiting. The trust added Pharmacy resource to the board assurance framework in January 2023. They proposed a risk score of 20 (high).

The health and safety team ensure regular audits of buildings and facilities and reported to the health, safety and security committee. Wards had local health and safety champions to further support compliance with health and safety legislation.

The trust recognised the challenges faced with capacity of acute wards for adults of working age and psychiatric intensive care units. In December 2022 the average length of stay was 74 days and although this had reduced from November 2022 (91 days) it remained above the benchmark. The trust discharged 79 patients in December 2022, 29 of which were patients who had been in hospital for 60+ days. The trust set up weekly consultant led meetings to clinically review all patients ready for discharge and those with stays over 60 days. The trust flow and capacity team managed inpatient capacity. The team had plans to implement various work projects to address the capacity issues and pressures on the services. The trust ensured they met with system partners on a regular basis to discuss flow and pressure and to work towards solutions for patients who had experience delayed transfers of care. Pressures with capacity meant bed occupancy was at 92% for December.

The trust saw an increase in out of area placements in December 2022. Performance was rated by the trust as inadequate at 1722 days. There were two wards in their inpatient portfolio that were capped on the number of

admissions they could take following previous CQC inspections: a decision made by the trust. The trust placed 24 new patients out of area in December 2022 and returned 27 patients to Essex services. This left 56 patients out of are in total for December 2022. The trust recognised it would be challenging to meet the target set by NHS England/Improvement of 0 patients being out of area by March 2023.

Performance scorecards indicated that access to Psychology was inadequate (trust rating). This related to first meaningful contacts in the community, although there had been improvements in people waiting for therapy following assessment.

The NICE (National Institute for Health and Care Excellence) and clinical audit report from December 2022 provided an update to the board about how well services implemented best practice guidance and an update on the progress of clinical audits. The report referred to a lack of clinical time available to staff to undertake audit and progress implementation of guidance.

In January 2023 the trust reported to board that safer staffing levels were inadequate on their quality and performance scorecard. This related to day qualified staff fill rates which reported at 94%. Mitigation recorded included the introduction of twice daily situational report (SitRep) calls to review staffing needs across services and work towards a 7 days forward view of any staffing challenges. It was recorded that in the previous 2 months the trust target had been achieved in this area, but the rating would remain inadequate until the target was met for 3 months consecutively. Staffing fill rates below 90% applied to 22 wards which was an increase from the previous performance. There were also 13 wards where there were more than 10 days where shifts remained unfilled. In January 2023, fill rates were at 94%, having improved for the last 2 months. Board papers did not identify wards with concerning staffing levels or record conversations by the executive team that showed their plans to address this. The trust told us that their Board would not discuss this level of detail and it would be captured at ward level. In acute wards for adults of working age and psychiatric intensive care unit's there remained high use of bank and agency staff which meant patients did not experience regular staff who knew them and their needs well. On Galleywood ward from February 2022 to October 2022 leaders filled 66% of shifts with temporary staff. There also remained issues with filling shifts at all. For the same time period, Kelvedon ward had 64% of shifts not filled by qualified staff. Staff in the services described challenges with staffing and ways in which they attempted to resolve this, but we were not able to see the grip the board had on this issue when they focused on trust wide figures alone, which are impacted by those services with good staffing data.

In December 2022 the use of temporary staffing breached the trusts targets. There were 1039 breaches of agency cap rates and 338 breaches relating to shift frameworks (meaning too many agency staff featured on one shift). There were 231 times where both the agency cap rate and shift framework was breached. The trust held 13 vacant consultant posts, some of which the trust covered with locum staff but other relied on internal staff cover. The proportion of temporary staff used was 10% across the trust in December.

The board planned to agree and launch a new physical healthcare strategy in April 2023, a further example of a 'new' strategy. The previous strategy was dated 2020 – 2022. In order to monitor physical health within the trust there was a physical health sub committee which reported to the quality committee. The committee had worked on identifying gaps in physical healthcare provision to inform the development of the new strategy. The committee reported positive performance for physical health issues such as resuscitation and physical health deterioration. Physical health leads worked to establish positive working relationship with primary care nurses to ensure patients with mental health problems could access physical health support.

The performance and finance committee provided comprehensive updates to the board about the trusts financial position. As at month 9 of 2022/23, the trust was reporting a £1.3m year to date deficit and forecasting a year-end break-

even position. There were concerns about the growing underlying deficit position which has moved from c£6m to c£11.8m over the last 3 years, this was reported monthly to the finance and performance committee. The finance team was currently being restructured and the new structure was expected to be implemented before the end of the 2022/ 2023 financial year. The new structure would introduce finance business partners to support the Care Units. The chair and NEDs and members of the finance team made it clear that there was enthusiasm for the move to the trust being operationally and clinically led rather than financially led. Care Units would be 'corporately enabled' and frontline care was the priority rather than a strategy driven by the financial position of the organisation. Other initiatives included Time to Care, the Safety First Safety Always Strategy and the Accountability Framework. We heard frustration from some NEDs about the pace of change being slower than they had anticipated. The Audit Committee will continue to seek assurance on the impact of these initiatives as they are introduced and embedded.

Information Management

The trust faced challenges with electronic patient records and used 7 different systems across their services dating back to the merger in 2017. Whilst the trust had developed interim measures to mitigate the risks associated with this (such as the health information exchange - a system to support record sharing), we were concerned this issue had lacked pace as the trust were in a current position of starting to work towards a single patient record system 6 years post-merger. Whilst recognising the trust had now secured external funding for this it had taken a long time to prioritise, particularly as themes and trends from investigations and Coroners reports continued to highlight this as an ongoing issue. Not all staff were able to use all systems, therefore there was a risk that key clinical information could be missed. It was described that it would be likely that it would take a further 12 months (2024) to identify a system to be brought in before any type of implementation would begin.

The trust did not use electronic prescribing and medicines administration (EPMA). There was a working group in place and a plan to present a business case to the board in March 2023. It was expected it would take 18 months to implement.

The executive director of strategy, transformation and digital heled the senior information risk officer position and the medical director held the role of clinical information officer. The trust had a chief information officer and a deputy chief information officer.

The trust data strategy was in draft format and had not yet been signed off by the board. The aim of the strategy was to empower people to use data to make informed decisions by providing a user-friendly service with single view of data that would be accurate. The implementation of the strategy was forecast over 3 years. The trust recognised their previous data strategy was not fit for purpose and required refreshing to best support staff working with patients in an effective way.

The trust described the need to have access to better quality, accessible information. We found issues with data quality in core service inspections and found issues with how accurate the information was. We were concerned about the quality of data the trust had to be assured about quality and safety. The trust introduced live dashboards, but these were in development stage and were not being used regularly. Concerns over the quality of data had been raised by the NEDs in board meetings.

The risk of cyber-attacks featured on the risk register and was rated as 'red' by the trust. Steps taken to mitigate risk included the purchase of new mobile phones where the older model provided some vulnerabilities, the same approach

was taken with other computing devices. The trust recruited a cyber assurance manager, due to start in February 2023. By March 2023 the trust intended to complete recommendation from a cyber security internal audit and develop a business continuity plan and disaster recovery for each electronic system. The trust did not have cyber security accreditation but were looking towards this on completion of recruitment to their cyber team.

Engagement

The trust had a head of patient experience and volunteers and a director of patient experience, co-production and participation. Their roles focussed on putting patients, families and carers as the centre of services by ensuring they were engaged and consulted with. The trust also had a patient experience team responsible for monitoring feedback and organising engagement events to ensure the trust provided positive experiences. The trust were considering the recruitment of patient participation leads, but this was in early stages and no plans were in place.

The involvement strategy described the need to move away from 'tokenism' to ensure that involvement was not just a 'tick box exercise' and that it had meaning. The strategy was created with the views of the public, stakeholders and people with lived experience of services. Five distinct roles featured as part of the strategy and these included: member, volunteer, ambassador, governor and partner. Two key objectives featured in the strategy: increase and elevate public involvement and engagement across the trust and breed a culture that values patient experience through involvement.

The patient experience team developed multiple ways for people to provide feedback on their experiences by working with local teams to understand what fitted their demographic. This included the use of text messages, quick response (QR) codes, paper ballot boxes and forms. The work on creating a variety of feedback methods contributed to an 800% increase in feedback from August 2022 – January 2023. Work was ongoing to ensure that patients and people who use service featured as a key stakeholder. The 'your voice' community provided challenge and feedback to the board and the trust launched 'I want great care' in January 2022. The patient experience annual review from November 2022 demonstrated positive results for involvement including 92% growth in the recruitment of volunteers (from 126 in 2021 to 243 in 2022) and a 720% growth in recruitment to the lived experience team (from 10 in 2021 to 82 in 2022).

Communication systems such as the trust website and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used.

There were some issues with response times to complaints that required attention, particularly those that had been received under the 'old' complaints system. Their new complaints process went live on 1 January 2023 and was co-produced with people who had made complaints about services before. The trust captured their views on what was positive about the process and where it was frustrating so they could design a process that would address those points. A dedicated complaints team oversaw the complaints process. Administrators logged complaints on the system and a dedicated complaint liaison officer (CLO) attempted to contact the complainant within 48 hours of the issue being logged. The team requested support from clinical advisors to support with investigations but the responsibility for completion was with the CLO. Complaint investigations opened with a record of conversations with the complainant, ensuring their concerns and issues were the focus of the report. Staff gave complainants the opportunity to decide how they would like to be updated, what desired outcomes might be and set expectations about timescales early in the process. Upon closure of complaints staff logged outcomes and shared learning and sent a satisfaction survey to the complainant. The team had received little response, but it was recognised that this was a process in its early stages. To be assured of the quality of the process and final response, a random 10% of complaints were reviewed by NEDs. At the time of the inspection, there were 118 'open complaints' which had been received prior to the new process being started. Three were over 12 months old, the oldest being logged in August 2021. When looking into the delay for the response it related to an open patient safety incident which ran alongside the complaint. We were not assured that the

complaints team and the patient safety team had developed effective working relationships to ensure people did not experience a delay in response when something went wrong. The last contact made with the complainant was in April 2022: 9 months prior to our inspection taking place. 31 complaints were over 6 months old. Nineteen complaints had been received under the new process, 3 of which had been closed.

The trust sought to actively engage with people and staff in a range of equality groups. Governors held non-executive directors to account for the performance of the board.

Care group leaders engaged with external stakeholders such as commissioners and Healthwatch. The trust undertook a partners' survey to understand how they could increase their confidence in the trust and were acting on the findings.

Learning, continuous improvement and innovation

The trust formed a transformation team in March 2021, initially to support the 'safety first, safety always strategy'. Since its formation the team have taken on further responsibilities to support positive change in the organisation. Examples included: ligature risk reduction and the development of the mental health emergency department. The transformation team were responsible for embedding a consistent end to end change methodology to capture all proposed changes, supported by governance from the transformation steering group.

In April 2022 the trust launched a transformation steering group (TSG). The purpose of the TSG was to review initiatives, projects and ideas from across the organisation. The TSG was made up of senior leaders and subject matter experts. Staff presented ideas through a single 'front door'. The 'front door' acted as a triage process to capture the change required and make decisions over how to progress, such as fast track or to proceed through change methodology. As of January 2023, the TSG approved 30 submissions through the 'front door'.

Quality improvement initiatives required embedding further at ward and service level. Staff in the services struggled to describe examples of changes made via quality improvement methodologies, which is reflected in the core service reports.

The perinatal mental health service is one of the only services in the country to provide appropriate care for bariatric patients in a room with specially adapted facilities. In 2021 the service received an excellent peer review from the college centre for quality improvement (CCQI) against the community quality standards. The perinatal mental health services were one of the best performing services in the country providing positive outcomes for those who use their service.

The trust launched a neuromodulation service on 7 December 2022 which was the first of its kind in the East of England. The service provided the latest treatment for treatment resistant depression such as vagal nerve stimulation.

The trust was due to open a mental health urgent care department (MHUCD) which would look to support the increasing pressures in the Mid and South Essex system. It would provide an alternative to local emergency departments. It would provide a bespoke facility for adult patients and was due to open 13 March 2023. The trust also had urgent care response teams (UCRT) whose focus was to treat people in their own homes, which included care and nursing homes, and avoid hospital admission. Between January 2022 and August 2022 3519 admissions were avoided through UCRT support. Between the same time period 5063 attendances at accident and emergency had been avoided. Patients with physical health problems had access to virtual, if appropriate and safe, which was another programme of work designed to reduce admissions to hospital. West Essex had created 66 virtual physical health patient beds that were delivering some early successes. The trust were considering how they might expand a virtual ward system to patients with mental health problems.

Our findings

The trust had strong working relationships with Anglian Ruskin University to support innovation and research that would benefit services and the people who use them.

Research was important to the trust. They had a dedicated research and innovation team who worked with clinicians, partner organisations, the commercial sector and The National Institute for Health Research (NIHR). The trust had 15 ongoing research studies, some examples included: tackling chronic depression and attitudes to voices. The research team had academic links to 12 universities across the country.

Wound care specialists from the trusts launched a pilot scheme using digital technology to improve care for patients with pressure ulcers and other wounds. Staff used a mobile application to measure, assess and monitor wounds. The application also built 3D wound scans. This supported the accurate recording of wounds to support monitoring and treatment. The application received positive feedback from patients.

The trust had seen success with awards. Two services won awards in the positive practice in mental health awards – for addressing inequalities and for integration of physical and mental health. Clinical team leads had won the Cavell star award. Two team were announced as winners at the NHS Parliamentary awards. The health service journal awarded the trust (along with their partner trust) an award for workforce initiative. The trust was recognised at the building better healthcare awards for improving patient environments and enhancing safety. Our health heroes awarded the trust for most progressive integrated care workforce programme.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Jun 2023	Requires Improvement ↓ Jun 2023	Good ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mental health	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall trust	Requires Improvement ➔➔ Jun 2023	Requires Improvement ➔ Jun 2023	Good ➔ Jun 2023	Requires Improvement ➔ Jun 2023	Requires Improvement ➔ Jun 2023	Requires Improvement ➔ Jun 2023

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Rawreth Court	Requires improvement Mar 2019	Requires improvement Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019
Clifton Lodge	Requires improvement Mar 2019	Requires improvement Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019
Overall trust	Requires Improvement ➔➔ Jun 2023	Requires Improvement ➔ Jun 2023	Good ➔ Jun 2023	Requires Improvement ➔ Jun 2023	Requires Improvement ➔ Jun 2023	Requires Improvement ➔ Jun 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Rawreth Court

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement Mar 2019	Requires improvement Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019

Rating for Clifton Lodge

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement Mar 2019	Requires improvement Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Requires improvement Jul 2022	Good Jul 2022	Good Jul 2022	Requires improvement Jul 2022	Requires improvement Jul 2022	Requires improvement Jul 2022
Wards for people with a learning disability or autism	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Good →← Jun 2023	Good →← Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023
Acute wards for adults of working age and psychiatric intensive care units	Inadequate →← Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement →← Jun 2023	Inadequate ↓ Jun 2023	Inadequate →← Jun 2023
Wards for older people with mental health problems	Requires Improvement →← Jun 2023	Requires Improvement ↓ Jun 2023	Good →← Jun 2023	Good ↑ Jun 2023	Good →← Jun 2023	Requires Improvement →← Jun 2023
Forensic inpatient or secure wards	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Long stay or rehabilitation mental health wards for working age adults	Good Oct 2019	Requires improvement Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Community-based mental health services of adults of working age	Requires Improvement ↓ Jun 2023	Good →← Jun 2023	Good →← Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023
Mental health crisis services and health-based places of safety	Requires Improvement →← Jun 2023	Good →← Jun 2023	Good →← Jun 2023	Good →← Jun 2023	Good →← Jun 2023	Good →← Jun 2023
Substance misuse services	Good ↑ Jun 2023	Good →← Jun 2023	Good →← Jun 2023	Good →← Jun 2023	Requires Improvement →← Jun 2023	Good ↑ Jun 2023
Community mental health services for people with a learning disability or autism	Good Jul 2018	Good Jul 2018	Outstanding Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community-based mental health services for older people	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community health inpatient services	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community end of life care	Good Oct 2019	Good Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019	Good Oct 2019	Outstanding Oct 2019
Community health services for children and young people	Good Jul 2018	Good Jul 2018	Outstanding Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Community-based mental health services of adults of working age

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Safe and clean environment

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Observation of the environments and review of the ligature risk assessments confirmed this.

All interview rooms had alarms and staff available to respond.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations.

All clinical areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. Review of the cleaning records in the patient's areas on each site confirmed this.

Staff followed infection control guidelines, including handwashing. In response to rising cases of Covid-19, the trust had reintroduced the wearing of face masks in clinical areas.

Staff made sure equipment was maintained, clean and in working order. "I am clean" stickers visible on clinical equipment.

Safe staffing

Managers, staff, and patients told us they had enough staff, who knew the patients and received appropriate training to keep them safe from avoidable harm. The number of patients on caseloads was not too high to prevent staff from giving each patient the time they needed. There were no waiting lists to access service. When managers used temporary bank and agency they were block booked to work in the service and knew the patients well.

Nursing staff

Managers, staff, and patients told us they felt they had enough staff in the service to keep patients safe from avoidable harm, and caseloads were not too high.

Community-based mental health services of adults of working age

Data at November 2022 showed the service had 33% vacancy rate (74 posts out of a total for 224) across all staff grades, professions, and teams. While we recognised this was a high vacancy rate across the service, the impact was minimised because the service used regular known, block booked, bank and agency staff to fill vacancies. Managers and staff confirmed that recruitment was getting better, bank and agency staff were good and because they were considered as part of the permanent staff team they received the same training, had access to the same information and attended the same meetings which ensured consistency. Patients and family members we spoke with did not identify this as a major issue for themselves.

Managers used a recognised tool to calculate safe staffing levels. The service had 224 staff across 20 teams in the trust. The number and grade of staff matched the provider's staffing plan.

The service had reducing rates of bank staff. Data for the period June to November 2022 showed bank staff rates for additional clinical staff, (which included psychologists, occupational therapists, social workers, healthcare assistants and recovery workers), had reduced from 25% to 13%. While bank staff rates for qualified nursing staff had reduced from 11% to 6%.

The service had stable rates of agency staff. Data for the period June November 2022 showed agency staff rates for additional clinical staff, had stayed constant at 62% and for qualified nurses had risen from 35% in June 2022 to 36% in November 2022.

Managers limited their use of bank staff in favour of known, blocked booked agency staff when required. Managers ensured that all bank and agency staff had full induction to the service and the teams they were working in. Temporary staff were involved in team training sessions, team meetings and service developments. Bank and agency staff we spoke to told us they were happy in the teams and felt a sense of ownership and commitment to the teams they worked in. Staff and patients told us they knew all the bank and staff they worked with and related to them as they would any other colleagues.

Managers supported staff who needed time off for ill health. Sickness rates across the service remained constant between 6% and 7% for the period May to October 2022. Managers told us that if the absence was short then any appointments scheduled for the clinician's days of absence were reallocated to another worker. Alternatively, and if the appointment was not very urgent, staff contacted those patients to see what support they might need during the period of absence. For long term absence, the clinician's case load was reallocated to other team members and patients were advised if this needed to happen.

Data showed that the service had a stable turnover rate of 7% between May and October 2022.

While individual caseloads were well managed, in some team's caseloads were slightly higher than the recommended numbers. In 16 out of 20 teams the overall caseloads had reduced while in the remaining four teams' overall caseloads had remained stable.

Data we received from the trust showed that team and individual case load numbers had improved significantly between 2017 to 2018 and continued to reduce slightly or remained stable between 2018 and October 2022. Staff we spoke with told us that caseloads in the recovery and wellbeing teams ranged from 28 – 35 cases per care co-ordinator, the recommended number was 35 per person. In the first response teams, individual caseloads ranged from 26 – 32 per care co-coordinator with the recommended number being 20 per person. However, we found no evidence that this impacted on patient care, and patients told us they usually got the time they needed with key staff.

Community-based mental health services of adults of working age

Medical staff

The service had enough medical staff. Managers could use locums when they needed additional support or to cover staff sickness or absence. Managers made sure all locum staff had a full induction and understood the teams they worked in.

Staff could get support from a psychiatrist quickly when they needed to. Medical staff contributed to the on-call duty roster and covered for each other where possible for periods of leave or sickness.

Mandatory training

Most staff had completed and kept up to date with their mandatory training. Mandatory training compliance across teams in the service ranged from 100% in the Basildon and Brentwood first response teams to 82% in the Southend recovery and wellbeing team. Thurrock recovery and wellbeing team was an outlier at 69% data we received did not explain why Thurrock team should be an outlier. However, post inspection the trust confirmed that all staff who needed to be, were now booked onto courses to bring their mandatory up to date.

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training included preventing suicide training 94%, clinical risk for register staff 88% and clinical risk for non-registered staff 91% as required.

Managers monitored their team's performance in mandatory training using information on their organisations dash boards. Managers alerted staff via e-mail when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. Most staff worked with patients and their families and carers to develop crisis plans. We saw policy and practice guidelines explaining how waiting lists were to be managed. Staff monitored patients on the psychologists waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Assessment of patient risk

The trust had clinical risk assessment policy and procedures in place along with guidelines for good documentation.

We reviewed 34 patient risk assessments across 8 teams we visited in the service. Staff undertook a full risk assessment for each patient and operated an ongoing risk management process using a recognised tool. Staff developed risk assessments in collaboration with patients, family, and friends. Most records we reviewed, 29 out of 34, showed staff updated risk assessments regularly, including after any incident. Risk assessments showed that staff encouraged positive risk taking and least restrictive options.

However, 4 patients' risk assessments at Colchester early intervention psychosis team, that were reviewed in April 2022 should have been updated in October 2022, at the time of our visit in November 2022 they still showed a review date of April 2022. We did see that the manager explained that due to a previous care co-ordinator leaving and new one taking

over there had been a delay in updating the documentation. Though we saw evidence that staff discussed risk at weekly MDT meetings, daily safety meetings and in the minutes of MDT meetings. Staff we spoke with appeared to have good knowledge of the patients in their care including any risks they presented with. We saw no evidence of impact on patient care.

Staff recognised when to develop and use crisis plans and advanced decisions according to patient need. We saw evidence of six advanced decisions as part of our review of 34 patient records.

Management of patient risk

We reviewed 34 patient risk management care plans. The trust had a clinical safety management policy and procedures in place.

Risk management plans showed that patient risks were clearly identified, and appropriate plans were in place to address those risks including plans to address any deterioration in mental wellbeing.

Staff responded promptly to any sudden deterioration in a patient's health. Staff told us they had standard practice for any patients, family, or friends to take in case of mental ill health or physical health deterioration. This was to either ring the team duty worker in office hours or the CRISIS team 24/7 who would then be able to advise based on the level of risk present. In case of extreme urgency, the process was to ring 111. If a patient presented to accident and emergency mental health liaison workers carried out triage and assessment of their needs.

When a patient care co-ordinator was not available another member of staff was allocated to continue with any planned visits or other actions. All the teams had duty systems in place, this meant that any patient or their family and friends needing help, advice or support could ring the team and staff formulated a suitable plan for the patient, family and friends.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when signs or symptoms of risk increased.

Staff followed clear personal safety protocols, including those for lone working. Staff carried alert alarms that were connected to a central 24/7 hub where any calls or alerts were responded to immediately. The alarms also allowed for quick access to emergency help such as paramedics or police when required. The alarms had a listening facility allowing the staff member to alert someone in the response team to listen into the clinician and patient conversation where the staff member had identified an element of potential risk.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Data at October 2022 showed that 90% of staff had completed safeguarding adults' level 3 including Mental Capacity Act, Deprivation of Liberty safeguards and Prevent and 83% staff had completed safeguarding children level 3 including Looked after children and Prevent. Prevent training is designed to make sure that when we share a concern of a vulnerable individual who may be being radicalised, the referral is robust, informed and with good intentions, and that the response to that concern is considered, and proportionate.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and when necessary, made changes based on the outcomes. Such as improving links and communication processes with community drug and alcohol teams and mental health liaison workers in accident and emergency departments.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Most records were clear and up to date. However, patient's historical information was not always easily available to all staff.

The trust used 3 different electronic patient recording systems across the county. Staff told us this made access to historical information difficult when patients transferred between teams in different parts of the county. This meant that important information about patients could be missed as the 3 systems did not interface with each other.

The trust had been working towards an integrated electronic recording system since their merger in 2017 but this had still not been achieved. The trust needed to address the issue urgently.

Staff worked well within teams, across services and with other agencies to promote safety including correct and timely use of systems and practices around information sharing.

All records were stored securely.

Medicines management

Staff did not always follow trust systems and processes when prescribing, administering, recording, and storing medicines. Although staff regularly reviewed the effects of medicines on each patient's mental and physical health.

The trust had systems and processes in place to safely prescribe, administer, record and store medicines. However, staff did not always follow these processes. For example, 2 of the 20-community prescription and administration records for intramuscular antipsychotic depot injection we reviewed did not have signed informed consent.

Staff did not always store and manage all medicines and prescribing documents in line with the provider's policy. We found 2 expired depot injections in a medicine's cupboard, this was raised with the staff member present and the medicines were immediately removed and disposed of.

We found 3 gaps in the November 2022 recording of medicines fridge temperatures at Basildon recovery and wellbeing team; 4 gaps in the November 2022 recording at Rayleigh recovery and wellbeing team and 5 gaps North Essex Tendering Specialist Community Mental Health team, Colchester. The above issue was raised as a should in 2018.

However, we also saw that in response to the 2018 report findings at Tendering the clinic room and fridge used temperature sensors on the fridge and in the room. This sent an alert to the team if room/fridge temperatures went out of range. Staff we spoke with were not sure if they needed to continue checking the temperatures daily as they were now using the sensor system. Managers had not given official guidance around this.

We found 1 doctor's prescription pad, at 1 team base the Basildon recovery and Wellbeing team, which was not kept securely as per the providers policy. At our previous inspection we had recommended the provider should ensure there were systems in place to audit the security of blank prescription forms. The doctor confirmed that the system in place was for all doctors to regularly check their FP10 prescription pads for completeness and to keep the pad secure, but on this occasion the doctor had omitted to do this.

Medicines advice and supply was available, and an on-call pharmacist was available outside of core working hours. The pharmacy team visited when possible and remote support was offered in between these visits. The pharmacists told us that due to pharmacy staff shortages the team could not visit as often as they would like to, however this did not have impact on patient care and staff were able to access pharmacy advice vis telephone when required.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff told us that patients could raise concerns about their medicines, and these would be considered and reviewed.

Staff reviewed the effects of each patient's medicines on their physical health in accordance with National Institute for Health and Care Excellence (NICE) guidance. After issuing an initial prescription, staff completed review appointments to check for medicine dose adjustments and side effects.

Staff only gave small quantities of prescribed medicines to control behaviour, especially where medicines were prescribed as required. We saw examples of daily reviews of the use of these types of medicines and that prescribing was stopped when it was felt that it was no longer needed.

Staff we spoke with could describe what they would do when someone refused their medicines and lacked mental capacity.

Track record on safety

The service had a good record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

We reviewed incident records and saw that staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in line with trust policy.

Community-based mental health services of adults of working age

Data for the period 01 December 2021 – 30 November 2022 showed that across all 20 teams the service had 2,543 incidents reported. The service reported no never events. Managers categorised and investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff understood the duty of candour and 98% of staff had completed duty of candour training. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers and psychologists debriefed and supported staff, patients, and their family and friends as necessary after any serious incident

Staff received feedback from investigation of incidents, both internal and external to the service, usually via email bulletins or one to one discussion if the staff member was personally involved.

Staff met in team meetings to discuss the feedback and look at improvements to patient care. There was evidence that managers had made changes because of feedback. Such as improved communication between general practitioners and community mental health staff and revised reporting protocols between hospital mental health liaison workers and the community mental health teams.

Managers shared learning with their staff about never events that happened elsewhere using the same systems as above.

Is the service effective?

Good  

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients, families, and friends to develop individual care plans and updated them as needed. Most care plans reflected the assessed needs, were personalised, holistic and recovery oriented. However, we found 5 care plans at Basildon recovery and wellbeing team did not have discharge plans or goals or notional discharge dates.

We reviewed 34 care plans across 8 out of 22 teams visited in the service. Not all care plans had discharge plans, goals, or notional discharge dates. We found 5 care plans at Basildon recovery and wellbeing team did not have discharge plans or goals or notional discharge dates. Managers in this team had not ensured that staff understood the significance of discharge planning at an early stage of treatment, and how important recording discharge plans was to the patients care pathway. This meant that without identified goals for discharge and no discharge plans staff and patients would not know what they were aiming to achieve in treatment or where their future care pathway would take them.

Staff completed a comprehensive mental health assessment of each patient. All patients were allocated a care coordinator.

Community-based mental health services of adults of working age

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. The trust included “make every contact count physical health screening” mandatory training across the recovery and wellbeing teams and data showed that 95% of staff were up to date with this training.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly carried out physical healthcare reviews and blood monitoring under the Care Programme Approach and updated care plans when patients' needs changed.

However, we observed patient review meetings and saw minutes of multidisciplinary team meetings and doctors’ letters that did cover all areas of care and they were personalised and holistic. The manager explained that due to a previous care co-ordinator leaving and their case load being held by other people in the team pending permanent reallocation updating documentation with the quality and level of detail was not as robust as it should be.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking, and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. This included cognitive behavioural therapy (CBT), supportive psychotherapy, family therapy and eye movement desensitisation and reprocessing (EMDR). Skills training return to work and education programmes, dialectical behaviour therapy (DBT) informed therapy and Schema Therapy.

Staff delivered care in line with National Institute for Health and Care Excellence guidance. The service was working towards the new NHS England Community Mental Health Framework for Adults and Older People. A new place-based community mental health delivery model, with a completion date of March 2023.

Staff made sure patients had support for their physical health needs, either from their general practitioner or community services. The service had physical healthcare nurses and work was underway to secure more physical healthcare services for people with mental ill health in general practice and primary care settings.

Staff encouraged patients to live healthier lives by supporting them to take part in healthy living programmes, such as smoking cessation, healthy diet and exercise, work, education, and leisure programmes.

Staff used recognised rating scales and outcome measures including patient reported outcome measures (PROMS) and clinician reported outcome measures (CROMS), Health of the Nations Outcome Scales, Model of Human Occupation and Recovery Star.

Staff used technology to support patient care where appropriate and if patients wanted this as an option. Such as face time, zoom, language line, and healthy living digital applications.

Staff took part in clinical audits, benchmarking, and quality improvement initiatives. Managers used results from audits and what they had learned during the COVID pandemic to make improvements. Such as offering text and telephone reminders about appointments, face time and zoom remote consultations digital progress letters via secure e mail, and flexible working times for staff. This was in addition to more traditional telephone and written correspondence.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of each patient. This included community psychiatric nurses, general registered nurses, recovery and support workers, occupational therapists, psychologists, doctors, and employment facilitators as well as peer support workers.

Managers made sure staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff including bank and agency staff a full induction to the service before they started work. The induction program was comprehensive and included a full orientation to the team the staff member would be working in including opportunities to shadow experienced colleagues.

Managers supported staff through regular, constructive appraisals of their work. The trust had an appraisal policy and procedure in place. Data at October 2022 showed that 75% of staff were up to date with annual appraisal.

Managers supported staff through regular, constructive managerial and clinical supervision. The trust had a supervision policy and procedure in place. Data at October 2022 showed that 83% of staff were up to date with clinical and managerial supervision.

Psychologists and occupational therapists also received profession specific supervision from more senior colleagues, and we saw evidence of case specific specialist training and peer supervision based on case study within the teams.

The trust supported permanent medical staff to develop through yearly, constructive appraisals of their work. All medical staff had updated their accreditations and received supervision from profession specific supervisors.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. We saw from the minutes of team meetings that they were well attended. Staff who could not get to team meetings had the option of joining via video link and staff told us that minutes from meetings were easily accessible.

Managers identified any training needs their staff and peer support workers had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. We saw evidence of specialist training sessions within the teams we visited. Psychologists and doctors told us they operated an open-door policy and always made themselves available to give advice and support to staff with queries about treatment care or more complex patients.

Managers recognised poor performance, could identify the reasons, and dealt with these.

Community-based mental health services of adults of working age

Multidisciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

We observed 3 multidisciplinary meetings where staff discussed patients' risk and any required changes to their care and risk plans. Staff told us these meetings were planned, prioritised, and rostered into their diaries, each week. We saw all staff present engaged with the discussions, were open and frank with each other, listened to each other and made notes of the outcomes and decisions made.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care.

Staff had effective working relationships with other teams in the organisation, including inpatients' teams, crisis and home treatment teams, safeguarding teams, primary care, and specialist therapy services. Care co-ordinators were invited to all team meetings.

Staff had effective working relationships with external teams and organisations, including adult social care, social, education and employment providers.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The trust offered separate training for registered staff and non-registered staff. Data at October 2022 showed 89% of registered staff had completed this training and 93% of non-registered staff had completed this training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

Staff followed clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

We reviewed five records where patients were subject to a Community Treatment Order, staff completed all statutory records correctly.

Community-based mental health services of adults of working age

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed.

Staff completed regular audits to make sure they applied the Mental Health Act correctly. Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of the five principles. Mental Capacity Act and Deprivation of Liberty Safeguards training was included with Safeguarding adults' level 3 and Prevent training. Data at October 2022 showed that 90% of staff were up to date with this training.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act.

Staff gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture, and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good

Kindness, privacy, dignity, respect, compassion, and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment, or condition.

Community-based mental health services of adults of working age

Staff were discreet, respectful, and responsive when caring for patients. Staff gave patients help, emotional support and advice when they needed it. Patients said staff treated them well and behaved kindly. This was demonstrated through observations of staff and patient interactions and in speaking with patients their families and friends.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help, such as employment support services, housing services and debt management services.

Staff understood and respected the individual needs of each patient. We heard this when staff discussed patients in MDT meetings.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients and staff.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff involved patients and gave them access to their care plans and recorded this in the patient record.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. This included translation line, large font for written information, and written information in other languages as well as English.

Staff involved patients in decisions about the service, when appropriate. Patients told us they had not liked the term carers, and following discussions with the managers and staff, the term was changed to family and friends rather than carers.

Patients could give feedback on the service and their treatment and staff supported them to do this. We reviewed 34 patient feedback forms from the previous 9 months and saw the results of 3 recent patient feedback surveys. Most of the comments in these documents were positive.

Staff supported patients to make advanced decisions on their care. We saw evidence of this in six patients care records.

Staff made sure patients could access advocacy services. Two patients and one carer told us they had accessed advocacy services. There were posters around the public parts of the team bases, explaining who the advocates were and how to access them. Staff knew about advocacy services in their areas.

Staff informed and involved families and friends appropriately and only after patients had given permission.

Community-based mental health services of adults of working age

Involvement of families and carers

Staff supported, informed, and involved families and friends. We saw in daily care notes how staff had contacted family and friends, with the patient's permission, when needing to arrange appointments, checking how they were coping, and enquiring on the whereabouts of their loved one.

Staff helped families to give feedback on the service. The trust had introduced family and friend's liaison workers to work across teams. Their role was to engage with family and friends, act as a source of information, arrange family and friends support and education sessions and run the family and friends support groups.

Staff gave family and friends information on how to access the carer's assessment.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Access and waiting times

We found a significant number of patients had experienced longer than expected periods of time in treatment in the recovery and wellbeing part of the service. However, the service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.

We found 37% of people using the recovery and wellbeing part of the service experienced longer than expected times in treatment across all recovery and wellbeing teams. There should be more support to move people on in their recovery journey in a timely way to achieve their full potential and allow wider accessibility to the service. We determined this figure based on the number of patients using the service for longer than 5 years. The longest period in treatment was 13 years at Basildon recovery and wellbeing team. This meant that if patients experienced longer stays in mental health services than they need then they could become overly dependent on clinical services, and not able to achieve their full potential for recovery and independence. However, neither staff nor patients and family we spoke with raised this as an issue.

Operational policy suggested that patients could expect to be in treatment for between 6 months and 3 years. However the policy also recognised that some patients may need to stay in treatment longer than this if they were receiving medicines that could only be administered via the community mental health team because they required ongoing and frequent blood tests and monitoring. This did not appear to impact on patient flow as there was no waiting list for access to the community mental health teams.

Data at November 2022 showed the number of treatment periods exceeding 5 years across the Recovery and wellbeing part of the service ranged from 15% (32 out of 219) in Rochford and Rayleigh to 33% (297 out of 905) in Southend. Other teams had 30% (72 out of 239) at Castle Point; 27% (139 out of 512) at Basildon; 25% (54 out of 214) at Brentwood; and 24% (107 out of 524) at Thurrock.

Community-based mental health services of adults of working age

Managers told us that patients were in treatment for longer than expected periods of time. This was primarily due to staff's reluctance to discharge patients once active treatment had been completed, for fear of destabilising patients with discharge to wider community services. Some staff also felt that they needed to retain patients who were on Clozapine and depot medicine regimes. We were told that this was because of a culture and reluctance for general practitioners to accept patients with a severe or enduring mental health diagnosis. Managers told us this issue was long standing and despite several trust initiatives, and high-level discussions with commissioners and general practitioners the situation had not resolved. Managers also told us that the latest initiatives put in place in 2019 were delayed due to COVID-19 and the pressures on primary care because of this. However, we heard from two team managers how they hoped this situation would change once the new community mental health framework for adults and older adults came into being during 2023. This national framework set out guidance and expectations for closer and more joined up working between secondary community mental health services and primary care services, including general practice, to speed up flow through the community mental health system, and implement more shared care practice.

We did not find these longer than expected periods in treatment in the other community teams in this core service. Such as the first response, access and assessment, and home treatment teams, because patients who required ongoing community support were transferred to the recovery and wellbeing service. While other teams in this core service such as early intervention in psychosis teams were required to work to clear national guidelines and there was a clear pathway of discharge to recovery and wellbeing teams or to general practitioners for patients at the end of this treatment phase.

The service was able to assess urgent referrals quickly when required, and staff saw all non-urgent referrals within the trust target time. The early intervention and psychosis service met all the assessment and treatment targets as set out in National guidance for early intervention and psychosis services. Patient flow through the service was good.

However, the service did have waiting lists for individual therapy, primarily specialist psychology input such as family therapy and integrated psychotherapy. The average waiting time for individual psychological therapy ranged from 4 weeks to 2 years. Staff we spoke with confirmed that this was due to insufficient numbers of psychologists in the service as a whole and a national shortage of psychologists wanting to work in the NHS.

The service used systems to help them monitor waiting lists and support patients on those lists. All patients on waiting lists were well supported and monitored during their waiting time. Patients waited on average 4 weeks for assessment to the recovery and wellbeing teams, and new referrals to the specialist teams were seen within the stated time frames for the type of service they were accessing, and in line with National Institute for Health and Care Excellence guidelines.

Staff supported patients when they were referred, transferred between services, or needed physical health care. The service followed national standards for transfer.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. They used face time and zoom for people who found it difficult to have face to face conversation, staff agreed to meet patients in places of their choosing subject to safety and lone working policy. Staff used text as well as telephone and letter to make and confirm appointments. The service developed outreach projects to meet vulnerable people and joint working with drug and alcohol teams.

Data for October 2022 showed the service offered 14,558 appointments that month. Appointments offered had risen steadily since January 2022 and remained stable throughout May to October 2022.

Community-based mental health services of adults of working age

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. During October 2022, 8% of the 14,558 planned appointments were cancelled by staff and 12% by patients. Data showed this was a steady decease month on month since August 2022.

Staff tried to contact people who did not attend appointments and offer support. During October 2022, the service saw a did not attend rate of 12%. The number of did not attend appointments had decreased month on month since August 2022. Patients had some flexibility and choice in the appointment times available between 8.00am and 6.00pm. Appointments ran on time and staff informed patients when they did not. Out of hours all patients knew how to access help and support usually through the first response teams.

The facilities promote comfort, dignity, and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy, and dignity.

We looked at the clinical areas of 6 team bases and 7 clinics. The service had a full range of rooms and equipment to support treatment and care.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Patients' engagement with the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy, and cultural and spiritual support.

The service could support and adjust for people with disabilities, communication needs or other specific needs. Managers tried to keep patient facing clinical areas on the ground floors of buildings whenever possible. There was level access to ground floor areas and working lifts to the clinical areas on upper floors. There were identified parking facilities for mobility scooters and blue badge holders, and posters advertising easy read information and hearing loop for those patients with sensory deficit.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service provided information in a variety of accessible formats so the patients could understand the information more easily. We saw posters advertising the facilities available for people with mobility, communication, or sensory needs.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could access interpreters or signers when needed. Staff also used language line and staff who were bilingual and happy to interpret were easily identifiable.

Listening to and learning from concerns and complaints

Community-based mental health services of adults of working age

The service treated concerns and complaints seriously, investigated them, learned lessons from the results, and shared these with the whole team and wider service.

Data for the period June to November 2022 showed this core service received 84 complaints and 25 compliments. We saw 82 complaints were categorised, investigated and outcomes recorded, along with learning points where required. A further 2 recent complaints were awaiting processing.

Patients, families, and friends told us they knew how to complain or raise concerns. We saw information in the foyers and waiting rooms of clinics explaining how to make a complaint.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints, identified themes, and made changes to the service based on outcomes. An example of one of themes was waiting times for consultants and psychologists were considered too long.

Managers shared feedback from complaints with staff and learning was used to improve the service. Examples included administration staff to check daily care notes and multi-professional team decisions when responding to patients' enquiries, and staff to routinely ask patients for updated contact details rather than just relying on patients to inform staff of any changes.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders we spoke with had the skills, knowledge, and experience to perform their roles. All leaders we spoke with said they felt supported to fulfil the role and responsibilities of their leadership role.

Within the teams we visited there was a cohesive leadership team including consultant psychiatrist and senior clinicians who were able to advocate for the service internally and externally.

Leaders had good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Managers told us about the trust's clinical leadership development programme, to help support succession planning and staff development within the organisation. Managers positively considered this.

Community-based mental health services of adults of working age

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. We saw posters around the buildings explaining the trust's values.

Staff could describe the trust's values and their role to provide quality care and treatment was key to achieving the values and goals.

Culture

The culture in the Adults community mental health service was positive.

Staff felt respected, supported, and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear. Staff e spoke with were aware of the freedom to speak up guardian.

Three staff and 2 managers told us that they did not have too many challenges with recruitment or retention of staff because this service was a good service to work in.

Managers respected staff autonomy and encouraged staff to develop their knowledge and skills by offering enhanced training opportunities such as family therapy, other specific therapy training and clinical leadership training. Two managers told us they felt the service had a lot of credibility within the trust, which helped to retain staff, even through the COVID pandemic.

Staff had access to the trusts Occupational Health service and the "Here for You" psychology service. There was also a range of other wellbeing initiatives including 1 to 1 staff support focussed on wellbeing, wellness planning and range of standalone staff wellness events such as Mindfulness and sleep clinics.

The trust provided support for managers to manage staff sickness and this was outlined in the trusts sickness absence policies.

Staff we spoke with knew about the trusts whistle blowing policy and how to use it.

The trust operated two staff recognition and awards schemes. The quarterly recognition awards where nominations were accepted from staff, patients, service users and the public. There are 5 categories a staff member can be nominated for including Hero Award – Beyond the Call of Duty; Peer to Peer Recognition Award; Team Recognition Award; Leadership Award and Research, Innovation and Improvement Award. The second scheme is known as the quality and excellence awards nominations are accepted from staff and there are 18 categories. Managers advised that while both of these award schemes were disrupted due to Covid, they will be holding an annual awards ceremony on 5 July 2023 (the 75th anniversary of the NHS) for the first time since the Pandemic.

Governance

Our findings from the other key questions demonstrated that while there were clear governance processes in place, managers did not always use these effectively to manage discharge from the recovery and wellbeing teams, or record keeping. Some managers did not use the audit process to good effect when looking at the quality care records.

Community-based mental health services of adults of working age

We found 37% of patients using the recovery and wellbeing part of the service experienced longer than expected times in treatment. Data up to end of October 2022 showed discharge planning and implementation was an issue across all the recovery and wellbeing teams. There was not enough emphasis on discharge and moving patients away from dependence on the team. There was not enough work with general practitioners to support and enable them to take back patients on depots. limits patients' recovery and could potentially make the service less accessible to others.

However, managers told us they expected this situation to improve once all the teams had adopted the new the new NHS England - Place-based, community mental health framework for adults and older adults in March 2023.

Not all care plans had discharge plans, goals, or notional discharge dates. We reviewed 34 care plans across the 8 teams we visited. We found at Basildon recovery and wellbeing team 5 care plans did not have discharge plans or goals or notional discharge dates. Managers had not ensured that staff understood the significance of discharge planning at an early stage of treatment, and how important recording discharge plans was to the patients care pathway. This meant that without identified goals for discharge and no discharge plans staff and patients would not know what they were aiming to achieve in treatment or where their future care pathway would take them.

Managers had not used record keeping audits to good effect. We saw that 4 risk assessments at Colchester early intervention in psychosis team, (out of 34 risk assessments reviewed across the service), had not been updated since April 2022. We also saw that 5 care plans at Colchester recovery and wellbeing team, (out of 34 care plans reviewed across the service), were not holistic or personalised and held minimal detail.

While the service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The trusts mediction safety officer post had been vacant for an extended period. No in-depth medicines incident analysis was being undertaken to provide a monthly medicines incident updates at governance committees for further distribution across the trust. We were not told what the contingency plans were for this vacant post.

Management of risk, issues, and performance

While teams had access to the information, they needed to provide safe and effective care and used that information to good effect, the trust used three different electronic recording systems that did not link with each other.

The trust used three different electronic patient record systems that did not link with each other. This made finding all that information time consuming and not dependable. This meant that when patients transferred between teams using different electronic systems, historical information had to be manually uploaded into archive files. This meant that not all historical information was available in a timely manner and there was potential for information to be missed in the uploading process. The inspection team found it difficult and time consuming on occasion to track a patient care where they had transferred from one electronic system to another. However, the health information exchange (HIE) remained in place to support record sharing between teams.

Within teams' managers had systems and processes in place to identify and address any risk issues as soon they arose. There were local risk registers that linked to service risk register, which fed into the trusts clinical risk meetings. Staff were careful to monitor any risk to patients and knew how to escalate concerns to managers.

Information management

Patients' information was stored securely on electronic data bases. However as noted above the trust used three electronic systems that were not integrated.

The service and the trust had business continuity plans in place to ensure that if normal business were interrupted for any reason staff could continue to provide safe care and treatment for patients.

Managers used information gained from findings following their investigations into complaints and serious incidents to make improvements to their service as reported above.

All managers attended the trusts clinical governance meetings where information and best practice was shared and disseminated across the services. Managers then met with their staff teams to share the key messages from these meetings.

The trust emailed individuals personally to ensure that all staff received the same key messages at the same time from the senior management team.

The trust had a staff newsletter that was sent to all staff via e mail and displayed in team bases. This helped to ensured that staff felt part of an organisation and not just part of one team or service.

Engagement

Managers actively engaged with other local health, integrated care boards, commissioners, and social care providers to ensure that services were provided to meet the needs of the local population.

Managers from the service participated in the work of the local transforming care partnership.

Managers were engaging with primary care colleagues in preparation for adoption of the NHS England Community Mental Health Framework for Adults and Older People.

Learning, continuous improvement and innovation

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Managers we spoke with were committed to continuous improvement and innovation within their service.

Managers engaged in a range of quality improvement programmes. We saw evidence of monthly quality improvement meetings, where any new action plans were agreed and monitored. Such as revised communication processes with family and friends of patients using the service. Routine introduction of video appointments as well as face to face appointments.

We saw the minutes from a range of local clinical governance meetings had been designed to ensure that good practice was shared across the service and to ensure that where there were any challenges to delivering quality services, these could be addressed and resolved.

Community-based mental health services of adults of working age

We saw evidence that staff engaged in a range of audits using the information they gathered to make improvements. Such as management of shared clinics in team bases and revised communication processes with patient, family, and friends.

We saw evidence of quality improvement projects that managers and staff were involved in including the review of access and waiting times, team skill mix and enhanced therapy training programs and introduction of carers liaison workers.

Wards for older people with mental health problems

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all wards areas and removed or reduced any risks they identified. Staff monitored the wards each day to identify any risks or repairs that were needed. Wards carried out a comprehensive annual health, safety and security inspection.

Staff could observe patients in all parts of the wards. The wards had installed convex mirrors to improve visibility at blind spots covering communal areas and corridors. Not all wards had CCTV in place. Henneage Ward and Tower Ward had CCTV covering communal areas and corridors. Meadowview had CCTV covering the ward entrance. Staff on this ward reported they had access to body-worn cameras if needed to support patients who presented with increased risk. Beech Ward, Gloucester Ward and Kitwood Ward did not have any CCTV in place. Beech Ward had vision-based patient monitoring system which enabled the staff to monitor patents' vital signs without entering their rooms. Staff on Beech ward said the system was highlighted to patients on admission and consent gained. Monitoring of rooms could be switched off if required. Staff increased the frequency of observations for patients assessed as being at risk.

All wards complied with guidance on mixed sex accommodation. Male and female patients had separate areas for bedrooms and bathrooms, and female patients had access to female only lounges. Staff and patients confirmed that patients were not placed in rooms that required them to walk past member of the opposite sex to reach toilet and shower rooms.

Staff knew about any potential ligature anchor points and most staff mitigated the risks to keep patients safe. Staff were able to identify ligature risks and said these were discussed as a team in team meetings and away days. Each ward had completed a ligature risk inspection audit. Each audit included a comprehensive list of ligature risks, an indication the severity of risk and details of action the ward manager and staff should take to protect patients. Action included increased observations by staff and ensuring offices, staff rooms, meeting rooms, laundry rooms and shower rooms were locked when they were not in use. However, on Beech Ward one of the showers was found to be unlocked. This shower room was listed in the ward's ligature risk inspection audit as needing to be locked when not in use. This posed a risk to patient safety as staff were not complying with the ward's ligature risk mitigation processes. This was highlighted to staff at the time and the room was locked.

Staff had easy access to alarms and patients had easy access to nurse call systems. On all the wards, staff carried personal alarms. Call buttons were installed in all bedrooms. Emergency call buttons were installed in bathrooms.

Wards for older people with mental health problems

Maintenance, cleanliness and infection control

Ward areas were clean, maintained, well furnished and fit for purpose. Patients said, and we observed, wards were kept visibly clean. Staff and patients told us that any faults or repairs were identified and addressed.

Staff made sure cleaning records were up-to-date and the premises were clean. Domestic staff were cleaning the ward throughout our inspection. Domestic staff signed cleaning rotas to confirm they had cleaned all areas of the ward.

Staff followed infection control policy, including handwashing. The service had standard operating procedures for hygiene, cleanliness and infection control. Staff followed infection control principles including handwashing and the use of personal protective equipment if required. Each ward had completed an audit to assess compliance with the requirements for infection prevention and control, hand hygiene, the environment and clinical practices. All wards had at least 85% or higher compliance at their last audit.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs. Clinic room observations confirmed this. Staff had access to emergency equipment. If medicines were required out of hours, staff could access these medicines via an on-call pharmacist. All the wards had an examination couch and scales.

Staff checked, maintained, and cleaned equipment. Staff attached stickers to equipment showing when it had last been cleaned and when it was due to be calibrated. Staff on most wards checked the emergency equipment daily in line with the trust's protocol. However, on Henneage Ward and Meadowview Ward emergency equipment was not always checked in line with this protocol. The trust's protocol on checks for the resuscitation bag stated the defibrillator must be checked daily to ensure that the machine is 'rescue ready'. On Henneage Ward the defibrillator was not checked on five individual days during September 2022, October 2022 and November 2022. When the emergency equipment was not correctly checked and/or checks were not recorded this posed a potential risk to patients as staff could not confirm the equipment was 'rescue ready'.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received appropriate training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff with the right qualifications, skills,

training and experience to keep patients safe and to provide the right care and treatment. Staff described the wards as being calm, safe and patients received consistent care that met their needs.

The majority of wards had low vacancy rates. As of November 2022, Beech Ward's total staff vacancy rate was 9%, Gloucester Ward was 7%, Meadowview Ward was 6%, Henneage Ward was 6%, and Tower and Kitwood wards were 5%. These vacancies had been covered by locum, bank and agency staff. Meadowview and Gloucester wards had just appointed staff to their nursing vacancies, while the other wards' vacancies were out to recruitment. Managers limited their use of bank and agency staff and requested staff familiar with the service. Staff and patients confirmed locum, bank and agency staff were regular and knew the patient group and the individual patients. Patients confirmed they

knew most of the staff on the wards. However, patients reported that sometimes activities did not take place when the service was short staffed. For example, on Henneage Ward, patients reported a lack of meaningful activities when the ward was short staffed. The service was aware of this and a new activities co-ordinator has recently been recruited to support staff in facilitating activities for patients.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Each ward had introduced a competency checklist for all staff working on the wards, including bank and agency staff. This checklist included assessment of competencies for patient observations, the procedure for rapid tranquilisation, and ligature risk awareness.

Managers supported staff who needed time off for ill health. Staff said managers supported them to return to work after illness in ways they were comfortable with.

Ward managers could adjust staffing levels according to the needs of the patients. Managers could increase the number of staff on the ward if there was a high level of acuity or there were patients assigned to enhanced observations.

Patients had regular one- to-one sessions with their named nurse. Ward staff met each morning to allocate staff to specific engagement throughout the day. Support workers and nurses were assigned to facilitate leave and escort patients to appointments whenever necessary.

The service had enough staff on each shift to carry out any physical interventions safely. Staff on all the wards could call for assistance from colleagues on adjacent wards if extra staff were needed to carry out physical interventions.

Staff shared key information to keep patients safe when handing over their care to others. Staff discussed any changes in patients' needs, support and presentation at daily handover meetings and reviewed risks for each patient at multidisciplinary meetings. This information was also documented in patients' care records.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. All wards had a consultant and a duty doctor cover. Patients said they were able to see the consultant and doctor when needed. Staff reported there was always sufficient medical cover. Staff said they would call an ambulance if a patient needed urgent medical attention.

Managers said they could arrange locums when they needed additional medical cover and all locum staff would have a full induction before starting their shift.

Mandatory training

Most staff had completed and kept up-to-date with their mandatory training. Overall staff achieved 95% compliance with mandatory training. The service achieved a 75% compliance rate or greater for all mandatory training except for Tower Ward in grab bag training and Beech ward in physical health screening training at 71%. At the time of the inspection Tower ward staff were at 59% compliance for grab bag training. Grab bag training familiarises staff with the content and application of emergency equipment that is kept within the grab bag such as bag valve mask, nebuliser mask and an anaphylaxis kit. Managers were aware of their teams training needs. Managers said they took this into account when planning the ward staffing and ensured each shift had the appropriate skills and knowledge mix. Training

was discussed in team meetings and supervision. Staff said training availability was significantly reduced during the COVID-19 pandemic. The service had re-introduced face-to-face sessions since the pandemic restrictions had eased although staff felt the training access had not yet fully returned to adapted to the return to business as usual as the COVID-19 pandemic eased.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training sessions were provided either in person or virtually. During the COVID-19 pandemic virtual sessions replaced face-to-face sessions as training availability was reduced. The service had recently re-introduced face-to-face sessions since the pandemic restrictions had eased. Staff they were informed when their training was due. They felt confident carrying out their roles and applied training to their practice. They were fully supported to carry out any additional required training.

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training courses included basic life support, immediate life support, moving and handling, safeguarding, medicines management and the management of actual or potential aggression.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. However, not all wards accurately recorded Do Not Attempt Cardiopulmonary Resuscitation information. Also, not all staff maintained trust standards when observing and interacting with patients.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. When patients first arrived at the ward, a doctor and nurse completed an initial risk assessment. A more comprehensive risk assessment was completed within 24 hours of admission. These risk assessments were regularly updated. Staff on each ward confirmed patients' Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) information and recorded this within their patient records. Patients who provide DNACPR information completed a DNACPR hardcopy form which was stored on the ward. The DNACPR information and form was often completed in another service and this information was transferred with the patient referral and/or admission. The DNACPR information was also recorded in the patients' records and added to the patient whiteboard in the staff office. However, on Tower Ward, of the 8 patients that had DNACPR information, for 4 of these patients their DNACPR information on the patient whiteboard and/or in their patient records did not match with the hardcopy DNACPR information in the service DNACPR folder. This posed a significant risk to patients should a patient be resuscitated when their preference was to not be resuscitated or vice versa. This was highlighted to staff at the time. The ward manager immediately reviewed the DNACPR information for all of the patients who had provided DNACPR information and confirmed the information in the DNACPR hardcopy forms was correct and immediately updated the patient whiteboard and patients' records for the 4 patients where the information was incorrect.

Staff used a recognised risk assessment tool. Risk assessments were recorded on a standardised form in the electronic patient record. This form included the patient's risk history, potential mental health and physical health risks and mitigation to reduce the likelihood of incidents occurring. Staff also used standardised risk assessments to assess risk areas such as malnutrition, skin integrity and falls.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff shared key information to keep patients safe when handing over their care to others. Shift changes, handovers and multidisciplinary meetings included all the necessary key information to keep patients safe. Staff in multidisciplinary team meetings discussed individual patient's needs and demonstrated an understanding of each patient. Staff on the ward met each day to discuss any changes to patients risks and to assign risk management activities to each member of staff.

Staff identified and responded to any changes in risks to, or posed by, patients. All patients presented complex risks in relation to their mental health. Many patients also had significant physical health risks. In relation to mental health, patients presented with risks of self-harm and aggression. Staff managed these risks through prescribing anti-depressant or anti-psychotic medicines and by assigning staff to conduct enhanced observations of the patient. Staff provided personal care to patients that required it along with support and encouragement to eat and drink. Staff monitored physical health risks through frequent observations, blood tests, electro-cardiograms and referrals to specialist services such as physiotherapists and dieticians. Staff monitored the physical health of patients regularly using the observation chart for the National Early warning Score 2 (NEWS2). This is a tool that aids the detection and response to clinical deterioration in adult patients. Staff were trained in the use of the NEWS2 chart to identify deteriorating patients. Staff said they were confident about using it and escalating issues as appropriate. Staff knew where the emergency grab bag was kept. Falls risk assessments were completed when required and updated after any subsequent falls.

Staff could observe patients in all areas. Staff checked all patients every hour. When patients presented a heightened level of risk, this was increased to 4 observations within the hour or constant observations. However, not all staff maintained trust standards when observing and interacting with patients. This compromised patient safety as the patient was not being observed appropriately. The review of CCTV on Henneage ward also showed one staff member reacting in an uncaring and punitive manner toward an unwell patient during an incident where the patient threw a pen. On review of the incident report the language within it was also punitive and uncaring.

Use of restrictive interventions

Levels of restrictive interventions were low. Ward managers explained that staff rarely used restraint due to the frailty of patients. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. If restraint was used, it would involve standing or seated restraint. None of the patients had received rapid tranquilisation. The service did not place patients in seclusion. The trust had policies and procedures which reduced the need for restraint. Staff kept records that showed that staff used de-escalation techniques to avoid the use of restraint. Electronic incident reports included information on how patients were supported when restrained with details that including length and type of restraint and debriefing for patients and staff.

Although the ward did not use rapid tranquilisation, staff were required to be aware of how to carry this out safely and conduct physical observations after the injection. This formed part of the competency checklist for staff working on the wards.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Wards for older people with mental health problems

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training. Compliance with mandatory training on safeguarding at level two and level three for adults and children ranged between 75% and 100% compliance across the wards.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Examples included situations where staff thought patients may be at risk of financial abuse, and instances of patients being assaulted by other patients, Staff addressed the risks of abuse by implementing safety action plans which included actions such as increasing patients' observation levels and asking the local authority to investigate allegations.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff were confident in identifying and making safeguarding referrals and knew who to inform if they had concerns. We observed a multidisciplinary team meeting that discussed safeguarding in a holistic manner and included reflections on areas such as the patient's cultural norms.

Patients said they felt safe on the wards. Staff understood their responsibilities to ensure that patients were protected from bullying and harassment. Patients and carers reported they could report any concerns to ward managers and staff at meetings or confidentially in one to one discussions.

Staff access to essential information

Staff had access to clinical information and it was easy for them to update clinical records – whether paper-based or electronic.

Patient records were comprehensive and all staff could access them. Records relating to patients' care and treatment were stored on an electronic patient record. Staff recorded hourly observations and food and fluid charts on paper. These were stored in the nurses' office and uploaded to the electronic records. Staff were able to access paper and electronic records quickly.

When patients transferred to a new team, there were no delays in staff accessing their records. The electronic records could be accessed by anyone working within the trust.

Records were stored securely. Staff needed to enter a personal identification name, a password and an identity card in order to access the electronic patient record.

Medicines management

Staff did not always follow the service's systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff did not always follow systems and processes to prescribe, administer, record and store medicines safely. The trust had systems and processes in place to safely prescribe, administer, record and store medicines. These processes were not always followed by staff and governance arrangements were not robust enough to identify and improve systems. For example, on one ward medicine was prescribed for an individual that needed to be taken at least 30 minutes before food and other medicines. However, this was prescribed and administered at the same time as other medicines. We pointed this out and the doctor changed the timings. We saw records for patients whose medicines were given covertly. There were no instructions on the drug charts for staff to follow when administering these medicines. Medicine records

were not always complete, and medicines reconciliation was not always updated when patients were transferred from different care setting. On Gloucester ward, we saw a large quantity of a patient's own medicines stored in a cupboard without being checked, recorded and reconciled when patients were transferred to the ward from other health care settings.

Medicines were stored safely and securely. Each ward had a dedicated clinic room with air conditioning and remote temperature monitoring of ambient room and fridge temperatures. Some wards also conducted daily physical checks to provide additional assurances. Medicines cabinets were locked when not in use and only accessible to authorised staff. Controlled drugs were stored securely and checks of these were conducted daily.

Medicines advice and supply were available, and an on-call pharmacist was available outside of core working hours. Pharmacists visited wards when possible and at some sites, remote support was offered due to pharmacy staff shortages. Ward staff knew the routes to contact pharmacy if required.

Staff reviewed each patient's medicines regularly. However, pharmacists did not provide specific advice to patients and carers about their medicines. Pharmacists or medicines management technicians attended the ward weekly on some of the sites, to screen prescription charts. On other sites, prescription charts were screened by the pharmacy team remotely using a specific Application. This Application allowed the pharmacist to review the medicines chart remotely in real time.

Staff stored and managed controlled drugs in line with the provider's policy. The service held controlled drugs (CD) on site. These were checked regularly and managed safely. They also completed regular CD audits which were shared with the ward's managers. Fridge and room temperatures were monitored centrally by estates, and we saw evidence of action being taken if out of range. Also, some ward still completed a physical daily temperature check.

Staff followed current national practice to check patients had the correct medicines. Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. When patients were admitted, an attempt was made to take baseline blood and electrocardiogram readings. All staff had completed their mandatory training in medicines management.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, the trust Medication Safety Officer post has been vacant for an extended period, therefore no in-depth medicines incident analysis in being undertaken in order to provide a monthly medicines incident update at governance committees for further distribution across the trust.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. When a medicine was administered to manage agitation or aggression, medicines were appropriately prescribed and monitored. Staff we spoke with understood the requirements within the policy. Staff we spoke with could describe what they would do when someone refused their medicines and lacked mental capacity.

Track record on safety

There had been 11 serious incidents on the wards in the 12 months before the inspection. Four incidents involved the unexpected death of a patient. Two of these deaths were a result of patient self-harm, and 2 were a result of physical health issues. At the time of the inspection each of these incidents were being reviewed by the trust's serious incident

investigation process. Of the remaining serious incidents in the 12 months before the inspection, 4 involved patient falls, 2 involved injuries to patients from unknowledge causes and 1 involved a physical illness. In all instances, staff completed a report of the circumstances surrounding the incident within 48 hours, referred the matters for a more comprehensive investigation.

Reporting incidents and learning from when things go wrong

The service managed most patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff recorded incidents on an electronic incident record.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff recorded incidents relating to slips, falls and aggression. Staff had completed all incident forms appropriately. Managers had reviewed and signed off all entries on the incident record.

Staff understood the duty of candour. They were open and transparent, and patients said staff discussed and explained incidents when things went wrong.

Managers debriefed and supported staff after any serious incident. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff and patients met to discuss the feedback and look at improvements to patient care in business and community meetings, and the clinical improvement groups.

There was evidence that changes had been made as a result of feedback. For example, on Meadowview ward following an unwitnessed fall of a patient while on enhanced observations the ward manager met with all staff to review observation competencies, the level of observations was discussed in subsequent safety huddles and staff meetings highlighting the importance of knowing patients' whereabouts at all times. This incident was shared across the wards via their lessons learnt processes. Supervision records and team meeting minutes showed discussion of incidents.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Most care plans reflected patients' assessed needs, were personalised, and recovery oriented. However, some care plans were extremely long which made them difficult to use.

Wards for older people with mental health problems

Staff completed a comprehensive mental health assessment of each patient either on admission. A doctor assessed the physical and mental health of each patient when they were admitted. The initial assessment typically involved recording the circumstances surrounding admission, a mental state examination and an assessment of any risk the patient presented. All patients had their physical health assessed soon after admission and regularly reviewed during their time on the wards. Staff supported patients with their physical health needs and worked collaboratively with specialists when needed. Comprehensive physical assessments were completed and plans for on-going monitoring of health conditions and healthcare investigations were developed. This included close and regular monitoring of blood samples, heart rate, oxygen saturation and respiration, urine tests, temperature, weight monitoring and electrocardiograms.

Staff developed a care plan for each patient that met their mental and physical health needs. There was some variation in the quality of care plans in place for patients, but most met their mental and physical health needs. However, on Gloucester ward, the patient care records system created extremely long care plans for patients with complex needs. For example, one patient had a care plan of 134 pages. Care plans were live documents with staff updating them as patients' needs and risks changed. In the patient care records system this created a rolling document for each care plan. This made it difficult to find recent updates and current information. This could cause delay in accessing important information about the current needs of patients. Staff said they found these long care plans documents difficult to use and understand. Patients on Gloucester ward were not familiar with their exact care plans but were aware of their support needs and how staff supported them with these.

Staff regularly reviewed and updated care plans when patients' needs changed. The multidisciplinary team reviewed every patient each week and regularly updated each patient's care plan.

Most care plans were personalised and recovery-orientated. Care plans showed that patients' and carers' views were recorded and addressed a range of issues such as medicines, safety, psychological needs, physical needs, social inclusion, social networks and community services and support.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit and benchmarking.

Staff provided a range of care and treatment suitable for the patients in the service and delivered care in line with best practice and national guidance. Patients were supported with their care and treatment at a pace that was comfortable to them. This meant the pace of support was set in partnership with the patient and their carers. Staff used non-pharmacological approaches during the first weeks of admission to establish whether there were particular triggers to the patient's behaviour or whether behaviour was random. Doctors prescribed mood stabilizers for patients with poor impulse control. When patients' symptoms included physical aggression, and non-pharmacological interventions had not been successful, doctors prescribed promethazine. The reasons for prescribing this were recorded in the patient's records. As a last resort, doctors prescribed a low dose of antipsychotic medicine. Doctors prescribed acetylcholinesterase to patients with dementia to increase communication between nerve cells in the brain which in turn helps to temporarily reduce symptoms. In addition to pharmacological interventions, the service offered interventions to promote cognition stimulation, independence and wellbeing such as occupational therapy and music and drama therapy.

Wards for older people with mental health problems

Staff identified patients' physical health needs and recorded them in their care plans. Staff completed physical observations including blood pressure, pulse, oxygen saturation and respiration, for each patient every day. Staff also provided a comprehensive range of physical health assessments and treatments according to patients' needs. Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. For example, for patients at risk of malnutrition staff completed food and fluid charts and supported patients at mealtimes. Due to the importance of nutrition and health eating mealtimes were protected times of the wards with most staff focused on assisting patients with meals.

Staff made sure patients had access to physical health care, including specialists as required. Each ward had access to specialists that included dietitians, diabetes nurses, physiotherapists and tissue viability nurses. These specialists met with patients to support their care and treatment and worked with staff to upskill their knowledge and support for patients. The wards referred patients to neurologists for specialist assessments where required.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. This included discussions with patients about diet, exercise and smoking cessation. Staff were able to give advice and refer patients to specialist services if needed.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. for example, the occupational therapists used the model of human occupation screening tool.

Staff took part in clinical audits and benchmarking. Managers ensured staff carried out a range of audits to check that staff followed good practice guidance. For example, there were audits of care plans, risk assessments, and escalation of physical health observations. Managers and staff met monthly to compared local audit results and learn from each other. Managers used results from audits to make improvements with development areas being addressed through reminders, training and supervision.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. Managers provided an induction programme for new staff. Managers supported most staff with appraisals and regular supervision to review and reflect on practice and skills.

The service had access to a range of specialists to meet the needs of the patients on the ward. This included consultant psychiatrists, doctors, nurses, occupational therapists, drama and music therapists and physiotherapists. However, full access to psychological support was limited across the service due to psychology vacancies. Managers were aware of this need and recruiting for these posts. The wards also had access to diabetes nurses, speech and language therapists, podiatrists, dietitians, and tissue viability nurses.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff were experienced and qualified to work with older people. All staff, including bank and agency staff, were required to complete competency checklists covering areas such as observations, awareness of ligatures, and fire safety.

Managers gave each new member of staff a full induction to the service before they started work. Staff were supernumerary for their first two weeks when they join the service to allow time for them to complete their corporate induction, be introduced to the ward and spend time shadowing more experienced colleagues.

Wards for older people with mental health problems

Managers supported most staff through regular, constructive appraisals of their work. Staff had a performance appraisal each year and planned their professional development for the following year. The trust's target was 90% for staff completing annual appraisals. As of October 2022, only Henneage ward at 69% and Ruby ward at 50% had not achieved the 90% target. Without regular appraisals staff were at risk of not being fully supported and developed in their professional role which in turn could impact of the quality of care for patients. Senior leaders were aware of the trust's data on staff appraisals and were supporting wards to make the completion of the appraisal procedure easier for staff and managers. Staff felt that appraisals were an important part of continuing professional development as it allowed them to reflect on their current performance and progress and to set goals for their future development.

Managers supported most staff through regular, constructive clinical supervision of their work. The trust's target was 90% for staff completing regularly supervision. The trust collected data on their staff supervision targets, and this showed for Kitwood ward for August 2022 their completion rate was 67%. For Tower ward for August 2022 it was 62% and for September 2022 it was 67%. For Henneage ward for October it was 69%. Managers were aware of their wards' supervision compliance. They said they had been prioritising staff supervision recently. For October 2022 all wards showed a completion rate between 86% and 100%. Most staff said they found supervision with their managers very helpful. During supervision sessions, staff talked about their clinical support and challenges at work along with administrative matters such as leave and sickness. Staff said they could discuss new opportunities and personal development. Without regular supervision staff did not get a one to one space to discuss work and personal issues which in turn impacts of the quality of care for patients.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Staff attended regular business meetings. At the meetings staff discussed activities on the wards, complaints and compliments, learning from incidents and audits.

Managers made sure staff received any specialist training for their role. Staff said there was an extensive range of mandatory, essential and specialist training on offer to develop their professional competence. Staff said they had completed additional professional development courses in understanding dementia and Alzheimer's disease.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff made sure they shared clear information about patients and any changes in their care. Staff held daily nursing handovers and multidisciplinary team handovers to discuss any incidents, any changes to patients' levels of risk and assigned duties across the multidisciplinary team for that day. We observed strong communication and team working during meetings and discussions attended by a variety of clinical and non-clinical staff. Staff valued these meetings. Staff felt they supported learning across their teams and encouraged holistic care.

Ward teams had effective working relationships with other teams in the organisation. We saw evidence that patients had been referred to, for example, dieticians, diabetes nurses and speech and language therapists and advice had been received and incorporated into patient care.

Wards for older people with mental health problems

Ward teams had effective working relationships with external teams and organisations. For example, ward managers held a 'safety huddle' with other managers from across their region. This meant that managers had a good understanding of any incidents or challenges across the directorate and they could provide support for each other.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Most staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received training on the Mental Health Act and the Mental Health Act Code of Practice. They received training on the Mental Health Act and knew how to access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. The service adhered to the requirements of the Mental Health Act. Patients' records did not show any unlawfully detentions.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. These policies and procedures covered information for patients, emergency detention, holding powers, renewals of detention, leave and discharge.

Patients had access to information about independent mental health advocacy. Advocacy details were displayed on the wards. Advocates visited the wards regularly. Staff offered the advocacy service to all detained patients. Written information about the trust's services stated that patients could talk to an advocate if they had concerns about the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Staff took steps to ensure that patients understood the provisions of the Act under which they were detained and advised patients and carers of their rights to apply to a tribunal in respect of their detention. These discussions were recorded in the patient's care records. Staff also ensured that patients who were subject to enhanced observations were aware of the reasons for this.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Staff reviewed the arrangements for leave at the multidisciplinary handover meeting each day.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Patient records included certificates of second opinion and records of discussions with the patient by the responsible clinician, following the visit of second opinion appointed doctors. However, staff did not always review consent to treatment forms to ensure that they were in line with agreed guidance. For example, on Kitwood ward we saw one instance of a patient being prescribed medicines which was not in line with the Mental Health Act certificate of second opinion treatment form. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Wards for older people with mental health problems

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There were 159 Deprivation of Liberty Safeguards (DoLS) applications submitted between December 2021 November 2022 across the all of the wards for older people with mental health problems. The service's safeguarding team managed and tracked all DoLS applications and authorisations. Staff made applications for a DoLS order only when necessary and monitored the progress of these applications. The service's DoLS data showed one instance on Roding ward where staff submitted a DoLS application after the previous DoLS authorisation had expired. This DoLS authorisation ended on 20 April 2022, and the application was submitted on 22 April 2022. The individual was deprived of their liberty safeguards unlawfully for two days. Applications for DoLS authorisation can be submitted 28 days in advance of previous authorisations expiring.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. The policy covered the key principles of the Act, assessments of capacity and roles and responsibilities of staff. Staff could access the policy on the trust's intranet.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could get advice on the Mental Capacity Act from colleagues in the Mental Health Law Office.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. For example, an assessment of mental capacity included details of the information provided to the patient to help them to understand the reasons for proposing additional nutrition supplements.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Consultant psychiatrists assessed and recorded the capacity of patients in relation to their admission. Further capacity assessments were also recorded in relation to other decisions such as treatment, and staff giving information about the patient to carers. Doctors recorded assessments of mental capacity on a standard form on the electronic patient record.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Staff sought support from families and people from patients' communities to help them understand patients likely wishes, culture and history.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Wards for older people with mental health problems

Staff were discreet, respectful, and responsive when caring for patients. We observed staff supporting patients with gentle encouragement at mealtimes. During meetings, we saw that staff were warm and friendly. Staff had a very good understanding of patients' lives, the things they liked and didn't like, and their social circumstances outside the hospital. Staff and patients were happy to laugh and chat together. Most patients were positive about the way staff interacted and supported them. Patients and carers said staff were respectful, attentive, non-judgemental and caring, and tailored care to individual needs. Patient also reported staff provided help, emotional support and advice when they needed it. Patients said staff treated them well and behaved kindly and were responsive to their needs.

Patients were treated with care, compassion, kindness, dignity, calmness and respect by staff. Staff interactions with patients were professional, sensitive and always appropriate. Staff spoke respectfully about patients and had in-depth knowledge of their personal needs and preferences and took the time to establish productive relationships. Staff were discreet, respectful, and responsive when caring for patients. They did not ignore or reject patients with requests, they responded respectfully each time. Patients said staff listened to how they were feeling and supported them to understand their care. They found staff were always friendly, honest and open with them.

Staff supported patients to understand and manage their own care treatment or condition. Staff understood and respected the individual needs of each patient. They adapted their approach to each individual and worked with patients' individual preferences. Discussions about patient leave were person-centred and involved reasonable adjustments to accommodate patients' particular needs.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients, although none remembered a time when they had had to do it. Several of them said they would be very confident about raising it directly with the staff member themselves, but they would tell manages as well.

Staff followed policy to keep patient information confidential. Staff understood the importance of patient confidentially. Patients felt staff were suitably discrete when communicating. Wards with whiteboards containing patient information were closed when not in use. We observed no instances of staff discussing patient information in patient areas.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that patients had easy access to independent advocates.**

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. A member of staff met with each patient and their carers on the first day of their admission. They explained the aims and purpose of the ward.

Staff involved patients in their care planning and risk assessments. The multidisciplinary team met with each patient once a week to discuss their care and treatment. Staff went through care plans with patients and/or carers.

Staff made sure patients understood their care and treatment and supported patients to make decisions on their care. The multidisciplinary team held meetings with patients each week. During these meetings they asked patients how they were feeling, talked about observations and discussed the schedule for medication and support. Staff said when patients did not have the capacity to engage with meetings, they worked closely with patients' families and carers to communicate with patients and gain a better understanding of patients' lives and preferences.

Wards for older people with mental health problems

Patients could give feedback on the service and their treatment and staff supported them to do this. The service had feedback posters on display around the wards. These included quick response (QR) codes that allowed patients to complete a quick survey about the ward. Wards held regular community meeting for patients. At these meetings, patients gave feedback on ward safety, the quality of food, the environment and activities. Staff also sought feedback in one to one session with patients.

Staff made sure patients could access independent mental health advocacy services. Advocacy services were available for patients.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Patients' carers were positive about the service. Relatives said they found staff very supportive. They said staff always asked how they were and provided updates on their family member. Carers said they met with doctors and that staff were always happy to answer any questions they had.

Staff helped families to give feedback on the service. Staff encouraged feedback directly and directed carers to the feedback posters on the wards.

Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Bed occupancy was above 85% on most the wards. However, Kitwood ward's bed occupancy was low, on average around 65%.

Managers regularly reviewed length of stay for patients and worked with staff to make sure they did not discharge patients before they were ready. Patients were not moved between wards during an admission episode unless it was justified on clear clinical reasons or it was in the best interest of the patient.

When patients went on leave there was always a bed available when they returned. The service did not admit new patients to bedrooms assigned to patients on leave.

The service had no out-of-area placements at the time of the inspection. Any of out-of-area placements were reviewed each day in the 'safety huddle' for each region.

Staff did not move or discharge patients at night or very early in the morning. All discharges were planned to ensure the patients were discharged to an appropriate setting.

Discharge and transfers of care

The service had a low number of delayed discharges. Managers ward kept a list of patients whose discharge was delayed due to non-clinical reasons. Staff said most delayed discharges were due to the accommodation or care provision in the community. This meant that arrangements had to be made for appropriate accommodation and/or ensuring appropriate support was in place before individuals could be discharged. Making these arrangements could cause delays.

Staff carefully planned patients' discharge and worked with local authorities, care managers, care coordinators and commissioners to make sure this went well. Service leads and managers monitored and reviewed upcoming and delayed discharges at regularly meetings. Actions and recommendations were discussed and implemented to support discharges. Staff said when there were delays this was generally due to partner organisations finding it difficult to find suitable resources to meet a patient's complex needs.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could have hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Across all wards patient bedrooms appeared personalised. Staff across the wards did not lock patients' doors unless requested, or if there was a specific risk such as a patient prone to repeatedly wandering into the wrong room. Patients said staff were responsive to requests to lock and unlock their bedrooms.

Patients had a secure place to store personal possessions. Patients could store valuable items in a safe or secure lockers in the nurses' office or the cashier's office.

Staff used a full range of rooms and equipment to support treatment and care. The wards all had a lounge area, dining room, occupational therapy kitchen, activities room and a therapy room.

The service had quiet areas and a room where patients could meet with visitors in private. Most wards had a designated quiet room. Patients could meet with visitors in the quiet rooms, meeting rooms, the lounge areas or the ward gardens.

Patients could make phone calls in private. Patients could use the ward telephone in private. Patients also had access to their own mobile phones.

The service had an outside space that patients could access easily. Ward garden areas were locked as these required staff supervision due to ligature risks. Patients said that staff always opened the garden doors and supported patients when they wanted to access outside space.

Patients were supported with hot drinks and snacks. Patients were able to make hot drinks and snacks on Beech ward and Gloucester ward which supported patients with functional conditions such as schizophrenia. However, on Meadowview, Tower and Kitwood wards which supported organic conditions such as dementia staff supported patients in making hot drinks and snacks as patients' conditions and poor motor function could create difficulties for patients.

The service offered a variety of good quality food. Wards displayed menus for lunch and dinner. For each meal, patients had options for starters, main courses, side dishes, salads, sandwiches and desserts. Patients said the standard of the food was good.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as interest activities and family relationships.

Staff helped patients to stay in contact with families and carers. Patients said staff supported in maintaining contact with families and carers. Most patients had their own mobile phone. Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Wards displayed information about local charities that provided support for older people.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Staff assessed each individual and completed a full assessment of patients when they were admitted. Staff provided the service in a way that met the specific needs of each patient.

Wards were dementia friendly and supported disabled patients. Wards had clear, large print signage and photographs of staff. Signs were clear, in bold face with good contrast between text and background, fixed to the doors they referred to, at eye level and well lit. Handrails were colour coded to designate male areas and female areas. Wards were well-lit and made as much use of natural light as possible. Floors were not highly reflective or slippery. The trust had an action plan in place for the continuing environmental works for Kitwood ward to further improve the dementia friendly environment. All the appropriate fixings and fixtures were in place but the painting and decorating were yet to be completed. This was due to be finished by March 2023.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Wards displayed information on the Mental Health Act, advocacy, how to complain, encouraging feedback, charities providing support for older people, how to cope with loneliness and information for carers.

The service was able to meet the diverse cultural, religious and linguistic needs of patients in the service. The service had information leaflets available in languages spoken by the patients and local community. This included information about mental health conditions and medicines. Patients and relatives could request information in different formats such as 'easy-read', large print, braille and other languages for patients who did not have English as their first language. Managers made sure staff and patients could get help from interpreters or British sign language interpreters to ensure patients and their families were fully included in care planning.

Wards for older people with mental health problems

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Each ward provided food that was halal, kosher and vegetarian. For patients with specific dietary needs, wards could provide food that was gluten free, easy to chew and high energy.

Patients had access to spiritual, religious and cultural support. Cultural and religious needs were addressed in care plans. Patients had access to religious leaders who visited the wards. Multi-faith rooms were available for use by patients.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Patients across the service told us that they were aware of how to make complaints. As well as the formal complaints process and raising issues directly with staff and managers, patients had the opportunity to raise issues in community meetings and in one to one sessions. Patients reported that in most cases staff responded promptly to any concerns raised.

Staff understood the policy on complaints and knew how to handle them. The trust had a complaints policy that all staff could access through the intranet.

Managers investigated complaints and identified themes. Between November 2021 and November 2022 there were 19 formal complaints in areas such as clinical management of mental health, attitude of staff, communication, and systems and procedures. All complaints were fully investigated. Themes were reviewed and learning points explored regardless of whether complaints were upheld. Six complaints were resolved locally, 2 were not upheld, 4 were partially upheld, 1 was fully upheld and 6 were still in the investigation process.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Actions points stemming from complaints were completed and followed up at the appropriate level. For example, in relation to one complaint all staff received additional training in the correct process for homeless patients and how to ensure that they were referred for assessment of their eligibility for social housing under the Homelessness Reduction Act 2017.

The service used compliments to learn, celebrate success and improve the quality of care. Staff routinely reviewed both complaints and compliments at team meetings.

Is the service well-led?

Good 

Wards for older people with mental health problems

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders, including ward managers and matrons, were experienced in health and social care. Ward managers had a very good understanding of their patients. This included knowing about the circumstances surrounding the admission for each patient, their social circumstances, their risks, their current treatment plan and the plans for their discharge. Senior managers in the regions spoke positively about their ward managers and the leadership they provided at a clinical level. Modern matrons worked closely with the ward managers and knew the patients and staff well. Managers were able to clearly explain how they led the wards and worked with their staff teams to ensure the quality of the service. Staff said that managers were both approachable and supportive.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The values of the trust were, "we care, we learn, we empower". Staff applied this in their work through the care they demonstrated to patients, their respect for patients and colleagues and the overall inclusivity shown to a everyone from very diverse communities. Staff were aware of the October 2022 Channel 4 Dispatches programme highlighting extremely poor care and support in the trust's acute inpatient services. Staff said they were disgusted by the way in which some staff behaved and conducted themselves in the footage. Staff said they came together as teams to discuss and reflect on the footage. Patients said they had not witnessed any mean or abusive behaviour from staff and felt staff in the wards for older people with mental health problems service showed competence, and strong compassion and care in their support.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff from all backgrounds and professions were proud of their work, felt positive and reported good staff morale. All staff showed passion and commitment to providing high quality patient care. Staff described strong staff teams that worked well together and supported each other. Staff described an open culture where everyone was encouraged to share their views. They felt respected by managers and peers**.** There were opportunities for career development. For example, some healthcare assistants were training to become registered nurses. Staff said they would have no hesitation in raising concerns with their manager or other supervisors. Staff were aware of the whistleblowing policy and freedom to speak up guardian.

Governance

Our findings from the other key questions demonstrated that most governance processes operated effectively at team level and that performance and risk were managed well.

Wards for older people with mental health problems

Governance and decision making were led in each borough by the executive nurse. The executive nurse met with the matrons, who then met with the ward managers each week to discuss action plans and compliance with operational standards. Risks were managed well. Care and treatment were consistent with national guidance. Feedback from patients and carers was positive. All wards carried out a programme of audits to monitor areas such as care and treatment records, staffing levels, staff supervision and appraisals. However, not all wards fully applied the trust's governance system and processes around clinical equipment monitoring, assessment and management of patient risk, and medicines management.

Management of risk, issues and performance

The service managed risk well. Risk registers accurately reflected risks identified by staff. Action was taken to mitigate risk.

Risk management was comprehensive and recognised as the responsibility of all staff. Each ward had a risk register and ward managers were aware of the key risk areas on their wards. The risks were discussed at team meetings. Staff carried out appropriate tests to measure the level of risk and took appropriate action to address this. This included the assessment and management relating to nutritional intake, falls, tissue integrity and diabetes. Risks relating to mental health were managed through medication, therapeutic engagement and enhanced observations. Each day ward teams reviewed the risks for their wards and patients. The ward teams knew the patients well. They were well informed about incidents and used the multidisciplinary team meetings to discuss any changes to patients' care or new insights into their presentation. There were systems in place to monitor risks associated with patients' physical health and any issues were quickly picked up and addressed.

The service had contingency plans for emergencies which wards reviewed as part of their risk registers. Wards carried out regular health and safety monitoring, including regular emergency simulations and fire drills.

Information management

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. The information used in performance management and delivering quality care was consistently accurate, reliable, timely and relevant.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was provided to meet the needs of the local population.

Managers engaged actively other local service providers to ensure that older people experienced good quality care on discharge. The service was transparent and collaborative with local health partners about performance. They were open and honest about the challenges and the needs of the population and felt comfortable in feeding back to system partners.

Learning, continuous improvement and innovation

All staff were committed to continual learning and improving services.

Wards for older people with mental health problems

The service did not use any structured quality improvement models to improve and develop the service. However, managers and staff were clearly committed to improving the service and responded to feedback from patients, carers and staff. A framework of meetings was in place which facilitated sharing of learning from incidents, complaints and safeguarding across the service.

Mental health crisis services and health-based places of safety

Good ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean environments

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. We reviewed the environment of 5 crisis and home treatment teams and 4 health-based places of safety. Two of the health-based places of safety were being refurbished but one was almost complete. Each area had an environmental risk assessment that included a ligature risk assessment. These were detailed and covered all risks. Risks were RAG (red, amber, green) rated and mitigation for each risk was included. In the Home First West health-based place of safety they included photos of the red rated risks. The service was in the process of refurbishing the health-based places of safety. We saw evidence that ligature risks will be reduced further as part of this process, Chelmsford site that was almost completed.

All interview rooms had alarms and staff available to respond. Staff in all locations had access to pinpoint alarms that would alert staff if assistance was required. There were panels located throughout the building which showed staff exactly where the alarm was activated.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. We reviewed the clinic rooms at all 5 locations. All clinic rooms were equipped with all necessary equipment for staff to complete physical examinations. Each location also had grab bags available for staff to take so they were able to complete physical health checks whilst visiting patients in the community.

All areas were clean, well maintained, well-furnished and fit for purpose. We completed a tour of each location. All locations were clean and well maintained. Rooms used for meeting patients were well furnished and fit for purpose.

Staff did not keep cleaning records. However, cleaning staff were on duty each day and ensured the environments were clean and tidy.

Staff followed infection control guidelines, including handwashing. Staff had access to hand washing facilities and there was disinfectant hand gel for staff to utilise at each location.

Staff made sure equipment was well maintained, clean and in working order. Staff put labels on equipment when they cleaned it to show that it had been cleaned and when it was due to be cleaned next. We reviewed the calibration records for equipment and saw that staff kept it well maintained.

Mental health crisis services and health-based places of safety

Safe staffing

The service had enough stuff, who received basic training to keep people safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Nursing staff

The service had enough nursing and support staff to keep patients safe. Staff told us that they were often short staffed, however they did not feel that the service was staffed unsafely. Managers told us they had regular bank staff who knew the service and the patient group and were able to work as part of the team. This enabled managers to ensure that any staff shortages did not affect patient care. We reviewed the duty rotas for 3 months, which showed that shifts were covered with bank staff where possible. If the team were short staffed, then staff would look at the workload for the day and offer lower risk patients telephone contact. The Health Based Places of Safety had staff allocated to attend each day should a patient require the service.

The service had high vacancy rates. The service had an overall vacancy rate of 30% for the past 6 months. The Crisis Resolution and Home Treatment Team East had a vacancy rate of 35% and the Crisis Resolution and Home Treatment Team West had a vacancy rate of 36%. Managers at these locations told us that recruitment was particularly challenging due to their proximity to London where potential staff could earn higher wages.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Each team had access to regular bank staff who were familiar with the service and patient group. Regular staff would also do extra hours on the bank to support the service and ensure patient care was not compromised due to unfamiliar staff. We reviewed the duty rota's which showed that the bank staff worked regular hours.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Managers ensured that new bank or agency staff completed an induction. This included shadowing a regular member of staff on shifts to ensure they were competent.

The staff turnover rate for the service was 2% for the past 6 months. However, the crisis resolution and home treatment team east had a turnover rate of 6.5%. This was below the trusts target of 12%.

Managers supported staff who needed time off for ill health.

Levels of sickness were high. The service had an overall sickness rate for the past 6 months of 9%. This was above the trusts target of 5 %. The crisis resolution and home treatment team east had a rate of 7% and the crisis resolution team west had a rate of 8%. However, the home first team west had a sickness rate of 21%.

Medical staff

The service had enough medical staff. Each team had a consultant psychiatrist and a staff grade psychiatrist. All teams also had junior doctors available for support.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

Managers made sure all locum staff had a full induction and understood the service.

Mental health crisis services and health-based places of safety

The service could get support from a psychiatrist quickly when they needed to. Staff had easy access to a psychiatrist when required. Psychiatrists were based with the teams and could be accessed when required. Psychiatrists would see patients within 24 hours of referral to the home treatment teams.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The overall compliance rate for the service was 88%. However, the Home First West team's compliance rate was 74%. The Home First West team had 17 out of the 32 mandatory training courses that fell below 75% compliance.

Care certificate training for health care assistants was 57%. The Home First East team only had a 50% compliance, Home First Mid team had a 33% compliance and the Home First West team had 0% compliance with care certificate training.

The mandatory training programme was comprehensive and met the needs of patients and staff. The mandatory training programme contained up to 33 different training courses covering a range of topics. These included safeguarding adults and children, Mental Capacity Act and Mental Health Act training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 25 care records across the Health Based Places of safety and the Crisis teams. Records showed that staff completed a risk assessment as part of the initial assessment process. Staff used the trust's risk assessment tool which covered a variety of risks. Staff completed detailed risk assessments that covered all identified risks, including historic risks.

Staff could recognise when to develop and use crisis plans according to patient need. Staff completed crisis plans during the assessment process. Staff told us that that they would usually complete the crisis plan as part of their initial home visit.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. Staff RAG rated each patient's risk daily. This meant that staff could respond quickly to deterioration in patient's health and could increase support where necessary or refer for admission to hospital.

Staff followed clear personal safety protocols, including for lone working. We reviewed the lone working policy for the service. Staff followed the lone working policy to maintain their safety. Staff had access to lone working devices which they could use to get assistance while in the community if they were at risk or required assistance. These devices alerted staff from an outside organisation who would then attempt to make contact and could call the police if required. The devices had GPS location signals so the staff at the outside organisation could send help to the right location.

Mental health crisis services and health-based places of safety

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff were mainly up to date with their safeguarding training. The overall compliance rate for safeguarding adult training was 90%. However, the Home First East team had a compliance rate of 79% and the Home First West team had a compliance rate of 71%. Safeguarding children compliance was 93% overall. Staff we spoke to were able to explain how they recognise and report abuse when they have concerns.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We spoke to 24 staff of different grades who were able to explain and give examples of how they protect people from abuse and harm. Staff demonstrated good knowledge of the providers safeguarding policies and procedures.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us that they would make a referral to the Trust safeguarding team who would triage the referral before passing it on to the local authority if required. Staff told us they could contact the safeguarding team for advice and support and could access safeguarding supervision if they had a complex case.

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The trust had an electronic recording system that was accessible to all staff, including bank staff.

When patients transferred to a new team, there were no delays in staff accessing their records. As all staff had access to the electronic information system there were no delays in accessing information.

Records were stored securely. The electronic record system only allowed staff to access the information they had a right to access.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. The trust had systems and processes in place to safely prescribe, administer, record and store medicines. We reviewed the process of all teams and found that these were being followed in 4 out of the 5 teams. However, these processes were not always followed by staff in the health-based place of safety in Rochford, and governance arrangements were not robust to identify and improve systems. We found an out of date, controlled drug in the controlled drugs cupboard, which staff immediately destroyed in line with the trust policy on destruction of controlled drugs. Staff had not completed the stock check since July 2022.

Mental health crisis services and health-based places of safety

There was an illicit drug, that staff had removed from a patient, in the controlled drugs cupboard. Staff had documented this in the controlled drugs book, but and had not followed the trust's policy and had not removed it since June 2022. Staff were informed of this and when we visited the following day, no action had been taken to remove it. Staff did act later that day to dispose of this in line with the trusts policy.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Patients saw a doctor on admission to the service who reviewed their medication. Patients only received support for a short period, so staff arranged for a review of medication if there were concerns or if the patient was experiencing side effects.

Staff completed medicines records accurately and kept them up to date. We reviewed 25 medication records. Staff completed records accurately and there were no gaps in signing for medication.

Staff mostly stored and managed medicines and prescribing documents safely. However, in the crisis resolution and home treatment team east the doctor kept his prescription pad in an unlocked drawer in an unlocked office.

Staff learned from safety alerts and incidents to improve practice. The trust shared a lesson's learned newsletter with staff which contained information on medication incidents and alerts.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff would monitor patient's for over sedation on every appointment. If staff felt that a patient was overly sedated, they would refer them to the doctor for a medication review.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute of Health and Care Excellence (NICE) guidance. Staff had access to a grab bag containing physical health monitoring equipment to monitor patient's physical health in line with the NICE guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. We spoke to 24 staff who were aware of what they needed to report as an incident and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

The service had not had any never events. We reviewed the incident report data and found the service had not reported any never events in the past 6 months.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed incident reports and investigations which showed that staff were open and honest and fed back the results of investigations to patients and their families.

Mental health crisis services and health-based places of safety

Managers debriefed and supported staff after any serious incident. Managers told us they could get support from the psychology team who would facilitate debriefs after serious incidents. Staff told us they would hold more informal debriefs after incidents within the service.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Incident reports demonstrated patient and family involvement. They were detailed and thorough and identified lessons to be learned.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received feedback from lessons learned during team business meetings. We reviewed the business meetings for the past 3 months and only found 2 examples of where lessons learned were discussed. The trust did produce a lesson's learned newsletter. We reviewed an example of this. It was very detailed and included lessons learned from both community and inpatient. It also highlighted good practice that was identified.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient. We reviewed 25 care records and found that staff completed a thorough and detailed assessment of each patient prior to treatment within the teams. Assessments cover a range of areas including past and present mental health history, current triggers, risk history, support networks and social circumstances.

Staff made sure that most patients had a full physical health assessment and knew about any physical health problems. Staff booked patients in to be seen by the doctor within 24 hours of assessment. The doctor would complete a physical health check as part of their initial assessment. Care records showed that staff were completing physical health checks and monitoring. However, we reviewed 4 care records in the Home First West Team and found staff were not completing regular physical health monitoring.

Staff developed a care plan for each patient that met their mental and physical health needs. Care records showed that staff completed care plans for each patient. However, in 11 out of the 25 care records we reviewed (4 care records in the Home First West and 7 care records home first east team), the care plans were not individualised. We saw evidence that care plans had been copy and pasted from one care plan into another. Care records the home first east team showed crisis plans were all the same with just the name changed. Staff told us this was due to their treatment plans being very similar for each patient such as, once or twice daily visits initially, and this would reduce once the patients risk would reduce.

Mental health crisis services and health-based places of safety

Staff regularly reviewed and updated care plans when patients' needs changed. Care records showed that staff updated care plans when necessary. Patients were only supported short term so staff would update care plans if needs changed.

Best practice in treatment and care

Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes. Staff working for the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Staff told us that psychology was limited within teams due to the short-term nature of their work, and that they could access psychology input for more complex cases. However, staff could refer to community services for psychological support as well as access specialist groups such as personality disorder focus groups.

Staff delivered care in line with best practice and national guidance. Managers explained that the service reviewed the National Institute for Health and Care Excellence (NICE) guidance Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults. Staff told us they followed NICE guidance on the use of anti-psychotic and anti-depressant medication.

Staff made sure patients had support for their physical health needs, either from their GP or community services. We saw evidence in the care records of staff referring patients for support with their physical health such as electro-cardiograms and blood tests.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. Staff used the National Early Warning Scale to monitor and assess patient's physical health. Staff also used the Health of the Nation Outcome scales to monitor patient's mental health severity and improvement.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. We reviewed the audit processes and saw that staff engaged in several clinical audits including record keeping, clinical audits, caseload audits and environmental audits.

Managers used results from audits to make improvements. We reviewed the audits for the past 3 months. We saw evidence that the managers would ensure action was taken to make improvements where the audits highlighted an issue.

Skilled staff to deliver care

Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients. However, teams did not routinely offer psychology as teams did not have psychologists as part of their teams as patients were only supported short term, however, staff could refer to community services if required.

Mental health crisis services and health-based places of safety

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. The service had a range of staff with differing skills and experience. Staff was made up of band 5 and band 6 nurses as well as occupational therapists and social workers. Staff had access to specialist training to improve their skills. Health care assistants could undertake training to become a band 4 assistant practitioner.

Managers gave each new member of staff a full induction to the service before they started work. Staff were expected to complete the trusts induction programme before starting work in the team. This included completing mandatory training. Once this was complete staff would then have to shadow an experienced staff before they lone worked.

Managers supported staff through regular, constructive appraisals of their work. We reviewed the appraisal rates for each team. The overall compliance for the service was 88%. However, the home first east team had an appraisal rate of 75 %.

Managers had not always supported staff through regular, constructive clinical supervision of their work. We reviewed the supervision rates for each team. The overall compliance rate for the service was 75%. The Home First West team had a compliance rate of 58%, the home first team east had a compliance rate of 74% and the crisis resolution and home treatment west team had a rate of 62%. This meant that staff were not receiving appropriate support and that any issues with performance may not be identified.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Each team had monthly business meetings. Managers would share the minute to these meetings with all staff so if staff were unable to attend, they could keep up to date.

Managers made sure staff received any specialist training for their role. Staff were able to access specialist training to enhance their skills. This included phlebotomy and nurse prescribing training.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff could arrange meetings when required to discuss patients care. Staff would arrange a multidisciplinary meeting prior to discharge and include all professionals involved in the patients care to ensure a safe transfer of care.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. Staff included all professionals involved in the patients care in discussions and decisions regarding the patients care and treatment. This ensured all staff involved with the patient was kept up to date.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Mental health crisis services and health-based places of safety

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff compliance with Mental Health Act training for all teams was 89%. However, the home first team west had an overall compliance rate of 61%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff told us that if they required advice regarding the Mental Health Act, they would speak to the team manager or the Mental Health Act administrators. Staff told us they have Approved Mental Health practitioners in the team who would also provide support and advice.

We reviewed the Mental Health Act documentation in the Health Based Places of Safety. We found the staff were complying with the Mental Health Act Code of Practice and that patients were discharged within 24 hours.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy. Staff provided patients with information on how to access advocacy support.

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed. We saw evidence in patients records that staff identified if they were subject to Section 117 rights under the Mental Health Act.

Staff completed regular audits to make sure they applied the Mental Health Act correctly. OR Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff received training in the Mental Capacity Act as part of their safeguarding adults training. Staff overall compliance for all teams was 90%. However, the home first team west had a compliance rate of 71%.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff were able to tell us their responsibilities regarding the Mental Capacity Act and how they would always assume a patient has capacity and that if they were concerned and if they thought a patient did not have capacity to make a decision, they would arrange a capacity assessment.

Staff knew where to get accurate advice on Mental Capacity Act. Staff told us they would speak to the team manager to get advice regarding the Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Mental health crisis services and health-based places of safety

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Staff told us that if a patient did not have capacity to make a decision, they would arrange a decision meeting and involve all those involved in the patients care, including family and carers to ensure the patient's wishes, feelings and culture were respected.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. We spoke with 12 patients who told us that staff always treat them with respect and dignity. Patients felt valued by staff and that staff were kind and responsive to their needs. We attended 4 appointments in patients' homes and saw that staff were very kind, caring and compassionate.

Staff gave patients help, emotional support and advice when they needed it. Staff provided patients with contact details for the service as well as the out of hours service, so patients could get the advice and support when needed.

Staff supported patients to understand and manage their own care treatment or condition. Staff provided patients with support and guidance to manage their condition so as to avoid hospital admission. We saw evidence in the care records of a patient who had been assessed as requiring hospital admission. The team was able to support the patient to learn coping skills and they avoided the patient having to be admitted to hospital.

Staff directed patients to other services and supported them to access those services if they needed help. Staff supported patients to access other services such as psychology services and community recovery cafes for support.

Staff understood and respected the individual needs of each patient. We attended 4 appointments in patients' home and saw that staff were respectful of patients in their homes. Staff demonstrated a good understanding of individual patient's needs.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. Records were electronic and staff could only access information they had a right to access.

Involvement in care

Staff in the mental health crisis teams did not always involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.

Staff informed and involved families and carers appropriately.

Involvement of patients

Staff involved patients and gave them access to their care plans. We reviewed 25 care records and found that 10 were not individualised or did not show involvement of the patient. Staff explained that due to patients being in a mental health crisis it was often difficult for them to be involved in writing their care plan when they first start treatment with the team. We reviewed survey results from January 2022 to November 2022 and saw that there was a 92% satisfaction rate with involvement in care.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). We found evidence in care records of staff getting support to communicate with a deaf patient using a signer.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff provided patients with information on how to give feedback in the service they have received. This included a code that patients could scan to access to an online survey and provide feedback.

Staff made sure patients could access advocacy services. Staff provided patients with information on how to access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Staff offered families and carers a carers assessment to assess their needs and what support could be offered. In the Home First West team staff could refer carers to local charitable organisations who ran carers groups and a telephone service. In the crisis resolution and home treatment team west, staff could refer carers to a support group or to 1 to 1 support. They also had a carer's link worker whose role was to provide support and guidance to carers,

Staff helped families to give feedback on the service. Staff provided families and carers with information on how to give feedback on the service they have received. This included a QR code which gave patients access to an online survey to provide feedback. We reviewed the survey results from January 2022 to November 2022 and found the service had an 80% satisfaction rate.

Mental health crisis services and health-based places of safety

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated people promptly. Staff followed up people who missed appointments.

The service had clear criteria to describe which patients they would offer services to. However, due to the lack of available beds the teams would have to support patients in the community who had been assessed as meeting the criteria for admission. We found evidence in the incident report log for the past 6 months of 74 patients who were being supported in the community because staff could not access a bed when required. Of the 74 patients waiting for admission 22 had been assessed under the Mental Health Act as requiring detention and were having to be managed in the community. We saw evidence of patients having to wait over 2 weeks for admission to hospital. This meant that staff were managing very high-risk patients in the community and that the team's caseloads were high. We reviewed the case loads for all teams. Staff in the East Essex crisis and home treatment team told us their maximum case load was 25. All other teams were operating above their case load maximum. The home first west team had a caseload of 33 which was 8 over their maximum. The home first east team had a case load of 40 which was 10 over their maximum. However, caseload sizes could be flexible depending on the risk rating of the patients they had on their caseload.

All other teams were operating above their case load maximum. The home first west team had a caseload of 33 which was 8 over their maximum. The home first east team had a case load of 40 which was 10 over their maximum. Staff would provide intensive support to manage high risk patients who were waiting for a bed to become available. We saw evidence in the care records of patients who were waiting for a bed, but the Home first teams had managed to reduce the risk so that they were discharged from the team without having to be treated in hospital.

The trust set and the service met the target times seeing patients from referral to assessment and assessment to treatment. Staff would assess patients within 24 hours and if suitable for the service they would be accepted immediately for treatment. Patients in the Health Based Places of safety were assessed and discharged within 24 hours.

The crisis team had skilled staff available to assess patients immediately 24 hours a day seven days a week. All teams worked 7 days a week. Patients had access to the 24-hour crisis line, out of hours should they need support. The trust also had an accident and emergency liaison team who would assess patients who arrived at the accident and emergency department needing mental health support. We spoke to one the managers of the liaison teams who explained the service and how they linked with the home treatment team.

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. We saw evidence in the care record of when staff had tried to engage with a patient who was reluctant to seek support. Staff visited the patient at different times of the day to try and make contact. They also tried phoning at different times. When this was unsuccessful, they wrote to the patient and asked them to make contact. If staff had significant concerns due to the risk of the patient, they would call the police and request a welfare check.

Patients had some flexibility and choice in the appointment times available. Patients could state their preference of either morning, afternoon or evening visits. Staff would always accommodate this where possible. Staff would also offer telephone contact if they were unable to facilitate a visit at an appropriate time for the patient.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. Staff would only cancel appointments when necessary due to staff shortages caused by sickness. If staff were unable to visit, they would offer the patient telephone support instead.

Staff supported patients when they were referred, transferred between services, or needed physical health care. Staff supported patients through their transition back to their care coordinators or GP. Staff would liaise with care coordinators and plan discharge with them to ensure a smooth transition between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. Each team had private rooms at their location so they could see patients on site if the patient preferred. The rooms were comfortable and promoted privacy and dignity.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Staff were able to refer patients to get support to access work and education opportunities. Staff would also offer flexible appointment times to enable patients to continue working or studying.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff supported patients to access a range of support networks including the recovery café and therapeutic groups in the community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments, for disabled people and those with communication needs or other specific needs. All teams had access to rooms with disabled access to use should they be required for a patient with disabilities. We saw evidence of staff using a sign language interpreter to assess a patient with a hearing impairment.

Mental health crisis services and health-based places of safety

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Staff had access to a variety of information on treatments, local services, rights and how to complain. Staff could access the information in various formats including different languages and large print.

Managers made sure staff and patients could get hold of interpreters or signers when needed. We saw evidence in the care records of staff utilising interpreters to communicate with patients whose first language was not English. We also saw evidence of staff using signers to assess a patient with a hearing impairment.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Staff provided patient's, relatives and carers with information on how to complain and what to expect should they need to complain.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke to were able to tell us the complaints process and what they would do if someone made a complaint to them.

Managers investigated complaints and identified themes. We reviewed the complaints for the past 6 months and saw that the crisis teams had received 6 complaints. Staff had investigated and responded to all complaints in line with the trust's policy. Staff investigated complaints thoroughly and wrote to complainants with the outcome and information on how to appeal the outcome. Staff identified lessons learned from complains and actions to take to make improvements.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers shared lessons learned from complaints with staff during handovers and team meetings. The trust also published a lessons learned newsletter with details of complaint outcomes and lessons learned from complaints throughout the trust.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. We spoke with 5 team manages. They all demonstrated good knowledge and awareness of their teams and were all experienced. Staff told us they were visible, and they could approach them anytime with any concerns or general advice and support. Managers demonstrated good knowledge of the patients and the current risks the team were managing.

Mental health crisis services and health-based places of safety

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team. Staff were aware of the trust's values of we care, we learn, we empower, and explained how these were demonstrated in their work.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear. All staff we spoke to told us that they felt supported and valued. Staff felt that they had opportunities for career development as they could undertake specialist training to develop their skills and knowledge. The trust had an equality and diversity policy. Staff felt that the trust followed the policy, and this was reflected in how staff were treated.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. Managers in 4 out of the 5 teams used the results of audits to monitor the performance of the services and make improvements. However, in the East Essex Crisis Resolution and Home Treatment Team they did not have robust governance systems to monitor medication management. Managers had not identified that staff were not completing controlled drugs stock checks which would have identified an out of date medication.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Staff attended daily handover meetings and weekly multi-disciplinary team meetings where patient information and risks were discussed. Staff would also share information on changes to patients care and treatment plan. All staff had access to the records system, including bank staff. The risk register was up to date and included patients being managed in the community whilst waiting for a bed.

Engagement

There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting. The service worked with the police and the local acute urgent care services. The services had police liaison teams who supported police in the community with assessing people in the community who may be suffering with a mental health crisis and supported them to get the most appropriate support. The services had a team who supported the local urgent care centres with assessing patients who presented in urgent care with mental health care needs.

Learning, continuous improvement and innovation

Staff did not provide any evidence or information of ways the service used quality improvement methods to make improvements to the service people received.

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

Inadequate ➔➔

Is the service safe?

Inadequate ➔➔

Our rating of safe stayed the same. We rated it as inadequate.

In the 2019 inspection safe was rated as requires improvement. We currently rate safe as inadequate.

Safe and clean care environments

Not all wards were safe, clean well equipped, well furnished, well maintained and fit for purpose. Patients' observations were not carried in accordance with trust policy. There was limited measurement and monitoring of safety performance.

Safety of the ward layout

At the November 2022 CQC visit, staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. We reviewed the ward ligature risk assessment which included a risk score coupled with a RAG (green, amber and red) rating risk score and description of the actions taken as mitigation. Managers had mitigated ligature risks. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff could not observe patients in all parts of the wards due to the layout of the buildings. However, patients were supported with daily observations. Closed-circuit television camera monitoring was present on wards with an overview of the communal and corridor areas. All wards had curved mirrors placed around the ward to assist staff with patient observations. In addition, the trust had an electronic system which including cameras and sensors in patient's bedrooms. We were told this system helped clinicians to plan care and intervene proactively by providing them with location, activity- based alerts, warnings and reports on risk factors. This was known as a contact-free patient monitoring and management system. There were large numbers of patients that required observations to help keep them safe. Some staff on wards used handheld electronic device to record patients' observations. Staff completed patient observations which were later reviewed and signed off by managers.

At the October 2022 CQC inspection of two wards Willow ward and Galleywood ward, we identified staff not following policies and procedures for patient observations and engagement; and staff falling asleep when undertaking patients' observations. The trust was required to make improvements. At the November 2022 visit staff across the inpatients service had undertaken observation training in line with trust patient's observation policy. Agency and bank staff new to the service, were not allowed to undertake patient observations until they had completed the observation training. Senior staff on wards would ensure new staff received the training and this was now part of staff induction and included training videos. On Willow ward and Galleywood ward managers introduced plans for a therapeutic engagement quality improvement plan to aid staff with patient observations. We saw on Willow ward poster wipe boards in patients' bedrooms, with talking points, prompts and ideas from patients for staff to consider when completing observations. Managers told us staff were meeting with patients weekly to review developments.

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

On the November 2022 CQC visit despite the trust taking some steps to follow up ongoing risks; four patients on Kelvedon ward said when they were on enhanced observations staff did not engage with them. On Willow ward two patients said they had seen temporary staff asleep during their night observations. Some patients from Galleywood and Ardleigh wards told us temporary staff had gone to sleep when they should have been observing them. The trust was aware of incidents where staff were sleeping on duty and were monitoring this. Managers reported that they did not have immediate access to closed-circuit television camera monitoring to check incidents, advising that access could take up to 14 days. Following the November 2022 inspection, the trust told us they had reviewed the list of staff members who could access closed-circuit television camera monitoring. The trust were undertaking a pilot to give appropriate staff direct access to CCTV and body worn camera footage to test using this routinely for learning. The trust reviewed who was part of the pilot and extended this to service managers and matrons from the 9 December 2022. The pilot was due to complete in quarter 4 and recommendations made.

At the October 2022 CQC inspection of two wards Willow ward and Galleywood ward. Staff had identified a blind spot in the garden at Galleywood ward. Staff had reduced the associated risk by keeping the garden locked. This meant that patients could only access the garden under the supervision of staff. At the November 2022 CQC visit the risks had not been addressed in the Galleywood ward garden area. The garden area remained locked, and patients had to ask staff to access the garden area.

On the November 2022 CQC visit, we visited Cherrydown ward and Grangewater wards, both were mixed sex wards. The wards had complied with guidance with mixed sex accommodation. On Peter Bruff a mixed sex ward, staff told us about a mixed sex breach two months ago, when a female patient had been found in male bedroom. Staff had reported this as an incident. One patient on Peter Bruff ward said the female lounge doubled up as a quiet room and was routinely used by male and female patients. We fed back to the ward manager for immediate action.

On the November 2022 CQC visit, most staff had easy access to alarms and most patients had easy access to nurse call systems. Visitors were provided with alarms when visiting their relative. At the October 2022 inspection of two wards Willow ward and Galleywood ward we found Willow ward had nurse call systems in the bedrooms but not on Galleywood ward. Staff used the contact-free patient monitoring and management systems as an additional safety tool to use when appropriate and were supplementary to clinical observations.

Maintenance, cleanliness and infection control

On the November 2022 CQC visit not all ward areas were clean, well maintained, well-furnished and fit for purpose. We saw Chelmer, Stort, Galleywood Grangewater, Cherrydown, and Kelvedon wards were exceptionally clean. The Galleywood ward manager arranged regular checks of the ward with a staff from estates to identify any maintenance issues. Grangewater, Cherrydown, Kelvedon wards had recently been refurbished.

However, on Christopher psychiatric intensive care unit the windows were dirty. The glass surround inside and outside the nurses' station were grubby with food stains. Christopher's psychiatric intensive care unit were at the beginning of a refurbishment plan which was due for completion in March / April 2023.

On Cedar ward, the environment was not therapeutic, the décor was worn and gloomy. The patients lounge on Cedar looked bare, with chairs lined up. Patients were unable to see outside their bedrooms due to privacy film on windows. We observed the extra care shower room was dirty and bedroom 12 toilet were visibly dirty. The dining room sink, and bin were dirty. Staff had not always stored food safely. For example, we found that cheese had not been covered in the

fridge. The Cedar ward main garden was stark with a large amount of litter and a large puddle had formed from the recent rainfall. We saw a separate therapy garden for patients to access that was very small. Estates were looking at the robustness of doors throughout the wards. Doors were scheduled for change over to keypads so patents could use a fob card to access their bedrooms. In the interim, patients had to request access to their bedrooms during the day.

On Ardleigh ward there were some maintenance issues. The tumble dryer had broken down 23 November 2022 and awaiting priority urgent repairs. The digital video disc player (DVD) was broken in the patient's main lounge. A communal toilet door was missing and broken in July 2022 and awaiting repairs (due 28 November 2022). In the patients' lounge noticeboards had been removed and left marks on walls with unpainted areas. Indoor and outdoor windows were dirty.

On Hadleigh psychiatric intensive care unit the environment was sparse and awaiting refurbishment. Staff said the ward was cold, and female staff said they could not wear warm long sleeves due to infection control issues.

On Peter Bruff ward, the ward environment looked worn and needed refurbishment. Some ward walls were damaged. Bedroom seven (bariatric bedroom, bathroom) had an unpleasant smell, due to the drains. Managers told us they had to keep chasing up repairs to be completed. The communal room walls were bare. The staff had lockers but there were no staff rest areas. Staff would have to go off the ward for their breaks.

Patients on Stort and Chelmer wards did not have access to their own garden. The garden is an adjoining garden off the ward.

Staff followed infection control policy, including handwashing. Staff washed their hands when in the clinic room. We saw staff wore personal protective equipment when needed. We saw cleaning stickers on items in bathrooms and clinic rooms.

Seclusion room

On the November 2022 CQC visit, we saw the seclusion room at Ardleigh ward which was shared with another hospital ward. The Ardleigh seclusion room allowed clear observation and two-way communication. They had an ensuite. We saw a portable clock broken with a sticky label on that identified the clock was to be replaced. The seclusion room door had a built-in privacy blind, with a key to access the blinds that could not be located. A set of spare keys were later found during the inspection. The seclusion room needed repair the floor was marked and peeling, and walls had scribbled pictures drawn on them and were marked, the inside of the seclusion room door was scuffed and marked. Managers told us the seclusion room had been identified for refurbishment. The estates team had recently visited to make repairs, but at that time a patient was using the seclusion room, so were unable to proceed with works.

The seclusion room at the Christopher's psychiatric intensive care unit was refurbished in September 2022. The seclusion rooms allowed clear observation and two-way communication. It had a toilet and clock that patients could see. The seclusion room had safe bedding, toilet and washing facilities, heating and ventilation.

Staff told us on Peter Bruff ward the de-escalation suite was not used regularly but had been used for seclusion. There was no clock in this area.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. All equipment, including the crash bag, was clearly labelled and all items were well within their expiry dates.

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

At the October 2022 CQC inspection on Willow ward and Galleywood ward the trust had not ensured ligature cutters were consistently accessible for staff. We saw improvements at the November 2022 CQC visit. Across all wards ligature cutters packs had been made accessible to staff and located in clinic rooms and nurses' stations. Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. There were frequent staff shortages and poor management of agency staff which increased risks to patients.

Nursing staff

During the October 2022 CQC inspection on Willow ward and Galleywood ward we found there were very high levels of vacancies and sickness amongst nursing and support staff across both wards. This meant that there were many different temporary staff working on the wards that were not familiar with the patients.

At the November 2022 CQC visit improvements had not been made since the last inspection, the service continued to not have enough nursing and support staff to keep patients safe. Staff on all wards visited, told us they had staff vacancies. The service had high vacancy rates. Cherrydown, Peter Bruff and Galleywood wards had high registered nursing vacancies whole time equivalent 6.4, the highest healthcare assistant vacancies were at Christopher's psychiatric intensive care unit at 7.9 and Willow ward 6.3.

During the inspection we found areas of the service had high rates of shifts filled by bank and agency nurses and healthcare assistants. Data from the trust February 2022 to October 2022 showed shifts filled by agency and bank staff were high for agency staff on Galleywood ward at 66%. The lowest for agency staff was Grangewater ward at 32%. For bank staff the highest was Grangewater ward at 68% and the lowest was Galleywood ward at 34%.

The service had shifts not filled by bank or agency staff. Data from the trust February 2022 to October 2022 showed for qualified staff Kelvedon ward had the highest with 64% shifts not filled and the lowest for qualified staff were Hadleigh with 36% shifts not filled. For unqualified staff the highest number of shifts not filled were for Ardleigh ward with 64% and the lowest were Kelvedon ward 36% shifts.

Managers limited their use of unfamiliar bank and agency staff and requested staff familiar with the service. Managers said they booked long term agency staff and bank short term contracts across wards to ensure consistency of staff. However, six patients on Willow and Kelvedon wards told us at evenings and weekends temporary staff didn't know the ward and patients well.

Data showed a large number temporary qualified and unqualified staff worked on wards. It was unclear from staff data which temporary staff knew the patients and wards. We sampled ward rosters for November 2022 for three wards Willows, Peter Bruff and Galleywood. Data showed Galleywood had the highest use of qualified temporary staff, 63 per month, this averaged two temporary staff per day. The highest use of temporary unqualified staff was Peter Bruff ward at 390 staff per month, which averaged at 14 staff per day. Followed by Willow ward temporary unqualified used at 333 per month with an average of 12 staff per day. The trust told us the temporary workforce were made up from a mixture of permanent staff doing additional shifts, staff block booked or well known to the ward and as a last resort would use unfamiliar staff.

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

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had high turnover rates for some wards. The service target turnover rates were 12%. Data from the trust from November 2021 to October 2022 showed Ardleigh ward at 20% with a higher turnover rate. The data showed Cedar ward had a consistently high turnover rates between August to October 2022 at 23%. Ardleigh wards turnover rates were highest in January at 25% and February and March 23%. Hadleigh psychiatric intensive care unit had no staff turnover between Nov 2021 to March 2022 and remained low April to October 2022 between 4% to 5%.

Measures had been put in place to reduce staff turnover rates with a 5% uplift payment for substantive staff at Christopher's psychiatric intensive care unit and Haleigh psychiatric intensive care unit. A new clinical site manager was now available out of hours and weekends to support leadership across core service locations. International nurses were deployed to increase nursing substantive nursing levels. The trust had introduced pilot twilight shifts on wards to support teams covered by unqualified staff.

Managers supported staff who needed time off for ill health. The trust provided for staff an employee assistant programme and *Here for YOU- psychology support*, and fast track physiotherapy support.

Levels of sickness were high. The trusts target sickness rate was 5%. However, staff sickness absence levels across urgent and inpatients care were 11%. Cedar ward showed the highest sickness levels with sickness ranging from 42% (Nov 2021 42%) to 22% (October 2022). Sickness levels on Chelmer ward followed, with sickness levels ranging from 27% (January 2022 to 17% (October2022). Stort ward sickness levels had been lower, between 1% to 14% and in October 2022 5%. The trust told us in early 2022 up to October 2022 there were Covid-19 outbreaks which impacted on staff sickness levels.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients, however there were frequent staff shortages and poor management of agency and locum staff.

There were enough staff on each shift to carry out any physical interventions safely.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. A seven day a week rota included a nominated doctor and senior manager on call. Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift. Staff were supported by a speciality doctor who worked up to five days a week on wards.

Mandatory training

At the October 2022 CQC inspection Willow ward and Galleywood ward staff were not up to date with mandatory training. At the November 2023 visit Willow and Galleywood ward training compliance rates were between 77% to 92%.

Not all staff completed and kept up to date with their mandatory training. Out of the twelve wards visited, four wards were not up to date with their mandatory training. Training data showed mandatory training compliance rates for some wards less than 75%. CQC view mandatory compliance rates of 75% or below as non-compliant. The trust staff training

target rate was 85%. We found low training rates on Stort ward for fire compliance 73% and Cherrydown 71%. On Ardleigh ward prevention management of violence and aggression 73%, level 3 Looked after children and PREVENT 71% and fire compliant 63%. Peter Bruff ward for Mental Capacity / Deprivation of Liberty & PREVENT 71% and safeguarding children 43%.

Staff said training availability was significantly reduced during the COVID-19 pandemic.

Staff also received essential training. Training included diabetes level 1 & 2, engagement and supportive observations, preventing suicides by ligatures, moving and handling and positive cultures.

Staff told us bank and long-term agency staff were provided mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Manager received regular staff training compliance reports.

Assessing and managing risk to patients and staff

Not all staff assessed and managed risks to patients and themselves well or followed best practice in anticipating, de-escalating and managing challenging behaviour. Opportunities to prevent or minimise harm are missed. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff did not assess, monitor or manage risks well to patients who use the services. Staff used a recognised risk assessment tool. We examined 60 risk assessments across twelve wards. We found 16 (26%) risk assessments were not complete or updated regularly including after an incident. However, managers told us patients' risk assessments should be reviewed weekly as part of ward reviews at multidisciplinary meetings, after the daily review of patient observations and following incidents.

On Willow ward we looked at six risk assessments, none of these had been completed. One patient had been admitted on 17 November 2022 (with five days on the ward), however there was no evidence that a risk assessment had been completed on admission. The patient had an incident recorded of head banging, but the date had not been recorded and there had been no review of risk after the incident. The patient had been restrained on 21 November 2022; however, the risk assessment had not been updated following the incident. Three other risk assessments had been partially completed but were not updated regularly. One patient had an eating disorder, but there was no evidence of weight monitoring and body mass index information. A skin integrity assessment had not been completed.

On Cedar ward we looked at three risk assessments, of which two were not completed. One patient had been on the ward for 45 days with a risk assessment dated July 2021. A risk assessment for this patient had not been completed upon admission. A second patient's records indicated that the patient had been admitted to the ward 7 November 2022. However, other records showed the patient were admitted 779 days ago. The patients risk assessment was not completed upon admission.

On Galleywood ward we looked at three risk assessments with two not up to date. One patient had transferred from another ward 04 August 2022. Their risk assessments had not been updated since 15 October 2022. We saw the patient

had taken an overdose on the same date 15 October 2022, but the risk assessment had not been updated to reflect this, and there was no evidence that the patients' enhanced observation changes. A second patient was given rapid tranquilisation 27 October 2022, but this was not recorded as an incident. There was no documented review of risk after the incident.

On Stort ward we looked at six risk assessments for three patients, however there had been no regular updates. The three patients' risk assessments had not been reviewed for between twelve days to one month. On Chelmer ward we examined six risk assessments with five not updated weekly.

On Peter Bruff ward we looked at four risk assessments. One was completed. We saw on one patient's records dated 3 - 16 November 2022 had raised eight sexual safety concerns. The risk assessments and care plan had not been updated following the concerns We found for another patient risk assessments included sexualised behaviours. The patient was later transferred to a single sex ward.

We examined six risk assessments on Christopher's psychiatric intensive care unit. All six risk assessments were updated regularly including after an incident. One patient had declined the vision-based patient monitoring system monitoring. It was difficult for staff to locate consent within the patient's electronic records. Staff told us the trust were developing a record to be added to the existing patients care records specifically for vision-based patient monitoring system consent and ongoing consent.

We looked at twelve risk assessments at Kelvedon ward and Grangewater wards. All risk assessments were comprehensive updated regularly including after an incident. We found records written in the patient's voice.

Management of patient risk

On the November 2022 CQC visit we found safety was not a sufficient priority. Some staff did not always know about risks to each patient and acted to prevent or reduce risks. On Willow, Cedar and Peter Bruff wards staff did not always know about risks to each patient and acted to prevent or reduce risks. Staff did not always identify and responded to any changes in risks to, or posed by, patients.

On Willow ward, one patient had left the ward by moving through two air locks and forced opened the main outer door into the car park. Staff found the patient and returned to the ward. A previous incident of the same type had been recorded.

On Willow ward a male staff member was observed holding a female patient's hand as they escorted them to a health appointment. It was unclear if the staff member understands about potential risks and professional boundaries. This issue was immediately raised with managers. The female patients care plan were followed up and reviewed by the inspection team.

Staff followed procedures to minimise risks where they could not easily observe patients. We saw the sensor alerted staff on Ardleigh ward when one patient's oxygen levels had dropped in her bedroom. Staff immediately checked the patient and summoned medical attention.

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

Not all staff followed trust policies and procedures when they needed to search patients to keep them safe from harm. Patients on Willow, Cedar and Hadleigh ward had pat-down searches in the corridor (which is part of the air lock). Pat-down search is where a staff member pass their hands over the body of a clothed person to detect prohibited or restricted items. On Cedar ward security staff carried out security checks with patients. The Cedar ward manager had identified a room to use as the patient search room and was waiting final environmental changes with estates.

At the October 2022 CQC inspection the trust were required to take immediate steps to review and reduce all blanket restrictions on wards. On the November 2022 visit we found concerns around blanket restriction and restrictive practice. We raised the concern with the trust around blanket restriction during the CQC visit 4 to 5 January 2023 for Willow ward, one staff said they continued to search patients for security checks before they come on the ward in the main doorway area. Another staff member said they searched patients on the ward in the locker area and used the metal detector without clear rational or assessment.

Ardleigh ward had a patient search room near the main entrance. This was shared with an adjoining acute ward. The search room included locked storage for patient's tobacco and lighters and a pod to temporary store any illicit drugs. We saw a list of prohibited of items on display, but this was different to lists displayed around wards. Managers told us the trust were in the process of reviewing a standard list of prohibited of items.

Use of restrictive interventions

At the October 2022 CQC inspection for Willow and Galleywood ward the trust were required to take immediate steps to review and reduce all blanket restrictions, restrictive practices on wards. On the November 2022 CQC visit we found high levels of restrictive interventions on some wards. On Willow, Cedar, Peter Bruff, Galleywood and Ardleigh wards there were restrictions where patients had to ask staff to access the garden, bathrooms, beverages areas.

On the November 2022 CQC visit, the door to the Willow ward garden was locked and the manager was unwilling to accept this was a restriction. On the CQC visit to Willow ward 4 to 5 January 2023 we saw improvements around this aspect. The garden door was unlocked and monitored by staff. Patients could access the garden area anytime. A staff member was rotated hourly to the garden area and supported patients when they accessed the garden. We observed the nurse on garden duty in the garden talking with patients while they vaped and were popular with patients.

On the October 2022 inspection Galleywood staff had identified a blind spot in the garden area and reduced the risk by keeping the garden door locked. At the November 2022 CQC visit some improvements had been made. Staff had received garden competency training and were aware of blind spot in the garden. The Galleywood ward garden remained locked, and patients had to ask to access the garden area with one patient and one staff member only.

On the November 2022 CQC visit on Peter Bruff ward the manager told us that as the ward was an assessment ward the restrictions were necessary, and they did not believe it to be restrictive practice. On Peter Bruff ward the garden area is accessible to patients every two hours at set times until 23:00 hours. Four patients said they would like to go out to the garden when they wanted to. We reviewed this during the visit on 4 and 5 January 2023. Staff told us they thought that as the ward was an assessment ward the restrictions were necessary and was not restrictive practice despite this being raised as part of the letter of intent sent to the Trust.

On Willow, Hadleigh and Cedar wards, patients could not access the beverage areas for hot and cold drinks and snacks, instead must ask staff. On the CQC visit 4 to 5 January 2023 to Willow and Cedar wards we saw some improvements, patients could access drinks and snacks in the dining area.

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

On Christopher psychiatric intensive care unit, the hot water dispenser had tested too hot and so was no longer in use. On Ardleigh the beverage room had not been in use for three weeks following an incident where a patient had self-harmed and scalded themselves with the hot water dispenser.

Eleven patients from Cherrydown, Kelvedon and Hadleigh wards told us the coffee provided was caffeine free, and staff encouraged them to be in bed by midnight to aid good sleep hygiene.

Most wards had a fob key system. The fob key is the small handheld remote-control device that controls a remote keyless entry system to patients' bedrooms. On Willow ward staff told us the fob door key system had been fitted 22 November 2022 during the inspection but wasn't operational at the time of inspection. On Cedar ward the fob key system was fitted 22 November 2022 so patients could access bedrooms.

On Grangewater ward there was a designated garden area for the ward accessed by patients, three staff were required to escort patients outside. There was a shared garden scheme in place with hourly access for all patients. Patients we spoke with said that hourly access to the garden was sufficient.

On Grangewater ward patient's status were informal, however patients told us they would have their "leave discussed with matron." The matron informed us that all patients were admitted informally to the ward and that they would not be allowed to leave the ward for the first 72 hours, despite the fact that the patients were informal and free to leave at any time. Six patients told us there were unhappy with how the matron and staff worked with them as informal patients.

We saw lists of prohibited of items that varied ward to ward. Some wards displaced posters- What are the blanket rules. Staff across wards were unsure of standard items that were restricted. However high-risk items on the prohibited list were seen on the ward for example plastic bags, bars of soap and pens. On Chelmer and Stort wards we saw one patient with a plastic bag, which were a prohibited item.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We saw trust data from 1 December 2021 to 23 November 2022 across wards there were 753 restraint incidents. The highest were on Willow ward with 228, the most in August with 52 incidents. Christopher's psychiatric intensive care unit second highest with 143 incidents the most incidents in January 2022 with 27. The lowest restraint incidents were Chelmer ward with 24.

During the same time period (1 December 2021 to 23 November 2022), across wards there had been 22 incidents of prone restraint. Prone restraint is when a patient is lying chest down on their front during restraint. The highest number of prone restraints were on Christopher's psychiatric intensive care unit (13) and the lowest Ardleigh, Cedar, Chelmer, Peter Bruff with one prone restraint each ward. The remaining wards had none.

Not all staff followed NICE (National Institute for Health and Care Excellence) guidance when using rapid tranquilisation. We saw trust data from 1 December 2021 to 23 November 2022 across wards there were 299 incidents of rapid tranquilisation. The highest incidents were on Willow ward with 132. There were high incidents in three months January 29, April and August 22 incidents. Christopher's psychiatric intensive care unit had a total 52 incidences with October nine incidences.

There were ten incidences of rapid tranquilisation on Galleywood ward. One patient was given rapid tranquilisation 27 October 2022. However, this was not recorded as an incident and there had been limited post tranquilisation patient monitoring. During the inspection the patient made an allegation (to the CQC team) of a sexual inappropriate incident post rapid tranquilisation. We passed this to the ward manager to take immediate action. The ward manager immediately raised a safeguarding referral and reviewed the care plan and risk assessment.

When a patient was placed in seclusion, not all staff kept clear records and followed best practice guidelines. We examined one set of seclusion records for a patient in Christopher's psychiatric intensive care unit and found records were accurately recorded. However, on Peter Bruff ward one patient had been secluded, but no seclusion records were commenced on the start date (12 November 2022) or when the patient left seclusion (13 November 2022).

Trust data from 1 December 2021 to 23 November 2022, showed that across wards there were 88 incidents of seclusion. On Christopher's psychiatric intensive care unit there had been a total of 32 incidents of seclusion between 1 December 2021 to 23 November 2022. In February there were ten incidents of seclusion. Ten incidents of seclusion took place in February 2022. Stort ward had a total of ten incidents of seclusion. Willow, Grangewater and Galleywood wards all had a total of one incident of seclusion. Overall, we saw the incidents of seclusion were reducing in December 2021 with ten incidents of seclusion to November 2022 with two incidents of seclusion.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. Trust data from 1 December 2021 to 23 November 2022 across wards there were 11 incidences of long-term segregation. Peter Bruff ward had four and the remaining wards ranged from nil to two long-term segregation incidents.

The trust was piloting body worn cameras on Ardleigh ward. Four staff were using body worn cameras on the day of our visit. Managers planned to review footage of incidents for the purpose of learning and professional standards. The footage would be used to identify patients and staff safety incidents and safeguarding concerns.

Staff told us systems were in place to monitor the use of restrictive practices at weekly ward rounds, multidisciplinary meetings, incident audits, professionals' meetings, monthly consultants' meetings. Data provided by the trust did not provide adequate plans or evidence of learning from events or action taken to improve safety it's unclear how effective systems were in reducing restrictive practices across wards.

Safeguarding

Not all staff were up to date with safeguarding adults and children training. There was insufficient attention to safeguarding adults. Staff do not always recognise or respond appropriately to abuse.

Staff received training on how to recognise and report abuse, appropriate for their role. Most staff kept up to date with their safeguarding training. Training included safeguarding adults and safeguarding children. Across wards safeguarding compliance rates ranged from 43% to100%. The trust mandatory training compliance rate target were 85%. Three wards were below the trust target. Peter Bruff ward safeguarding children 43%, Cherrydown ward safeguarding adults 78% and Cedar ward safeguarding adults and children 83%.

Most staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. Children were allowed on wards but must be agreed in advance with the multidisciplinary team.

Some staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust provided safeguarding data from December 2021 to November 2022. There had been 183 safeguarding referrals. The highest referrals were on Galleywood ward with 31, followed by Willow ward with 26, Grangewater one referral and Kelvedon ward had none.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

On Christopher's psychiatric intensive care unit, we saw patient notes were comprehensive and of a good standard. The trust used six different electronic systems at locations that staff could access.

Managers said they monitored patients care records to ensure they were detailed and up to date. However, we did not see this across all wards. We saw some risk assessments and care records were not completed or updated regularly.

When patients transferred to a new team, there were no delays in staff accessing their records. We saw new patients admitted to wards clinical records were appropriately shared with the new team caring for the patient.

Records were stored securely. We saw patients' records were held electronically and managed securely.

Medicines management

Not all staff used systems and processes to safely prescribe, administer, record and store medicines. Staff did not always regularly review the effects of medications on each patient's mental and physical health.

Not all staff followed systems and processes in line with trust policy, when safely prescribing, administering, recording and storing medicines. We visited seven ward clinic rooms and found gaps in following different aspects of best practice across wards. We saw evidence of patients not receiving their medicines as prescribed, including antipsychotic medications such as Clozapine, Lithium and Sodium Valproate. On Hadleigh ward we saw that a patient missed four doses of Lithium. This resulted in low therapeutic levels and led to the medication having to be recommenced and re-titrated again. On one occasion, we observed a staff member signing a patients' medicine chart in retrospect after finishing the medicines administration round.

Where rapid tranquilisation by an intramuscular medicine was used, this was only as a last resort. Staff understood the importance for post dose physical health monitoring which was to be taken every hour for the first four hours. However, staff were uncertain with regards to trust guideline for physical observation in the first hour of administering rapid tranquilisation medicine. Comments ranged from 5 minutes to 30 minutes. Records we reviewed showed that there were some gaps in records.

Medicines advice and supply were not always available. An on-call pharmacist was available

outside of core working hours. Ward staff knew the routes to contact pharmacy when required but would prefer more clinical pharmacist involvement on wards which was lacking due to pharmacy staff capacity issues. For example, on Ardleigh ward staff told us that on one occasion, the insulin dose had been missed as insulin had not been delivered by pharmacy team.

Staff checked Mental Health Act consent to treatment documents before giving a medicine. We reviewed patient's treatments against those authorised on consent to treatment document. These were correct and in line with the consent to treatment documents.

We looked at 15 prescription charts on Chelmer ward. There were staff signatures missing on six patients' prescription charts with a total of 20 signatures missing.

On Ardleigh ward one patient told us they were awaiting antibiotics for a urinary tract infection for four days. The same patient told us their insulin had not been provided. We reviewed their medicine records and found 13 November 2022 insulin was signed as given but administered to the patient on the 11 November. Insulin was due on the 13 November but given on the 12 November. There was missed dose on the 21 November. Staff told us that on one occasion, the insulin dose had been missed as insulin had not been delivered by pharmacy team. We were unable to find information recorded about the urinary tract infection, but staff confirmed the information was correct. The manager agreed to take immediate action to support the patient with their medicines and diabetic care.

On Ardleigh ward permanent staff hold their own key and fob key to the clinic room and on occasions had taken keys home. This may potentially compromise the safety of the clinic room.

Staff reviewed patient's medicines regularly but did not provide specific advice to patients and carers about their medicines. Pharmacist or medicines management technician attended the ward weekly to carry out medicine's reconciliations and screen prescription charts (either on site or remotely using the PANDO APP). Pharmacists did not attend ward rounds and only spoke to patients directly when doing medicines reconciliation, but no patient education was undertaken. Medications were discussed by the consultant in ward rounds and when prescribing.

Staff stored and managed the majority of medicines and prescribing documents in line with the provider's policy. The service held controlled drugs stocks on site. These were checked regularly and manged safely. However, we found illicit drugs brought in by patients in the CD (controlled drug) cupboard had not been documented. Fridge and room temperatures were monitored centrally by estates, and we saw evidence of action having been taken if out of range. Some wards also carried out a physical daily temperature check. However, on Cedar ward fridge temperatures had not been recorded on three occasions, 5, 6 and 27 November 2022.

Most staff followed current national practice to check patients had the correct medicines. Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. When patients were admitted to the ward, an attempt was made to take baseline blood and electrocardiogram (ECG) readings. Monitoring was attempted when changes were made to medication in line with NICE guidance. All staff had completed medicines management training as part of the Trusts' mandatory training.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, staff told us there had been an increase in medicines related incidents reported on the trust reporting system. It was not clear the reason behind this. However, the trust medications safety officer post had been vacant for an extended period. Therefore, no in-depth medicines incident analysis had been undertaken to provide a monthly medicines incident update at governance committees, for further distribution across the trust.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. When a medicine was administered to manage agitation or aggression (rapid tranquilisation), medicines were appropriately prescribed however, monitoring was not in line with trust policy. Staff used rapid tranquilisation as a last resort on wards.

Staff we spoke with could describe what they would do when someone refused their medicines and lacked mental capacity.

Track record on safety

The provider did not measure and monitor safety well.

Reporting incidents and learning from when things go wrong

Staff did not manage patient safety incidents well. When concerns were raised the approach to reviewing and investigating causes were insufficient. There was limited measurement and monitoring of safety performance. However, some managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

For this core service, there was little evidence of learning from incidents or action taken to improve safety. Opportunities to prevent or minimise harm were missed. Patient incident data from the trust showed between December 2021 to November 2022 a total of 5691 incidents. Of these, there were 3849 patient safety incidents. Actions were taken with all incidents with lessons learnt documented in 1167 (30%) with 13 serious incidents reported. Incidents with no harm 3057 (79%), 660 (17%) low harm, 32 (1%) moderate harm, one severe harm and five deaths. Ninety-four (2%) incidents were not graded.

There were 1651 incidents non patient safety incidents: 1207 (73%) no harm, 375 (23%) low harm and 30 (2%) moderate harm. One death was listed. The trust data showed action taken and lessons recorded for 466 (23%). Thirty-eight (2%) incidents were not graded. Incidents not graded would be due to the incident being open at the time of data extraction.

Trust data identified top lessons learnt types: Self-harm 1201 (21%), moving handling 772 (14%), assault physical 758 (13%), assault verbal 389 (7%) and anti-social behaviour 444 (8%). The trust identified types of lessons learnt: Education at service level 132 (32%), clinical care 105 (25%), communications 33 (8%) and environment 39 (9%). We did not see detailed plans of lessons learnt.

Staff did not always follow trust guidance and report all incidents. On Christopher's psychiatric intensive care unit staff had not reported racial abuse. The CQC inspection team observed on eight separate occasions during a two-hour period a patient being racially abusive towards several staff. We observed staff and managers ignoring the patient's behaviour. We asked staff if managers took any action and were told this type of behaviour was seen "regularly and normal" and no action were taken to report or escalate. On 4 to 5 January 2023 CQC visit, staff on Willow, Cedar, and Peter Bluff said any reports of racial incidents would be discussed at handovers and escalated with ward managers. However, staff were still not reporting these as incidents despite new guidance being issued from senior leaders, following the inspection in November 2022, that racial abuse should be reported as an incident.

Staff had not always reported serious incidents clearly and in line with trust policy. On Peter Bruff ward we found examples where staff had not reported incidents. On the 2 November 2022 another patient had been taken to A&E for a hand injury. Staff had not recorded this as an incident. On the 9 November 2022 the same patient had become stuck in an air conditioning unit. The patient was subsequently released by the fire services with no injuries. This had not been recorded as a serious incident.

The trust provided data from 1 June 2022 to 23 December 2022 with incidents of staff sleeping on duty. The trust had recorded action taken and lessons learnt. In total there were 20 incidents. The highest number were on Willow ward; 5, Ardleigh; 4 and Peter Bruff 3 incidents. One of the 3 incidents of staff sleeping on duty were on Peter Bruff ward (23 July 2022). A patient reported a staff member had fallen asleep during their level 3 observations. (This is an enhanced observation with the patient kept within line of sight whereby the staff member can observe, engage with, and maintain contact with the patient to ensure their well-being, safety, and safety of others). Although records showed the incident of staff sleeping on duty had been raised as an incident, the close circuit television monitoring records had not been viewed and managers had not taken any action. Other wards had reported between none or one incident of staff sleeping on duty. The data showed there were four other incidents for Basildon Hospital, but the name of the ward had not been recorded.

Managers told us that lessons learnt around actions to mitigate staff sleeping on duty, was reflected in one of four training videos on the intranet for staff to watch and improve their practice. Safety action alerts were available to staff with lessons learnt including themes- self harm, record keeping. We also saw an alert about staff sleeping on duty.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff could attend weekly debriefs and had support from a psychologist. Managers encouraged staff to take part in reflective practice following any incident.

Managers investigated incidents. Patients and their families were involved in these investigations. Staff received feedback from investigation of incidents, both internal and external to the service. Managers held quality improvement meetings where they shared lessons learned with staff. They recorded this in meeting minutes. Staff could access safety actions, alert notices and lessons learnt on the trust intranet with identified themes used to improve care. Staff discussed incidents at staff handovers and huddles. We saw lessons learnt bulletins and staff had an icon on the intranet desktop to view lessons learnt bulletins past and present.

Managers did not always make changes and improvements in safety specific to this service. The service had close circuit television monitoring across inpatient wards. Managers can request to view close circuit television monitoring following a patient incident, but this may take up to 14 days for a request to be processed. A register of requests was maintained.

We sampled incidents on close circuit television monitoring for Peter Bruff ward 5-21 November 2022. We found several incidents which staff had not reported. On the 17 November a patient had threated a staff member on the ward, no incident had been recorded. On the 17 November a staff member were seen texting on their mobile phone near a patient. Managers had told us staff were not allowed to bring their mobiles phones onto the ward. No action had been taken. On the 18 November a patient were found with a bladded article and had threatened to hurt staff. On the 20 November the same patient were observed to be very unwell. The patient was seen by the duty doctor and attended A&E. No incident had been reported. On the 18 November another patient had repeatedly showed self-harming behaviour, no incident had been recorded.

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

We sampled incidents on the close circuit television monitoring for Willow, Grangewater and Cherrydown wards during the November 2022 CQC visit . We saw staff took appropriate action and sensitively engaged with patients throughout interventions.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

At the previous 2019 inspection effective was rated good. We currently rate effective as requires improvement.

Assessment of needs and planning of care.

Not all staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Not all care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

At the November 2022 CQC visit, not all staff completed a comprehensive mental health assessment of each patient either on or soon after admission. Not all patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We reviewed 60 care plans across 12 wards. We found 24 (40%) care plans were not complete or reviewed regularly. Not all care plans had been regularly reviewed and updated when patients' needs changed. Most care plans were personalised, holistic and recovery orientated and included 'My care, My recovery' plans.

On Willow ward we looked at seven care plans. We saw care plans were reviewed regularly but there were gaps on three care plans around physical health care and physical health care checks. On Cedar ward we looked at three care plans. The three care plans were not reviewed regularly and did not fully meet patient's needs. One patient had recently been on a community treatment order and recalled to hospital and had been receiving treatment without written consent. We raised this with managers and staff immediately met with the patient and gained the patients consent during our visit.

On Galleywood ward we looked at four care plans. Two care plans were up to date and reviewed regularly. Two care plans had some gaps around recovery and strengths and goals; and no care plan after rapid tranquilisation incident 27 October 2022.

On Ardleigh ward we looked at six care plans. Five care plans were complete and reviewed regularly. One care plan had gaps with no reviews for regular insulin checks and recording events around antibiotics for a urinary tract infection. The patient had a history of restrictive diets and purging episodes and were historically under the outpatient eating disorder service in May 2022 but had lost contact. The patient did not have a restrictive diet care plan. The matron said they would take immediate action and make a referral to the eating disorder service; and follow up the antibiotics for the patient's urinary tract infection.

On Peter Bruff ward four care plans were not updated regularly when patients' needs changed. We saw on one patient's records dated 3 -16 November 2022 eight sexual safety concerns listed and no recorded action taken. On the 27 October 2022 a patient was holding hands with a staff member. During the inspection we saw the same patient holding hands with a staff member. Providing "hand support" was included in the patients care plan.

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

On Hadleigh psychiatric intensive care unit, Stort and Cherrydown wards care plans were reviewed regularly, personalised holistic and recovery orientated. On Stort ward six care plans did not record patient involvement. On Cherrydown ward one care plan did not include a specific care plan for an existing medical condition.

On Kelvedon, Grangewater, Chelmer wards care plans were personalised holistic, and recovery orientated, complete and reviewed regularly, however all care plans were difficult to follow and up to 46 pages long.

On Christopher psychiatric intensive care unit. All five care plans were complete, personalised, holistic and recovery orientated, complete and reviewed regularly. One care plan was written to a high standard with evidence of robust wellbeing and safety plans.

At the October 2022 CQC inspection at Willow ward and Galleywood ward the trust were asked to make improvements around the contact-free patient monitoring and management system. This system helped clinicians to plan care and intervene proactively by providing them with location, activity -based alerts, warnings and reports on risk factor. Not all patients had provided consent upon admission or were aware of the systems in their bedrooms. The trust told us that they assume implied consent for this system to be used and they required staff to record if a patient declines.

On the November 2022 CQC visit we looked for evidence of patient's consent to contact-free patient monitoring and management system on Willow, Galleywood and Peter Bruff wards; we were unable to locate consent within patients' records sampled.

On Christopher's psychiatric intensive care unit one patient had refused consent. Staff took a long time to locate the refused consent in the patient's care records. There was no record of ongoing consent being sought.

Staff said the trust were developing a record to be added to the existing patients care records specifically for ongoing consent to the contact-free patient monitoring and management system. We sampled ward welcome packs for Kelvedon and Ardleigh wards and did not see any information around contact-free patient monitoring and management systems. However, wards displayed posters with brief information about technology to monitor patients' vital signs.

Best practice in treatment and care

Not all staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Most staff identified patients' physical health needs and recorded them in their care plans. Staff used NEWS 2 (a system of physical health monitoring scoring the physiological measurements that are routinely recorded at the patient's bedside). However, we saw a lack of physical health care monitoring in some patients care plans.

Most staff made sure patients had access to physical health care, including specialists as required. We saw examples of food and fluid charts for some patients.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. We saw patients with specific dietary needs being met.

Staff used technology to support patients. Staff used handheld device to record patient observations. However, these devices were not available to staff across all wards. The trust provided contact-free patient monitoring and management systems, but systems were not fully embedded for recording patient's ongoing consent.

The service participated in clinical audit, benchmarking and quality improvement initiatives which included staff sleeping during patient observations, care plans, medicines safety, and patient experience. The results of monitoring were not always used effectively to improve quality.

Skilled staff to deliver care.

The ward teams mostly included or had access to a range of specialists required to meet the needs of patients on the wards. However, there were no psychologists on Willow and Cedar wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

At the November 2022 CQC visit, wards had access to a range of specialists to meet the needs of the patients on the ward, this included a consultant, junior doctor, matrons, psychologists, nurses, occupational therapists, occupational therapy assistants, healthcare assistants and activity coordinator. Social workers were also available across some teams. However, there were no psychologists on Willow or Cedar wards. Registered staff told us they needed psychology input to provide specialist care for patients.

Occupational therapists, occupational therapy assistants and activity coordinators worked as a central team and deployed across wards. Activity coordinators worked seven days a week across the core service.

On the 4 to 5 January 2023 CQC visit staff on Willow, Cedar, Hadleigh, Peter Bruff wards staff were not aware of professional boundary training that had been introduced following the inspection in November 2022 CQC visit.

Managers gave each new member of staff a full induction to the service before they started work.

Managers did not support staff through regular, constructive appraisals of their work. The trust's target rate for appraisals was 90%. Data received from the trust November 2021 to 30 November 2022 had been manually calculated. Staff told us they received annual appraisals, but data showed across wards low appraisals compliance rates did not meet trust's appraisals target rate of 90%. For five wards Cedar, Kelvedon, Willow, Ardleigh, and Chelmer ward appraisals were low and ranged from 9% to 89% compliance rates. Ardleigh ward appraisals rates were lowest at 9% November 2021, increasing to 64% September. However, in October 2022 the figure had fallen to 46%. The trust manually calculated this ward at 94% compliance, however the trust manual calculations were not accurate. For Cedar ward November 2021 to April 2022 the appraisal rates ranged from 26% to 37%, however the trust had calculated the compliance across the 12 months as 100%. The trust's appraisals target rate for 90% were not met.

For seven wards Cherrydown, Peter Bruff, Grangewater, Galleywood, Christopher's psychiatric intensive care unit, Hadleigh psychiatric intensive care unit and Stort ward appraisals varied between 50% to 100% compliance rates with some months not meeting the trust's appraisal target rate of 90%.

The trust clinical supervision and management supervision compliance target rate was 90%. The trust provided data for clinical supervision and management supervision between November 2021 to October 2022. Two wards Ardleigh ward 72% and Chelmer ward 78%, did not meet the compliance target rate of 90%. The remaining wards ranged from between 80-91% compliance rate.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We saw evidence of regular team meetings and daily huddles. Medical staff had their own specialist regular meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff across wards told us they were encouraged to attend training and development opportunities and staff forums.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers had support of human resources teams.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Meetings were held weekly across all wards.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings and hub meetings.

Ward teams had effective working relationships with other teams in the organisation. We saw multidisciplinary teams worked closely with the social services GP practices and community nurses, including diabetic nurses.

Ward teams had effective working relationships with external teams and organisations. We observed a ward round on Willow ward and heard detailed discussion about patients care and treatment and discharge arrangements. Staff updated on patients' records during the meeting. The multidisciplinary teams worked closely with the crisis team and social services care coordinators.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Most staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Most wards were up to date with Mental Health Act mandatory training. However, two wards were not meeting the trust target of 85%. Peter Bruff and Stort were both at 80%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Managers said they would access the ward social workers or the Mental Health Act administrators for advice and guidance. Staff knew who their Mental Health Act administrators were and when to ask them for support.

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

The service had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. There was a standardised process in place for reviewing and updating Mental Health Act policies.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Posters were on display showing how to contact advocacy on the ward. Patients were also aware.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Staff and patients told us section 17 leave were rarely cancelled. Staff routinely completed risk assessments prior to patients leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw T3 certificates of second opinion in care records. Clinicians also completed reviews of treatment in line with Section 61 of the Mental Health Act.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Patients could request sight of these on the wards.

Not all informal patients knew that they could leave the ward freely. On Grangewater ward the assessment service, all 16 patients were informal. Patients told us staff asked them to stay on the ward until they completed their initial assessment. The assessment duration could be up-to 72 hours to complete. Staff provided patients with information about their informal status and procedure to follow on exiting. However not all patients knew they could ask to leave the ward.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The mental health administrator completed audits.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Not all staff were kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Mental Capacity Act training compliance was under 85% on two wards. Peter Bruff ward was at 71% and Cherrydown ward 78%.

The trust- Lessons Identified October 2022 newsletter- included Mental Capacity Act awareness needed to be embedded in clinical teams in readiness for the introduction of Liberty Protection Safeguards.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards; and there was a mental health legislation team who provided advice and support.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Care records showed that staff revisited capacity regularly and documented the outcome.

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

Staff mostly assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. However, patients being were observed, using a vision-based monitoring system and staff did not routinely record that they had assessed patients' capacity to consent to this. We raised this with staff who told us a standardised process was being developed to record this.

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

At the previous 2019 inspection caring was rated as good. We currently rate caring as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Not all staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

At the November 2022 CQC visit, we saw across wards that most staff were discreet, respectful, and responsive when caring for patients. We spoke with 39 patients. Most patients told us that staff were responsive, kind and caring and promoted their recovery and independence.

However, two patients on Willow ward told us staff temporary had fallen asleep during their night observations. Three patients on Galleywood ward said staff at night were uncaring, talked loudly, had fallen asleep during their observations and talked in languages other than English.

Patients on Willow, Cedar and Hadleigh wards were searched in the corridor (which is part of the air lock), which did not protect the patients' privacy and dignity.

On Kelvedon ward, managers told us it was possible to see a patient unclothed following a shower in their bedroom, on the contact-free patient monitoring screen. However, access to contact-free patient monitoring and management systems were not routinely used, only when an alarm sounded staff would review the monitoring screen and check the patient.

On Cedar ward we saw some patients dressed in nightclothes early in the afternoon. Staff told us this was because the patients had not been changed back into their clothes after "toileting accidents." We did not see any soiled clothes in the laundry area. The practice did not ensure patients dignity and respect.

Four patients on Peter Bruff ward told us it was not dignified to queue up at the office hatch for their vapes. Patients said there were a lack of privacy at the office hatch. We observed when a patient attempted to speak to staff at the office hatch there were a lack of privacy.

Staff gave patients help, emotional support and advice when they needed it. On Ardleigh ward we saw staff caring for a patient immediately following a seizure. Staff showed kindness, care and compassion. On Galleywood ward staff supported a patient with sensitivity, compassion and kindness during a de-escalation incident. Staff stayed with the patient and continued to monitor the patient whilst offering emotional support.

Staff supported patients to understand and manage their own care treatment or condition. We observed this during patient incidents where individual staff provided patients with emotional support and in patients mutual help meetings notes.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. We saw welcome packs on Ardleigh and Kelvedon wards for patients which included a range of information, including therapy on wards with the occupational health team.

Most staff involved patients in multidisciplinary reviews and gave them access to their care planning and risk assessments. Patients were not routinely offered a copy of their care plan.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Patients could give feedback on the service and their treatment and staff supported them to do this. Some staff involved patients in decisions about the service, through mutual help meetings. These were regular meetings where patients met together to discuss service improvements. Mutual help meetings were intended to be mutually beneficial and chaired by either a patient or a staff member. However, we saw how the quality of these meetings varied from ward to ward. For example, on Galleywood ward patients chaired the meetings three times weekly. While on Ardleigh ward the mutual help meeting was opened by a staff member asking patients “What they were thankful for.” Patients were expected to think of something they were thankful for and provide a response. Staff then asked “How can you help us (staff). If you can help us, we can help you.” The session showed a power imbalance that did not support patients.

Staff made sure patients could access advocacy services. We saw information about advocacy in ward welcome packs and displayed around wards.

Involvement of families and carers

Staff informed and involved families and carers appropriately. However, carer and family feedback regarding the service was mixed and didn’t support staff’s views.

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

At the November 2022 CQC visit, we spoke with three families and carers. Two carers reported a lack communication between the staff and their relative. Two carers said some staff were very caring, engaging and built positive relationships with their relative. They had observed occupational therapy staff carry out therapeutic activities with their relative. A third carer was unhappy with the service their relative received and raised concerns directly with staff on the ward.

Staff supported, informed and involved most families or carers. We saw welcome packs on Ardleigh and Kelvedon wards which included carers information and contact details for carers support organisations.

The trust had a Carers Charter that highlighted the importance of involving carers. Ward welcome packs included information about access to friends and relatives support groups.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

At the previous 2019 inspection responsive was rated as requires improvement. We currently rate responsive as requires improvement.

Access and discharge

Staff managed beds well. A bed was not always available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

At the November 2022 CQC visit managers made sure bed occupancy did not go above 85%. We saw trust data from November 2021 to October 2022. Four wards were below bed occupancy of 85%, Christopher's psychiatric intensive care unit 62%, Willow ward 65%, Hadleigh psychiatric intensive care unit 76% and Galleywood 84%. Eight other wards ranged in occupancy levels between 94% Cherrydown ward to 102% Cedar ward. Chelmer and Stort wards had swing beds between female and male to support demand. Other wards had patients that had been transferred to acute hospitals for physical health needs, were on leave; or supported by home treatment teams or the community teams as part of their discharge plans.

Staff from the home treatment team confirmed waiting lists were exceptionally high for beds. On the 4 to 5 January 2023 CQC visit staff reported access to beds had not improved. Staff caseloads had reduced over the Christmas break due seasonal variations. However, patients were still experiencing unacceptable waits for services and patients were frequently not able to access available beds in a timely manner.

Staff in the home treatment team reviewed patients' caseloads daily with bed meetings, patient risk management and safety planning. Where patients needed urgent help, staff referred patients to accident and emergency services. In the home treatment team incident report log for the past 6 months of 74 patients were being supported in the community

because staff could not access a bed when required. Of the 74 patients waiting for admission 22 had been assessed under the Mental Health Act as requiring detention and were having to be managed in the community. This meant that staff were managing very high-risk patients in the community. Staff would support the patients in the community with visits sometimes twice a day, day and evening phone calls, Shout (text messages|) and other interventions. Staff tried to keep patients local as possible, and occasionally placed out of county. Staff told us senior managers had not taken action to improve bed availability, despite the trust providing examples such as safer staffing calls and 'huddles' where bed occupancy was discussed. Staff on wards did not provide these examples.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. We saw trust data from November 2021 to October 2022. The wards with the highest length of stay were Hadleigh psychiatric intensive care unit with 14 to 463 days. The ward with the lowest length of stay were Grangewater ward between nine and 17 days.

The service had out-of-area placements. We saw trust data from November 2021 to October 2022. The out-of-area placements were mainly low across the service from December 2021 (4) to August 2022 (21). The out-of-area placements became higher in October 2022 at 35 and in November 2022 were 44.

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends. Ward managers on the acute wards liaised closely with the intensive care beds team.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. We saw trust data from November 2021 to October 2022. Cedar ward had five patient delayed discharges in November 2021, four February 2022, five in March and April 2022 and four in October 2022. Kelvedon ward followed with three patient delayed discharges in October 2022 only. All other wards showed nil to low patient delayed discharges. The trust worked with local authority partners towards the implementation of an accommodation pathway which would support patients transferring from an inpatient pathway and help to prevent avoidable admission with appropriate support.

Patients did not have to stay in hospital when they were well enough to leave. We saw across ward patients would be discharged once well, in consultation with the multidisciplinary team and their family and carers.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. On Willow ward we observed a discharge meeting with the: patient, their family members, discharge care coordinator and ward staff. The patient's needs were central to the discharge planning process.

Staff supported patients when they were referred or transferred between services. The ward team provided after care support with wellbeing phone calls.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

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

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

On the November 2022 CQC visit on Cedar ward the indoor area was sparse and lacked comfort. The outside area was littered with rubbish and looked unkempt. On Hadleigh psychiatric intensive care unit the environment was sparse and awaiting refurbishment. On Peter Bruff ward the environment looked worn and did not promote patient's recovery.

Each patient had their own bedroom, which they could personalise. However not all patients could access their bedrooms and had to ask staff. Fob keys were being introduced across most wards so patients could access their bedrooms independently. However, on Willow ward the fob key system was fitted 22 November 2023 but not operational at the time of inspection. We did not see individual patients risk assessments or the ward plans for the fob keys.

Patients had a secure place to store personal possessions. We saw additional storage areas that included lockers on all wards for patients' personal belongings.

Staff used a full range of rooms and equipment to support treatment and care. Ardleigh ward had a patient search room. The manager on Cedar ward had identified a patient search room and awaiting final changes to the room.

The service had quiet areas and a room where patients could meet with visitors in private. Each ward had access to a family/visitor's room.

Patients could make phone calls in private. Each ward had a payphone. Calls could be made on the ward phone by arrangement. The trust discouraged the use of mobile phones in the ward communal areas. Patient were not allowed to hold a mobile phone on some wards.

Not all wards had an outside space that patients could access easily. On Peter Bruff ward patients said they would like to go to the garden when they wanted to. Currently the garden is only accessible at set two-hour slots throughout the day. Since the last November 2022 visit access to outside space had improved; patients had access to the garden at any time. We reviewed this during the visit on 4 and 5 January 2023. Staff told us they thought that as the ward was an assessment ward the restrictions were necessary and was not restrictive practice despite this being raised as part of the letter of intent sent to the trust.

Not all wards had provision so that patients could make their own hot drinks and snacks and were dependent on staff. We saw across wards in communal areas biscuits and fresh fruit bowls.

The service offered a variety of good quality food. The service provided a variety of food to meet the dietary and cultural needs of individual patients; and where appropriate patients were encouraged and supported to shop for themselves.

On the 4 to 5 January 2023 CQC visit we spoke with four patients on Peter Bruff ward. One patient told us the meal portion sizes were not big enough. They were in their twenties and had noticed they were given the same portion size as another patient with a smaller appetite. There was no toast available for breakfast.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff helped patients to stay in contact with families and carers. We saw information booklets for patients' families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community, for example attending church services.

Meeting the needs of all people who use the service.

Not all staff met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Wards were on the ground and first floor and supported disabled patients. However, on Peter Bruff ward the assisted bathroom was used as a storeroom. We saw, where appropriate patients had personal fire evacuation plans in place.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. There were notice boards across wards with a wide range of patient information displayed.

Managers made sure staff and patients could get help from interpreters or signers when needed. However, on Cedar ward we saw one patient did not have access to an interpreter.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients told us a range of meals were available. Not all wards had provision so that patients could make their own hot drinks and snacks and were dependent on staff. We saw fruit and biscuits available on all wards.

Patients had access to spiritual, religious and cultural support. Notice boards across wards showed access to spiritual support.

Therapeutic timetables varied across wards. Activities included psychology led groups, occupational therapy led groups, healthy living exercises, access to gym one to one with a trained instructor, art and music therapy and visiting therapy dogs.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives, and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Patient complaint information was displayed around wards.

Managers investigated complaints and identified themes. The trust provided complaints data without dates about complaints received by patients with themes. Across wards there were 78 complaints. The highest theme identified in complaints from patients were 18 complaints regarding patients unhappy with treatment, followed by poor care 11 complaints. Cherrydown had the most complaints (13), Hadleigh psychiatric intensive care unit eight and Kelvedon and Christopher's psychiatric intensive care unit seven complaints.

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

There were 13 formal patients' complaints received and upheld across this core service. Cherrydown Galleywood wards and Hadleigh psychiatric intensive care unit had the most concerns for: poor patient care. This was followed by three complaints for: patients belongings on Cherrydown, Ardleigh and Hadleigh psychiatric intensive care unit.

The trust provided data for the last 12 months for this core service with one complaint referred to the Ombudsman, however the decision not to investigate. We found there were delays in managing these types of complaints.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw outcomes from complaints in team meeting notes, in the trust monthly lessons identified newsletters and on the staff intranet under the culture of learning icon on staff desktops and laptops.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

At the previous 2019 inspection well-led was rated as requires improvement. We currently rated well-led as inadequate.

Leadership

Not all leaders had the skills, knowledge and experience to perform their roles. Some leaders had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

On the November 2022 CQC visit we saw a lack of leadership on two wards. Two managers did not have the knowledge about the service they delivered or capability to lead effectively. For example, despite CQC raising serious concerns around restrictive practices impacting on patients in a previous inspection, one manager was unaware about restrictive practice on their ward. CQC were not provided with assurance in some cases when asked during our inspections, with one manager being resistant during our discussions. However, we saw on Kelvedon the ward manager was knowledgeable about patient centred care and quality issues.

There were opportunities for leadership development and staff said that there was a leadership training course available. We saw evidence of promotion within teams.

Vision and strategy

Not all staff know and understood the provider's vision and values and strategic goals.

Not all staff felt consulted and committed to the trust's vison and values. One manager told us there had been a consultation in the summer 2022 to refresh the trust Visions and Values. They were: Respect and dignity, Commitment to quality care, Compassion, Improving lives, Working together for patients, Everyone counts.

These had changed to; 'What we do together, We Care, we learn, We empower'. The providers old vision and values were on display in reception and waiting areas across locations but had not been updated since the summer review.

Culture

Not all staff felt respected, supported and valued. Some staff said the trust did not always promote equality and diversity in daily work. Staff were provided opportunities for development and career progression. They could raise any concerns without fear.

At the November 2022 CQC visit not all staff felt respected, supported and valued by senior managers. There appeared to be a good culture developed within teams and most staff had a good understanding of the service they provided.

Some staff were unhappy that leaders had not communicated with all staff regarding the airing of Channel 4 despatches documentary. Staff told us that they had found out about the documentary from patients on Hadleigh ward.

At the November 2022 CQC visit on Christopher's psychiatric intensive care unit, we saw staff experience repeated racist abuse by a patient. In contrast staff on Ardleigh ward told us any racist comments from patients were not tolerated and managers would take immediate action. On 4 to 5 January 2023 CQC visit staff on Willow, Cedar, and Peter Bluff said any reports of racial incidents would be discussed at handovers and escalated with ward managers. However, not all staff said they would fill out an incident form for incidents of racial abuse despite the trust issuing guidance stating this should be done.

Staff were provided opportunities for development and career progression. On Ardleigh ward a health care assistant told they were selected for the associate practitioner scheme supported by the trust to study to be a nurse and attended university one day a week.

Governance

Leaders had shown little evidence of learning from previous inspections or taken sufficient action to improve safety. The delivery of high-quality care was not assured. The arrangements for governance processes did not operate effectively and performance and risk were not dealt with appropriately.

We rated safe and well led as inadequate, the other domains as requires improvement which means this service is still adequate overall**.** The trust failed to ensure that all the concerns highlighted in the warning notice issued in October 2022 had been achieved consistently across all wards. For example, on some wards staff still applied blanket restrictions. Examples included searching all patients returning to wards and preventing patients from taking fresh air. There remained ongoing challenges with staffing wards consistently; and we identified problems with staff completing patient observations safely in line with trust policies. The rating for safe had remained inadequate, the same rating applied during the inspection in October 2022. CQC recognised trust wide plans to address the issues such as staffing however several aspects of these plans were not fully implemented embedded to impact care on all wards yet.

We found one breach identified at the October 2022 CQC inspection had been met at this inspection. The trust must ensure ligature cutters are consistently accessible for staff. At the November 2022 visit across all wards visited we saw ligature cutters were accessible to staff. Ligature cutters were held in large plastic packs in clinic rooms and in nurses' stations.

However, leaders had not ensured all aspects of breaches from the 2019 and 2022 inspection had been met. Five out of six breaches had not been fully met. The trust had passed the identified date for completion of 18 November 2022, despite senior managers taking steps to address issues, some of the risks continued to impact patients.

Leaders had not fully met the five breaches as follows: The trust did not ensure staff carried out observations in accordance with trust policy to protect patients from harm. At this inspection patients on Willows, Galleywood and Ardleigh wards told us temporary staff slept when they should be observing them. The service had close circuit television monitoring across inpatient wards. Managers were not always able to access this footage in a timely way to make the necessary improvements. Staff were still falling asleep while carrying out therapeutic observations. Improvement plans had started with staff training programme and videos and increased managers presence on some shifts. Risks remained and practice was not embedded. This breach had not been fully met.

The trust did not ensure that there were enough regular staff working on the wards who were familiar with individual patients. At this inspection shifts covered by bank or agency staff were high. The trust had international recruitment to address some of the staffing gaps during. On 4 to 5 January 2023 CQC visit, staff on Willow, Cedar and Peter Bluff said there were some improvements with staffing levels and managers present. This breach had not been fully met.

The trust did not ensure that all aspects of care and treatment of patients was provided with the consent of the relevant person in respect of the contact-free patient monitoring and management system. We were told this system helped clinicians to plan care and intervene proactively by providing them with location, activity-based alerts, warnings and reports on risk factors. The provider must ensure patients are aware of the nature of the contact-free patient monitoring and management system, are given an explanation of the reasons for its use and how the information obtained will be stored and used, along with who has access to it. It should seriously consider any individual patient's objection to the technology and respond appropriately. On Willow and Galleywood Peter Bruff ward wards we did not find consent for contact-free patient monitoring and management systems. On Christopher psychiatric intensive care unit, one patient had declined the contact-free patient monitoring and management systems. It was difficult for staff to locate consent given within the patient's electronic records. This breach had not been met.

The trust did not ensure patients could easily access the garden, bedrooms, bathrooms and toilets. At this inspection on Willow, Cedar, Ardleigh wards there were restrictions where patients must ask staff to access the garden, bathrooms, beverages areas. The door to the Willow ward and Peter Bruff ward garden was locked and the managers was unwilling to accept this was a restriction. Most wards had a fob key system. On Willow ward staff told us the fob door key system had been fitted 22 November 2022 during the inspection but wasn't operational at the time of inspection. This breach had not been fully met. On 4 to 5 January 2023 CQC visit, staff on Willow ward had ensured patients access to the garden area with hourly staff rostered on to cover. On Peter Bruff ward the manager still refused to accept this was restrictive practice and the restrictions remained in place. On Willow, Cedar wards we saw improvements where patients could freely access beverages and snacks. This breach had not been fully met.

The trust did not ensure that all incidents were accurately recorded or reported. We found multiple examples of incidents that had not been reported around patient safety. For example, one patient had a hand injury and went to A&E not recorded as an incident. On another day a patient had become stuck in an air conditioning unit and released by the fire services with no injuries. These had not been recorded as incidents. This breach had not been met.

Management of risk, issues, and performance

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

Staff did not manage patient safety incidents well; recognise incidents and reported them appropriately. Safety concerns were not consistently identified or addressed quickly enough. Managers did not always make changes and improvements in safety specific to this service. Teams did not always have access to the information they needed to provide safe and effective care and used that information to good effect.

We found risks and issues were not addressed across all domains. Ward areas on Hadleigh, Christopher's psychiatric intensive care units, Cedar, Ardleigh, Peter Bruff were not always clean, well maintained, and well-furnished. In addition, the seclusion room at Ardleigh ward required maintenance. Managers had not taken the necessary steps in a timely manner.

Staff vacancies were high on Willow ward and Galleywood ward for nursing and health care staff. Other wards had high staff vacancies Cherrydown, Peter Bruff and Christopher's psychiatric intensive care unit. Willows and Cedar wards had no psychology staff and no plans to recruit. Staff turnover rates were high at four wards. The service target was 12%. The highest turnover rates were Ardleigh at 25% followed by Cedar, Willow, Christopher psychiatric intensive care unit and Stort ward. Levels of staff sickness were high. Staff sickness absence across urgent and inpatients care were 11% which were higher that the service target of 5%.

Mandatory training compliance rates were less than 75% on some wards. The trust staff training compliance target rate were 85%. For example, Stort ward fire compliant 73% and Cherrydown 71%. Three wards had low safeguarding training compliance rates ranged from 43% to 83%. Mental Capacity Act training compliance rates were low on Peter Bruff 71% and Cherrydown ward 78%. Mental Health Act training were low on Peter Bruff 80% and Mental Capacity / Deprivation of Liberty & PREVENT 71%.

Staff did not assess, monitor or manage risks well to patients who use the services. Patients risk assessments were not all complete or updated regularly including after an incident. On Willow, Cedar, Hadleigh, Peter Bruff wards, patient safety concerns were not consistently identified and addressed. Staff did not always know about risks to each patient and acted to prevent or reduce risks. For example, we saw incidents of a staff member holding a female patient's hand as they escorted them to a health appointment. This showed staff did not understand about risk and professional boundaries. On the 4 to 5 January 2023 CQC visit staff on Willow, Cedar, Hadleigh, Peter Bruff professional boundary training were not aware of training.

On Willow, Galleywood, Peter Bruff, Christopher's psychiatric intensive care units' consent to the contact-free patient monitoring and management system were not embedded or robust.

Ardleigh ward was the only ward out of twelve wards visited with a patient search room. Staff said patients on Willow, Cedar and Hadleigh ward were searched in the corridor which is part of the air lock. The current arrangements did not support patient's treatment and care or privacy and dignity. We reviewed this during the 4 and 5 January visit and found that action had been taken to identify appropriate areas for patient searches.

Levels of restrictive practices were high on some wards. On Willow, Cedar, Ardleigh wards there were restrictions where patients must ask staff to access the garden, bedroom, bathrooms and beverages areas. However, we saw improvements for Willow, Cedar during the 4 to 5 January 2023 CQC visit. Prohibited items lists varied from ward to ward. We saw prohibited items on wards for example plastic bags, bars of soap and pens.

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

Staff did not manage patient safety incidents well; recognise incidents and reported them appropriately. It was unclear if lessons learnt were learnt, and lessons implemented. We found multiple examples of incidents that had not been reported around patient safety, staff sleeping on duty. Managers were not accessing the closed-circuit television footage of safety incidents and taking actions to make improvements.

Staff did not manage systems and processes well; to safely prescribe, administer, record and store medicines. Staff did not always regularly review the effects of medications on each patient's mental and physical health.

Patients care plans were not all complete or reviewed regularly and did not always consider the full range of patient's needs. Most staff assessed the physical and mental health of all patients on admission. We saw on Cedar ward one patient did not have access to an interpreter. The patient's communication needs were not considered.

There were gaps in management and support arrangements for staff. For five wards Cedar, Kelvedon, Willow, Ardleigh, and Chelmer ward appraisals were low and ranged from 9% to 89% compliance rates. Ardleigh ward appraisals rates were lowest at 9% November 2021, increasing to 64% September. The trust clinical supervision and management supervision compliance target rate were 95%. Two wards were not compliant Ardleigh ward 72% and Chelmer ward 78%.

Patients were not always respected and valued as individuals. Five patients on Willow and Galleywood ward told us temporary staff had fallen asleep during their night observations. Staff at night were uncaring, talked loudly and talked in community languages. On Kelvedon ward managers told us it was possible to see a patient briefly in their bedroom unclothed following a shower on the vision-based patient monitoring screen. On Cedar ward we saw two patients in pyjamas around 2.30 in the afternoon. The practice did not ensure patients dignity and respect. On Ardleigh ward the patients mutual help meetings showed a power imbalance that did not support patients. On Peter Bruff one patient did not feel their privacy and dignity were upheld when queuing on the ward and speaking with staff at the office hatch.

Information management

Information presented to the CQC team was not always accurate and reliable. Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff used electronic patient record systems. Information governance systems included policy on confidentiality of patient records.

Managers had access to dashboards with information that supported them. However, some trust staffing, staff supervision and appraisal data showed inconsistencies and anomalies. For example, staffing vacancy data provided was not reliable; and staff supervision and appraisal data was unreliable and did not correspond.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff actively and openly engaged with patients; planned, manage services at regular mutual help meetings.

Learning, continuous improvement and innovation

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

Staff on Christopher's ward were working towards accreditation for inpatients mental health services (AIMS- PICU) for psychiatric intensive care units. Staff and managers were due to attend a conference to make plans early 2023. Front line staff currently told us this improvement work was on hold until they had attended refresher training.

Wards for people with a learning disability or autism

Requires Improvement

Is the service safe?

Requires Improvement

Requires improvement Down one rating

Our rating of this service went down. We rated it as requires improvement.

Safe and clean care environments

The ward was safe, clean well-equipped, well-furnished, well-maintained and fit for purpose.

People were cared for in wards that were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the ward was decorated and furnished to a good standard. Furniture was sturdy and suitable for people who had behaviours that challenged. All areas were well maintained. Staff completed monthly environmental checks and we saw examples of these.

Safety of the ward layout

Staff completed and regularly updated thorough environmental risk assessments of all wards areas and removed or reduced any risks they identified.

People were cared for in wards where staff had completed risk assessments of the environment and removed or reduced any identified risks. Staff completed environmental risk assessments of all wards areas and reduced any risks they identified. Managers made sure that staff on the wards had easy access to ligature packs with information on environmental risks. This included a map of hotspot areas. Staff we spoke with knew about any potential ligature anchor points and knew where ligature cutters were located and felt confident in their abilities should they need to use these. Staff could describe mitigations taken to reduce risks to people's safety. We saw from staff team meeting minutes that ligature audits and their findings were shared and discussed.

Staff could not observe people in all parts of the wards. This risk was identified and recorded within the ligature risk assessment and mitigated by the use of convex mirrors and staff observations. At the time of inspection, 100% of eligible staff had completed suicide by ligature prevention training.

People had access to three secure gardens, providing a space for people to access fresh air. Potential blind spots within the gardens had been identified. This risk was reduced by supervising people when accessing the garden and use of CCTV in outside spaces. All three gardens had adequate seating. Staff told us people could request to use the outdoor spaces at any time.

CCTV was installed in the seclusion, de-escalation and long-term segregation areas and outside spaces. Staff were encouraged to put on body worn cameras in the event of an incident. A named security nurse was allocated daily who was always required to wear a body worn camera during the shift. However, on the second day of inspection the allocated security nurse was observed not to be wearing a body worn camera. Staff told us this was because incidents were rare. This was not in line with Trust policy.

People who had been placed in seclusion, were able to communicate easily with staff. Staff ensured that if people were in seclusion, that they were kept in a clean and safe environment, and their basic needs were met, including access to a toilet, food, water and outside space. The seclusion room and de-escalation room both met the Mental Health Act Code of Practice standards. There had been no episodes of seclusion in the past 6 months.

People had access to nurse call systems and staff had access to personal alarms in case of an emergency. All bedrooms were en-suite and each room had an alarm call bell. Communal areas with windows had privacy glass fitted throughout providing privacy for people.

The ward complied with guidance on mixed-sex accommodation. There was a female only lounge. There were male and female only bedroom corridors. A third corridor had two bedrooms, which staff used to accommodate either gender, enabling greater flexibility for admissions. Bedrooms were single occupancy with en-suite shower rooms. All bedrooms were fitted with viewing and privacy panels, which could be closed from the inside to provide people with privacy.

Maintenance, cleanliness and infection control

The ward and clinic rooms were clean and well-maintained.

The service made sure that infection outbreaks could be effectively prevented or managed. Staff

used personal protective equipment (PPE) effectively and safely. At the time of inspection there

was a COVID-19 outbreak on the ward. We observed staff followed infection control policy, including handwashing and the use of PPE. Staff followed local and government guidance for COVID-19. We observed staff regularly changing masks and using hand sanitiser throughout the day. Masks and hand sanitiser were available at the entrance of the ward and hand wash and sanitiser were available in bathrooms and toilets.

We observed a monthly cleaning walk-around audit. Staff also undertook regular cleaning audits, hand hygiene audits and infection and prevention control audits. We saw examples of these that were complete and up to date. We observed the environment to be visibly clean and well maintained.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. We viewed the most recent monthly clinic room checklist summary record and Byron court were 100% compliant.

Staff carried out regular checks on equipment to ensure it was fit for purpose and recorded this. Staff used stickers to indicate when equipment had been cleaned.

We saw the ward had an electronic blood glucose monitor, pulse oximeter and defibrillator machine present in the clinic room. Staff had not kept calibration records for the blood glucose machines. This meant there was the potential risk of inaccurate blood sugar readings for people. We raised this with managers during the inspection who completed an incident form and took action that day to calibrate the machine.

We found the first aid kit had two empty packets of triangular bandages and one bandage that was not in any packaging. Staff were unsure if the first aid kit had been checked on a regular basis. This meant we were not assured that staff regularly checked and replaced the contents of the first aid box.

The ward had visibly clean clinic rooms. Staff kept cleaning records for all clinic rooms and equipment.

Safe staffing

Nursing staff

The service did not have enough regular nursing and support staff, who knew the person well.

We reviewed staffing rotas for the previous 6 weeks. The service had high rates of bank and agency staff and relied on temporary staff to fill shifts. Managers attempted to book regular bank and agency staff to fill shifts up to 3 months in advance.

We reviewed the staff rosters and found during the period 10 October 2022 to 6 November 2022, 17 different registered staff worked on the ward, out of which 7 staff members worked regularly. For the same time period 27 different support worker staff worked on the ward, of which five worked regularly. A high number of different staff meant that not all staff working on the ward knew the people well which could impact on the consistency of care people received.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and health care assistants for each shift. The ward manager could adjust staffing levels according to people's needs. Managers regularly reviewed rotas to ensure safe staffing levels were maintained. Managers attended twice daily trust wide meetings to review staffing levels and to raise any staffing concerns. Managers worked shifts if needed for example if staff were sick at short notice.

The service had a high number of vacancies for qualified nursing staff and support worker. At the time of inspection, the service had a 50% vacancy rate for registered nurses (5.7 vacant posts out of 11.3) and a vacancy rate of 18% for support workers (2.4 vacant posts out of 13.0).

Between May and October 2022, the sickness rate ranged from 0% (June) to 14% (October). The service target was for sickness rates to fall below 5%. During the previous 6 months the actual sickness rate was above the target for 4 months.

Between May and October 2022, the turnover rate ranged from between 9% (July and August) to 14% (June and October). The service target for turnovers rates to fall below 12%. During the previous 6 months the actual sickness rate was above the target for 3 months.

Managers ensured there was enough staff for people to have one-to one time. However, managers did not always ensure there was enough staff, for people to take part in outdoor activities and visits how and when they wanted. Families and carers told us that they were able to visit the ward as often as they chose to and were not aware of any activities being

cancelled. However, one carer told us about an occasion when a person's walk had been cancelled and there had been one complaint about a lack of transport for an appointment. Staff confirmed that there were rare occasions when leave had been postponed as there was not enough staff. Staff told us that there was always enough staff for one-to-one time with people on the ward.

Managers made sure all bank and agency staff had a full induction and understood people's needs before starting their shift. Managers made sure that staff were made aware of essential information such as emergency procedures and were given a tour of the ward and an induction checklist. Staff confirmed they had completed the checklist when starting work and we saw examples of this. Each person had a clear one-page profile "about me" with essential information so that new or temporary staff could see quickly how best to support them.

Staff shared key information to keep people safe when handing over their care to others. 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. We saw examples of these.

Medical staff

The service had enough daytime and night-time medical cover, and a doctor was available to go to the ward quickly in an emergency. The service had 3 consultants, 2 specialty doctors and 2 junior doctors. Managers ensured that staff knew how to contact medical staff providing 24-hour cover to the ward. We saw a flow chart so that all staff on the ward could easily see who was on duty, at what time, who and how to contact medical staff in an emergency.

Mandatory training

Staff had completed and kept up to date with their mandatory training.

Staff employed by the trust had completed and kept up to date with their mandatory training. Compliance rates for individual mandatory training course ranged from 83% to 100%. Examples of mandatory training courses included consent; infection prevention and control; engagement and observation; physical health screening and clinical risk for both registered and unregistered staff.

The mandatory training programme did not include specialist learning disability and autism training. There was a risk that staff did may not have sufficient skills or experience to meet the needs of the people they were caring for.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Managers told us that a central team in the trust had responsibility for ensuring that agency staff deployed on the ward had the appropriate training for the role. All agencies under the approved NHS agencies framework had full responsibility for ensuring agency workers received and were up to date with the NHS mandatory training standards.

Assessing and managing risk to patients and staff

Staff discussed and managed patient risks but did not always record how they assess and manage risks to people well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support peoples' recovery.

Wards for people with a learning disability or autism

The service helped keep people safe through formal and informal sharing of information about risks. Staff discussed specific risks to each person at handover meetings, daily safety huddles, weekly clinical meetings and monthly multidisciplinary meetings. We viewed minutes for these meetings and found risks were discussed and clearly recorded in these forums. Multidisciplinary staff held discussions that determined the level of risk for each person and the level of observation needed. Staff we spoke with knew about any risks to each person and acted to prevent or reduce risks.

Staff completed risk assessments for each person on admission. However, these were not always regularly updated. We viewed 5 risk assessments, we found there were gaps in 2 of these. For example, one record had identified staff had carried out a security check, however the outcome of that check and the level of risk was not recorded. This was not in line with Trust policy. We saw in another record that the multidisciplinary team had discussed a risk relating to a person's travel. This risk was not was added to the risk assessment and the person did not have a risk management plan.

Despite trust guidance available for staff on levels of harm, staff we spoke with gave differing views about the level of risk incidents could present. We saw 1 record that had 5 incidents of assault towards others in one month and that was rated low risk. Staff we spoke to told us this was low risk as the assault could have been a minor tap on the arm, as assault to others could be interpreted in different ways.

There were policies and procedures for observation and supportive engagement of people. We viewed observation charts for all 5 patients and found all were completed in line with Trust policy. At the time of inspection 100% of eligible staff had completed mandatory engagement and supportive observation training. We saw examples of daily checklists and completed induction competency checklists managers used to ensure staff undertook observation and supportive engagement in line with Trust policy.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff could recognise signs when people experienced emotional distress and knew how to support them to minimise the need to restrict their freedom to keep them safe. Staff gave an example of a person becoming distressed and attempting to self-harm by head banging. They described the action they took to calm the person and de-escalate the situation to prevent the need of use of restraint.

People were restrained only where evidence demonstrated it was necessary and for the minimum period of time. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained people only when these failed and when necessary to keep the person or others safe. Staff understood the Mental Capacity Act definition of restraint and worked within it.

In the previous 6 months there had been 6 episodes of restraint. During this time there had been no episodes of prone restraints and no use of rapid tranquilisation. At the time of inspection, 100% of eligible staff had received trauma and self-injury (TASI) training.

There had been no episodes of seclusion or long-term segregation in the past 6 months.

Safeguarding

Wards for people with a learning disability or autism

Staff understood how to protect people from abuse and the service worked well with other agencies to do so.

Staff received training on how to recognise and report abuse, appropriate for their role and kept up to date with their safeguarding training. Staff knew how to make a safeguarding referral and who to inform if they had concerns. At the time of inspection, 100% of eligible staff were up to date with safeguarding levels adults and children levels 1 and 2; 100% of staff were up to date with safeguarding children level 3 and 83% of staff were up to date with safeguarding adults level 3 training.

We viewed the services' safeguarding log. In the past 6 months one safeguarding concern had been reported. This related to concerns regarding financial abuse. The concern had been properly reported and managed by the Trust safeguarding team.

The ward manager was the lead for safeguarding and worked with the Trust safeguarding team who had responsibility for overseeing the safeguarding process.

Managers took part in serious case reviews and learnt lessons. For example, during our inspection, staff had attended a review meeting (further to a serious case review) at an independent mental health provider, for adults with learning disabilities and/or autism.

Staff discussed and learnt from safeguarding concerns. We saw that safeguarding was a standard agenda item at staff team meetings.

Staff access to essential information.

Staff had access to essential information. However, it was not always easy for them to maintain high quality clinical and care records. Records were a mixture of paper-based or electronic. For example, positive behaviour support plans and 'ABC' charts were paper-based and kept in a folder. The electronic system was cumbersome, and the risk assessments were lengthy. This meant that it was not always easy for staff to find information quickly. Paper-based records were kept securely.

Not all agency staff had access to electronic systems. This meant that permanent qualified staff were required to complete some records. This added to their workloads and meant that records were not always updated in a timely manner.

Medicines management

The service used systems and processes to safely prescribe, administer and store medicines. Staff regularly reviewed the effects of medicines on each person's mental and physical health. Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. However, medicine records were not always fully completed in line with Trust policy.

The ward safely stored and stocked emergency medicines. Review of stock medicines showed that medicines held on the premises were within the expiry date. The trust pharmacist supported staff to ensure that medicines were stored securely and audited.

Medicines requiring refrigeration were monitored and temperatures recorded were within range.

Wards for people with a learning disability or autism

We reviewed 5 medicine charts. Staff had not always recorded administration of medication. We found that one administration chart where one administration had not been signed off by staff. It was unclear from the records if this had been administered or omitted. We raised this with managers during the inspection who completed an incident form.

Of the 5 medicine charts we viewed 1 chart had a consent to treatment form. We raised this with staff during the inspection. Staff told us that there needed to be a change in the filing system, to ensure that consent to treatment forms were kept with medicine administration charts. All 5 medicine administration charts did not have the location of consent to treatment forms prompt completed.

Medicine administration charts had names and patient number on the front page however, they did not always have names and patient identifying number on all pages. This meant if the pages got separated it would be difficult to identify who they belonged to.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles. Staff knew about and worked towards achieving the aims of STOMP. We saw posters on display in staff areas.

Track record on safety

There were no serious incidents reported in the last 6 months for this service.

Reporting on incidents and learning from when things go wrong

Staff learned from safety alerts and incidents. Managers showed us examples of safety alerts both internal and external to the Trust. These could be accessed on the Trust intranet site. We saw paper copies of internal safety alerts were made available for staff to read in handover areas. For example, we saw a safety alert about staff sleeping on duty.

Staff raised concerns and recognised incidents. They reported them appropriately and managers investigated incidents and shared lessons learned. Staff knew what situations required reporting as an incident. The trust used electronic recording systems to record incidents and staff knew how to use the system. We reviewed the service incident report log. Since May 2022 there had been 85 reported incidents. There had been no reports of severe harm. The service had no never events.

Lessons were shared with staff. We reviewed staff team meeting minutes and saw evidence that learning from incidents, safety alerts and staff huddles were discussed and shared. A recent example included Mental Health Act section papers and a reminder to all staff to upload and send papers to Mental Health Act administrators. We saw example of a trust newsletter with five key messages. An example of recent learning was that all ligature cutters were to be stored in one bag. Staff told us there was an open forum with senior staff to talk about lessons from incidents.

When things went wrong, staff apologised and gave people honest information and suitable support. Managers understood the duty of candour.

Managers were aware of the Learning from Deaths Mortality Review (LeDeR) Programme.

Wards for people with a learning disability or autism

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff undertook functional assessments when assessing people's needs. They worked with people and with families and families and carers to develop individual care and support plans. Care plans reflected the assessed needs, were personalised and comprehensive. However, it was not clear from records when positive behaviour plans were reviewed or if care plans had been shared with people and their families and carers.

Staff completed a comprehensive assessment of each person's physical and mental health either on admission or soon after. Care records showed that a physical examination had been undertaken at admission and there was ongoing monitoring of physical health problems. Staff ensured specific care plans were available for people with diabetes around diabetes management and weight and constipation for a person who had high levels of psychotic medication as well as uncontrolled diabetes. This was monitored on a water low chart which measured weight gain as well as constipation weekly. However, at the time of inspection there was no physical health nursing lead in post. Managers told us this post was in the process of being filled and there were staff checks underway for those offered this post.

People had care and support plans that were personalised, holistic, strengths-based and reflected

their needs and aspirations, including physical and mental health needs. People, those important

to them and staff reviewed plans regularly together. We viewed 4 care plans, these had

comprehensive plans for physical, mental and sensory information personalised to the individual.

Records showed that staff assessed people's communication skills and needs and provided information in a way that was tailored to these needs. For example, the speech and language therapist devised a holistic care plan to meet the needs of a non-verbal person. However, in three records staff had not completed the box to show that the care plan had been shared with people in easy read format. This meant we weren't assured people had been given a copy of their care plan. We saw one care record showed the care plan had been read to the person.

We saw 'about me' books provided comprehensive valuable person-centred information.

Staff assessed and managed challenging behaviour for people. We viewed three positive behavioural support plans, these were comprehensive. The positive behaviour plans included strategies around behaviour which was linked to therapies intervention as well as the care records around agitated behaviour and sensory strategies. Staff told us this was because the lead for positive behaviour support had recently left the service and the psychology team were taking the lead whilst a new nurse lead was identified. However, people, their families and the multidisciplinary team met on a monthly basis to review and discuss care plans and positive behaviour plans.

Best practice in treatment and care

Wards for people with a learning disability or autism

Staff supported people with their physical health and encouraged them to live healthier lives. This included access to psychological therapies, support for self-care and the development of everyday living skills.

Staff offered patients psychological therapies which they delivered in line with National Institute for Health and Care Excellence guidance. Patients received regular one to one sessions with members of the multidisciplinary team, such as psychologists, occupational therapists or speech and language therapists.

Staff prepared positive behaviour support plans to help plan their support of people with behaviour that was challenging or harmful. Staff told us that the lead for positive behaviour support had recently left the service and the psychologist team were taking the lead whilst a new nurse lead was identified. Staff also told us that there was a positive behaviour support lead in the learning disabilities community team that could be accessed. Staff prepared (antecedents, behaviour, consequences (ABC)charts for people however, we found one person did not have an ABC chart. Managers told us this had been missed.

Staff made sure people had access to physical health care, including specialists as required.

Staff provided access to physical healthcare when necessary and staff facilitated transfer of people to physical healthcare appointments. However, staff did not always record vital signs on the National Early Warning Scores (NEWS) charts. NEWS is a tool developed by the Royal College of Physicians, which improves the detection and response to clinical deterioration in adult patients. Two of five charts did not always have a score on some dates. NEWS scores determine whether further action is needed. This meant that staff might not identify a deteriorating person and take prompt action to address their needs. The deputy ward manager told us NEWS training had been scheduled for all staff.

Staff developed easy read information for people such as, 'my choices for food and activities' and management of conditions such as diabetes. Staff used a document 'all about me', which detailed the best way staff, should communicate with people.

Staff met peoples' dietary needs and assessed those that may need specialist care for nutrition and hydration.

Skilled staff to deliver care

The ward team included or had access to the full range of specialist roles required to meet the needs of people on the ward. Managers supported staff with appraisals and supervision. Managers provided an induction programme for new staff. However, managers did not ensure staff had access to specialist learning disabilities and autism training to provide high quality care.

The ward had access to the full range of disciplines to support people's care; including occupational therapists, psychologists, social worker, nurses and support staff and medical staff.

People were not always supported by staff who had received relevant and good quality training

including training in the wide range of strengths and impairments people with a learning disability and or autistic people may have or positive behaviour support. Not all nursing and support staff were trained to work with patients with a learning disability and/or autism. The service employed 6 permanent qualified nursing staff of which 4 were specifically trained in learning disabilities (RNLD). However, the Trust did not offer any specialist training including learning disabilities, autism and sensory awareness to other staff working in the service. Managers told us the psychology team had previously delivered training as part of the induction programme however, this was paused during

the COVID-19 pandemic and had not re-started. Managers told us that training needs were identified through staff appraisal and supervision. However, we did not find any examples of staff accessing specialist training. Staff we spoke with told us they would welcome additional training. Psychologists told us they had offered training on positive behaviour support to the nursing team. However, managers were unable to release staff other than for one to one sessions due to staff shortages. Managers told us there used to be an 11-day learning disabilities course that most staff had previously undertaken, however this was no longer available. This meant we were concerned that not all staff had received the necessary up to date training or had the skills to fully meet people's needs.

At the time of inspection 22% of eligible permanent staff and 3 bank staff had received Makaton training. Mangers told us planned training was due to take place in February 2023.

Staff received support in the form of regular, constructive supervision of their work, appraisal and

induction training. At the time of inspection 86% of staff had received supervision and 82% had an annual appraisal. Managers ensured that new staff received the trust induction programme and a ward induction. We saw examples of induction training checklists that included essential information such as fire safety, emergency equipment and observation and supportive engagement protocols.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care. Multidisciplinary team professionals were involved in and made aware of support plans to improve care.

Staff held regular meetings to discuss people and improve their care. The multidisciplinary team included nursing staff, medical staff, physiotherapists, occupational therapists, speech and language therapists and social workers.

Staff shared clear information about people and any changes in their care, including during multidisciplinary team meetings and handover meetings. We reviewed weekly multidisciplinary team minutes (ward round), staff handover notes and monthly patient forum meetings and monthly commissioner's reports. We saw that staff regularly discussed people's care and support plans and shared clear, essential information about people.

The ward team had effective working relationships with staff from services that would provide aftercare following people's discharge and engaged with them early on in people's admission to plan discharge. The ward worked very closely with the community teams which were located opposite the ward. Staff told us there was good communication between the ward and community team when discharging people back into community placements and when accepting referrals.

We saw that people had health hospital passports that enabled health and social care services to support them in the way they needed.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain peoples' rights to them.

Staff understood their roles and responsibilities and were able to explain people's rights to them.

Wards for people with a learning disability or autism

Staff received and kept up to date with training on the Mental Health Act. At the time of inspection,

100% of eligible staff had undertaken training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support

Staff explained to each person their rights under the Mental Health Act in a way that they could understand. Staff told us how they adapted the information about rights to the needs of the individual to help them understand and we saw examples of easy read information.

People had easy access to information about independent mental health advocacy.

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician, the Ministry of Justice or both.

Managers and staff made sure the service applied the Mental Health Act correctly by completing

audits and discussing the findings. Managers completed a monthly Mental Health Act audit. The

most recent audit showed the service was 94% compliant. However, the audit identified that consent to share information, people's capacity and T2/T3 forms had not always been completed.

Good practice in applying the Mental Capacity Act

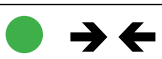
Staff supported people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005.

Staff received and kept up to date with training in the Mental Capacity Act. Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of inspection 100% of eligible staff had received mental capacity act and Deprivation of Liberty Safeguards training.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave people all possible support to make specific decisions for themselves before deciding a person did not have the capacity to do so.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Wards for people with a learning disability or autism

Staff treated people with compassion and kindness. They respected people's privacy and dignity. They understood people's individual needs of and supported them to understand and manage their care, treatment or condition.

People received kind and compassionate care from staff who used positive, respectful language at a level people understood and responded well to. There were easy read information leaflets that people were given on admission to the ward, and staff ensured that people were orientated to the ward environment. There were visual aids throughout the ward and Makaton signs throughout the ward that explained to people the purpose of the room or described various activities.

Staff were patient and used appropriate styles of interaction with people. They were calm, focused, and attentive to people's emotional and other support needs and sensory sensitivities.

Staff were discreet, respectful, and responsive when caring for people. Staff gave people help, emotional support and advice when they needed it. Staff supported people to understand and manage their own care treatment or condition. They did this in a way the person could understand and took time to prepare how best they could communicate with them. People and families and carers said staff treated them well and behaved kindly.

Staff showed warmth and respect when interacting with people. We observed staff treating people with kindness dignity and respect.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards people. One member of staff gave an example of a concern that they had raised, which had been quickly responded to by managers.

Involvement in care

Staff involved people in making decisions and planning their care and sought their feedback on the quality of care provided.

We viewed patient forum minutes and multidisciplinary team minutes which demonstrated that people had been involved in their care plans. Families and carers said they were invited to attend weekly and monthly multidisciplinary meetings. Families and carers also told us they felt involved in care planning.

People were listened to, given time and supported by staff to express their views using their preferred method of communication. Staff always took steps to make sure that people were supported to communicate their individual needs and preferences. People gave feedback on the service at monthly 'patient forum' meetings and daily morning meetings. We observed a morning meeting, where people were encouraged to give their views and make choices about daily activities, individual time with staff and menus. We viewed notes from the monthly patient forum meetings and saw examples of people voting for 'staff of the month', choosing food and activities. We also saw examples of feedback via, 'you said, we did'. One example was that people had complained about internal doors loudly banging shut. As a result, new internal doors were ordered and fitted.

Staff made sure people understood their care and treatment (and found ways to communicate with people who had communication needs). For example, each person received a meeting with family and medical staff and professionals

once a month. Care and treatment and positive behaviour support plans were discussed verbally. We saw evidence that Speech and language therapists were involved in supporting the person with communication in advance of the meeting. This was beneficial as some subject areas might be difficult and the team recognised that people would need support to share their views.

Staff supported people to maintain links with those important to them. We spoke with families and carers who all told us that they could regularly visit with people and support them whilst they take community leave. Families and carers where able to visit the ward and attend weekly and monthly clinical and multidisciplinary meetings.

Staff informed and involved families and families and carers appropriately. Families and carers felt involved and informed about the care of the person using the service. Families and carers told us they were involved in reviews and discharge planning.

Staff helped families to give feedback on the service. Families and carers said they would feel comfortable to raise a concern but had no need to do so. We saw examples of written compliments received from families and carers.

Staff ensured that people had easy access to independent advocates. Staff ensured people had easy access to information about independent advocacy and posters were displayed in the ward.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare. Discharge was rarely delayed for other than a clinical reason.

Managers monitored average length of stay. Between June 2022 to October 2022 the average length of stay ranged from 69 days to 505 days. During this time the service reported there had been one delayed discharge. Managers told us this was because of a lack of appropriate provision of housing within the community. The service was working closely with the community team to address this issue.

There were no out of area placements in the service. The service only admitted people from the local area. Bed occupancy was at 100% across the service. Byron ward had capacity for 7 people, on the day of inspection there were 5 people on the ward.

When people went on leave there was always a bed available when they returned.

Staff carefully planned people's discharge and worked with other professionals to make sure this went well. The ward worked closely with the community learning disability team. Managers provided commissioners with weekly reports and updates on people including plans for discharge. Discharge plans were also discussed at weekly reviews. Families and carers told us they were involved in discharge planning.

Wards for people with a learning disability or autism

The service worked closely with the community team for learning disability and autism who provided community support as an alternative to hospital admission and supported people on leave from the ward.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported people's treatment, privacy and dignity.

Each person had their own bedroom, which they could personalise, with an en-suite bathroom. They were able to keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and was based on the person's likes and dislikes and dietary needs. People could make hot drinks and snacks at any time, with supervision. Managers told us that due to risks, staff assisted people with preparing refreshments. Light snacks such as fresh fruits and hot and cold drinks were available throughout the day and night. During our visit, we observed staff assisting people to access refreshments.

People's care and support was provided in a safe, clean, well equipped, well-furnished and well-maintained environment that met people's sensory and physical needs. The service had two sensory rooms. We viewed both the internal and external sensory rooms which were both well equipped. The external sensory room had a sensory swing.

The ward had a range of rooms to support treatment and care such as an activity room, female only lounge and an activities kitchen. The service had quiet areas and a room where people could meet visitors in private. Families and carers told us they were able to meet with people in quiet, clean, accessible rooms.

People had access to outside space and gardens that people could access easily, this included a ramp so that wheelchair users could easily access the garden. People could access the garden with supervision. Staff told us there were always staff available to support people to access the garden. We observed one person requesting to play football in the garden and staff playing with them.

Patients' engagement with the wider community

Staff supported people with family relationships, community and leisure activities outside the service.

Managers told us that the COVID-19 pandemic had been challenging and had adversely affected some links within the community. Staff were working on re-establishing these links.

Staff gave examples of community activities which included going to the nearby football ground, visiting shops and cafes, walks to the park and cycling. Relatives told us they regularly kept in touch and could visit with their person.

Meeting the needs of all people who use the service

The service met the needs of all people. Staff helped people with their communication needs and spent time with people to understand their individual needs.

People learned everyday living skills, understood the importance of personal care and developed new interests. People could access a range of activities. For example, life skills, mindfulness, self-esteem, cooking and relaxation groups. The activity room contained a variety of resources such as adult colouring books and a world map which was used to illustrate different countries and cultures. Each person had an individualised activity box which contained activities chosen by the person. These were available at any time.

Wards for people with a learning disability or autism

Staff ensured there was a range of choice in activities offered and personalised choice boxes were provided. Staff delivered planned sessions within the ward in a dedicated room with a range of activities as well as outdoor physical activities, sensory rooms. People could access community activities which were arranged as and when appropriate such as cycling and accessing shops and the community. People were supported to develop skills around laundry and preparing and cooking meals.

Psychology staff provided sessions on wards and speech and language therapy staff provided a journal session with an autistic focus around feelings and interaction.

We viewed the service's two sensory rooms which offered a quiet space for alternative therapies such as massage, aromatherapy and pamper sessions.

Staff identified people's preferences and staff were available to support people. Staff offered choices tailored to individual people using a communication method appropriate to that person. We spoke with one person who was using the service. They told us they enjoyed the food and showed us some visual meal choices they were making. They explained that their activity timetable was reviewed with the occupational therapist weekly and that they enjoyed mindfulness, walking, sports, cycling and colouring. We observed them playing football with a member of staff. We observed two people doing arts and crafts with staff.

The service met the needs of all people using the service, including those with needs related to their protected characteristics. There were suitable adjustments for people requiring disabled access including an assisted bathroom and bedroom and accessible ramps to outside spaces. We saw a compliment from a carer, they commented "it had been the best care they had ever had".

Staff ensured people had access to information in appropriate formats. People had individual communication plans/ passports that detailed effective and preferred methods of communication, including the approach to use for different situations. For example, occupational therapists provided people with visual guidance for outdoor activities and to support transition into the community.

Staff had good awareness, skills and understanding of people's individual communication needs. They knew how to facilitate communication and when people were trying to tell them something. Staff were able to engage and support people with their communication needs by using Makaton and visuals.

Staff were trained and skilled in using personalised communication systems. At the time of inspection 22% of permanent staff and 3 bank staff were trained in the use of Makaton.

Managers made sure staff and people could get help from interpreters or signers when needed. Information was available in other languages for people for whom English was not their first language. Staff could access this and print leaflets from the Internet. Information was also available in easy read format and we saw examples of this such as information about treatments, people's rights and how to complain.

The service provided a variety of food to meet people's dietary and cultural needs. There was a designated chef on the ward. People had a choice of food to meet their dietary requirements and could make individual requests. People were supported to prepare their own meals if they chose. We observed people preparing pizzas for lunch with the occupational therapy assistant. Staff told us that people could request meal choices and we saw visual aids for people

to choose their food. Staff told us people were encouraged to choose healthy-eating options, vegetables grown in the garden were used in menus. We saw the use of pictorial aids of different world foods as part of a weekly cultural menu. Each person had an individualised snack box with items chosen by them. People had access to drinks when they wanted. People accessed outside areas when they wanted.

People could access spiritual, religious and cultural support in the community if, and when they chose to.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

People and those important to them could raise concerns and complaints easily, and staff supported them to do so. Families and carers told us they knew how to raise a concern and make a complaint, should they need to.

Staff were committed to supporting people to provide feedback so they could ensure the service worked well for them. People were encouraged to give feedback on the service at daily morning meetings and monthly patient forum meetings.

Staff knew how to acknowledge complaints, and people received feedback from managers after the investigation into their complaint. We viewed the service complaints log. In the past 6 months there had been 1 formal complaint made by an advocate on behalf of a person. This complaint was undergoing investigation.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service. Managers shared feedback from complaints with staff, and learning was used to improve the service. The service was open about investigating complaints and concerns. For example, one staff member gave an example of person's feedback regarding a staff member using their mobile phone whilst on escorted leave. The staff member described how the person had raised the concern, and how the concern was quickly dealt with by managers to the satisfaction of the person, and lessons were learnt.

Is the service well-led?

Requires Improvement ↓

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles and had a clear understanding of people's needs. Management and staff put people's needs and wishes at the heart of everything they did.

Staff said leaders were good and supported them in their day to day work. We observed managers were visible in the service and knew the needs of the service and the people using the service in their care.

Vision and strategy

Wards for people with a learning disability or autism

Staff knew and understood the provider's vision and values and how to apply them in the work of their team.

Managers had a clear vision for the direction of the service that demonstrated ambition and a desire for people to achieve the best outcomes possible.

The vision for the service is that all people with a learning disability in Essex (with or without Autism) are able to:

Enjoy good health and wellbeing

Experience the best quality of life

Be fully included and feel valued members of the community

Lead independent lives and do as much as they are able to

Make their own choices.

Culture

Staff felt respected, supported and valued. They could raise any concerns without fear.

Staff felt able to raise concerns with managers without fear of what might happen as a result.

Staff were passionate about their work and committed to delivering a good service for people. They told us that the morale was generally good. However, staff said they had felt frustrated at times due to low staffing levels.

Staff said there was good team working and they felt supported by their manager. They said they knew how to use the whistle-blowing process and raise concerns without fear of victimisation. Managers said they have an 'open door' for staff to approach them with any concerns. Staff shared an example of a concern they had raised with managers following overhearing a member of staff using discriminatory language whilst watching television with a person using the services. Staff told us managers took immediate action and the staff member was required to undertake equality and diversity training.

Governance

Our findings from the other key questions demonstrated that whilst governance systems and processes where in place they were not fully embedded at team level.

The service had governance systems and processes in place. The manager had oversight of a wide range of monthly audit data that included for example, the environment, Mental Health Act, Mental Capacity Act, care plans, medicines management, infection prevention and control amongst other aspects of the care and treatment given to people. We saw findings from audits were shared in staff meetings and actions set to ensure outcomes were met and improvements made where needed. However, whilst audits and analysed data had identified the concerns addressed in this report, the required actions had not always been taken to fully address these concerns. For example, we found gaps in record keeping during the inspection in risk assessments, care plans, consent to treatment forms and administration of medicines.

Wards for people with a learning disability or autism

The ward manager ensured that systems were in place to gauge and monitor the performance of the team. The manager used key performance indicators to ensure that there were enough staff to support people safely and that staff received regular training, supervision and appraisals and feedback about their performance. Managers knew when staff required refresher training and knew the reasons for any delays.

The service had high vacancies, sickness and turnover rates. Managers told us recruitment of permanent qualified nursing staff was a challenge and recruitment processes were in place for a number of vacant posts. Due to the low number of permanent staff managers relied heavily on bank and agency staff.

Management of risk, issues and performance

Managers had oversight of performance and risk.

The service had a risk register. The register described the issue, rated the risk and detailed mitigations put in place. Staff were able to add items onto the risk register if needed. Managers were aware of what the risk to their service were and how they took action to reduce these.

Managers attended quarterly quality, performance and risk management group meetings for Essex Learning Disability Partnership. We reviewed minutes and found topics discussed included essential information such as, service user safety, workforce, clinical supervision, sickness rates, vacancies, incident reporting, restrictive practices, complaints, service engagement, risk assessments, audits and safeguarding.

Information management

Staff had access to the equipment and information technology needed to do their work.

Managers have access to a range of information to support them with their management role. This includes information on the performance of the service, staffing and people's care.

Engagement

The provider sought feedback from people and those important to them and used the feedback to develop the service.

The service used comments and compliments to improve the service. The service's principles had been co-produced with people who use services which have influenced the service. The principles expressed what good quality integrated care looks like from the person's perspective, in their words, and were a constant thread running through the service's model.

Managers engaged with other local health and social care providers and participated in the work of the local transforming care partnership.

Substance misuse services

Good

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Safe and clean environment

All premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. The premises used by the service were owned by a partner agency. The trust had completed risk assessments of the areas they used and ensured that any risks were mitigated.

All interview rooms had alarms and staff available to respond. All staff used an electronic safety device to call for assistance if required.

All clinic rooms had the necessary equipment for clients to have thorough physical examinations and staff regularly checked and calibrated equipment.

All areas were clean, well maintained, well-furnished and fit for purpose. Staff used clean stickers on equipment to evidence when it had been last cleaned.

Staff followed infection control guidelines, including handwashing and wearing personal protective equipment. Each team had an infection prevention and control lead.

Safe staffing

The service had enough staff, who knew the clients and received basic training to keep them safe from avoidable harm. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed.

Nursing staff

The service had enough nursing and support staff to keep clients safe. Staff had manageable caseloads that allowed them enough time to spend with clients on a regular basis.

The service had low vacancy rates with four vacancies across the four services, with two of these covered by long term bank nurses and one covered by an agency nurse.

Managers made arrangements to cover staff sickness and absence. Managers could use bank or long-term agency nurses if required to cover absences and these were regular staff who were familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We spoke with an agency nurse who told us they had a thorough induction to the service including informal training.

Medical staff

The service had enough medical staff. The service had two consultant psychiatrists in post to cover the four teams. The service was nurse led and the consultants co-worked with nurses with complex case clients.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

Managers made sure all locum staff had a full induction and understood the service.

The service could get support from a psychiatrist quickly when they needed to. The consultant psychiatrists covered two teams each and were available to provide advice and training to nurses when needed.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training and overall training compliance was 92%.

The mandatory training programme was comprehensive and met the needs of clients and staff. The programme comprised of nine mandatory sessions and 23 essential sessions, and these included infection prevention and control, immediate life support, medicines management, safeguarding adults and children, and anaphylaxis.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers received a weekly email update of training compliance.

Assessing and managing risk to clients and staff

Staff assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health. Staff made clients aware of harm minimisation and the risks of continued substance misuse. Safety planning was an integral part of recovery plans.

Assessment of client risk

Staff completed risk assessments for each client entering treatment, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 20 client records and saw they all had comprehensive risk assessments which included physical and mental health, medication home storage and forensic history. Staff liaised with client's GPs to ensure they had all the required information prior to starting treatment.

Management of client risk

Staff responded promptly to any sudden deterioration in a client's health. Staff completed prescribing reviews every 12 weeks to monitor client's health or more frequently if needed.

Teams held a meeting each morning with their partner agency and discussed any clients who had not attended their appointment or had not collected their prescription from the pharmacy to review their risk. The service liaised with pharmacies when clients did not collect their prescription medicines after 3 occasions and halted their prescription until they had been reviewed in person. .

Staff provided naloxone to clients with a history of opiate use, which is used to temporarily reverse the effects of an opiate overdose. Staff also provided harm reduction information including blood borne virus and safer sex advice as well as tolerance and overdose advice. Staff provided safe storage boxes for clients to store any medicine at home out of reach of children.

Staff followed clear personal safety protocols, including for lone working. All staff used an electronic safety alarm device to call for assistance if required. Staff attended home visits with a staff member from a partnership service so were not alone on home visits.

Safeguarding

Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training. All staff were up to date with level 1 safeguarding training, with 92% having completed level 3 safeguarding children and 96% having completed level 3 safeguarding adults training.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them**.** Staff we spoke with could all give examples of safeguarding referrals that they had made.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had a safeguarding lead allocated to substance misuse and each team had a local safeguarding lead to advise on any concerns.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff kept detailed records of clients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Client notes were comprehensive, and all staff could access them easily. The service used a different electronic record system to the rest of the trust that was more suitable for the service type. Staff could also access the system used by GP surgeries to enable closer joint working.

When clients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Staff had individual log ins for client records to access the system.

Substance misuse services

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each client's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed 40 medicine prescription charts and saw that staff had prescribed and administered medicines safely and within guidance.

Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. Staff completed 12-week medicine reviews with clients in line with national guidance.

Staff completed medicines records accurately and kept them up to date. We reviewed 40 medicines records and saw that they were accurate and up to date.

Staff stored and managed all medicines and prescribing documents safely. We found a supply of rectal diazepam at the Harlow service which had been delivered in error by the trust pharmacy and had not been disposed of according to trust policy. However, this was a one-off error and all other medicines were stored and disposed of correctly.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff completed prescribing reviews every 12 weeks for clients to ensure that medicine levels were appropriate and safe.

Staff reviewed the effects of each client's medicines on their physical health according to National Institute for Health and Care Excellence guidance. Staff completed physical health checks including electrocardiogram tests for clients receiving high doses of methadone.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

Staff knew what incidents to report and how to report them. The trust used an electronic incident reporting system and staff we spoke with knew what to report.

Staff raised concerns and reported incidents and near misses in line with the service's policy. The service had reported 95 incidents in the six months before inspection with the highest number at 22 for medication errors. These incidents caused no or low harm to service users in all cases and represented a very small number in relation to the number of prescriptions issued. The trust had recorded 13 unexpected deaths in the six months prior to inspection. This is a low number of deaths in comparison to substance misuse services nationally.

Substance misuse services

Staff reported serious incidents clearly and in line with the service's policy. The service did not report any serious incidents in the six months before inspection. The service did not routinely report client deaths as serious incidents but did review all deaths in a monthly mortality review meeting. Learning from these meetings were distributed to all staff as a 'key learning' bulletin.

The service had no never events.

Staff met to discuss the feedback and look at improvements to client care. Staff discussed incidents and any lessons learned in the multi-agency clinical and team business meetings.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff completed comprehensive assessments with clients on accessing the service. They worked with clients to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each client at the initial clinical assessment.

Staff made sure that clients had a full physical health assessment and knew about any physical health problems. We reviewed 20 client records and saw that staff completed a full physical health assessment at the initial clinical assessment.

Staff developed a prescribing plan for each client that fed into the recovery care plan completed by staff from a partnership agency.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.

Staff delivered care in line with best practice and national guidance (from relevant bodies such as NICE). We reviewed 40 medicines records and saw that staff followed clinical guidelines in prescribing and dose optimisation for opiate detoxification. Treatment was collaborative with clients and partner agencies to agree length of detoxification and maintenance.

Staff prescribed pabrinex to assist in alcohol detoxification and the Chelmsford service were able to prescribe buprenorphine injections as a long-lasting opiate substitution.

Substance misuse services

Staff made sure clients had support for their physical health needs, either from their GP or community services. We reviewed 20 client records and saw that staff updated GP's with outcomes of physical health reviews, including outcomes of electrocardiogram tests, blood pressure and blood tests. We saw examples of where electrocardiogram results were abnormal, and staff referred clients to their GP for further investigation. The electrocardiogram was then repeated regularly after.

Staff supported clients to live healthier lives by supporting them to take part in programmes or giving advice. The service offered testing for blood borne viruses and hepatitis B vaccinations, with 90% of opiate using clients having been fully vaccinated.

Staff did not regularly take part in clinical audits, benchmarking and quality improvement initiatives. The service had conducted an audit of Naloxone provision. Staff had completed two controlled drugs audits at Chelmsford in the six months before inspection but no other audits or quality improvement initiatives.

Managers used results from an audit when they took place to make improvements. We saw that outcomes of the controlled drugs audit at Chelmsford had been used to make improvements such as a signatory list of nurses authorised to order controlled drugs being kept in the drugs cabinet.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of each client. The service employed a range of nursing staff including non-medical prescribers to meet the needs of clients. The service also employed hospital liaison nurses who worked on hospital wards to support hospital doctors with safe detoxification prescribing.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the clients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. Staff completed mandatory training, specialist training with the consultant psychiatrist and shadowed colleagues as part of their induction.

Managers supported staff through regular, constructive appraisals of their work with 98% of staff having an appraisal completed in the last year.

Managers supported staff through regular, constructive clinical supervision of their work and supervision compliance was at 85% across the service.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Teams held two meetings per month, one business meeting and one joint clinical meeting with partnership agencies to discuss client care.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The consultant supported staff with any informal training required. The Colchester team had recently received training in National Early Warning scores for assessing physical health and the Basildon team had received training in dealing with aggressive behaviour.

Managers made sure staff received any specialist training for their role. Staff completed training in delivering pabrinex, in hepatitis testing and vaccination and nurses had the opportunity to qualify as non-medical prescribers.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation, however these were not always recorded effectively.

Staff held regular multidisciplinary meetings to discuss clients and improve their care. Staff held a meeting each morning with partner agency staff to discuss any complex or high risk clients, any clients who had not attended their appointment the previous day and any clients requiring additional support.

Staff made sure they shared clear information about clients and any changes in their care, including during transfer of care. Staff shared clear information with GPs when there was any change in clients' health or treatment.

Staff had effective working relationships with other teams in the organisation.

Staff had effective working relationships with external teams and organisations however they had not always clearly document joint working in client records.

Staff and patients told us appointments were regularly held with staff from the partner agency and we saw examples in client records of effective joint working. However, we reviewed 20 care records and saw clear documentation of joint working appointments in seven of these. This was a requirement from the previous inspection. Whilst a standard template to record joint appointments had been developed, this was not being used consistently across the different teams.

Good practice in applying the Mental Capacity Act

Staff supported clients to make decisions on their care for themselves. They understood the service's policy on the Mental Capacity Act 2015 and knew what to do if a client's capacity to make decisions about their care might be impaired.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff we spoke with had a good understanding of capacity and 97% of staff had completed training.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff knew how to access the Mental Capacity lead for the trust.

Substance misuse services

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated clients with compassion and kindness. They understood the individual needs of clients and supported clients to understand and manage their care and treatment.

Staff were discreet, respectful, and responsive when caring for clients. Staff worked with some clients who were unable to attend clinics and so visited these clients at home with partner agency staff to provide collaborative care.

Staff gave clients help, emotional support and advice when they needed it. We spoke with 7 clients who all told us they felt staff listened to them and were helpful and supportive.

Staff supported clients to understand and manage their own care treatment or condition. All clients we spoke with told us staff encouraged them to be involved in their treatment and took their wishes into account when setting treatment goals.

Staff directed clients to other services and supported them to access those services if they needed help. The partner agency worked with clients to access additional services such as housing and benefit support.

Clients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each client. Clients told us that staff were understanding and adapted treatment according to their needs.

Staff followed policy to keep client information confidential.

Involvement in care

Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support.

Involvement of clients

Care plans were completed by a partner agency, but staff contributed to the care plan and involved clients in agreeing goals.

Staff made sure clients understood their care and treatment. Staff involved clients in discussions about their prescribing plans and any changes in treatment.

Substance misuse services

Staff involved clients in decisions about the service, when appropriate including discussion about opening times and access.

Clients could give feedback on the service and their treatment and staff supported them to do this. Staff encouraged clients to complete 'I want great care' feedback questionnaires and the results were collated centrally. The feedback from client satisfaction questionnaires was an average of 4.9 stars out of 5 across the service.

Involvement of families and carers

Staff informed and involved families and carers appropriately where required.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Access and waiting times

The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.

The service had clear criteria to describe which clients they would offer services to. The service was commissioned to provide clinical interventions for opiate and alcohol use and worked alongside a provider agency that provided psychosocial interventions.

The service met the service's target times for seeing clients from referral to assessment and assessment to treatment. The target was for all clients to receive a prescribing appointment within 3 weeks of referral and 96% of clients were seen within this period, with 83% being seen within a week of referral.

Staff saw urgent referrals quickly and non-urgent referrals within the service's target time. Clients being released from prison were seen on the day of their release to ensure their safety. Pregnant clients were also prioritised for appointments.

Staff tried to contact people who did not attend appointments and offer support. The service liaised with pharmacies when clients did not collect their prescription medicines after 3 occasions. The partner agency would contact the client before the prescription could be restarted.

Clients had some flexibility and choice in the appointment times available. The teams all had one day of the week where they could offer evening clinic appointments. All of the teams also ran satellite clinics across the county in local community centres and could also offer to see clients at pharmacies or GP surgeries.

Staff worked hard to avoid cancelling appointments and when they had to, they gave clients clear explanations and offered new appointments as soon as possible. We saw examples of this in client records.

Appointments ran on time and staff informed clients when they did not.

The service did not have a waiting list.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported clients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. All teams had suitable clinic rooms to see clients and had separate bathroom areas to conduct urine drug screening.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Meeting the needs of all people who use the service

The service met the needs of all clients, including those with a protected characteristic or with communication support needs.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. The service locations were not accessible to clients who used a wheelchair or had limited mobility. However, staff held satellite clinics in accessible services and could visit clients at home if their mobility prevented them attending clinics.

The service worked closely with specialist midwives to support pregnant and post-natal clients.

The Colchester service had implemented a women only session which had been well received by clients.

Staff made sure clients could access information on treatment, local services, their rights and how to complain and had posters and leaflets displayed in the service.

The service had information leaflets available in languages spoken by the clients and local community.

Managers made sure staff and clients could get hold of interpreters or signers when needed.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Clients, relatives and carers knew how to complain or raise concerns.

The service had not received any complaints in the six months prior to inspection but the trust had a complaints policy in place. Clients we spoke with knew how to make a complaint if needed but were confident that any concerns they raised informally would be addressed.

Staff understood the policy on complaints and knew how to handle them.

Substance misuse services

Staff protected clients who raised concerns or complaints from discrimination and harassment.

The service used compliments to learn, celebrate success and improve the quality of care. Staff at each team collected compliments from clients and these were shared within the team.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for clients and staff.

Team managers were based in their service and in some teams were also a prescriber and clinical lead for the team. Managers had good knowledge and skills and a good understanding of their services.

Managers and staff told us that local leaders visited and were visible within the service, that senior trust management had tried to be more visible and had more awareness of the service. However, frontline staff still did not feel that senior management were visible within the service or that they fully understood the service.

Vision and strategy

Staff knew and understood the trust vision and values and how they applied to the work of their team.

Most staff we spoke with were aware of the trust values of 'we care, we learn, we empower' and could evidence how they used these in their day to day work.

Culture

Staff felt respected, supported and valued. They reported that the service promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Staff we spoke with all felt supported and valued by their teams, they reported good morale and job satisfaction.

The trust offered opportunities for career progression including funding non-medical prescriber training for nurses.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. However, there was a lack of oversight of audit and quality improvement.

Substance misuse services

Governance processes generally operated well with teams with risks and performance managed well.

Whilst most of the requirements from the previous inspection had been implemented, client records still did not always clearly document collaborative working with partner agencies. The trust action plan from the last inspection stated that staff would use a standardised template for recording appointments that would capture joint working however only Harlow team were using a standardised template. Managers did not complete any audits of client records and so this had not been identified as an ongoing issue.

The service did not have an audit schedule or complete audits across the teams with only a naloxone audit completed for the service in the last six months. Chelmsford team had completed 2 controlled drugs audits but none of the other teams had completed any audits of controlled drugs or medicines management.

There was a clear framework for team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The service used an electronic client record system that suited the needs of the service and clients, and all staff had access to the system including bank and agency staff. The system was also used by partner agencies so that records were complete and stored on the same system.

Staff could also access the record system used by local GP surgeries which improved communication and ensured physical health issues were monitored effectively.

Information management

Staff collected analysed data about outcomes and performance.

Staff collated data for key performance indicators and input client data into the national drug treatment monitoring system.

Engagement

The service engaged with commissioners to ensure the needs of clients were being met. Staff worked closely with partner agencies, physical health providers and mental health teams.

Learning, continuous improvement and innovation

The service had an action plan in place following the last inspection to address the requirements.

Agenda Item: 7c

SUMMARY REPORT	COUNCIL OF GOVERNORS PART 1	24 August 2023

Report Title:	**Governor Composition and Attendance**					
Report Lead:	Chris Jennings, Assistant Trust Secretary					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Governance Committee 9 August 2023					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides details of any changes to composition, current sub-committee membership and attendance at the Council of Governors.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Council of Governors is asked to:

1. Note the contents of the report

Summary of Key Issues

Composition

Owen Carty, Public Governor for Essex Mid & South has resigned following his election as a local councillor.

David Bamber, Public Governor for West Essex & Hertfordshire has resigned due to personal reasons.

Kate Shilling, Public Governor for West Essex & Hertfordshire has resigned due to a change in personal circumstances.

The terms of office of three Appointed Governors have come to an end:

- Councillor Shane Ralph, Thurrock Council
- Councillor Mark Durham, Essex County Council
- Councillor Maxine Sadza, Southend-on-Sea Council

They have been replaced by:

- Councillor Vikki Harstean, Thurrock Council
- Councillor Jaymey McIvor, Essex County Council
- Councillor James Moyies, Southend-on-Sea Council.

Councillor Vikki Harstean has completed all relevant forms and has been invited to the next Council of Governors meeting. The Trust Secretary's Office is awaiting completed forms from the remaining two councillors.

Committee Membership

The following sub-committees have vacancies:

- Governance Committee (3 x vacancies)
- Remuneration Committee (1 x vacancy)
- Membership Committee (1 x vacancy)
- Training & Development Committee (2 x vacancies)
- Nominations Committee (1x vacancy)

Governor attendance

Governor attendance at general meetings is reviewed in line with the agreed procedure for monitoring attendance. A summary of attendance to date is attached at Appendix 1. Of the three Governors that have not attended two Council meetings consecutively, two have

resigned and another has not sought re-election. Two individuals have as at the last Council meeting in May have missed two meetings in a row and these will be contacted by the Lead Governor.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered	
1: We care	
2: We learn	
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Health watch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications			
Governance implications			✓
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	

Impact on Statutory Duties and Responsibilities of Council of Governors	
Holding the NEDs to account for the performance of the Trust	
Representing the interests of Members and of the public	
Appointing and, if appropriate, removing the Chair	
Appointing and, if appropriate, removing the other NEDs	
Deciding the remuneration and allowances and other terms of conditions of office of the Chair and the other NEDs	
Approving (or not) any new appointment of a CEO	
Appointing and, if appropriate, removing the Trust's auditor	
Receiving Trust's annual accounts, any report of the auditor on them, and annual report	
Approving "significant transactions"	
Approving applications by the Trust to enter into a merger, acquisition, separation, dissolution	
Deciding whether the Trust's non-NHS work would significantly interfere with its principal purpose or performing its other functions	
Approving amendments to the Trust's Constitution	
Another non-statutory responsibility of the Council of Governors (please detail):	✓

Acronyms/Terms Used in the Report			
CoG	Council of Governors		

Supporting Documents and/or Further Reading
Council of Governors Meeting Attendance (Appendix 1)

Lead
Chris Jennings, Assistant Trust Secretary

Governor	Notes	22 May 2023		Total Meetings Attended	Total Meetings
		Part 1	Part 2		
David Bamber		A	A	0	1
Keith Bobbin		√	√	1	1
Lara Brooks		√	√	1	1
Owen Carty		x	x	0	1
Dianne Collins		√	√	1	1
Mark Dale		√	√	1	1
Jared Davis		x	x	0	1
Mark Durham		√	√	1	1
Pippa Ecclestone		√	√	1	1
Paula Grayson		√	√	1	1
Sharon Green		√	√	1	1
Jason Gunn		√	√	1	1
Julia Hopper		√	√	1	1
John Jones		√	√	1	1
Megan Leach		√	A	1	1
Pam Madison		√	√	1	
Nicky Milner		√	√	1	1
Tracy Reed		A	A	0	1
Stuart Scrivener		√	√	1	1
Kate Shilling		x	x	0	1
David Short		√	√	1	1
Susan Tivy-Ward		x	x	0	1
Edwin Ugoh		x	x	0	1
Paul Walker		√	A	1	1
Cort Williamson		√	√	1	1

Key	
Attended	√
Apologies Received	A
No Apologies Received	x
Sabbatical / Agreed Absence	S
Not Required	NR
Holiday	H

		Agenda Item No: 7d
SUMMARY REPORT	**COUNCIL OF GOVERNORS PART 1**	**24 August 2023**

Report Title:	**Lead and Deputy Lead Governor Report**					
Report Lead(s)	John Jones, Lead Governor and Pam Madison, Deputy Lead Governor					
Report Author(s):	John Jones, Lead Governor and Pam Madison, Deputy Lead Governor					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides an update on activities involving the Lead and Deputy Lead Governors	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Council of Governors is asked to:

1. Note the contents of the report.

Summary of Key Issues

The report attached provides information in respect of:

- Our role as your Lead and Deputy Lead Governor
- The Regional Network of Lead Governors
- Engaging with Members
- Links with the ICB
- Who chairs Nomination Committee and who chairs Remuneration Committee?
- Board of Directors meeting
- Meeting with the Chair

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	
SO2: We will enable each other to be the best that we can	
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	
2: We learn	
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:

Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	

Impact on Statutory Duties and Responsibilities of Council of Governors	
Holding the NEDs to account for the performance of the Trust	
Representing the interests of Members and of the public	✓
Appointing and, if appropriate, removing the Chair	
Appointing and, if appropriate, removing the other NEDs	
Deciding the remuneration and allowances and other terms of conditions of office of the Chair and the other NEDs	
Approving (or not) any new appointment of a CEO	
Appointing and, if appropriate, removing the Trust's auditor	
Receiving Trust's annual accounts, any report of the auditor on them, and annual report	
Approving "significant transactions"	
Approving applications by the Trust to enter into a merger, acquisition, separation, dissolution	
Deciding whether the Trust's non-NHS work would significantly interfere with its principal purpose or performing its other functions	
Approving amendments to the Trust's Constitution	
Another non-statutory responsibility of the Council of Governors (please detail):	

Acronyms/Terms Used in the Report			
NEDs	Non-Executive Directors	LGs	Lead Governors
NHSE/I	NHS England / Improvement	FT	Foundation Trust

Supporting Documents and/or Further Reading
Main Report

Lead

John Jones
Lead Governor

Pam Madison
Deputy Lead Governor

Agenda Item 7d
Council of Governors Part 1
24 August 2023

UPDATE REPORT FROM THE LEAD AND DEPUTY LEAD GOVERNORS

1 Purpose of Report

The purpose of this report is to provide an update on activities involving the Lead and Deputy Lead Governors.

2 Summary

2.1 Background

Foundation Trusts (FTs) are required by NHS England/Improvement (formerly operating as Monitor) to have in place a nominated Lead Governor who can be a point of contact for NHSE/I and can liaise with NHSE/I, on behalf of Governors, in circumstances where it would be inappropriate for NHSE/I to contact the Chair and vice versa. The Council of Governors agreed at its meeting on 16 August 2017 that in addition to the Lead Governor, elections should be held to appoint a Deputy Lead Governor to provide for cover as well as succession planning.

2.2 Our Role as your Lead and Deputy Lead Governor

Our role as a Governor is the same as for all Governors. There may, however, be occasions when we are asked to represent Governors at meetings, coordinate consultations, etc. For this reason, it is important that we get to know our fellow Governors and to understand their views. We would be pleased to hear from Governors, and also to catch up with you at the various Council meetings as well as at the Board of Director meetings which we usually attend. We will also ensure that we provide you with regular updates on the work in which we are involved in our Lead and Deputy Lead Governor roles.

2.3 The Regional Network of Lead Governors

Colleagues may recall that this group was established by myself in early 2017 and meets every 3 months, and the last meeting was held virtually on 10th August 2023, when the following items were discussed:

2.3.1 Engaging with Members

The importance of member engagement was discussed, particularly given the low percentage voting in Governor Elections and the need to increase diversity among members. Initiatives started included a revamped electronic newsletter, with an emphasis on ways in which members can get involved, and some Governor biographies and, from one FT, a video about the role of Governors. Other FTs have presented a medical lecture about every 3 months (virtually), which attracted an audience of between 80 and 120. It is a bit too early to assess the effectiveness of these developments. A junior CoG has been established at the University of East Anglia.

2.3.2 Links with ICB

There has been a meeting with ICB chair in the Cambridgeshire area involving 4 FTs. There is a recognition that Governors have a statutory role to represent the community, and to do so needs an established link with the relevant ICBs.

2.3.3 Who chairs Nominations Committee and who the Remuneration Committee?

This was discussed again and practice seems to vary around the region. Most FTs have a Governor chairing the Remuneration Committee to avoid potential conflicts of interest. But the practice for Nominations is more varied. Advice on this point is still awaited from NHS Providers. There is increasing concern that Governors are being sidelined in what is a fundamental part of the role, in some cases by the Chair of the Trust, in others by NHSE who are increasingly expecting to be a part of the appointment procedure not just for the Chair but also for other NEDs.

2.4 Board of Directors Meeting.
We were pleased to be able to attend the May and July 2023 meetings of the Board and to ask questions on behalf of our members.

2.5 Meeting with Chair
The scheduled meeting with the Chair to discuss and adjust the Agenda for this Council meeting was held virtually on 14th July 2023. Additionally, we raised other issues which as Governors, we felt should be aired with the Chair. We are grateful for the open and receptive way in which these meetings are conducted.

2.6 Other Matters
May we take this opportunity to thank those of you who have raised queries with either of us. We hope that the answers which you have received have been satisfactory. Please let either of us have any comments on how we are doing as your Lead and Deputy Lead Governors. May we also thank colleagues for their co-operation with the Trust as we attempt to carry on using a mixture of virtual and face-to-face meetings.
We are also grateful for the assistance given by the Trust Secretary's Office during these difficult times. Their patience and understanding is a real credit to them all.

3 Action Required

The Council of Governors is asked to:

1 Note the contents of the report.

Report prepared by

John Jones
Lead Governor
Public Governor
24th August 2023

Pam Madison
Deputy Lead Governor
Public Governor
24th August 2023

Council of Governors 24 August 2023