Review of compliance

Southend University Hospital NHS Foundation Trust Location: Southend University Hospital	
Region:	East
Location address:	Prittlewell Chase Westcliff on Sea Essex SO0 0RY
Type of service:	ACS Acute Services
Regulated activities provided:	Treatment of disease, disorder or injury Surgical procedures Diagnostic or screening procedures Management of supply of blood and blood derived products etc Maternity and midwifery services Termination of pregnancies Family planning
Type of review:	Responsive Review
Date of site visit (where applicable):	12/10/2010

Review of compliance

Name of site(s) visited (where applicable):	Southend University Hospital NHS Trust
Date of publication:	06/01/2011

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
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Introduction to our review of compliance

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards that everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards. This is called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and we will constantly monitor whether they continue to do so. We formally review a service when we receive information that is of concern and, as a result, decide we need to check whether it is still meeting one or more of the essential standards. We also formally review services at least every two years to check whether they are meeting all of the essential standards in each of their locations. Our reviews include checking all the available information and intelligence we hold about a provider. We may seek more information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for more information from the provider, and carry out a site visit with direct observations of care.

When we make our judgements about whether services are meeting essential standards, we will decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions, compliance actions or take enforcement action:

Improvement actions	These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.
Compliance actions	These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards, but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.
Enforcement actions	These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

How this report is presented

On page 5 below, there is a summary that shows whether the essential standards about quality and safety that were checked during this review of compliance are being met. The section on each outcome is set out in this way:

Outcome	Judgement
XX: The outcome number and title	**Whether the service provider is compliant, or whether we have minor, moderate or major concerns about their compliance**

Following the summary, there is a detailed section on the outcomes for each of the essential standards that we looked at. The evidence that we used when making our judgements for each one is set out in the following way:

Outcome XX (number): Outcome title

Details of the outcome, taken from our *Guidance about compliance: Essential standards of quality and safety*.

What we found for the Outcome

Our judgement

Our judgement about whether the <service/provider> meets the outcome described in the *Guidance about compliance: Essential standards of quality and safety*, or whether there are minor, moderate, or major concerns in relation to compliance.

Our findings

A summary of the evidence and findings used to reach our judgement, related to regulated activities as appropriate.

At the end of the report you will find details of:

- Any improvement and/or compliance action(s) that the service provider should make to maintain or achieve compliance with the essential standards of quality and safety.
- Any formal enforcement action that we are taking against the service provider.

Summary of findings for the essential standards of quality and safety

The table below shows the judgement that we reached for each of the essential standard outcomes that we reviewed.

Outcome	Judgement
4: Care and welfare of people who use services	**Moderate concern**
6: Cooperating with other providers	**Minor concern**
7: Safeguarding people who use services from abuse	**Minor concern**
10: Safety and suitability of premises	**Minor concern**
14: Supporting workers	**Minor concern**

Summary of key findings:

Background to Responsive Review:

A responsive review was carried out following notifications received from the trust by the Care Quality Commission of two serious untoward incidents at the trust. Evidence was requested from the trust and evaluated by us. This included the trust's policy and practices around enhanced supervision, training in relation to carrying out risk assessments of service users who require close supervision and assessment of the safety of the proposed care environment, as well as arrangements for more specialist support from the local mental health partnership trust. In addition we also gathered information about the investigations and actions taken following the incidents.

A visit to the trust was undertaken on 12 October 2010 to look at the essential standards of quality and safety relating to the care and welfare of people who use services, the safety and suitability of premises and supporting staff and to examine any further evidence the trust could provide to demonstrate compliance in these areas. During the visit a range of staff were spoken with including the senior management team, clinical staff and support staff. In addition policies, procedures and other documents were examined and the inspection team spent time observing practice and assessing the environment.

Key Findings:

The trust does not have an overarching policy addressing the provision of services to people with mental health needs and overall there were deficiencies in processes around the service provided to this patient group. These shortcomings included unacceptable delays in the Accident and Emergency Department (A&E) in carrying out psychiatric assessments of patients or delays for people waiting to move to more suitable services. This was less of a problem at times when psychiatric liaison nurses, provided by the local mental health trust, were available. The presence of nurses from the psychiatric liaison service contributed to a more prompt assessment and move-on. However, there are a number of issues that impede this process. Psychiatric liaison nurses have no access to the mental health trust's patient computer records when in the A&E department. Liaison nurse cover is limited to afternoons and evenings each day. Protocols around the mental health trust's policy of only assessing patients once they are 'medically fit' can create further delays when agreements cannot be reached between the mental health trust and Southend University Hospital Foundation Trust (SUHFT) doctors. It was noted that the trust has clear care pathways for a range of clinical conditions but there is no specific care pathway for people with mental health needs.

The trust has taken the step of introducing 'safe rooms' for people who may be at risk because of their mental health needs. The rooms we saw were light, airy and comfortable. Effort has been put into developing a range of checklists for the use of safe rooms, including a health and safety checklist and a 'Close Supervision Side Room Occupancy Checklist' for use prior to occupation. However, further work needs to be carried out to ensure the processes around the use of safe rooms effectively meet the needs of patients. Supervision of patients in safe rooms is sometimes carried out by security staff who do not have training around mental health issues, which in effect may mean their observational role is primarily custodial. This raises the question as to whether it is either effective or appropriate for distressed patients with mental health needs to be observed by staff with no clinical training. We were made aware that the trust is in the process of revising its observation policies and believe this will reflect that observation should be an opportunity

for constructive engagement rather than passive observation by untrained staff. In addition not all staff appeared to be aware of protocols around using safe rooms. There is insufficient evidence relating to the effectiveness of the use of safe rooms as a log is not currently kept of which rooms are used and how often. There is no process in place for collecting and collating data in order to evaluate the value and efficacy of the use of safe rooms.

The process for reviewing and updating policies and procedures is ongoing and when gaps or omissions in processes were noted the senior management team demonstrated a willingness to address the issues and revise policies. However, the process for reviewing policies and procedures could be more proactive and should not be dependent on Compliance Reviews or as a reaction to the occurrence of untoward incidents.

Staff have received training around the Mental Capacity Act (MCA), although this is not mandatory, and in general some staff had a basic understanding of MCA and Deprivation of Liberty Safeguards (DOLS). However, when asked about their understanding of supporting people with mental health needs and what training they had received, some staff described to us Conflict Resolution training and how to recognise signs of aggression. Staff in the trust are required to undertake this training, including those who work in the A&E department. Staff spoken with confirmed that the have had Conflict Resolution training. It was further noted that there was a general lack of awareness of the Mental Health Act (MHA) Code of Practice or information about the treatment of patients who had mental health needs in acute settings. Overall staff training around issues relating to mental health, including MCA, DOLS and MHA Code of Practice, is insufficient to ensure that patients who are at risk because of mental health issues receive a service that meets their needs.

The introduction of a Safeguarding Lead has raised awareness amongst staff about issues relating to vulnerable people. Staff have access to a Safeguarding Adults Staff Handbook which gives clear guidance around reporting concerns. However one member of staff spoken with said that the Safeguarding Lead dealt with all issues relating to safeguarding and a few others demonstrated only a superficial awareness of their responsibilities. In addition, when asked about what training they had received around safeguarding, some staff again cited Conflict Resolution training.

Improvements need to be made to training provided to ensure staff have the skills and knowledge to care for and treat patients who also have mental health needs.

The arrangement for support for patients with mental health needs in the hospital has not been formalised and it is evident that the absence of a service level agreement and joint protocols between the hospital and the local mental health trust has affected the standard of the service received by people with mental health needs. Senior management confirmed that they do not have a formalised contract or any written arrangement with the local mental health trust. A ‘mutual system’ operates where the mental health partnership trust provides support to people with mental health needs in the hospital and hospital staff provide healthcare to those people who were inpatients in the care of the mental health trust.

In addition, there was a lack of evidence of formal liaison arrangements with other agencies such as police, ambulance and local authority. We were informed that police ‘routinely’ use the A & E department as a place of safety, irrespective of whether the person requires urgent medical treatment and despite the fact that the local mental health trust has a designated Section 136 facility; place of safety.

We acknowledge that some progress had been made in liaising with the local mental health trust and there is now a point of contact at associate director level, although this is confined to office hours. However, further progress needs to be made in developing formal protocols and arrangements with other agencies if people using services are to be confident that the care, treatment and support provided to meet their assessed needs is robust and all those

involved co-operate to ensure this happens.

What we found for each essential standard of quality and safety

The section below details the findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

Further detail about each of the outcomes described below can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 4:
Care and welfare of people who use services

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

This is because providers who comply with the regulations will:

- Reduce the risk of people receiving unsafe or inappropriate care treatment and support by:
    - assessing the needs of people who use services
    - planning and delivering care, treatment and support so that people are safe, their welfare is protected and their needs are met
    - taking account of published research and guidance
    - making reasonable adjustments to reflect people's needs, values and diversity
    - having arrangements for dealing with foreseeable emergencies.

What we found for Outcome 4

Our judgement

There are moderate concerns with Outcome 4: Care and welfare of people who use services

Our findings

The lack of specialist mental health support and a service level agreement with the local mental health trust has an impact on the care and welfare of people who use services.

Support from specialist psychiatric nurses employed by the mental health trust is available in A&E between 14.00 hrs and 22.00 hrs daily. Outside of these times, junior doctors from Rochford provide support to the hospital.

Evidence provided by the trust showed that there were significant breaches of the 'four-hour wait' (the national target time for patients to be seen in A&E departments) in relation to patients who also require a psychiatric assessment. Records examined confirm that there was particular poor performance during August 2010. The records show that for the 5 weeks between week commencing 01 August 2010 and week commencing 29 August 2010 there were a total of 69 people with psychiatric needs attending the Accident and Emergency Department (A&E) and of these only 12 were seen within four hours. The report indicates that fewer people were seen within four hours in August due to the availability of staff from the mental health trust. Staff spoken with confirmed that the availability of nurses from the psychiatric liaison service led to a more prompt assessment and move-on for people with mental health needs. Other staff spoken with in A&E spoke highly of the input provided by the mental health trust nurses. This underlines the importance of having a formal service level agreement in place, so that a consistent service is provided for people presenting at A&E with mental health needs.

A psychiatric nurse provided by the mental health trust explained that the use of inexperienced junior doctors can cause delays to treatment for mental health patients. The crisis teams do not currently work out of hours so the response times for junior doctors to come over from Rochford is sometimes a problem. We were also informed that the length of time it can take to arrange a transfer to a mental health unit can also be an issue. We were informed that waiting times can be prolonged to the point that the patient walks out, especially at night when there is no transfer service until 07.00 hrs the following day. Non-clinical support staff confirmed that some patients wait all night for transfer or review and again confirmed that sometimes patients will leave without being seen because the wait has been so long. There is only one receptionist on the desk at night. There is a 'panic button' but the staff interviewed did not know with whom it connects. The record of psychiatric attendance and waiting time breaches in A&E also confirms that another, although lesser, issue is transport availability once a decision has been made to admit a patient to a mental health facility. A comment from staff indicated that there may be use of the emergency services for non-emergency transfers during the night, although there was

greater recognition that use of the East of England emergency ambulance service for daytime transfers was not an option.

A senior member of the management team in the hospital acknowledged there were at times long waits in A&E, which sometimes was due to the coordination of staff in order to facilitate a section under the Mental Health Act, as well as waiting for transport to the mental health trust's services and the availability of beds. Some progress has been made, as there is now a point of contact at associate director level for access to mental health services if needed, although this was confined to office hours.

One member of staff with whom we spoke felt that the service to people with mental health needs would be improved if there was a doctor on site at all times with a clinical background in psychiatry to support vulnerable people. Other staff interviewed indicated that there were typical delays of 2-3 hours waiting for a psychiatrist to arrive from the mental health trust. The document recording psychiatric attendance and details of those who had to wait more than 4 hours in A&E states that, 'the fundamental issue regarding breaches is the availability of the Psychiatrist to see the patient'.

A report relating to a service user with mental health needs, who experienced an unacceptably long wait of 18 hours from the time of arriving in A&E, documents the delays in an assessment being carried out by the Duty Psychiatric Doctor and further delays whilst awaiting a social worker.

A further issue raised with us was that the hospital does not currently hold stocks of psychiatric drugs so patients are unable to promptly receive any antipsychotic medication that may be required.

The use of 'safe rooms' for people who are mentally distressed has been introduced in the hospital. Senior staff interviewed confirmed that patients in safe rooms may be supervised, depending on the circumstances, either by a member of the hospital's security team or by a specialist nurse When the supervision of a patient in a safe room is carried out by security staff, they either wait outside the room or, if deemed necessary and appropriate by the nurse in charge, the security guard will remain in the room. We were told by senior staff that security guards have no training for this role but will be briefed, as necessary, by nurses. Their role, therefore, is passive and primarily custodial.

Some senior clinical staff with whom we spoke highlighted problems in relation to the mental health trust's policy of only assessing people with possible mental health issues once they are declared 'medically fit'. A rigid adherence to this policy can result in unnecessary delays in obtaining psychiatric advice about a person's care and treatment, although it appears to be easier to obtain the services of a psychiatric nurse to provide specialist input once there has been a consultant to consultant agreement. Records examined of a Department of Health (DoH) 'Southend Whole System Urgent and Emergency Pathway Review' in July 2010 indicate that the acute trust felt that the mental health service provided to the emergency department (ED) and the assessment units was unresponsive and led to both delays in A&E and unnecessary admissions. They felt there were unnecessary delays in assessment whilst waiting for a patient to become 'medically fit' as opposed to 'medically stable'.

The director of nursing confirmed that there is no named lead for mental health within the

trust. In addition, although there is a clear care pathway for physical conditions such as cardiac events or fractured neck of femur, there is no care pathway for mental health conditions. These issues potentially lead to gaps in the service provided for people with mental health needs.

Outcome 6:
Cooperating with other providers

People who use services:

- Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

T**his is because providers who comply with the regulations will:**

- Cooperate with others involved in the care, treatment and support of a person who uses services when the provider responsibility is shared or transferred to one or more services, individuals, teams or agencies.
- Share information in a confidential manner with all relevant services, individuals, teams or agencies to enable the care, treatment and support needs of people who uses services to be met.
- Work with other services, individuals, teams or agencies to respond to emergency situations.
- Support people who use services to access other health and social care services they need.

What we found for Outcome 6

Our judgement

There are minor concerns with Outcome 6: Cooperating with other providers

Our findings

There is significant evidence that the lack of provision of specialist mental health support outside the hours of 14.00 hrs – 22.00 hrs has an impact on the health and welfare of people who use services. The absence of a service level agreement with the local mental health trust is felt to be a major contributing factor.

Senior staff with whom we spoke stated that the trust had made progress in establishing contact points with the mental health trust at associate director level and improving consultant to consultant contact, but that it had been a 'disappointingly slow process'. Throughout our interviews with senior staff, a number of references were made to the difficulties raised by the absence of more formal liaison with other agencies, including the mental health trust, the police, the local authority and ambulance services. We were informed by staff that there are no policies in A&E regarding the specific service provision provided by nurses from the mental health trust. In addition the psychiatric liaison nurses do not have access to the mental health trust computer systems containing patient records.

We were informed through discussions with senior managers that the arrangement for support for people with mental health needs in the hospital had never been formalised but they had been operating on a 'mutual system' with the local mental health partnership trust. This means the mental health partnership provides support to people with mental health needs in hospital and the mental health trust received healthcare from staff at the hospital. This informal arrangement currently comprises liaison between consultants in the two different services. The hospital is working, with support from the primary care trust, to formally commission advice and a service from the local partnership trust. Records of the DoH 'Southend Whole System Urgent and Emergency Pathway Review' recorded that 'the provision of a psychiatric liaison service across the acute hospital has not been commissioned and was therefore provided on a minimal and inconsistent basis'.

The Mental Health Act (MHA) Code of Practice states that 'it is preferable for a person thought to be suffering from a mental disorder to be detained in a hospital or other healthcare setting where mental health services are provided (subject, of course, to any urgent physical healthcare needs they may have). We were informed that police 'routinely' use the A&E department as a place of safety, irrespective of whether the person requires urgent medical treatment and despite the fact that the mental health partnership trust has a designated place of safety, under Section 136, facility at Basildon Hospital's mental health unit.

One specific example we looked at showed that the person concerned had experienced an

18 hour delay in A&E due to the lack of availability of firstly a psychiatrist and then a social worker.

Outcome 7:
Safeguarding people who use services from abuse

People who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

This is because providers who comply with the regulations will:

- Take action to identify and prevent abuse from happening in a service.
- Respond appropriately when it is suspected that abuse has occurred or is at risk of occurring.
- Ensure that Government and local guidance about safeguarding people from abuse is accessible to all staff and put into practice.
- Make sure that the use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual.
- Only use de-escalation or restraint in a way that respects dignity and protects human rights, and where possible respects the preferences of people who use services.
- Understand how diversity, beliefs and values of people who use services may influence the identification, prevention and response to safeguarding concerns.
- Protect others from the negative effect of any behaviour by people who use services.
- Where applicable, only use Deprivation of Liberty Safeguards when it is in the best interests of the person who uses the service and in accordance with the Mental Capacity Act 2005.

What we found for Outcome 7

Our judgement

There are minor concerns with Outcome 7: Safeguarding people who use services from abuse

Our findings

The safeguarding lead in the trust explained that his role is fairly new and is developing. Currently he is looking at restructuring to strengthen safeguarding throughout the trust. The safeguarding lead further explained that, from his perspective, he is aware of local authority processes relating to safeguarding. He is liaising with the local authority and has brought safeguarding information and related documentation back into the trust.

One member of staff with whom we spoke demonstrated a good understanding of processes around safeguarding, such as awareness that referral forms had to be completed and faxed safely to the local authority. The individual also demonstrated a good awareness of their personal responsibilities in recognising signs of abuse and taking appropriate action. The member of staff said that the safeguarding lead was also there for advice. Another member of staff spoken with demonstrated a good understanding of safeguarding children and adults as well as an understanding of issues that may be linked to a person's mental health.

However, when asked about safeguarding, other staff with whom we spoke indicated that the safeguarding lead 'deals with that'. Overall, the level of staff understanding about safeguarding processes and responsibilities was not consistent across areas of the trust visited.

Outcome 10:
Safety and suitability of premises

People who use services:

- Are in safe, accessible surroundings that promote their wellbeing.

This is because providers who comply with the regulations will:

- Make sure that people who use services, staff and others know they are protected against the risks of unsafe or unsuitable premises by:
    - the design and layout of the premises being suitable for carrying out the regulated activity
    - appropriate measures being in place to ensure the security of the premises
    - the premises and any grounds being adequately maintained
    - compliance with any legal requirements relating to the premises
- Take account of any relevant design, technical and operational standards and manage all risks in relation to the premises.

What we found for Outcome 10

Our judgement

There are minor concerns with Outcome 10: Safety and suitability of premises

Our findings

There is evidence that some measures have been taken to improve the premises and reduce risk to people using the service, in particular those with mental health needs, including the introduction of ‘safe rooms’. Window restrictors with ‘Jack-Locs’ (key operated proprietary type cable window restrictors) have been fitted to all windows within identified ‘safe’ side rooms and in other critical locations. This work was completed on 02 August 2010.

There is a comprehensive health and safety inspection checklist for safe rooms. The risk manager told us that he had contributed to the setting up of the safe rooms and developing checklists for the use of these rooms. Some work has been carried out on developing environmental risk assessments but the director of nursing explained that this is a work in progress. The risk manager told us that none of the safe rooms are ligature free but that a risk assessment is carried out before use. However, as the environmental risk assessments are still in the process of being developed and improved, the process is not yet sufficiently robust.

The director of nursing confirmed that there is no process in place for gathering data as to the use of the safe rooms and she was unaware whether the safe rooms on the wards had been used for that purpose, as no log is kept. The risk manager was unaware of whether the safe rooms on the wards had been used or not.

A psychiatric nurse provided by the mental health partnership trust was not aware that specialist nurses from the mental health trust had been consulted about the setting up of the safe room in the A&E department. Senior management staff informed us that specialist nurses were consulted and the mental health trust provided some funding towards the decoration and furnishing of the room. In the safe room in A&E the door opens inwards, which could compromise the safety of an accompanying staff member and there is no panic button if assistance is required. Senior management staff have confirmed that installing double hinges on this door could be considered.

It is evident that further progress needs to be made to the premises and staff awareness of the use of the safe rooms to ensure these are used effectively. There is no robust process in place to assess the effectiveness of the safe rooms.

Outcome 14:
Supporting workers

People who use services:

- Are safe and their health and welfare needs are met by competent staff.

This is because providers who comply with the regulations will:

- Ensure that staff are properly supported to provide care and treatment to people who use services.
- Ensure that staff are properly trained, supervised and appraised.
- Enable staff to acquire further skills and qualifications that are relevant to the work they undertake.

What we found for Outcome 14

Our judgement

There are minor concerns with Outcome 14: Supporting workers

Our findings

The security manager has identified that an understanding around issues relating to mental health is an area in which security staff would benefit from having training.

There was no training for staff in the trust on either understanding or specifically supporting people with mental health needs. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) training is available within the trust although neither is mandatory. Clinical staff with whom we spoke were aware of a policy addressing the Mental Capacity Act although it was of concern to find some clinical staff spoken with did not have an understanding of what Deprivation of Liberty Safeguards meant.

The introduction of the safeguarding lead role has raised awareness amongst staff about issues relating to vulnerable people. However, when asked about safeguarding, a few staff spoken with indicated that they believed the safeguarding lead dealt with such issues and there was only a superficial awareness of their own responsibilities in relation to safeguarding. There is a 'Safeguarding Adults Staff Handbook' available to staff on the trust's Intranet system, which contains a clear flowchart around reporting concerns. Out of three staff we asked about safeguarding vulnerable adults, only one was able to demonstrate a good awareness of the process and their personal responsibilities.

When asked what training they had received about mental health, staff responded that they had received conflict resolution training and how to recognise signs of aggression. One person told us that this is mandatory and all staff attend annually. Information from the management team clarified that this training is not required for all staff across the trust, only for identified groups. However, not all staff spoken with were able to demonstrate an understanding of how to recognise signs that may indicate a service user had issues with mental health. Non-clinical administration staff with whom we spoke stated that training related to mental health was "minimal". One member of staff said there is a lack of training regarding DOLS and the Mental Health Act for staff in the A&E department. We were informed that training set up by the mental health trust nurse in the A&E was poorly attended.

The deputy director of nursing explained that Mental Capacity Act training is offered across the trust and that this training is about to be made mandatory for front-line staff. She explained the trust has just introduced a learning management system which will be able to monitor levels of training to staff groups accurately. Guidance and policies are available on the Internet for staff reference and there is online training available relating to DOLS and safeguarding. In addition the 'Newly Qualified Nurse Induction and Development

Programme' provides a session on Safeguarding, Deprivation of Liberty and Mental Capacity Act. It is recognised that the introduction of mandatory Mental Capacity Act training for all frontline staff should address some of the identified gaps in staff knowledge.

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury Surgical procedures Diagnostic or screening procedures Management of supply of blood and blood derived products etc Maternity and midwifery services Termination of pregnancies Family planning	11	7
	Why we have concerns Staff skills and knowledge about safeguarding were not consistent amongst front line staff.	**The outcome for people that should be achieved** People accessing the service can be confident they are protected from abuse and appropriate action is taken to respond to any suspicion of abuse or poor practice by competent, knowledgeable and well trained staff.
Treatment of disease, disorder or injury Surgical procedures Diagnostic or screening procedures Management of supply of blood and blood derived products etc Maternity and midwifery	15	10
	Why we have concerns There are some concerns relating to the safe rooms, including ensuring that escape routes for staff are clear, looking at how staff can summon assistance if required and ensuring all frontline staff are aware of protocols for using these rooms.	**The outcome for people that should be achieved** People using the service who have mental health needs can be confident that they are in safe surroundings that promote their wellbeing.
	Why we have concerns Add_"what"	**The outcome for people that should be achieved** Add_"why"

services Termination of pregnancies Family planning		

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The report should be sent within 28 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury Surgical procedures Diagnostic or screening procedures Management of supply of blood and blood derived products etc Maternity and midwifery services Termination of pregnancies Family planning	9 **How the regulation is not being met** There are concerns regarding the potential risks to the health, safety and welfare of service users with mental health needs due to delays in assessment and accessing appropriate healthcare professionals for treatment.	4 **The outcome for people that should be achieved** People attending the trust must be assessed promptly and monitored safely at all times both in the A&E department and when admitted to the hospital, to ensure that their physical and mental health needs are met.
Treatment of disease, disorder or injury Surgical procedures Diagnostic or screening procedures Management of supply of blood and blood derived products etc Maternity and midwifery services Termination of	24 **How the regulation is not being met** The absence of a formal service level agreement between the trust and the local mental health partnership has led to gaps in the service people with mental health needs receive, placing them at potential risk of harm.	6 **The outcome for people that should be achieved** The trust must make certain that they have robust processes in place to work collaboratively with other agencies to ensure people using their service receive safe, co-ordinated care.

pregnancies Family planning		
Treatment of disease, disorder or injury Surgical procedures Diagnostic or screening procedures Management of supply of blood and blood derived products etc Maternity and midwifery services Termination of pregnancies Family planning	23 **How the regulation is not being met** Staff in the hospital do not receive sufficient training to provide them with the skills and knowledge to meet the requirements of people with mental health needs.	14 **The outcome for people that should be achieved** Staff must be appropriately trained and supported to enable them to manage the additional challenges presented by people with mental health needs so that service users and others are safeguarded from harm.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.