Sussex Partnership NHS Foundation Trust

Quality Report

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Date of inspection visit: 6, 7, 12 – 16, 20, 22, 29 September 2016 AND Focused follow up inspections: 1 – 4 November AND 7 December 2016
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Core services inspected	CQC registered location	CQC location ID
Community-based mental health services for older people	The Harold Kidd Unit Trust Headquarters	RX240 RX219
Long stay/rehabilitation mental health wards for working age adults	Woodlands Hospital Rutland Gardens Connolly House Shepherd House Amberstone Hospital 78 Crawley Road	RX2L6 RX202 RX237 RX232 RX2F3 RX2DX
Acute wards for adults of working age and psychiatric intensive care units	Millview Hospital Department of Psychiatry Langley Green Hospital Meadowfield Hospital Woodlands Centre for Acute Care Oaklands Centre for Acute Care	RX213 RX2E7 RX2P0 RX277 RX2L6 RX26N
Wards for older people with mental health problems	Harold Kidd Unit Horsham Hospital Salvington Lodge (The Burrowes) St Anne's Centre & EMI Wards Beechwood Unit Meadowfield Hospital Millview Hospital Department of Psychiatry	RX240 RX2C8 RX2A3 RX2K3 RX2L8 RX277 RX213 RX2E7

Summary of findings

	Langley Green Hospital Lindridge	RX2P0 RX2Y5
Community-based mental health services for adults of working age	Millview Hospital Trust Headquarters	RX213 RX219
Mental health crisis services and health based places of safety	Department of Psychiatry Langley Green Hospital Meadowfield Hospital Millview Hospital Woodlands Centre for Acute Care	RX2E7 RX2P0 RX277 RX213 RX2L6
Community mental health services for people with learning disabilities	Trust Headquarters Hove Community Learning Disability Team	RX219 RX2XD
Specialist community mental health services for children and young people	Trust Headquarters	RX219
Wards for people with a learning disability or autism	The Selden Centre	RX2Y6
Child and adolescent mental health wards	Chalkhill	RX2X4
Forensic inpatient/secure wards	The Hellingly Centre Southview Low Secure Unit The Chichester Centre	RX2E9 RX2Y3 RX2X5

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

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Ratings

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

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

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

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Overall summary

We rated Sussex Partnership NHS Foundation Trust as requires improvement because:

- At the last comprehensive inspection of the trust in January 2015 we identified a number of areas where improvements were needed across a number of core services, with five of the 11 core services rated as requires improvement.
- At this inspection four core services were rated as requires improvement. There were ongoing concerns in the acute wards for adults of working age and psychiatric intensive care units, and wards for older people with mental health problems. Physical health monitoring was not taking place following the intramuscular administration of rapid tranquillisation andpatients were prescribed high dose antipsychotics. On the acute wards for adults of working age and psychiatric intensive care units we also identified concerns in relation to the Mental Health Act records and consent to treatment. In the specialist community mental health services for children and young people we identified that there was a lack of risk assessments for some children and young people using the service. This had been identified at the January 2015 inspection and a requirement notice issued. This was an ongoing issue and so we took enforcement action through serving two Warning Notices on the trust to ensure that action was taken to improve these services.
- Some areas identified at the previous inspection still needed to be improved upon from the January 2015 inspection, such as access to psychological therapy for all patients. Progress had been made across the trust to meet the Department of Health guidance on eliminating mixed-sex accommodation. However, on wards for older people with mental health problems there were mixed-sex wards that were not always managed in accordance with Department of Health guidance on mixed-sex accommodation, though risks were being mitigated on a day-to-day basis.
- Within the community services there were long waiting times from assessment to treatment within the specialist community mental health services for children and young people, with Hampshire and Kent as the services with the longest waiting times.
- There was a high level of bed occupancy across the acute wards for adults of working age and psychiatric intensive care units. Patients did not always have a bed to return to following a period of leave and patients were sometimes moved to other wards for non-clinical need, due to the pressures on beds.
- The governance processes had undergone a review and the changes as a result of this were still embedding. As a result of this the systems did not provide sufficient oversight to the board around clinical risks, such as physical health care and medicines optimisation to ensure that patients were not at risk of insufficient care and treatment. It was also unclear how findings from staff surveys, clinical audits and national enquiries were being used to develop the trust.

However:

- At this inspection seven core services were rated as good, which was an improvement on the six rated good following the January 2015 inspection. Three core services had moved from being rated as requires improvement to good at this inspection. These were the ward for people with a learning disability or autism, the long stay/rehabilitation mental health wards for working age adults and the child and adolescent mental health ward.
- Since the last comprehensive inspection of the trust the trust had developed and implemented an action plan for improvement. During this inspection we found that the majority of actions had been implemented and many improvements made to services and people's experiences of these. This was particularly noticeable in the ward for people with a learning disability or autism at the Selden Centre

Summary of findings

and long stay/rehabilitation mental health wards for working age adults, where a number of improvements had been made to make the services safer and enhance the experience of patients.

- Since the last inspection in January 2015 the trust had improved staffing levels to ensure that wards were safely staffed. The majority of staff were caring, kind and respectful towards patients, people who use services and their carers, involving them in decisions about their care. This had an impact on the care planning which, where in place, was generally good.
- Since the last inspection the trust had improved access to physical healthcare and this was kept under regular review. Most areas had access to good physical healthcare support to meet patients' needs.
- The trust had clear information about the cultural diversity of populations across the different areas they served and they sought feedback about people's experience of the care they received and future priorities. The trust had a clear strategy and initiatives to improve people's experience.
- The trust had a patient advice and liaison service that offered advice and support to people wanting to make a complaint.
- The trust responded positively and proactively to concerns identified during the inspection and made marked improvements to the services to ensure patients were kept safe from the risks of medicines.
- The trust had met the fit and proper persons test and there was very positive feedback about the leadership of the trust. The chief executive had had a positive impact on making staff feel more engaged and improving the culture of the trust. Staff felt positive and incorporated the trust values into their work.
- From the 1 - 4 November 2016 we carried out a focussed inspection to follow up the Warning Notice served on the acute wards for adults of working age and psychiatric intensive care units, and wards for older people with mental health problems. At this inspection we identified that the trust had responded positively to the findings in the Warning Notice and significant improvements had been made. The trust had developed an action plan and staff were well aware of this and what they needed to do. The wards were being supported by senior managers, peer review and practice development nurses. The e-learning for physical health monitoring had been updated and all staff were receiving refresher training. The records we viewed showed that consent to treatment paperwork was recorded appropriately. The records relating to physical health monitoring for patients prescribed high dose antipsychotics and following intramuscular administration of rapid tranquillisation medicines demonstrated this was being carried out.
- On the 7 December 2016 we carried out a focussed inspection to follow up the warning notice served on the specialist community mental health services for children and young people. At this inspection we identified that the trust had responded positively to the findings in the warning notice and significant improvements had been made. The trust had developed an action plan to ensure compliance with the trust target of 95% of risk screens completed. We looked at a random selection of 127 care records from 19 teams across Hampshire, Kent and Sussex. Out of the 127 care records we found only 4 risk screenings were missing, this equated to a 97% compliance rate for the records looked at. The trust target was 95%. This demonstrated a significant improvement from our findings in September 2016, where we found only 43% of risk screens having been completed.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- Whilst improvements had been made to the recording of risk assessments, there was a lack of consistent recording of patient risk across the services to ensure risks were recorded, planned for and patients kept safe. This was particularly evident in the specialist community mental health services for children and young people, as not all children or young people had a risk assessment in place. Within the acute wards for adults of working age and psychiatric intensive care units sufficient action had not been taken to support patients at risk of harm to themselves, and further improvements were needed to keep patients safe.
- Staff did not always follow the trust policy around the safe handling of medicines requiring cold storage, which could make the medicines ineffective or unsafe for use.
- Where there were mixed-sex wards in the wards for older people with mental health problems, these were not always managed in accordance with Department of Health guidance on eliminating mixed-sex accommodation, despite risks being mitigated on a day-to-day basis.
- The systems for capturing information of the mandatory training undertaken by staff did not always provide consistent information, where the trust-wide information did not correspond with records held in local services. This meant that the board did not always receive sufficient assurance that staff had received appropriate training.

However:

- The trust had responded positively to the warning notices served and made significant improvements in these areas.
- The wards and other trust buildings from which care was delivered, were generally clean and well maintained across the trust sites.
- The trust had improved staffing levels to ensure that wards were safely staffed.
- Improvements had been made to the management of risk, though further work was will needed in some areas. Though the trust had good overall systems for safeguarding children and adults at risk.

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- The trust was meeting the duty of candour requirements.

Are services effective?

Requires improvement 

We rated effective as requires improvement because:

- Within the specialist community mental health services for children and young people care plans had not been developed by staff for all children and young people. Care plans in this core service were not always personalised or recovery-orientated.
- Access to psychological therapies for people with mental health problems was not consistently provided across the trust, for instance, this was not readily available to all patients in the long stay/rehabilitation mental health wards for working age adults or for all the wards for older people with mental health problems. Within the long stay/rehabilitation mental health wards this was the same situation as at the last inspection of the trust in January 2015.
- The rate of supervision and appraisals of staff across the trust did not ensure that staff were receiving appropriate support in their work.
- Training in the Mental Health Act was lower than the trust target of 65% which could lead to staff not working effectively with patients at risk of harm to themselves or others.

However:

- Where in place, the quality of care planning was generally good.
- There was good access to physical healthcare across the services and this was kept under regular review. Some services had developed service-specific ways to support patients and people using service with their physical health needs.
- The trust used a number of nationally recognised tools and audits to measure and improve the outcomes of patients and people using their services. The Transforming Care Agenda permeated all the work we observed in the learning disability inpatient and community services.
- Implementation of the Mental Capacity Act was good across the services.

Are services caring?

Good 

We rated caring as good because:

Summary of findings

- We rated all of the core services good for this domain, apart from the child and adolescent mental health wards, which we rated as outstanding. This was because people were treated with kindness and respect and generally involved people in their care.
- We observed many examples of positive interactions where staff communicated with people in a calm and professional manner.
- The trust incorporated national initiatives undertaken to seek feedback about people's experience of the care they received.

However:

- There were occasions where improvements were needed to ensure that patients were treated with dignity and respect at all times.

Are services responsive to people's needs?

Good

We rated responsive as good because:

However:

- Generally, the inpatient facilities promoted the independence of people, through areas such as access to outside areas and menu choices.
- The trust had clear information about the cultural diversity of populations across the different areas they served which enabled them to focus work and compare the staff profile of the trust to the local population demographics. This helped them to see how it reflected the diversity of the population it served.
- The trust had a patient advice and liaison service that offered advice to people about making a complaint and handled the initial query before passing it to the complaints team.
- Within the community services 13 failed to meeting national targets of referral to assessment time, of which 12 were specialist community mental health services for children and young people. The five services with the longest waiting times from assessment to treatment were all specialist community mental health services for children and young people, with Hampshire and Kent as the services with the longest waiting times.
- The crisis team did not operate 24 hours a day seven days a week. Between 9.30pm and 7am people who used the service would need to access support via the trust-wide mental health line or by attending accident and emergency departments.

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- There was a high level of bed occupancy across the acute wards for adults of working age and psychiatric intensive care units. High bed occupancy meant that patients who were on leave from the ward did not have a bed to return to if they needed to urgently access care and treatment. Patients did not want to have leave for fear of not having a bed to return to. Also, when patients returned to the ward after leave, they were sometimes referred out of area or to other wards were there was bed availability.
- Patients in the acute wards for adults of working age and psychiatric intensive care units were sometimes moved to other wards for non-clinical need, due to pressures on beds.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The governance processes had undergone a review and the changes as a result of this were still embedding. Senior managers were not always clear how risk information was escalated to the board. It was also unclear how staff survey findings, clinical audits, national confidential inquiry trust reports were being used to develop the trust.
- The trust governance systems did not provide sufficient oversight to the board around clinical risks, such as physical health care, physical health monitoring, risk assessment and medicines optimisation to ensure that patients were not at risk of insufficient care and treatment.

However:

- The trust responded positively and proactively to concerns identified during the inspection and made marked improvements to the services to ensure patients were kept safe from the risks of medicines.
- Directors and managers demonstrated commitment and enthusiasm to the trust and spoke passionately of the work being undertaken to develop services.
- The trust had a clear strategy and initiatives to improve people's experience. The trust had consulted about future priorities with people who use services and the public.
- The trust had met the fit and proper persons test.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: James Warner, Consultant Psychiatrist and National Professional Advisor for Old Age Psychiatry

Team Leader: Natasha Sloman, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Louise Phillips, Inspection Manager, mental health hospitals, CQC

The team included seven inspection managers (one from adult social care); 14 inspectors; three Mental Health Act reviewers; two assistant inspectors; a pharmacy inspector; five experts by experience; support staff and a variety of specialists. The specialists included senior managers, consultant psychiatrists, specialist nurses in mental health and learning disabilities, a pharmacist, psychologists, occupational therapists and social workers.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit the inspection team:

- Requested information from the trust and reviewed the information we received.
- Asked a range of other organisations for information including NHS Improvement, NHS England, clinical commissioning groups, HealthWatch and the Royal College of Psychiatrists.
- Sought feedback from patients and carers through social media and reaching out to user and carer groups.
- Received information from patients, carers and other groups through our website.
- Held focus groups with the trust governors and non-executive directors, union representatives, clinical commissioning groups, nurses, health care assistants, black and minority ethnic staff and managers and local authorities.
- Observed a trust board meeting and a quality and safety committee meeting.

During the announced inspection visit from the 6, 7, 12 – 16, 20 September, and unannounced inspections on the 22 and 29 September; and focussed follow up inspections on the 1 – 4 November and 7 December 2016 the inspection team:

- Visited 76 wards, teams and clinics.
- Spoke with 257 patients and people using services or their relatives and carers, either in person or by phone.
- Looked at the care and treatment records of more than 601 patients (208 of these were looked at during the focussed follow up inspection).
- Collected feedback from 173 patients, carers and staff using comment cards.
- Joined 7 patient meetings/ groups.

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- Spoke with 89 ward and team managers (15 of these were spoken with during the focussed follow up inspection) and more than 420 staff members (4 of these were spoken with during the focussed follow up inspection).
- Attended and observed a minimum of 48 multi-disciplinary meetings, including care reviews, handovers and risk meetings.
- Held 11 focus groups attended by 72 staff or stakeholders.
- Interviewed 27 senior staff and board members.
- Joined care professionals for 12 home visits and clinic appointments.
- Carried out a specific check of the medication management across a sample of wards and teams.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Requested and analysed further information from the trust to clarify what was found during the site visits.
- Had a tour of the premises at each location.

We visited all of the trust's hospital locations and a sample of community mental health services. We inspected all wards across the trust including adult acute services, the psychiatric intensive care unit, the forensic wards and older people's wards. We looked at all of the trusts' health based place of safety under Section 136 of the Mental Health Act. We visited a sample of adult community mental health, crisis, learning disability, children and young people community mental services and older people's community services.

Information about the provider

Sussex Partnership NHS Foundation Trust provides mental health services in Sussex and specialist community mental health services for children and young people into Hampshire and Kent and Medway. Within Sussex the trust serves a population of approximately 1.6 million people and employs approximately 3840 staff. Sussex Partnership NHS Foundation Trust became a foundation trust in 2008.

There are 612 inpatient mental health beds and 27 locations registered with the Care Quality Commission. These include two adult social care services and primary medical services for HMP Lewes and HMP Ford.

The trust provides the following 11 mental health core services:

- Acute wards for adults of working age and psychiatric intensive care units.
- Child and adolescent mental health ward.
- Forensic inpatient/secure wards.
- Long stay/rehabilitation mental health wards for working age adults.
- Wards for older people with mental health problems.
- Wards for people with a learning disability or autism.
- Mental health crisis and health-based places of safety.
- Community-based mental health services for adults of working age.
- Community-based mental health services for older adults.
- Community-based mental health services for people with a learning disability or autism.
- Specialist community mental health services for children and young people.

During this inspection we did not inspect the primary medical services or adult social care services provided by the trust.

The Care Quality Commission has inspected Sussex Partnership NHS Foundation Trust 21 times since registration. The last comprehensive inspection of the trust took place from the 12 – 16 January 2015, the trust was rated as requires improvement. The five domains were rated as follows:

- Safe - Requires Improvement
- Effective - Requires Improvement
- Caring - Good
- Responsive - Requires Improvement
- Well Led - Requires Improvement

Summary of findings

The January 2015 inspection was an announced visit and there were a number of actions that the trust was informed they must or should make to improve. Areas where they were informed they must improve included medicines management being conducted in accordance with trust policies; ensuring staff were appropriately trained; improving the effectiveness of the links between corporate and local governance processes; reviewing the provision of gender segregated facilities on the wards; the trust meeting the fit and proper person test, capacity assessments completed and the mitigation of ligature risks on the young person's ward. We identified that there was some good practice taking place in core services, with some rated as good overall, such as community-based mental health services for older people; community-based mental health services for adults of working age; and forensic inpatient/ secure wards. However, improvements were needed in the core services of: long stay/rehabilitation mental health wards for working age adults; acute wards for adults of working age and psychiatric intensive care units; wards for older people with mental health problems; wards for people with a learning disability or autism; specialist community mental health services for children and young people; and the child and adolescent mental health wards.

At this inspection we found that the trust had taken action on all areas and the majority of regulatory breaches met.

Where these had not been met we have taken enforcement action to ensure the trust makes improvements to services. These findings are highlighted later in this report and detailed in the core service reports.

On 25 - 26 January 2016 we undertook an unannounced follow-up inspection of the wards for older people and rated this core service as 'requires improvement'. The three domains inspected were rated as follows:

- Safe - Requires improvement
- Effective - Good
- Well Led – Good

The trust was informed they must ensure that the wards complied with the Department of Health requirements for eliminating mixed sex accommodation requirements.

The CQC undertook 22 Mental Health Act reviewer visits between 8 July 2015 and 8 July 2016, all of which were unannounced. There were 141 issues in total identified at location across the trust. These were followed up as part of this inspection. The issues included lack of respect to patients, participation and use of least restrictive practices. In March 2016 we undertook a thematic review, which focused on the use of seclusion and long term segregation. This identified concerns in the environment and physical health monitoring following rapid tranquilisation.

What people who use the provider's services say

We received feedback from people using the service of the trust via 173 comment cards from 32 sites across the trust. Of these, 45% were positive in nature, 23% were negative and 23% were of a mixed sentiment. Unfortunately 9% were not relevant due to being blank or not having comments in relation to the trust, site or care received.

Overall, the main positive findings were:

- 15 locations had comments around the clean and hygienic care environments; St Mary's house, Selden Centre, New Park house, New Haven rehab centre, St Raphael ward, Connolly house and south lodge, Oak park, Highmore, Woodlands, East Brighton Community mental health centre, George Turle House, Aldershot centre for health, Cavendish house, Bellbrook centre and Ashurst children's centre.
- 14 locations has comments saying patients were treated with dignity and respect; St Mary's house, Selden Centre, Stockbridge, Connolly house and South lodge, Department of Psychiatry, Highmore, Shepherd house, Woodlands, East Brighton community mental health centre, Millwood, George Turle house, Bedale centre, 78 Crawley road, Bellbrook centre, and Chapel street clinic.
- Seven locations had comments saying that patients felt listened to by staff; Seldon centre, Stockbridge, St Raphael ward, Oak Park, Oaklands, Highmore and Shepherd house.
- Three locations had comments saying that there was good availability of amenities and activities; Shepherd house, Meadowfield and Chapel St Clinic.

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- Two locations had comments praising the availability of appointments; St Mary's house and Stockbridge.

The main negative findings were;

- Eight locations had comments around poor communication or not being listened to; St Mary's House, New Park House, Oaklands, Chalkhill, Highmore, Woodlands, Cavendish house and Chapel St Clinic.
- Six locations had comments reporting poor availability and upkeep of amenities; Oak Park, Woodlands, George Turle House, Meadowfield, Chapel St Clinic and Ashurst Children's centre.
- Four locations had comments regarding unfriendly or rude staff; St Mary's house, Oaklands, Department of Psychiatry and George Turle House.
- Two locations had comments regarding long referral to treatment waiting times; Stockbridge and New Park House.

We received feedback from two HealthWatch teams who provided us with general feedback and details of their 'enter and view' visits.

During the inspection the teams spoke with 257 patients and people using services or their relatives and carers, either in person or by phone. Most of the feedback we received was positive and patients found the staff were friendly, committed, caring and respectful. The majority of patients on the acute wards for adults of working age and psychiatric intensive care units said they felt safe, and that where the behaviour of other patients made them feel unsafe the staff did everything they could to manage the situation.

We rated one core service as being outstanding in the caring domain. This was the child and adolescent mental health ward. This was partly due to staff demonstrating a real commitment to delivering good care and the importance of recognising young people as individuals, all with different needs. The care plans were developed in partnership with young people and the staff responded well to patients' requests to make the environment more welcoming for transgendered young people.

However, we also found that improvements were need in some services. Some patients on the forensic/ secure inpatient wards said that not all staff knocked on their bedroom door before entering. Some patients in the acute wards for adults of working age and psychiatric intensive care units told us that not all bank and agency staff were responsive to their needs. In the specialist community mental health services for children and young people there was negative feedback around waiting times once a referral had been accepted. We heard on numerous occasions that getting an appointment took a very long time.

Good practice

- The Badgers Café at the Hellingly Centre was a patient run café for staff and patients to use. Staff supported and encouraged patients to participate in the running of the café. The patients were proud of their achievements in running the café, which improved their self-esteem and promoted their recovery.
- The forensic inpatient/secure wards ran a risk clinic for patients to be involved in their own risk assessment and risk planning. Staff invited patients to attend a risk clinic two weeks prior to their care programme approach meeting so they understood the rationale for the risk assessment and planning, and could be involved in discussing their own risks. This approach gave patients ownership of this element of their treatment and care.
- The forensic/ secure inpatient wards observation policy and practice was thorough and robust. Staff had to complete a skills and knowledge assessment before being permitted to complete patient observations. Each observation required staff to record how they had interacted with the patient and each observation clipboard had a digital clock in built so that all observations were recorded accurately using the same clock. The clock was set to the same time as the CCTV so that incidents could be reviewed if necessary. The clipboard also had basic physical health warnings and action plans so that staff could be vigilant to patient's physical as well as mental health. The charge nurse

audited the observation recording sheets twice per shift, and these were audited weekly by the ward managers to ensure staff were compliant with the policy.

- On the ward for people with learning disabilities or autism the staff had developed a pictorial tool to support patients' to feedback their feelings after they had been restrained. Staff used this feedback to develop their understanding of patients and how to support them.
- In the community services for people with a learning disability Staff were committed to providing effective services for people with a learning disability across all the teams we inspected. The Transforming Care Agenda permeated all the work we observed. Staff reported numerous initiatives and good working practices to improve services for people with a learning disability. The recovery college ran a course specifically for people with a learning disability. This is only one of two courses in the whole of the country. The trust are accredited with the British Institute of Learning Disability to deliver training on positive behaviour support and when indicated training on the use of physical interventions.
- Brighton and Hove community learning disability team and Hastings and Rother community learning disability team offered a sexual offenders group for people with a learning disability that was accredited with the sex offenders treatment service collaborative. The parenting team have been accepted for one of three sites for positive practice in support of parents with a learning disability. The Norah Fry Institute hosted by Bristol University was sponsoring the project.
- There had been a significant reduction in the use of crisis services since the Lighthouse service had opened three years ago.
- The Lighthouse recovery support service had a lesbian, gay, bisexual, transgender, queer or questioning (LGBTQI) group and were reviewing how they could engage other minority groups The group treatment service had links with LGBTQI community groups. People who used services at the Lighthouse recovery support service were involved in the reference group to set up the service. They were also involved in staff recruitment. The Lighthouse recovery support service held a monthly carers group and held a twice yearly friends and family day.
- Cavendish House adult community team had set up a 'Wisdom on Wednesdays' doctors academic session for staff. This was linked to the National Institute for Health and Care Excellence (NICE) guidance. Topics discussed included managing expectations and good endings, family interventions and personality disorders.
- The rapid response service is linked to the Stay Alive app. The app is full of information to help people stay safe.
- The trust had participated in a pilot project called the "Golden Ticket". The aim of the Golden Ticket' was to promote physical and emotional wellbeing and support the basic needs of a person living with dementia and of their carer. This included comfort, attachment, identity, love,inclusion and meaningful occupation and activities. It 'prescribes' a best practice framework for post-diagnosis care and support for people with dementia and their carers. It aims to embed psycho-social support as a health imperative for Living Well with dementia, promote interagency working and support the patient and carer. Sussex Partnership NHS Foundation Trust had contributed with other stakeholders to the development of this new model of care which won the Health Foundation's Award for Innovation in 2015.
- The trust had an award for proactive ideas. The Living Well team at Linwood were recently nominated for this award for their work with dementia alliance on producing "twiddle mitts". These are memory mitts which people can hold and 'twiddle', helping to reduce anxiety and promote calm. Staff told us that this was a whole team effort and that their desire was to promote awareness of dementia in their community and to make it "dementia friendly".
- The Department of Psychiatry provided an urgent care lounge. This gave people, presenting to accident and emergency departments with mental health issues in

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East Sussex, a calm area to wait for assessments. It had been well received and the trust had secured £630,000 to provide similar facilities in four other hospital sites.

- Street triage was in operation in four areas of Sussex. It had started as a pilot scheme in October 2013 in Eastbourne and had gradually been commissioned throughout the county.Street triage consisted of mental health professionals working alongside police officers. They provided on the spot advice to police officers who were dealing with people with possible mental health issues. Street triage had significantly reduced the occurrences of people with mental health issues being taken into police custody. It had also reduced overall use of people needing to be taken to a health-based place of safety as skilled staff were able to assess risks and offer less restrictive options.
- At Rutland Gardens there was a Sacred Space and a Spirituality Champion who offered all patients a spirituality assessment and care plan
- At Bramble Lodge the occupational therapy technician was a qualified gym instructor and had developed links with the local council run gym who offered discounted fees and inductions for patients.
- Shepherd House offered a programme called 'Albion In The Community' a football group run in conjunction with Brighton & Hove Albion FC.This group was facilitated by a support worker at Shepherd House and open to all patients.
- At Shepherd House and Amberstone the services were offering community titration of clozapine therapy. This was based on evidence that appropriate use and management of clozapine reduces suicide rates and violence in patients with psychosis and to reduce incidence of antipsychotics polypharmacy. This in turn is linked to a reduction in bed usage for patients with psychosis.
- Chalkhill child and adolescent mental health ward worked pro-actively with the urgent help service to prevent admission of young people and offered intensive care at home.
- The psychologist on Caburn acute ward for adults of working age and psychiatric intensive care units had developed a 'therapeutic keyring' containing distraction activities and emergency contact numbers to support patients when they were distressed or experienced post traumatic flashbacks.
- Open ward environments on Maple, Rowan and Oaklands acute wards for adults of working age and psychiatric intensive care units were an example of least restrictive practice. The ward used research published in the Journal of Psychiatric and Mental Health to underpin their open ward policy.
- Hampshire child and adolescent mental health service had employed an innovation worker in order to enhance the delivery of services using innovation and creative ideas. There were several examples of innovation to engage with schools, families and young people using initiatives such as FITFEST, CARE and creating an app for phones and tablets. There were future plans to provide information events to communities. There were participation workers in place throughout the trust who were working directly with young people and their families to change the service using their experience.
- Hampshire had set up a single point of access into the service. The single point of access was a result of recommissioning so that they could provide a single route into the Hampshire service through one phone number. This allowed referrers such as GP's to submit electronic referrals and phone up for advice about whether a referral was relevant. The single point of access had developed to include tier two services such as substance misuse and counselling who could pick up referrals not relevant to CAMHS.
- Within the wards for older people with mental health problems, the Brunswick ward manager held a weekly family forum, which was initially set up with support from the Alzheimer's Society. Grove ward had a care home in-reach proactive care programme, to try and reduce admissions.
- Within the core service reports there are more good practice points noted.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

Provider:

- The trust must ensure that each patient or person using the service has a complete, and updated risk assessment.
- The trust must ensure staff are following trust policy around the safe handling of medicines requiring cold storage, to ensure these are safe for use.
- The trust must ensure there are sufficient systems to monitor the training, appraisal and supervision of staff working across the services to ensure staff receive the appropriate level of support in their work.
- The trust must ensure the governance systems provide sufficient oversight to the board around clinical risks, such as physical health care, risk assessment and medicines optimisation to ensure that patients are not out at risk of insufficient care and treatment.

Core services:

Mental health crisis services and health-based places of safety:

- The trust must ensure that mandatory training is sufficiently available to meet staff demand.

Wards for older people with mental health problems:

- The trust must take action to ensure that wards comply with the Department of Health mixed-sex accommodation requirements. This applies to five of the 11 wards we inspected.
- The trust must ensure that all the required checks and tests are undertaken for patients taking high dose antipsychotic medicines and the monitoring forms are fully completed.
- The trust must ensure staff are given annual appraisals and regular supervision.
- The trust must ensure that all of its older adult inpatient wards have access to psychology.

Community-based mental health services for adults of working age:

- The trust must ensure staff complete comprehensive and detailed risk assessments, which are reviewed regularly, for people who use services.
- The trust must ensure that staff complete mandatory training to enable them to fulfil the requirements of their role.
- The trust must ensure staff complete training in the Mental Capacity Act, Deprivation of Liberty Safeguards and the Mental Health Act so that staff can effectively use the legislation with confidence to protect people's human rights.

Specialist community mental health services for children and young people:

- The trust must ensure that the waiting lists are reduced to allow young people treatment within the 18 week target. The waiting list at Eastbourne showed that there was a delay in care being provided to young people accepted into the service. There were delays of up to 610 days for young people needing therapy. The demand on the service was not being met, meaning that there was an increased risk to young people due to the delay in accessing treatment. We spoke with parents and staff who felt that the delay in accessing the service was incredibly stressful for them.
- The trust must ensure that all young people are risk assessed and a risk management plan developed where relevant.

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

- The trust must ensure that medicines and equipment are in date and in working order.
- The trust must ensure that medicines prescribed to people detained under the Mental Health Act are documented and include the route of administration and the maximum dose to be administered.
- The trust must ensure that mandatory training compliance across all subjects meets the trust's compliance targets. This was a requirement following our inspection in January 2015.

Summary of findings

- The trust must ensure that all patient risk assessments are updated and patients at risk of harm to themselves are kept safe.
- The trust must ensure that patients on Amber ward have access to phones to make calls in private while on the ward.
- The trust must ensure that sufficient action is taken to manage ligature risks to patients.

Action the provider SHOULD take to improve

Provider:

- The trust should ensure staff are following trust policy around the checking of controlled drug stock balances.
- The trust should ensure that staff learn from incidents and change practice to reflect updated policies and procedures, by monitoring the effectiveness of their method of communicating those changes.

Forensic inpatient/secure wards:

- The trust should ensure all staff to knock on patients' doors and wait for a response before entering. This is to maintain the privacy and dignity of patients.

Community mental health services for people with learning disabilities:

- The trust should improve its learning from incidents.
- The trust should ensure all records have people have a crisis plan.
- The trust should improve ways to gain feedback from people using the service.
- The trust should ensure consistent procedures are in place for recording in care notes.

Mental health crisis services and health-based places of safety:

- The trust should ensure that crisis teams support people to produce individualised plans that they can refer to when in crisis or relapsing.
- The trust should ensure that physical health monitoring equipment is regularly calibrated.
- The trust should ensure that crisis teams approach early discharge with consistency across the service.
- The trust should ensure that generic information provided to people is consistent across the trust.
- The trust should ensure that all clinical staff are receiving regular supervision.
- The trust should ensure that people in health-based places of safety do not experience delays that exceed timescales recommended in The Mental Health Act Code of Practice.
- The trust should ensure that Mental Health Act documentation is completed fully and accurately.
- The trust should consider how they could provide a more accessible service to people experiencing mental health crisis outside normal working hours.
- The trust should ensure that crisis teams have a uniform approach to supporting people who are not engaging with the service.
- The trust should ensure that important information, such as outcomes of audits and innovative practice, is shared across all teams offering the same service within the trust.

Community-based mental health services for older people:

- The trust should ensure that progress in improving the frequency of staff supervision and completing all staff appraisals is monitored.
- The trust should ensure that all staff have completed their mandatory training.
- The trust should ensure that all staff complete Mental Health Act and Mental Capacity Act training.
- The trust should review the disabled toilet facilities in one location.
- The trust should ensure that all care records contain evidence of discussion of consent and capacity issues.
- The trust should ensure that planned audits of care records are undertaken.

Wards for older people with mental health problems:

Summary of findings

- The trust should ensure that all of its older adult inpatient services have access to prompt specialist nursing services such as nutritional support, tissue viability, podiatry or diabetic services.
- The trust should consider how bank and agency staff can be given access to be able to update notes and upload data onto the electronic notes system.
- The trust should ensure section 17 leave forms are sufficiently detailed regarding conditions of leave.
- The trust should ensure the ligature risk assessment on Meridian ward details how risks are to be mitigated.
- The trust should make sure that therapeutic activities and access to occupational therapy are consistently and equally available across all older adult inpatient wards.

Community-based mental health services for adults of working age:

- The trust should ensure that people who use services are involved in their care planning and that all relevant information is recorded in care records so they are accurate and up to date.
- The trust should ensure that staff explain rights under the Mental Health Act to people who are subject to a community treatment order.
- The trust should ensure that staff use appropriate and safe methods to transport medicine and ampoules.
- The trust should ensure that staff follow policy regarding medicines management and record fridge temperatures daily.
- The trust should ensure effective communication regarding discharge planning for people who use services.
- The trust should ensure that learning of all incidents is effectively shared with staff.

Specialist community mental health services for children and young people:

- The trust should ensure that all toys within the CAMHS service are cleaned regularly. The toys at several sites we visited appeared to be dirty and there was no cleaning rota. Inspection staff found dirty toys on the floor in therapy rooms and in reception areas. The provider should ensure that toys are cleaned regularly to prevent any infection control issues.
- The trust should ensure that all incidents are reported. Staff within the service told us that they would only report more serious incidents and trends amongst the young people. This meant that that lower level incidents were not being reported on the system and that trends across the wider service could be missed. For example, staff did not report individual incidents of self-harm among the young people on their caseload.
- The trust should ensure that electrical appliances are safety tested. We found that electrical appliance testing was overdue at the sites we visited.
- The trust should ensure that there is oversight of supervision. There was lack of knowledge amongst the management team about who was up to date with supervision.
- The trust should ensure that staff are properly equipped with alarms in the therapy rooms to ensure they are able to call for assistance.
- The trust should review the appropriateness of the clinic room at the Eastleigh site as the one staff used when we carried out our inspection was not fit for purpose.
- The trust should ensure that the physical monitoring equipment is regularly calibrated at all sites.

Long stay/rehabilitation mental health wards for working age adults:

- The trust should consider carrying out the requested works to mitigate high risk ligature points at Connolly House in a timely manner.
- The trust should consider how it will respond to the patient's requests to have more separation between the male and female corridors at Connolly House. The trust should consider how it will respond to comments from the two female patients at Connolly House that the female shower cubicle was small and difficult to access which meant they used the wet room in the male corridor.

Child and adolescent mental health wards:

Summary of findings

- The provider should ensure that there are familiar staff on shift at night time and at least one permanent member of the staff team.
- The trust should ensure work is carried out to ensure the action plan identified from the Mental Health Act Reviewer visit for the seclusion/s136 suite is implemented.

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

- The trust should resolve its staff shortages. This was a recommendation following our inspection in January 2015.
- The trust should ensure that all the required checks and tests are undertaken for patients taking high dose antipsychotic medicines and the monitoring forms are fully completed.
- The trust should continue to embed the recording of observations of patients' health following administration of intramuscular doses of medicines as rapid tranquilisation.
- The trust should ensure that medicines prescribed to people detained under the Mental Health Act are documented and include the route of administration and the maximum dose to be administered.
- The trust should ensure that all Mental Health Act treatment authorisation certificates are attached to patients' prescription charts.
- The trust should ensure all agency, bank and substantive staff receive the trust's prevention and management of violence and aggression training.
- The trust should ensure that the mattress is fixed to the wall and the two way communication system is fixed in the seclusion room on Amber ward.
- The trust should ensure that staff are trained in search techniques.
- The trust should ensure that patients' care plans are recovery focused.
- The trust should ensure that all agency and bank staff, where appropriate, have training and access to the care notes electronic recording system.
- The trust should ensure that all patients receive a copy of their care plan.
- The trust should ensure there are a variety of activities available for patients including weekends.

Sussex Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

- The Mental Health Act was mandatory training for staff, with an unambitious trust target rate of 60%completion. At the time of the inspection only 62% of staff had completed this training. This meant that not all staff had a working knowledge of the Mental Health Act and associated code of practice (amended in 2015). This may lead to staff not having essential knowledge to work effectively with people at risk to themselves or others.
- Administrative support and legal advice on the implementation of the Mental Health Act and the associated code of practice was available from the central Mental Health Act office. A 2015/16 trust-wide audit showed a 59% compliance rate with the Mental Health Act (MHA) policy. This did not meet their target of 100% and indicated risks both to the rights of the patients and to the trust. The audit checked if there was evidence of consent to treatment, where appropriate, on patient files. The ward managers carried out regular audits to ensure the Mental Health Act was being implemented correctly.
- The Mental Health Act documentation we viewed on the mental health wards was generally completed appropriately. The exceptions were in the ward for people with a learning disability or autism where the staff needed to ensure that they assessed patients' capacity to consent fully and act upon these assessments appropriately. On Opal ward for older people with mental health problem, the section 17 leave forms did not specify leave parameters so it was not always clear what leave patients could take. In the mental health crisis services and health-based places of safety there were some gaps around recording the time that Section 12 doctors and approved mental health professionals had been contacted or arrived. There were gaps in recording that the person had their rights explained to them. We also found that on occasions Mental Health Act assessments did not commence within three hours of the person arriving at a health-based place of safety. This exceeded recommendations in the Mental Health Act code of practice. We were told that this target was not always met due to availability of approved mental health professionals and section 12 doctors. Within the acute wards for adults of working age and psychiatric intensive care units, improvements were needed to the recording of consent to treatment and capacity. This included improvements to ensuring the appropriate consent forms were attached to medicine charts to inform staff of what medicines the patient consented to.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust expected staff to undertake training in the Mental Capacity Act and Deprivation of Liberty Safeguards. It had set an unambitious trust-wide target

that 65% of staff would undertake the training. The training was provided through an e-learning package, designed by the trust lead for this area. The compliance rate for staff having received training in this was 68%.

- There was a generally good implementation of the Mental Capacity Act across the services. Staff from each core service had a clear understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. The records indicated that decisions were made in the best interests of the patients. On the wards for older people with mental health problems best interest meetings were held for patients who might need covert administration of medicines and paperwork was completed appropriately and reviewed monthly. Some patients, who did not have the mental capacity to make decisions for themselves, were having their medicines administered covertly (disguised in food or drink). However, on Grove and Meridian wards we found staff were not always following the trust policy with regard to recording decisions made in people's best interest or reviewing those decisions on a regular basis to ensure they were still appropriate.
- The Mental Capacity Act does not apply to young people under the age of 16. For children under the age of 16, their decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke with in the children and young person mental health community teams and inpatient ward were conversant with the principles of Gillick and used this to include the children and young people where possible in the decision making regarding their care.
- Staff in the trust had made 151 applications for Deprivation of Liberty Safeguards between January and July 2016. Of the applications, 92 had been granted. Applications were highest in the older people mental health wards with 94% emanating from the service. However, during the same time period the Care Quality Commission had only been notified of four applications.
- The trust had carried out a recent clinical audit of capacity to consent. The findings of this showed that documentation of the Mental Capacity Act procedures was presenting a risk to the trust and to the patients. This was due to their being a 59% total compliance with the completion of the documentation to evidence that the assessments had been carried out (an increase of 9% since 2014/15). In response to these findings the teams involved have been completing weekly re-audits of capacity to consent in order to make rapid improvements in this area. Emphasis had also been put onto ensuring staff were trained in the Mental Capacity Act and the completion of records on the electronic care records system.

Requires improvement

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Our findings

Safe and clean environments

- The services provided by the trust were across different sites, with the majority of mental health inpatients services provided at Langley Green Hospital, Millview Hospital and Meadowfield Hospital. However, the older people inpatient wards were spread across Sussex, with 12 wards located at 11 different locations. There were 185 community sites providing community mental health services across Sussex, Hampshire and Kent.
- The inpatient and community sites visited by the inspection team were generally well maintained. Where issues had been identified these had been reported and were awaiting repair. However, within the specialist community mental health services for children and young people we found that whilst the majority of sites were child friendly, those at Horsham, Brighton and Hove, and Hastings the entrances and some waiting areas were shared with adult services, which did not promote a safe and welcoming environment for the young people.
- At the last inspection of Chalkhill child and adolescent mental health ward in January 2015 a requirement notice was issued as the trust had failed to ensure that risks to patients from ligature points had been identified, assessed and works taken to address these. At this inspection we found that this had been addressed to make the environment safer for young people. On the other inpatient wards, staff had carried out ligature risk assessments which detailed specific actions to mitigate the risks identified. On the Coral acute ward for adults of working age a ward ligature risk map was displayed in the ward manager's office as a visual reminder to staff of ward risk points. On each ward patients were clinically risk assessed to determine the level of staff observation required to manage their safety on the wards. However, despite improvements, shortly prior to the focussed follow up inspection a serious incident occurred where a person died following the use of a ligature point on an acute ward for adults of working age. This meant that further improvements were needed to ensure that patients were not put at risk.
- There were alarms on the wards so that patients could summon assistance when needed or in an emergency. Interview rooms in most of the community teams we visited were fitted with alarms so that staff could summon assistance if needed. However some of the rooms in which staff from the specialist community mental health services for children and young people interviewed patients did not have an alarm, nor did one room at Brighton and Hove community-based mental health service for older people. The alarm in the disabled toilet in Brighton and Hove community-based mental health service for older people was located by the door and not accessible if using the toilet. The light in this room also automatically went out after a few minutes. This could put people at risk of falling.
- Two of the five health-based places of safety had blindspots and staff mitigated risks through close observation when people were being nursed in the area. We were also shown refurbishment plans for both to make them safe once an appropriate contingency plan for covering the facilities had been established. In the acute wards for adults of working age and psychiatric intensive care units we found that nine out of the 12 wards had blind spots. The potential risks were mitigated by staff patrols and observation levels which were adjusted depending on patient and ward risk.
- At the time of the last two inspections of the trust, some wards did not comply with Department of Health guidance on the elimination of mixed-sex accommodation. During this inspection, where there were mixed-sex wards, such as at Chalkhill child and adolescent mental health ward, positive progress had been made and these were managed appropriately. However, on the wards for older people with mental

health problems there were four of the 11 wards that still did not comply with the guidance. For example, on St Raphael ward female patients had to walk past the male bedrooms to use the bathroom facilities. On The Burrowes male patients had to walk past female bedrooms in order to access the bath or shower room and there was no female only lounge on the ward. Following the CQC inspection of the wards for older people with mental health problems in January 2016 the trust made a commitment to set the wards up as single-sex units. Since the time a number of wards have become single-sex and there was ongoing work to address this, though not a definite timescale for completion. On all wards there were plans in place to mitigate risks of mixed-sex accommodation on a day-to-day basis.

- Patient-Led Assessment of the Caring Environment assessments are self-assessments undertaken by teams of NHS and private/independent health care providers and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness. In the 2016 patient-led assessment the trust scored 97% for cleanliness. The trust scored higher than the England average of 98% for 11 of the 22 sites, of these sites, seven scored 100%.
- At the last inspection improvements were needed to the cleanliness of the long stay/rehabilitation mental health ward for working age adults at Rutland Gardens. This had been addressed and the service maintained in a clean and hygienic way. Teams across the trust had infection control leads and there were posters reminding staff of the safest way to wash their hands and minimise risk of infection. The ward and community environments were clean and well maintained.

Safe staffing

- The trust employed approximately 3840 staff. During the 12 month period to end of March 2016, 536 staff had left the trust. At the time of the inspection 12% of all staff posts were vacant. The majority of these vacancies were for nursing posts, with 209 whole time equivalent qualified nurse vacancies and 183 healthcare assistant vacancies. The highest number of qualified nurse vacancies was on the ward for people with learning disabilities or autism at the Selden Centre, which had 57% vacancies. The crisis and health based place of safety teams had the highest nursing assistant vacancies with 48%. Managers of the Selden Centre ensured that patients received support from suitably qualified agency staff who they knew and used regularly. These nurses were block bookedfor long periods of time to maintain consistency.
- At the last comprehensive inspection of the trust in January 2015 we identified that the trust needed to ensure that safe staffing levels were maintained on the wards. On this inspection we found there were vacancies across some of the teams we inspected. Temporary staff were used to cover shortfalls in an attempt to maintain a consistent level of service. However, the Woodlands health-based place of safety occasionally was unable to accept people due to a lack of available staff. To help with this, the street triage service in East Sussex was able to accept people into health-based place of safety to ensure that staffing issues did not impact them using available facilities.
- In the 12 month period leading up to the end of May 2016 there were 6258 shifts covered by agency or bank staff. During this period 569 shifts were not covered by bank or agency staff. The trust monitored the use of bank and agency staff, which included monitoring the reason for the request to ensure this was appropriate. Staffing levels were increased dependent upon the acuity of need on the wards, for example wards with higher levels of close observation, or to support escorted leave on the mental health wards.
- The overall staff turnover rate for the trust was 14%. The highest turnover rate by core service was the learning disability and acute wards/ psychiatric intensive care units with 16% and the lowest was the child and adolescent mental health wards with 6%.
- The trust used the National Institute for Health and Care Excellence guide for acute hospital staffing levels of 1 (qualified): 8 (patients) to monitor the wards staffing levels. The services used ‘e-rostering’ to roster staff on a daily basis. Ward managers monitored staffing levels and reported this in a monthly safer staffing report to the trust board.
- The trust leadership and commissioners were concerned about the recruitment and retention issues within the trust, and were looking at innovative ways to

recruit staff and develop existing staff. A monthly safer staffing report was sent to the trust board each month, outlining any wards with exceptional reporting, whose returns for that month prompted questions about non-compliance to the levels of staffing with an overfill rate of 10% variance and shifts where the qualified nurse fill rate was below 95%. Where this occurred the care delivery service was responsible for providing responses and action plans to ensure safe and effective care. On some wards where shifts for qualified nurses was below 95%, due to the high vacancy rates, additional health care assistants were booked to cover the shifts when the ward was unable to fill their qualified nurse shifts from either bank or agency staff.

- There was generally sufficient medical cover across the wards, with staff and patients confirming that there was no difficultly accessing a doctor out of hours. However, in the acute wards for adults of working age and psychiatric intensive care units there were low numbers of junior doctors across the wards. Caburn ward had five junior doctors each working one shift throughout the week, which did not offer consistency to patients. The consultant on Coral ward only received support from a junior doctor for one shift weekly which meant the consultant spent a lot of time completing general administrative tasks, such as completing blood forms rather than spending time with patients.
- As at 31 May 2016, the staff sickness rate for the previous 12 months was 4%, this was average for similar trusts. The highest sickness rate was in the learning disability ward with 8% and the lowest was in specialist community mental health services for children and young people, with 3%.
- At the last comprehensive inspection of the trust we found that the trust did not ensure staff were appropriately trained. The trust had a compliance target of 85% of the end of quarter 4 2016/17 for all mandatory training. At the time of the inspection the overall training rate was at 78%, however the information did not specify which services had undertaken specific training. The mandatory training provided by the trust included safeguarding adults, fire safety, safeguarding, health and safety awareness, infection control and information governance. The mandatory training rates varied across the core services. The information systems did not always support the training undertaken by staff, and the information held at local level did not always correspond with trust-wide information, so not providing the senior managers with accurate information.

Assessing and managing risk to patients and staff

- The trust had good overall systems and processes for managing safeguarding children and adults at risk. There were multi-agency procedures in place and there was a joint responsibility for safeguarding adults. The executive director of nursing and patient experience was the board member with oversight of safeguarding and there were a number of individuals within the trust with responsibility for safeguarding. Flow charts had been created to assist staff with the referral process. There was an annual safeguarding for adults and children report that went to the board, with quarterly reports to the quality committee for review. The report was also sent to the local safeguarding adults board.
- The trust attended the joint Sussex Partnership NHS Foundation Trust and local authorities safeguarding leads meeting. The meeting was chaired by the strategic director of social care and partnerships. The meeting considered a strategic view of adult safeguarding activity by the trust and social care. The trust was also represented at all local authority safeguarding boards. There were good relationships across the trust and local authority and this was confirmed in our meetings with commissioners and local authorities,
- All safeguarding training was delivered in house using eLearning. Staff from the trust could also access local authority training. At the time of the inspection 64% of staff had received level 1 safeguarding adults training and 79% had received safeguarding children level 1 training (the number of staff eligible to undertake child safeguarding training was less than those eligible for adult training). Training in level 2 and 3 was also available to staff. The numbers of staff who had accessed local authority training had not been captured at the time of the inspection. Across the majority of services staff had a good understanding of safeguarding issues, of what to report and how to report it.

Requires improvement

Are services safe?

- Between 1 April 2015 and 31 March 2016 the trust submitted 501 safeguarding referrals. The majority of these related to emotional harm. The highest number of safeguarding referrals were in the specialist community mental health services for children and young people.
- At the last inspection of the trust in January 2015, we found that staff in the wards for people with learning disabilities or autism and specialist community mental health services for children and young people did not update or review all risk assessments regularly or following incidents. During this inspection we reviewed 474 care records. The completion of risk assessments had improved but varied across the services. In some services, such as the ward for people with learning disabilities or autism, the risk assessments were comprehensive, reviewed regularly and supported staff to minimise risks to patients. However, in other areas such as the community-based mental health services for adults of working age, risk assessments were not present in all the care records we reviewed. In the community mental health services for people with learning disabilities, crisis plans were not routinely present to ensure that people using the service and their carers knew how to get help and support in an emergency. In the mental health crisis services we found that two out of eight care records viewed at the Department of Psychiatry did not have an updated risk assessment. Similarly, in the acute wards for adults of working age and psychiatric intensive care units we found that of the 43 care records viewed, five risk assessments that had not been updated following incidents or since the patient had been admitted to the ward. Within this core service we found that the trust had not taken sufficient action to support patients at risk of harm to themselves. A serious incident occurred on Woodlands ward prior to our follow up inspection, concerning a patient at risk of harm to themselves.
- The specialist community mental health services for children and young people did not have an effective system across the services to consistent complete risk assessments. There was no set standard of practice of recording risks across the teams and there were a large portion of the care records we reviewed that had no documented risk assessments at all. This meant that there was the potential for vital risk and care information being missed by staff members, resulting in the potential for harm to come to people using the service. This had been identified in the previous inspection of the trust in January 2015, where a requirement notice had been issued. Due to the continued non-compliance in this area we served a Warning Notice on the trust to make improvements.
- On the 7 December 2016 we returned to carry out a focussed inspection to follow up this Warning Notice. At this re-inspection we identified that the trust had responded positively to the findings in the Warning Notice and made significant improvements. The trust had developed an action plan to ensure compliance with the trust target of 95% of risk screens completed. We looked at a random selection of 127 care records from 19 teams across Hampshire, Kent and Sussex. And found only 4 risk screenings were missing, this equated to a 97% compliance rate. The trust target was 95%. This demonstrated a significant improvement from our findings in September 2016, where we found only 43% of risk screens having been completed. The care records dashboard had been improved to tell each practitioner when they logged on which risk assessments (on their caseload) were coming up to needing to be reviewed and which ones were overdue. This was to ensure that the assessments were reviewed at regular intervals and after each risk incident.
- The wards had good observation policies and procedures. Observation policies were available on the trust's intranet and the staff we spoke with knew how to access them. We did note some good practicein relation to observation, where on the forensic/ secure inpatient wards, all staff, including bank and agency staff, completed a knowledge and skills assessment in observation before they were permitted to complete patient observations.
- Between 1 December 2015 and 31 May 2016 there were 417 uses of restraint of 206 different patients. Of these, 50 (12%) were in the prone (face down) position and 20 (40%) resulted in rapid tranquilisation. The highest use of restraint occurred on the acute wards for adults of working age and psychiatric intensive care units (215 incidents), followed by the wards for older people with mental health problems (94 incidents). The acute wards for adults of working age and psychiatric intensive care units also had the highest use of restraint in the prone position where 35 occurred during the period, followed by the forensic inpatient/ secure wards with nine.For

rapid tranquilisation, 14 occurred on acute wards for adults of working age and psychiatric intensive care units, followed by four on the forensic inpatient/ secure wards.There was some good practice taking place in relation to restraint. An example of this was on the ward for people with learning disabilities or autism at the Selden Centre, where staff had implemented a restraint reduction toolkit and analysed their use of physical interventions regularly. Staff on this ward also had monthly challenging behaviour workshops facilitated by a psychologist or occupational therapist. Staff had developed a pictorial tool to support patients' to feedback their feelings after they had been restrained. Staff used this feedback to develop their understanding of patients and how to support them.

- Data provided by the trust showed that in the six months between 1 December 2015 and 31 May 2016 there were 132 uses of seclusion. The majority of these (101) taking place on the acute adult inpatient wards and psychiatric intensive care units. There were also eight instances of long-term segregation with all of these occurring on the forensic inpatient/ secure wards.
- We found that improvements had been made to the use of blanket restrictions. These are rules or policies that restrict a patients liberty or rights and are routinely applied to all patients). There were managed blanket restrictions across the services where we identified these. For example, in the long stay/rehabilitation mental health wards for working age adults at 78 Crawley Road, the use of lighters were individually assessed with the patients and restricted to maintain the safety of the ward, following the setting of fires within the service.
- The pharmacy team for Sussex Partnership NHS Foundation Trust worked in four locality teams; West to include Worthing and Chichester, Brighton and Hove, East to include Eastbourne and Hastings and North to include Crawley and Horsham. The department had been led for some time by two chief pharmacists, one with a focus on strategy and another for governance. Medicines were supplied from Worthing General Hospital except for Chichester where supplies were from St Richards Hospital, Chichester. Wards told us that they were able to obtain supplies of medicines daily during the week, with the pharmacy team involved in developing and reviewing stock lists. Medicines were available at weekends using the on-call service or emergency medicine cupboards. Sites further away from Worthing told us that sometimes medicines being delivered could take a long time to arrive and they preferred to prescribe medicines needed at the weekend on community prescriptions, which could be dispensed locally. Medicines were available when patients needed them. The pharmacy team supported a range of inpatient and community services. Four new pharmacist community roles had recently been developed to work with patients in localities. One of these pharmacists described how they could provide support for patients on the ward, during discharge and in the community. This was a new and developing service. One of the chief pharmacists was the trust controlled drug accountable officer. They had oversight of all controlled drug incidents in the trust, attended and produced reports for, the local intelligence network. The department had run a range of audits across the trust and participated in some prescribing observatory for mental health (POMH-UK) audits. Wards were carrying out a missed dose audit to identify gaps on prescription and administration charts. Wards described how the incidence of gaps on charts had reduced since starting the audit.
- During our previous inspection in January 2015, the acute wards for adults of working age and psychiatric intensive care units had not protected patients against risks associated with unsafe use and management of medicines. During this inspection we found that medicines were stored securely across the trust. Pharmacy technicians and dispensary assistants supported the wards. We found that the temperature of some medicines refrigerators was not recorded according to trust policy. This may mean that medicines were not kept at the manufacturers recommended temperature to keep them safe and effective for use. Controlled drugs (medicines which need tighter controls due to their potential for abuse) were ordered, stored and recorded appropriately. However, we found that controlled drugs stock checks were not always happening at the frequency recommended by the trust. The trust policy was for this to take place at every shift handover if needed or as a minimum, once a week. Staff described how they would record medicines errors and examples were seen where practice at ward level had changed following learning from medicines errors. The

trust had a medicines safety officer and were developing a medicines safety committee and database to track all medicines errors and identify themes and learning points. Learning from medicines errors was communicated to staff via newsletters and bulletins. Staff on the wards were aware of these documents, but there was limited evidence of their effectiveness to influence change. For example, following two serious incidents the trust had updated the rapid tranquillisation policy in June 2016. Members of the pharmacy team had communicated this to staff via a newsletter and discussions at ward level. Yet we saw on the acute wards for adults of working age and psychiatric intensive care units and wards for older people with mental health problems that staff were not following the requirements of the new policy or using the monitoring forms included in it. This meant that patients were at serious risk, as physical observations following rapid tranquillisation were not being carried out and recorded in a way that kept them safe. We served a Warning Notice on the trust to ensure that physical health monitoring took place following the administration of rapid tranquilisation and patients were kept safe.

- Pharmacists across the trust reviewed prescription charts and were involved in multi-disciplinary team meetings to review patients' medicines. We saw that patients prescribed anti-psychotic medicines above the recommended dose range were identified by pharmacists and their prescription chart highlighted. The trust policy stated that a monitoring form should be completed for these patients and attached to the prescription chart. This monitoring form details the additional monitoring that is recommended for these patients, in order to keep them safe from the increased likelihood of adverse effects. These monitoring forms were not being used on the acute wards for adults of working age and psychiatric intensive care units and people were not being monitored to ensure that they were not suffering adverse effects from high dose medicines. We served a Warning Notice on the trust to ensure that physical health monitoring took place for patients prescribed with high dose antipsychotics and patients were kept safe.

Track record of safety

- We analysed data about safety incidents from three sources: incidents reported by the trust to the national reporting and learning system and to the strategic executive information system and serious incidents reported by staff to the trust's own incident reporting system. These three sources were not directly comparable because they used different definitions of severity and type and not all incidents were reported to all sources. For example, the national reporting and learning system did not collect information about staff incidents, health and safety incidents or security incidents.
- Providers were encouraged to report all patient safety incidents of any severity to the national reporting and learning system at least once a month. The most recent patient safety incident report (covering 1 April 2015 – 30 September 2015) stated that for all mental health organisations, "50% of all incidents were submitted to the national reporting and learning system more than 27 days after the incident occurred." For Sussex Partnership NHS Foundation Trust, "50% of incidents were submitted more than 27 days after the incident occurred". When benchmarked, the trust were in the lowest 25% of reporters of incidents when compared with similar trusts.
- The trust reported a total of 3607 incidents to the national reporting and learning system between 1 June 2015 and 30 May 2016. Of these, 70% of incidents (1326) reported to national reporting and learning system resulted in no harm. Self-harming behaviour was the incident type with the highest number of incidents attributed, with 1112 (31%) overall. Most of the incidents resulted in no harm, with 2354 (65%). The number of deaths reported in this period was 124 (3%), all of which were self-harming / suspected suicides.
- Trusts were required to report serious incidents which include 'never events' (serious patient safety incidents that are wholly preventable). Between 1 June 2015 and 31 May 2016 the trust reported 309 serious incidents. None of these were never events. The largest number of incidents occurred in the adult community services with 116 (38%). A total of 214 (69%) of the incidents concerned apparent/actual/suspected self-inflicted harm meeting serious incident criteria.
- A total of five prevention of future death reports had been sent to the trust in the 12 month period up to 30

April 2016. These reports highlight concerns found by Coroners (at inquests) in the systems or processes of organisations which, if they are not improved, could lead to future deaths. The trust had responded to each report with an action plan and areas of learning to take forward.

Reporting incidents and learning from when things go wrong

- In the period 1 June 2015 to 31 May 2016 the trust reported 308 serious incidents through their 'serious incidents requiring investigation' reporting system. Of these, 113 (37%) were related to community-based mental health services for adults of working age, 44 (14%) were related to mental health crisis services and health-based places of safety and 39 (13%) were related to acute wards for adults of working age and psychiatric intensive care units.
- A majority of incidents (78%) were unexpected/ avoidable death or severe harm followed by loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation (12%).
- The NHS safety thermometer measures a monthly snapshot of areas of harm including falls, pressure ulcers and catheter with new urinary tract infections. The trust recorded 12 new pressure ulcers throughout the period of June 2015 – April 2016. One each was recorded in June and August, October 2015 and April 2016. Two were recorded in November 2015 and three each were recorded in January and March 2016. All were in older people mental health wards. The trust reported 78 falls with harm during this period with the highest totals being 22 in December 2015. The majority of these (74) occurred in older people wards, 49 of which occurred in Grove Ward.
- The CQC intelligent monitoring reflected that the trust was flagged as an elevated risk for the number of deaths of patients detained under the Mental Health Act based on the period 1 August 2014 – 31 July 2015. This specifically related to the number of suicides of patients. The trust was a negative outlier for suicides of detained patients and deaths of patients in contact with the community teams. This meant that the trust had a higher number of suicides than similar trusts.
- At the last comprehensive inspection of the trust it was identified that whilst there were a high number of suicides, the trust did not have a suicide prevention strategy in place. In response to this the trust took action and in September 2015 they approved the organisations' suicide safer strategy. This is a multi-stakeholder, public health facilitated and engaged communities approach. The trust had also undertaken work around suicide prevention, such as the implementation of the 'stay alive' suicide prevention app and looking at clusters of community deaths and increasing follow up activity with people. There was increased board level scrutiny of deaths via the quality committee and the recognised need to triangulate incidents and embed further learning from incidents. For this inspection we looked at the impact that this could have had on the number of suicides of patients in receipt of care from the trust, using a snapshot of data. We found that in the years 1 June 2014 to 31 May 2016 there were 516 unexpected deaths of which 193 were classed as suicide. Of these, 94 suicides occurred in the period 1 June 2015 and 31 May 2016, compared with 99 in the same reporting period for the previous year. This shows that there had been a reduction in the number of suicides over the period.
- The trust used an electronic system for recording and reporting incidents. The trust had a mortality review panel that met weekly to review all serious incidents. This enabled the identification of 'hotspots' and clusters of incidents to support the trust to focus on these areas. An example of this was where a cluster of falls had been identified on Iris older people ward, and a physical health nurse was assigned to support the ward with falls work. The mortality review panel also picked up under-grading of incidents was also identified by the panel and actions taken to address this so that all serious incidents were graded consistently.
- Commissioners and the trust had identified there had been significant delays in completing serious incident investigations. The trust chair and chief executive had prioritised this and there was significant board oversight of these. There was a clinical safety team to address the high backlog and they were undertaking investigations and reducing the report turnaround. There was specific training for staff who were required to complete incident reports, review clinical incidents, formulating route cause analysis and developing action plans. Mandatory

training in route cause analysis was provided to staff (band 8a and above) to improve the governance and quality around the investigation of serious incidents. All deaths were now subject to level 2 root cause analysis investigation and independent panel review. A mortality review panel met weekly to review all deaths and serious incidents to help progress these and look for lessons to be learnt.

- The recommendations of serious incidents and Coroner prevention of future deaths reports were owned and implemented by the care delivery service leads, where they took responsibility for developing and implementing the action plans. However, during the inspection we found some inconsistency in terms of staff being clear about what needed to be reported as an incident. This was specifically in relation to the specialist community mental health services for children and young people where we found that staff reported emerging patterns of self-harm for a number of young people as opposed to individual incidents. This meant that in these services there was an under-reporting of incidents and therefore missed opportunities to learn from when things went wrong.
- Lessons learned from serious incidents and complaints were shared at regular ward manager meetings facilitated by matrons and general managers. It was also disseminated to local teams via a monthly governance newsletter. However, feedback from the inspection of core services was that most staff do not recall seeing the newsletter. Staff that were aware highlighted that the font of the newsletter was so small and had too much information packed in, so they did not read this. This meant that learning from incidents was lacking, and there were missed opportunities for services to improve as a result. An example of this is that we identified a lack of learning in relation to previous concerns raised following a thematic review that took place in March 2016 by CQC Mental Health Act reviewers. This focussed on the use of seclusion and long term segregation and had identified a concern in the physical health monitoring, following the administration of rapid tranquilisation.
- A serious incident had highlighted similar concerns, whereby physical observations of patients following rapid tranquilisation (particularly where a risk identified) had not been carried out. This along with further similar concerns to the practices surrounding the lack of physical monitoring following the administration of rapid tranquilisation led us to take enforcement, through the serving of a Warning Notice on the trust (as detailed above). Also, within the wards for older people with mental health problems there was a lack of learning from a serious incident that had occurred where a patient had died following having swallowed a piece of equipment, yet this equipment was observed on one of the wards, though removed once we alerted staff to this.
- The trust had been involved in three serious case reviews and two multi-agency reviews where the trust had direct involvement with the patient during 2015/16. At the time of the inspection two of the serious case reviews were ongoing and so it was not possible to identify actions and the learning at that stage. Similarly, the two multi-agency reviews had not been finalised at the time of inspection. Action plans arising from these reviews were monitored through the trust performance quality and safety meetings.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) ofcertain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust implemented the 'being open' policy to improve openness and transparency with patients and/ or their next of kin. The implementation of the policy was monitored by the director of nursing through identifying any incident reported as moderate or above. This would then be subject to a full duty of candour review to ensure all necessary steps have been taken. At a local level, where a duty of candour incident had been identified by the staff team, an electronic message was forwarded to the service manager, general manager and the duty of candour champion for that area. This was then subsequently followed up within the ten working days to ensure that communication with the effected person/ or relative had occurred, and this communication was followed up in writing.
- Compliance with the duty of candour was collated centrally and presented to the board in the trust

quarterly quality and patient safety report. In addition, compliance was also monitored through the local contracts with the clinical commissioning groups. The feedback we received from commissioners was that the trust had an open and transparent approach in their relationship and dealing with incidents.

Anticipation and planning of risk

- All risks clinical and non-clinical were managed through the trust's incident reporting system. Any member of staff could identify a risk and each risk was considered at differing levels throughout the trust. The most serious risks were pulled through to the strategic risk register and ultimately the board assurance framework.

Requires improvement

Are services effective?

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

Summary of findings

Our findings

Assessment of needs and planning of care

- Comprehensive care assessments were documented in most care records we reviewed. The assessments were service-specific to each core service so that they were relevant to the individual needs of the patient. On the forensic/ secure inpatient wards we saw that admissions were pre-planned and the assessment process started before the patient was admitted to the ward. In the specialist community mental health services for children and young people, following referral, young people were offered a choice assessment. This gave them the opportunity to meet a member of the team to discuss the reasons for being referred to the service and the options for treatment or therapy.
- The quality of the care plans varied across the services but were generally of holistic to peoples' needs and kept under regular review. However, we did identify some concerns in the specialist community mental health services for children and young people. Of the 77 records we reviewed across this core service 22 had no care plan and only 20 were personalised and focussed on outcomes, strengths and goals. We found 29 of the 77 care plans had not been shared with the young person or their parent or carer. However, young people told us that they felt involved in their care.

Best practice in treatment and care

- At the last inspection of the trust in January 2015 improvements were needed to the physical healthcare across different core services. We found on this inspection that improvements had been made and there was good access to physical healthcare across the services. For example, on the ward for people with learning disabilities or autism a GP had started to visit the ward and the staff had developed health action plans and health passports to meet the patients' physical health needs. In the specialist community mental health services for children and young people there were strong links with local services to arrange for blood tests and electrocardiograms. Staff were able to measure height, weight and blood pressures on site. For young people on the attention deficit hyperactivity disorder pathway, six monthly physical health checks took place in accordance with National Institute for Health and Care Excellence guidance. On the forensic/ secure inpatient wards the trust employed an on-site GP and practice nurse to provide medical cover at the Hellingly Centre. Within the community-based mental health services for adults of working age at Shoreham, the staff had developed the depot clinic into a wellbeing clinic. This included physical health care, similar to the modified early warning score system, as well as blood testing, blood pressure, height and weight. Trust-wide, there was a recently appointed associate director of nursing physical health to lead on physical health improvements across the trust. They had a clear understanding and insight into the baseline state of physical care within the trust, the hot spots of poor practice and the standards which needed to be achieved in the different specialist areas. The care plans showed evidence that staff regularly reviewed patients physical healthcare. However, on the wards for older people with mental health problems the access to physical healthcare varied.
- During 2015 -16 the trust was involved in six projects that aimed to demonstrate that clinical practice specific to physical healthcare was in line with the national institute for health and care excellence guidance recommendations. These included the nutrition audit report, falls pilot and antipsychotic prescribing in people with a learning disability. Across a number of services staff referred to the best practice national institute for health and care excellence guidance and showed us how their practice met this. For example, the community-based mental health services for adults of

working age and specialist community mental health services for children and young people utilised national institute for health and care excellence guidance into care pathways for people using the service.

- We rated the forensic/ secure inpatient wards as outstanding for the effective domain. This was in part because each ward had a dedicated psychologist to provide suitable therapy to groups and individuals. The range of therapies on offer included mentalisation based therapy, anger management programmes, dialectical behaviour therapy and cognitive behaviour therapy. However, access to psychological therapies for people varied across the trust. The national institute for health and care excellence recommended that the psychological therapies of cognitive behavioural therapy and interpersonal psychotherapy are available for patients. The inspection found that the majority of patients on the inpatient wards and those using community services had access to psychological therapies. However, on Heathfield and St Raphael wards for older people with mental health problems there was a lack of a psychologist. This meant that no structured therapy was available to patients on these wards, and staff lacked the psychology input to help them support patients.
- The trust had a number of processes to measure and improve the outcomes of patients and people using their services. This included the use of nationally recognised rating scales such as the health of the nation outcome scale, which uses scales covering a variety ofhealth and social care domains. This enabled the clinicians to build up a picture over time of their patients' responses to interventions. Staff in the specialist community mental health services for children and young people used a wide range of routine outcome measures in order to evaluate young people's progress in both the long and short term. Occupational therapists used the model of human occupation screening tool to analyse patients' strengths and limitations. Re-assessment of patients highlighted the progress they had made in skills development. The community mental health services for people with a learning disability used the diagnostic interview for social and communication disorders for autism. The trust used specialist dementia rating tools for people with a learning disability who are also developing dementia and general anxiety and phobia scales.
- The trust had completed a number of national and local audits during 2015/16 in areas such as national audit of memory clinics, national confidential enquiry into suicide and homicide by people with a mental illness, prescribing for attention deficit hyperactivity disorder in children, adolescents and adults and prescribing for bipolar disorder. Staff in the service also participated in clinical audits to measure and improve on practice. Examples of this were in the community mental health teams for people with a learning disability, where they carried out audits around dementia and how adults with a learning disability may benefit from the green light toolkit, for improving services for people with a learning disability. The community-based mental health services for adults of working age carried out audits in relation to Clozapine medicine prescribing. The findings of these were used to make improvements to the services.
- In Brighton and Hove there was an outreach team called Teen to Adult Personal advisors, which facilitated staff to work with young people (aged 14-25) who services found difficult to engage. There were early intervention in psychosis services for young people below the age of 35 with a first episode of psychosis.
- The modified early warning signs physical healthcare audit had been completed on a quarterly basis over the previous two years. This showed that there was increased compliance trust-wide in relation to completing the form correctly, assessing physical health on admission and raising the alarm for patients whose physical health was deteriorating.
- The most recent national audit of schizophrenia (an audit of community treatment for people with schizophrenia) in 2014 found that the availability and uptake of cognitive behavioural therapy was average and above average for family intervention, though still below what should ideally be provided. Performance in monitoring of physical health factors was below average. Some aspects of prescribing practice were below average, where a high proportion of patients were receiving more than one antipsychotic medicine at a time or a higher dose than normally expected. The trust published an action plan in response to this and took actions such as recruiting a community pharmacist to

support the appropriate use of antipsychotics and offering electrocardiograms to patients in the community and inpatients who were on high doses of antipsychotics.

- The trust had four quality priorities for 2016/17, which were care planning, suicide prevention, physical health, staff health, wellbeing and development. Quality measures (targets) had been identified for each priority, such as 65% care plans signed/ agreed with patients and/or carers; 95% patients admitted received a physical health assessment; and 90% staff receive an annual appraisal.

Skilled staff to deliver care

- Improvements had been made since the January 2015 trust inspection and the teams across the trust had of a range of experienced staff in different disciplines including nurses, social workers, occupational therapists, doctors, psychology assistants, peer support workers and recovery support workers. However, the wards for people with learning disabilities or autism were still without a permanent consultant psychiatrist and the long stay/rehabilitation mental health ward for working age adults at Rutland Gardens still did not have a psychologist. Some of the memory services in the older people community mental health services had specialist dementia nurses, called Admiral nurses, who have expert practical and emotional care and support to carers and patients with dementia. Most of the services could access additional support for patients when needed.
- All new staff received a trust induction and local induction to their service. This included meeting members of their team/ ward area expectations, an introduction to trust policies and procedures and lone-working protocols (where relevant).
- Staff generally had access to additional specialist training to develop their knowledge and skills. For example, in the community mental health services for people with a learning disability staff could access training in hydrotherapy, family therapy, autism and specialist degree in learning disabilities. In the community-based mental health services for adults of working age staff received additional training in areas such as eating disorders, perinatal care and conflict resolution.
- At the last comprehensive inspection of the trust in January 2015 we identified that improvements were needed to ensure that staff receive appraisal and supervision in their work. As at 5 July 2016 the overall appraisal rate for staff working at the trust was low at 26%. The acute wards for adults of working age and psychiatric intensive care units had the lowest with 9% and mental health crisis and health-based place of safety and wards for older people with mental health problems the second lowest with 18% of appraisals having been completed. Rates of medical appraisal and revalidation were better, with a 78% revalidation rate. However, the percentage of non-medical appraisals completed needed to improve. The average clinical supervision rate across all teams was 73%. The learning disability inpatient ward had the highest level of clinical supervision taking place with 100%, followed by the forensic inpatient/ secure wards with 88%. Of the 35 teams, five had a clinical supervision rate below 50%, these were for 78 Crawley Road rehabilitation service, Bodiam, Larch and Rowan acute adult inpatient wards and psychiatric intensive care units and Beechwood older people inpatient ward.
- Team managers monitored staff performance regularly and at the time of our inspection were managing a number of cases where performance was being monitored for improvement.

Multi-disciplinary and inter-agency work

- Across the core services there was effective multi-disciplinary work taking place to support people's needs. Throughout the inspection, we observed 48 multi-disciplinary meetings and staff handovers that took place regularly in the services. These reflected some good practice and were opportunities to discuss work with individuals and utilise the skills, experience and knowledge of each discipline. There was appropriate sharing of information to ensure continuity and safety of care across teams, including involvement of external agencies, for example the local authority, care homes, primary care services and the police. Within the mental health crisis services at the Department of Psychiatry the service manager had delivered training to the local GP surgeries aimed at reducing the amount of inappropriate referrals into secondary mental health services. Within the specialist community mental health services for children and young people in Hampshire the

early help hub was a joint multidisciplinary meeting with police, health visitors, substance misuse services and social services to provide a multidisciplinary approach to care and ensure that the necessary services were in place.

- A daily trust-wide bed management meeting took place. This was attended by senior members of the management team in addition to team managers from crisis teams and community adult mental health teams to promote joined up working with inpatient colleagues. The meeting reviewed bed availability across the trust as well as the reasons for inpatient admissions in the last 24 hours and discussion of what additional action, if any, could have been taken to avoid these admissions.
- In the community mental health services for people with a learning disability we heard from a local authority that real improvement in joint working had taken place over the last 18 months. This was particularly in relation to joint referral meetings and joint assessments and visits happening regularly. This meant that people using the service experienced a full assessment of their health and social care needs. Similarly, Brighton and Hove community learning disability team and Hastings and Rother community learning disability team both worked effectively with probation and other agencies to deliver groups for people with learning disabilities at risk of sexual offences.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- The Mental Health Act was mandatory training for staff, with an unambitious trust target rate of 65% completion. At the time of the inspection only 62% of staff had completed this training. This meant that not all staff had a working knowledge of the Mental Health Act and associated code of practice (amended in 2015). This may lead to staff not having essential knowledge to work effectively with people at risk to themselves or others.
- A central Mental Health Act office provided administrative support and legal advice on the implementation of the Mental Health Act and the associated code of practice. A 2015/16 trust-wide audit showed a 59% compliance rate with the Mental Health Act (MHA) policy. This did not meet their target of 100% and indicated risks both to the rights of the patients and to the trust. The audit checked if there was evidence of consent to treatment, where appropriate, on patient files. The ward managers carried out regular audits to ensure the Mental Health Act was being implemented correctly.
- The Mental Health Act documentation we viewed on the mental health wards was generally completed appropriately. The exceptions were in the ward for people with a learning disability or autism where the staff did not ensure they always assessed whether patients' had the mental capacity to consent or act upon these assessments appropriately. On Opal ward for older people with mental health problem, the section 17 leave forms did not specify leave parameters so it was not always clear what leave patients could take. In the mental health crisis services and health-based places of safety there were some gaps around recording the time that Section 12 doctors and approved mental health professionals had been contacted or arrived. There were gaps in recording that the person had their rights explained to them. We also found that on occasions, Mental Health Act assessments did not commence within three hours of the person arriving at a health-based place of safety. This exceeded recommendations in the Mental Health Act code of practice. We were told that this target was not always met due to availability of approved mental health professionals and section 12 doctors. Within the acute wards for adults of working age and psychiatric intensive care units, improvements were needed to the recording of consent to treatment and capacity. This included improvements to ensuring the appropriate consent forms were attached to medicine charts to inform staff of what medicines the patient consented to.

Good practice in applying the Mental Capacity Act

- The trust expected staff to undertake training in the Mental Capacity Act and Deprivation of Liberty Safeguards. It had set an unambitious trust-wide target that 65% of staff would undertake the training. The training was provided through an e-learning package, designed by the trust lead for this area. The compliance rate for staff having received training in this was 68%.
- There was a generally good implementation of the Mental Capacity Act across the services. Staff from each core service had a clear understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. The

records indicated that decisions were made in the best interests of the patients. On the wards for older people with mental health problems best interest meetings were held for patients who might need covert administration of medicines and paperwork was completed appropriately and reviewed monthly. Some patients, who did not have the mental capacity to make decisions for themselves, were having their medicines administered covertly (disguised in food or drink). However, on Grove and Meridian wards we found staff were not always following the trust policy with regard to recording decisions made in people's best interest or reviewing those decisions on a regular basis to ensure they were still appropriate.

- The Mental Capacity Act does not apply to young people under the age of 16. For children under the age of 16, their decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke with in the children and young person mental health community teams and inpatient ward were conversant with the principles of Gillick and used this to include the children and young people where possible in the decision making regarding their care.
- Staff in the trust had made 151 applications for Deprivation of Liberty Safeguards between January and July 2016. Of the applications, 92 had been granted. Applications were highest in the older people mental health wards with 94% emanating from the service. However, during the same time period the Care Quality Commission had only been notified of four applications.
- The trust had carried out a recent clinical audit of capacity to consent. The findings of this showed that documentation of the Mental Capacity Act procedures was presenting a risk to the trust and to the patients. This was due to their being a 59% total compliance with the completion of the documentation to evidence that the assessments had been carried out (an increase of 9% since 2014/15). In response to these findings the teams involved have been completing weekly re-audits of capacity to consent in order to make rapid improvements in this area. Emphasis had also been put onto ensuring staff were trained in the Mental Capacity Act and the completion of records on the electronic care records system.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

- Caring was good across all of the services inspected and staff were generally committed to providing a positive experience to patients and people who used the services. Staff supported patients in a kind and considerate manner, whilst maintaining their privacy and dignity. During the inspection we observed many examples of positive interactions where staff communicated with people in a calm and professional manner using an empathetic approach at all times. For example, in the community-based mental health services for older people staff took the time to explain medicines and treatments in a way that people could understand and they provided advice on health issues and the recognition of the persons' relationships with significant others. Within the specialist community mental health services for children and young people we received very positive feedback about the service and staff, where they said that staff were caring and that they were treated with respect.
- We identified occasions where improvements were needed. At Langley Green Hospital acute wards for adults of working age and psychiatric intensive care units, three patients informed us that some substantive and agency staff were uncaring. This was addressed at the time when we raised it with the ward manager. Within Opal ward for older people with mental health problems at Langley Green Hospital, five patients states reported that staff were not always respectful, did not have time for them and demonstrated an uncaring attitude.
- The feedback from surveys carried out was mixed. The 'friends and family test' was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment. The latest friends and family test data (May 2016) found that 85% of patients would recommend the trust for mental health services. This was below the England average of 88% for people using their mental health services.
- The trust's overall score for privacy, dignity and wellbeing in the 2016 patient-led assessment of the cleanliness and environment (PLACE) score was 87%. This figure was below the national average of 90%. Eight locations out of 22 scored above the national average, with the Oaklands Centre for Acute Care scoring 98%. Eight locations out of 22 scored below the national average, with St Anne's Centre and Elderly Mentally Infirm wards for older people scoring the lowest with 76%.
- The Care Quality Commission survey of patients using community services for 2015 showed that the trust scored 'about the same' as other mental health trusts, with the top performing scores related to 'organising your care' and 'reviewing your care', scoring 8 and 7 out of 10 respectively. The trust scored 7 out of 10 for 'your health and social care workers'. Of the respondents, the trust scored 7 out of 10 for overall experience of the community mental health services.

The involvement of people in the care they receive

- Across the services we found examples where patients and carers were involved in their care. We rated the child and adolescent mental health ward at Chalkhill as outstanding for caring. The reason for this was because staff demonstrated a real commitment to delivering good care and the importance of recognising young people as individuals, all with different needs. The care plans were developed in partnership with young people and the staff responded well to patients' requests to make the environment more welcoming for transgendered young people. On this ward the young people had developed a video of what to expect when going to Chalkhill in their own words, and this was available on the trust website. We rated the specialist community mental health services for children and young people as good in the caring domain. This was because young people and parents felt fully involved in

Good

Are services caring?

their care and as part of the initial choice assessment young people were asked what they wanted from the service rather than being told specifically what the treatment was. Families and carers groups had also been developed in these services to enable parents and carers to meet staff and ask questions about the service. Staff had set up the recovery college where they offered young people and their carers groups and courses to attend. Courses included drama, music, art and woodland workshops.

- In the community-based mental health service for older people we saw that significant others were fully involved in planning and agreeing the care of their relative. In the forensic inpatient/ secure inpatient wards patients were invited to attend their fortnightly recovery review meeting to enable them to be involved in their treatment and care. Patients at the Hellingly Centre were actively involved in the running of the Badgers Café on site. Patients took pride in working at the café and staff valued the work they did there. Staff invited patients to a six monthly risk clinic to encourage patients to be involved in their own risk assessing and management. However, improvements were needed in the community-based mental health services for adults of working age to involve people in their care more, including people on a community treatment order.
- The trust advertised methods for patients and carers to get involved and provide feedback about the services. This included through social media, suggestion boxes in community waiting areas and feedback formswhich encouraged comments for people to feedback their views on the service they received. Staff invited carers to patient discharge planning meetings and signposted them to other sources of help when this was appropriate, including for an assessment of their needs as a carer.
- The trust website was available in different languages and easy read version. The website encouraged people to feedback about the services with links to an online survey and information about the friends and family test and NHS patient survey. In the ward for people with a learning disability or autism the staff had developed a communication strategy to improve interactions and help involve patients more in their care.

Good

Are services responsive to people's needs?

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

Summary of findings

Our findings

Service planning

- The trust worked collaboratively with commissioners and other NHS trusts served by the geographical area covered by the trust to plan and meet the needs of local populations. Senior practitioners and service managers told us they had regular communications and constructive working relationships with commissioning bodies. Feedback from stakeholders such as clinical commissioning groups, local authorities and HealthWatch was that the trust worked proactively with them and other stakeholders to meet the needs of people across the areas covered by the trust.

Access and discharge

- The trust worked to make the access to services as straightforward as possible. For example, within the mental health services, the home treatment teams were able to respond to referrals to the service within four hours. The trust also operated a street triage service, where staff from the trust worked with the police and helped to identify people who needed mental health services and arranged for them to access the health based place of safety if necessary. Within the specialist community mental health services for children and young people in Hampshire a single point of access had been set up, whilst the West Sussex team had centralised their referral process and East Sussex triaged referrals. Urgent referrals were prioritised and were aimed to be seen within seven days, with more urgent referrals seen quicker through protected timeslots. However, the crisis team did not operate 24 hours a day seven days a week.Between 9.30pm and 7am people who used the service would need to access support via the trust wide mental health line or by attending accident and emergency departments.
- The trust provided details on 'referral to assessment' and 'referral to treatment' for 82 community mental health services. The national target for referral to assessment was for 95% of patients seen within four weeks and for assessment to onset of treatment, 92% of patients treated within 18 weeks. The data provided shows that 13 services failed to meet their relevant targets in terms of referral to assessment. Of these 13 services, 12 were specialist community mental health services for children and young people. The five services with the longest waiting times from assessment to treatment were all specialist community mental health services for children and young people. The trust had identified that specialist community mental health services for children and young people in Hampshire and Kent as the services with the longest waiting times. The waiting times had reduced since the previous year, due to the services working with commissioners to focus on waiting times. Feedback we received from a local stakeholder in Kent was that the wait for treatment that children and young people after referral to specialist community mental health services for children and young people had improved over the past year.
- Between 1 December 2015 and 31 May 2016, the average bed occupancy ranged from 37% – 110%. Bed occupancy means the number of patients accommodated on a ward. There were 35 out of 40 wards that had bed occupancies of 85% and above. The wards with the lowest average bed occupancy were 78 Crawley Road (a long stay/rehab ward) with 74%, Beechwood Specialist Dementia Treatment Unit (an older people's ward) with 73% and St Gabriel Ward (an acute adult ward) with 37%. However, St Gabriel Ward was closed for refurbishment during Dec 2015, and remained closed for the rest of the reporting period through to 31 May 2016. The low occupancy was therefore a result of the ward being emptied. The wards with the highest average bed occupancies were Jade Ward at Langley Green Hospital (an adult acute ward) and Meridian Ward at Mill View Hospital (an older people's ward). This meant that demand for beds was high, but a bed could generally be available when needed.

Good

Are services responsive to people's needs?

- Staff we spoke with on the wards informed us that patients were able to return to their bedrooms after coming back to the ward following a period of leave. This meant that the ward did not admit new patients to beds that belonged to patients who were on leave. This was apart from the acute wards for adults of working age and psychiatric intensive care units, where patients routinely did not have a bed to return to on the same ward after a long period of leave from the ward. It was trust policy not to keep leave beds empty. However, patients usually did have a bed to return to after a single night's leave. Staff routinely waited until patients were ready to be discharged before they allowed them to go on leave because they were unable to retain a bed for them. This meant that patients did not want to have leave for fear of not having a bed to return to. Pressures on bed management meant that patients on the acute wards for adults of working age and psychiatric intensive care units were sometimes moved to other wards for non-clinical reasons to allow for new patients to be admitted. Also, when patients returned to the ward after leave, they were sometimes referred out of area or to other wards were there was bed availability.
- On the wards for people with a learning disability or autism we found that staff generally worked proactively to discharge patients, completing discharge plans and working with other agencies. This was an improvement since the last inspection of the trust. Between 1 December 2015 and 31 May 2016 there were a total of 158 delayed discharges. The older people mental health wards of Beechwood and Brunswick were the highest with 26 and 15 respectively. The majority of delayed discharges were in older people's mental health wards, with 103 (65% of all delayed discharges). The main reasons for these were housing, funding disputes, shortage of care home places, shortage of rehab beds and family choice.
- There were 28 out of area placements between January and June 2016, all of which were for the acute wards for adults of working age and psychiatric intensive care units. The placements were made to independent hospitals in Sussex, Surrey or London.

The facilities promote recovery, comfort, dignity and confidentiality

- The services were delivered from a range of sites across Sussex (plus Kent and Hampshire for the specialist community mental health services for children and young people). There was variability in the quality of the environment in the community services and the space available between teams. For example, the mid Sussex adults team were located in an old building that had narrow corridors and lots of stairs. However, interview and group rooms were located on the ground floor to make access as easy as possible for people who used the service; whereas the interview and group rooms at Cavendish House were large and bright.
- At our last inspection in January 2015 we found the physical environment of the ward for people with learning disabilities or autism did not focus on the promotion of independence, meal choice and patients could not access areas such as the kitchen and garden. During this inspection we found that improvements had been made and staff supported patients to use skills equipment to develop their independence, there was a choice of four meal options at each meal and patients could access all areas.
- In the community team reception areas there was relevant information on displayregarding local services, carers support, workshops and how to make complaints. For children and young people age appropriate information was available. On admission to the wards patients were given a welcome pack which included relevant information. This helped people to orientate them to the service and ward routines, such as times of meals, relative and carers information, how to complain, information on the advocacy service as well as how to access information in other languages. Staff were able to access interpreters as necessary.
- Confidentiality was promoted across the services and during the assessments and home visits we observed. Staff in all team handovers and meetings discussed people in a positive, respectful manner. Staff were aware of the need to ensure a person's confidential information was stored securely and staff access to electronic case notes was password protected. Interview rooms in the community teams were sound proofed to promote confidentiality during meetings.
- All wards had weekly activity schedules. However on the acute wards for adults of working age and psychiatric intensive care units there were very few activities available at weekends, particularly at Millview and Langley Green Hospitals.

Good

Are services responsive to people's needs?

Meeting the needs of all the people who use the service

- In accordance with the Equality Act 2010, the trust collated data about its workforce and the local population. The trust had clear information about the cultural diversity of populations across the different care delivery services and local authorities they served. From this the trust had an understanding of the diversity of needs and used the information to compare the staff profile of the trust to the local population demographics to see how it reflected the diversity of the population it served.
- The equality, diversity and human rights steering group was chaired by the chief executive and had the corporate responsibility of reviewing the trust progress every six months. There were equality reference groups for each protected characteristic, and they maintained the responsibility of producing, managing and delivering a focused action plan on one or a number of the protected characteristics. Since the launch of the Equality Performance Scheme in 2014, each of the reference groups had consulted with the relevant stakeholders both in and outside of the trust and co-produced an action plan with focus on the agreed areas of concern. For example, the trust had identified that improvements were needed to the experience of black and minority ethnic staff and people using the services. An action plan had been developed by the reference group to focus on work in this area, which included improving engagement with black and minority ethnic communities and improving access to services through areas such as developing links with local groups and third sector organisations.
- Staff in the community-based mental health services for older people had a good awareness of local groups to meet the different needs of people and provided information on this. The patients who used the service tended to be predominantly white
- The patients were generally positive about the choice and quality of food provided, though some patients on the acute wards for adults of working age and psychiatric intensive care units said they would like more variety, including salads. There was a good variety and choice of food options, including a healthy choice, vegetarian, kosher, Caribbean, pureed and gluten-free food. Patients told us that it was easy to request and access these options.
- Access to faiths were supported by the wards and chaplaincy services visited on a regular basis. In the long stay/rehabilitation mental health ward for working age adults at Rutland Gardens there was a 'Sacred Space' and a Spirituality Champion who offered all patients a spirituality assessment and care plan.
- The inpatient wards and community sites had generally good facilities, and promoted confidentiality. Community sites were generally accessible and had toilet facilities appropriate for patients who used a wheelchair. However, within the community-based mental health service for older people there were some accessibility issues. Also in the Brighton and Hove service the alarm in the disabled was located by the door and not accessible if using the toilet. The light in this room also automatically went out after a few minutes, which could put people at risk of falling. In the longer stay wards, such as theforensic inpatient/secure wards and ward for people with a learning disability or autism, patients were able to personalise their bedrooms.

Listening to and learning from concerns and complaints

- The majority of patients and carers were told about the complaints process upon admission and supported to make complaints if they wished. Carers told us they were sent information in the post about how to complain and information of how to complain was displayed across the wards and in community reception areas. However, some people using community mental health services were not always aware of how to make a complaint. Staff were able to describe the complaints process and how they would process any complaints. Staff knew how to respond to anyone wishing to complain and logged complaints on an electronic recording system. However, informal complaints that were resolved locally at ward or service level were not uploaded into this electronic system or routinely captured centrally. Therefore issues and learning from informal complaints were not captured.

Good

Are services responsive to people's needs?

- The patient advice and liaison service (PALS) is an information and advice service for patients, relatives and the public to help resolve situations and assist with dealing with concerns. The trust had a patient advice and liaison service that offered advice to people about making a complaint and handled the initial query before passing it to the complaints team. The trust complaints team was a small team with only two complaints officers and an administrator with a manager who had oversight of the team. The team had recently secured more resources for complaints officers.
- Formal complaints were investigated by a complaints case worker who was external to the service involved. The trust followed the national process with the investigating officer contacting the complainant to enable them to participate in the development of terms of reference and agreeing a plan with the complainant for management of the complaint.
- The trust had a complaints policy to deal with complaints and concerns received about the care and treatment provided. The policy had been developed in line with the NHS Complaints (England) Regulations 2009. The executive director of nursing and quality was the board member with oversight of complaints. The trust compiled an annual complaints report which was taken to the board. The board also receive a complaints report at every board meeting. The quality committee, who met quarterly, received reports on complaints and outcomes. The report contained information about lessons learned from complaints, themes and trends.
- The trust received 738 formal complaints during the period June 2015 – 31 May 2016. Of these complaints, 295 (40%) were upheld either partially or fully. Of these, 166 complaints had been fully upheld and 129 partially upheld. Community based mental health services for adults received the highest number of complaints with 241 complaints, 56 were upheld (39 partially upheld). There had been no complaints referred to the Ombudsman. The themes for the highest number of complaints was 'all aspects of clinical treatment' followed by 'attitude of staff'.
- Learning from concerns and complaints was disseminated within services, however, learning was not effectively disseminated to all parts of the organisation. Although learning from complaints was shared in a monthly newsletter,findings from the inspection were that staff were not knowledgeable about learning from complaints that had happened in different services.

Requires improvement

Are services well-led?

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

Summary of findings

Our findings

Vision, values and strategy

- The trust had five values which were:

- people first;

- future focused;

- embracing change;

- working together;

- everyone counts.

- The 2020 vision was the trust's strategic priorities through its board assurance framework over the next four years to improve patient, carer and staff experience. The trusts' five goals to achieve this were:
- safe, effective, quality patient care
- local, joined up patient care
- put research, innovation and learning into practice
- be the provider, employer and partner of choice
- live within our means.
- The vision and values of the organisation were well developed and understood by staff, and their annual appraisals were based on these values. The staff felt that the values represented the work they did within the trust. There was consistent reference to the 2020 vision and what it meant for how the trust will move forward. Efforts had been made to put patients and families at the heart of the strategy and to set the vision. This was through the implementation of the care delivery services, which aimed to provide quality care, with clinical leadership, support from corporate directorates and partnerships with local communities. There was progressively active participation in board to floor engagement by the chair, non-executive directors and chief executive to help embed the values, which was valued by staff and stakeholders.

Good governance

- At the last comprehensive inspection of the trust in January 2015 we identified that improvements were needed to the effectiveness of the governance systems. Since that time there had been a significant review of the governance processes within the trust. Since January 2016 the trust had implemented care delivery services, which were operational management units responsible for clinical services in specific areas. These were established to devolve decision making closer to where patients were treated. There were nine care delivery services in total which were supported by a corporate infrastructure of teams such as human resources, estates and information technology. In adult services the care delivery services were divided into geographical areas, and there was a separate care delivery service for each speciality, such as children and young people services, learning disabilities and forensic healthcare.It was clear from interviews with senior managers that the arrangements for these were still bedding in and were to be further refined going forward. An example of this was that the governance framework was not fully understood by all managers, where we were unable to get a consistent narrative through interviews about the route for flagging risks from care delivery services to the board.
- We found that governance processes were still embedding in other areas, such as financial and quality governance in the recent divesting of the trust substance misuse services. There was concern that not sufficient weight had been given to the risks associated with the gap in services to patients with dual diagnosis /co-morbid substance misuse and mental health problems. The July 2016 board meeting papers further identified this, where it highlighted the negative contribution substance misuse made to the number of

serious incidents within the trust. It was also unclear how staff survey findings, clinical audits, national confidential inquiry trust reports were being used to develop the trust.

- At our last inspection in January 2015 we identified multiple concerns across a number of core services, with five of the 11 core services rated as requiring improvement. In response to this the trust developed an action plan for improvement, which had been reviewed by the senior managers on an ongoing basis. During this inspection we found that the majority of actions had been implemented, with many improvements made to services and people's experiences of these, as highlighted throughout the report. This was particularly noticeable in the ward for people with a learning disability or autism and long stay/rehabilitation mental health wards for working age adults where a number of improvements had been made to make the services safer and enhance the experience of patients. However, we did find ongoing concerns in the acute wards for adults of working age and psychiatric intensive care units, wards for older people with mental health problems and specialist community mental health services for children and young people. We took enforcement action, through serving two Warning Notices, to ensure that the trust took action to improve these services. On our focussed inspection from the 1 – 4 November 2016 to follow up the concerns identified in the Warning Notice on acute wards for adults of working age and psychiatric intensive care units, and wards for older people with mental health problems concerns, we found that the trust had responded positively and had implemented an action plan that was being worked through. There were marked improvements noted on the areas of initial concern. On our focussed inspection on the 7 December 2016 of the specialist community mental health services for children and young people to follow up the warning notice served we found that the trust had responded positively and significant improvements made to the risk assessment and risk management planning of young people.
- The risk management strategy and policy had been approved by the board in July 2016. The trust risk register highlighted 15 risks. Two of the extreme (red) rated risks had remained at the same level of risk since having been added in 2014 and the trust had not detailed any recent progress for these risks. However, another extreme (red) risk that had been added in September 2015 had been lowered to a moderate (yellow) risk following recent progress. The trust has identified eight high (orange) risks within their risk register, six of which had remained at the same level of risk since been added to the register, and two which has been reduced to a moderate (yellow) risk. The six remaining high risks included the current training systems not supplying sufficient information to line managers; low numbers in reporting patient safety incident forms; and increased number of incidents reported to the strategic executive information system and commissioners. The board did not have oversight of all risks, but the trust had a risk register system that ensured the top five risks in each care delivery service were escalated to the board through the executive assurance committee and board assurance framework. The care delivery services were responsible for all aspects of risk management relating to their local services.
- The trust governance systems did not provide assurance to the board that there was consistency across the trust's services in rates of staff appraisal and supervision. The average rate of supervision was 73% every six weeks compared with the trust target of 100%. Similarly, the governance systems did not provide assurance that staff appraisals were taking place consistently across all services. A total of 982 permanent non-medical staff had an appraisal within the last 12 months (trust wide), which equated to 26% of all staff. In the NHS staff survey 2015 the trust scored 3% below the national average for these being undertaken, and also for quality of appraisals, which was a negative finding. This meant that staff were not always receiving the appropriate support and supervision in their work.
- The trust had not ensured that the uptake of mandatory training was consistent across services and meeting the trust target of 65%. This was acknowledged by the senior managers we spoke with who were aware that mandatory training compliance was a concern across the trust. They acknowledged that the electronic systems did not capture and provide an accurate record of all training that took place.
- Board assurance was lacking around the oversight of the clinical risks that were present within services. This was because the IT systems of the trust needed further

improvement to support the running and governance of the trust. The introduction of the new electronic care record system was at an early stage of implementation and did not have the functionality needed to pull through the key clinical risks identified around serious incidents, physical health care, risk assessment and medicines optimisation to inform the board and the identification of improvements needed in these areas.

- The trust had a programme of clinical and internal audit which was used to monitor quality and systems to identify where action should be taken. These include the GP communication audit, national early intervention in psychosis audit, of which the findings were used to make improvement to the services.

Leadership and culture

- We received positive feedback about the chief executive of the trust from staff and different stakeholders. Staff spoke of feeling more engaged since the chief executive had joined the trust in 2014. Staff said that they felt more able to raise concerns, as these were listened to and acted upon. Staff said the board were more accessible and approachable as a result of the board to ward initiatives. Staff told us about regular emails that were sent from the CEO that felt "in touch" with what was going on in the organisation.We saw regular "report and learn" bulletins were sent by the trust to each of the service managers and these were generally being discussed in team meetings and available on notice boards. Feedback from clinical commissioning groups and local authorities was that there was clear leadership and a focus on patients and families. Directors and managers demonstrated commitment and enthusiasm to the trust and spoke passionately of the work being undertaken to develop services. Executive directors and non-executive directors had a clear understanding of their roles and responsibilities. We saw several examples of strong leadership and culture, particularly at care delivery service level. However, we also found that the care delivery service managers were stretched in terms of their remit, making consistent delivery a significant challenge across a large geographically spread organisation.

- The commissioning landscape was complex, with eight clinical commissioning groups across the areas covered by the trust,each with differing levels of investment and priorities. Collaboration was building with clinical commissioning groups, where opportunities were routinely taken to learn from other trusts and commissioners to inform local service development. However, the use of the national, local population and in-house information to assess and maximize the levels of access, quality, efficiency, outcomes and available resource across the patient pathways was not yet in place. The feedback we received from stakeholders was that they had generally positive working relationships with the trust, who they found to be open and transparent. Commissioners spoke of good communication with service leads and directors. They said they worked well together to deliver cost efficiency savings to services with a limited impact on output and delivery.

- In the NHS staff survey 2015, the trust had four key findings that were better than average for mental health trusts. These included the percentage of staff satisfied with the opportunities for flexible working patterns and percentage of staff experiencing discrimination at work over the past 12 months. The trust has 23 key findings that were below average for mental health trusts, which included staff satisfaction with the quality of work and patient care they are able to deliver and percentage of staff agreeing that their role makes a difference to patients/ service users. The survey showed that the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months had increased by 2% from the 2014-15 survey. The 2015 score is 5% higher than the national average for mental health.

- There were opportunities for leadership development in the trust. The trust had a line manager development programme and some staff had completed leadership and management training courses. For aspirational band six nurses there was an apprentice programme to support them develop into a leadership role. Managers also had the opportunity to enrol on the Nye Bevan programme for the development of senior leaders within the trust.

Staff engagement

- The trust had undertaken much work to improve the engagement of staff since our inspection in January 2015. This included drawing up a communication strategy. The strategy was driven by a number of factors, including the need for significant cultural change signalled by staff feedback; arrival of a new chief

executive and the development of a five year strategy. It was also needed to support the major change programmes which were happening across the trust.Key objectives from the communication strategy were:

- encourage clear, targeted, relevant internal communications to support meaningful staff engagement;
- help craft and communicate a clear, credible and compelling organisational narrative to promote confidence in our services / direction of travel and create a shared sense of purpose;
- promote organisational visibility, responsiveness and accountability through engagement activity such as media relations, public events and use of digital communications.
- Staff across all core services reflected positively on the visibility of the senior team and felt that the chief executive was approachable and in touch with the concerns of staff.
- The NHS Staff Survey 2015 found that the percentage of staff reporting good communication between senior management and staff has increased by 2% from 2014 to 2015. This score is equal to the national average for mental health trusts and is marked as being in an average range.
- The 'staff friends and family test' was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff whether they would recommend their service as a place to receive care and whether they would recommend their service as a place of work. The trust had a lower staff response rate than the England average (3% compared to 12%) during 1 January – 31 March 2016. The percentage of staff who would recommend the trust as a place to receive care was worse than the England average at 53% compared to 79%. In addition, staff who would not recommend the trust as a place to receive care was also 23%, compared with 7% nationally.
- The trust recognised the different professional group unions that included Unite, UNISON, the Royal College of Nursing and the British Medical Association. Meetings were held on alternate months for the joint consultative committee and these were chaired by the deputy chief executive.Locality meetings took place every three months and were diarised to take place a month before the joint consultative committee so that relevant issues could be escalated in a timely way. In between these meetings the union (staffside) representatives met with the human resources manager to go through any staff issues that were suitable for the wider meeting environment. The union representatives comprised of different grades of staff working across the trust, some of whom were employed in a full-time capacity in their union representative role. The union representatives we met with spoke of positive relationships with senior trust leadership, who they said were supportive and listened to their concerns. Themes that arose for staff working in the community settings was increased caseloads due to ward closures and higher acuity needs of people living in the community. For inpatient staff a theme that came through was the lack of opportunity to take time off the ward to either attend training or complete this through eLearning.

Workforce race equality standard

- We looked at the implementation of the workforce race equality standard on this inspection. The workforce race equality standard is a mandatory requirement for NHS organisations to identify and publish progress against nine indicators of workforce equality to review whether employees from black and minority ethnic backgrounds have equal access to career opportunities, receive fair treatment in the workplace and to improve black and minority ethnic board representation.
- The trust held detailed information on the equality characteristics of its workforce. This was acknowledged in its most recent workforce race equality standard report. Findings from the workforce race equality standard report showed that the workforce had 12% of black and minority ethnic staff. The percentage difference between black and minority ethnic board members compared to the percentage of black and minority ethnic staff within the trust had increased between 2015-16. The trust's executive management team comprised of 13 members, two of whom were from a black and minority ethnic background. However, black and minority ethnic staff remained significantly underrepresented within the senior manager/ leadership tiers, demonstrating that the leadership was not reflective or representative of the overall. There had

been a significant decrease in clinical black and minority ethnic staff representation at bands 8-9, but this had not been acknowledged in the trust action plan.

- There had been a significant deterioration in the black and minority ethnic responses to indicator 7. This asks black and minority ethnic and white staff if they believe the trust provides equal opportunities for career progression and promotion This was 76% compared with 83% for the previous year for black and minority ethnic staff and 86% compared with 87% for white staff.
- Of the 884 employees within Band 7 and above in the clinical workforce, 55 employees were from black and minority ethnic backgrounds. This evidences a significant underrepresentation of black and minority ethnic employees compared to the workforce average.
- In 2016, the likelihood of white candidates being appointed from shortlisting was 1.24 times greater than for black and minority ethnic candidates. Performance against this indicator had substantially improved during the period, as this likelihood was 2.40 in 2015.
- Black and minority ethnic staff were 1.06 times more likely to be subject to formal disciplinary proceedings when compared with white staff. This was an improvement on the previous year score which was 2 times more likely in 2015.
- The trust had developed an action plan though the trust had only proposed interventions to improve performance against three indicators. An example of this was that there was no action plan in relation to the 5% increase from the 2014-15 score in black and minority ethnic staff who had experienced harassment, bullying and abuse from patients, relatives of the public. For this and other indicators not included in the action plan, it was unclear what level of assurance the board had that all organisational challenges in relation to the workforce race equality standard were being worked through at a strategic and operational level. The equality, diversity and human rights steering group had the corporate responsibility for the delivery of the trusts equality and diversity action plan.
- The most recent NHS staff survey (2015) showed the trust scored better than average for similar mental health trusts. These included the percentage of staff experiencing discrimination at work in the last 12 months and the percentage of staff who experiencing physical violence from patients, relatives or the public in the past 12 months.
- The inspection team facilitated two separate focus groups for black and minority ethnic staff and black and minority ethnic managers from across the trust. Unfortunately these were not well attended. The feedback we received was that staff felt valued by the trust. However, there was feedback that inappropriate language/ 'banter' was not always dealt with, and that whilst cultural awareness training was provided to staff, more work was needed in this area.

Engaging with the public and with people who use services

- The trust outlined in its 'working together / involvement strategy', the work and initiatives to improve people's experience. The strategy laid out in six goals of how it would ensure this work is connected across the whole organisation and its plans for the future. The strategy acknowledged that people delivering and receiving services were best placed to advise about how to improve these. This is one of the principles underpinning the creation of the care delivery services. Each care delivery service will be expected to support the implementation of all six goals by 2020 and what to prioritise each year.
- At senior levels within the trust there was a focus on ensuring patient and carers' voices were heard and played a vital part in all improvement work. The strategy was clear in that the trust wanted to consider new and innovative ways to involve people and enable them to have an active role in the evaluation and improvement of services. There was an ex-service user non-executive director and service user governors. Feedback from them was that they felt very involved in consultations and decisions within the trust. Across the services, we found examples where patients and carers were involved in their care, but this was not always consistent. Feedback from service managers was very positive in regard to considering ways for patient participation. Allied health professionals said that participation with service users and families had 'become the norm'. For example care planning was done with people and not 'for' or 'to' them. Teams talked about consulting with patients' to come up with

better collaborative working ideas. The executive director of nursing spoke passionately about looking at how patients and people who use services would be involved at every level of the organisation but this had not yet fully embedded.Patient story / patient voice was seen as important.One example was meetings with local 'HealthWatch offices' to hear patient / carers' views. A 'People first' culture was spoken about in wards and services by staff at various levels.

- The trust had consulted about future priorities with people who use services. In July 2015 the trust spoke with their service user reference group about how to improve their service user policy. Public engagement was also included in the consultation.
- There was evidence of initiatives to inform and educate as well as consult with the public and examples of good practice in engagement to better meet people's needs.For example the suicide safer strategy; the speech language specialist ran sessions in local libraries to bring people together and offer support and guidance.
- The equality and diversity steering group was chaired by the chief executive and met quarterly. The reference group for disability was chaired by the director of finance and included service users to represent local learning disability user groups, local groups and staff with disabilities.

Fit and proper persons test

- At the last inspection of the trust in January 2015 we found it was not meeting the fit and proper person's test. At this inspection the trust met the fit and proper person's requirement and was compliant with the law. This regulation of the Health and Social Care 2014 ensures that directors of health service bodies are fit and proper persons to carry out their roles.
- The trust had developed a fit and proper persons document which detailed the trust policy procedures in relation to meeting the requirement. This outlined the checks required to be in place for those identified as needing to meet the fit and proper person test, such as checks with the 'disclosure and barring service', proof of identity, evidence of capability to lead, references and checks against the insolvency and bankruptcy register.
- We reviewed 11 personnel files of five directors and six non-executive directors, six of whom had been in post prior to the implementation of the fit and proper persons' requirement in November 2014. The trust had ensured that checks had been carried out for all new directors. Disclosure and barring checks had been carried out on the existing directors and up-to-date evidence of their proof of identification. All directors signed an annual declaration of their fitness to hold a director position.

Quality improvement, innovation and sustainability

- The street triage team had been implemented by the trust. Street triage consisted of mental health professionals who provided on the spot advice to police officers who were dealing with people with possible mental health issues. They assessed risk and whether less restrictive options were appropriate. The street triage service had led to increase partnership working and significantly reduced the number of people requiring the health based place of safety or custody.
- An urgent care lounge had been created within acute in-patient facilities as an alternative to people attending the accident and emergency department. This had involved joint protocols being developed with ambulance services to guide responses guiding responses to high-volume service users.
- New waiting time standards for early intervention in psychosis and for psychological therapies for common mental health services were being or were on target to be met this year.
- The trust had developed and implemented the 'stay alive' suicide prevention app for the public to download onto smartphones. This was advertised in public places around Sussex and provided a lot of information and tools for people in a crisis, or where people were worried that someone might commit suicide.
- The trust had worked in collaboration with East Sussex clinical commissioning group in the co-design of a new pathway and model of Dementia Care called the 'Golden Ticket'. This was piloted between October and December 2015 with positive outcomes for patients and awarded the Health Foundation's Innovation Award.
- The forensic/ secure inpatient wards used relational security principles of see, think, act to reduce the need for seclusion on the ward. Relational security is the collective knowledge and understanding staff have of

Requires improvement

Are services well-led?

the patients they care for. It combines four elements of the staff team, other patients, the inside world and the outside world to ensure safe care. The service had received national recognition for implementing this initiative from the Nursing Times.

- The trust were a partner in the Sussex recovery college which offered mental health recovery focused educational courses to adults of all ages. A peer support worker employed by the trust had recently received an award for outstanding contribution to the college.
- Within the community-based mental health services for adults of working age they had a commitment to be creative in improving services to meet local need included the employment of peer support workers and employment advisors and the introduction of a daily clinic so that staff could respond quickly to people in crisis.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Wards for older people with mental health problems:** Heathfield and St Raphael wards did not have access to psychology. **Community-based mental health services for adults of working age:** • The trust did not ensure that staff completed training in the Mental Capacity Act and Depriviation of Liberty Safeguards. • The trust did not ensure that staff completed training in the Mental Health Act. • There was evidence of an impact with regard to documentation and people not being read their rights. There was limited evidence of people having their rights, under the Mental Health Act or subject to a community treatment order, explained to them. **This is a breach of Regulation 9(1)(2)(3)(a)(b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Acute wards for adults of working age and psychiatric intensive care units:** Patients on Amber ward were not permitted to have or use their mobile phones on the ward. Patients used telephones in offices while supervised by staff, for patient safety. **This is a breach of Regulation 10(1)(2)**

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Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Provider:** • The trust did not ensure staff were following trust policy around the safe handling of medicines requiring cold storage. • The trust did not ensure that each patient or person using the service had a complete and updated risk assessment. **Wards for older people with mental health problems:** • The trust did not ensure that all the required checks and tests were undertaken for patients taking high dose antipsychotic medicines and that the monitoring forms were fully completed. **Community-based mental health services for adults of working age:** • The trust did not make sure that people who used services had a comprehensive risk assessment. • The trust did not make sure that risk assessments for people who used services were regularly reviewed so that they were accurate and up to date. **Specialist community mental health services for children and young people:** • Care and treatment was not provided in a safe way for service users. Where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of service users. The waiting list at Eastbourne showed that there was a delay in care being provided to young people accepted into the

This section is primarily information for the provider

Requirement notices

service. There were delays of up to 610 days for young people needing therapy. The demand on the service was not being met meaning that there was an increased risk to young people due to the delay in accessing treatment. We spoke with parents and staff who felt that the delay in accessing the service was incredibly stressful for them.

- Risk assessment and risk management plans had not been undertaken for all young people receiving the service.

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

- A number of risk assessments were not updated following incidents.
- On Amber, Maple, Pavilion and Jade wards we found clinical equipment which was broken and out of date.
- The trust did not ensure that medicines prescribed to people detained under the Mental Health Act were documented and include the route of administration and the maximum dose to be administered.
- The trust had not taken sufficient action to keep patients at risk of harm to themselves safe at all times.
- The trust had not taken sufficient action to manage ligature risks to patients.

This was a breach of Regulation 12(1), (2)(a)(b)(d)(e)(f)(g)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Wards for older people with mental health problems:** The trust did not ensure that patients were protected from the risks associated with unsafe or unsuitable premises. Five wards did not comply with Department of Health gender separation requirements. This relates to The Burrowes, Larch, Meridian, Orchard and St Raphael wards. **This was a breach of Regulation 15(1)(a)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Provider:** • There were insufficient systems to monitor the training, appraisal and supervision of staff working across the services. This meant that there was the potential that staff were not receiving the appropriate level of support in their work. • The governance systems did not provide sufficient oversight to the board around clinical risks, such as physical health care, risk assessment and medicines optimisation. This could put patients at risk of insufficient care and treatment. **This was a breach of Regulation 17(1),(2)(a)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

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Wards for older people with mental health problems:

- The trust did not have suitable arrangements in place to ensure that staff had received annual appraisal and regular supervision.

Community-based mental health services for adults of working age:

- Staff had not completed appropriate rates of mandatory safeguarding adults level two training.
- The trust did not provided sufficient availability of face to face mandatory training.

Mental health crisis services and health-based places of safety:

- Staff had not completed appropriate rates of mandatory training.

- The trust did not provided sufficient availability of face to face mandatory training.

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

- Not all wards had reached the trust's minimum mandatory training compliance levels. Not all staff had regular supervision and appraisals.

This was a breach of 18(2)(a)