Requires Improvement

Sussex Partnership NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute and psychiatric intensive care units	Meadowfield Hospital	RX277
Acute and psychiatric intensive care units	Oakland's Centre for Acute Care	RX26N
Acute and psychiatric intensive care units	Mill View Hospital	RX213
Acute and psychiatric intensive care units	Department of Psychiatry, Eastbourne General Hospital	RX2E7
Acute and psychiatric intensive care units	Woodlands Conquest Hospital	RX2L6
Acute and psychiatric intensive care units	Langley Green Hospital	RX2PO
Crisis services and health based places of safety	Department of Psychiatry, Eastbourne General Hospital	RX2E7
Crisis services and health based places of safety	Woodlands Conquest hospital	RX2L6
Crisis services and health based places of safety	Meadowfield Hospital	RX277
Crisis services and health based places of safety	Mill View Hospital	RX213

Summary of findings

Crisis services and health based places of safety	Oakland's Centre for Acute Care	RX26N
Child and adolescent inpatient services	Princess Royal Hospital, Chalkhill RH16 4EX	RX2X4
Community based services for adults	Trust Headquarters, Swandean, BN13 3 EP	RX2
Community based services for adults	East Brighton community mental health centre, BN2 2EW	RX21M
Community based services for adults	Chapel street clinic, Chichester, PO19 1BX	RX219
Forensic secure inpatient wards	The Hellingly Centre, BN27 4ER	RX2E9
Forensic secure inpatient wards	Southview Low Secure Unit, BN27 4ER	RX2Y3
Forensic secure inpatient wards	The Chichester Centre, PO19 6GS	RX2X5
Community based services for older adults	St Annes Centre	RX2K3
Community based services for older adults	Uckfield Hospital	RXC18
Community based services for older adults	Linridge Community Services	RX214
Learning disability community Services	Highdown, BN13 3EP	RX2
Learning disability inpatient services	Seldon Centre	RX2Y6
Inpatient wards for older adults	The Harold Kidd Unit,PO19 6AU	RX240
Inpatient wards for older adults	Horsham Hospital - Iris Ward, RH12 2DR	RX2C8
Inpatient wards for older adults	Salvington Lodge (The Burrowes), BN13 3BW	RX2A3
Inpatient wards for older adults	Lindridge, BN3 7JW	RX2Y5
Inpatient wards for older adults	St Anne's Centre & EMI Wards, TN37 7PT	RX2K3
Inpatient wards for older adults	Beechwood Unit, TN22 5AW	RX2L8
Inpatient wards for older adults	Meadowfield Hospital, BN13 3EF	RX277
Inpatient wards for older adults	Mill View Hospital, BN3 7HZ	RX213

Summary of findings

Long stay/rehabilitation mental health wards for working age adults	Connolly House, PO19 6WD	RX237
Long stay/rehabilitation mental health wards for working age adults	Amberstone Hospital, BN27 4HU	RX2F3
Long stay/rehabilitation mental health wards for working age adults	Shepherd House, BN11 2ET	RX232
Long stay/rehabilitation mental health wards for working age adults	Rutland Gardens Hostel – Community Wards BN3 5PA	RX202
Long stay/rehabilitation mental health wards for working age adults	Woodlands Bramble Lodge, TN37 7PT	RX2L6
Long stay/rehabilitation mental health wards for working age adults	Trust Headquarters12, Hanover Crescent BN2 9SB	RX219

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

Summary of findings

Ratings

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

Overall rating for mental health services at this provider	Requires Improvement 
Are mental health services safe?	**Requires Improvement** 
Are mental health services effective?	**Requires Improvement** 
Are mental health services caring?	**Good** 
Are mental health services responsive?	**Requires Improvement** 
Are mental health 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.

Summary of findings

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Overall summary

Overall, we rated the trust as requires improvement and this was because;

- Two core services were rated as inadequate under safe.
- The trust had no plan in place to tackle the high rate of suicide.
- There were significant gaps in the flow of information, particularly around learning from serious untoward incidents.
- There were significant gaps in training, appraisal and supervision for some staff.
- The quality of care planning was inconsistent and did not always demonstrate how people were involved in their care.
- The trust lacked strategic direction.
- The trust had gaps in relation to providing the board with assurance

However, caring in some areas was rated as outstanding and the trust is a place of innovation and ideas. It also clearly aspires to best practice in many parts of the services provided.

There were inconsistencies in how services were managed and we found that some areas of care in learning disability and older people's inpatient services were inadequate. These services require urgent attention to bring them up to acceptable standards of safety. We asked the trust to close Hanover Crescent (part of their rehabilitation services) to admissions due to an unsafe environment, with poor conditions of hygiene and low levels of staffing. The trust did this immediately.

It was clear that the trust recognised that some areas are facing particular challenges and we found the managers and directors of the service were responsive to our challenge and acted swiftly to put things right.

We have recommended a number of requirement notices to be put into force and these relate to ensuring that standards of hygiene are maintained, that staff are properly supported to receive their mandatory training, that risks are properly identified and that care plans involve people.

There was an elevated risk of people self-harming or committing suicide. Many of these deaths happened whilst people were in receipt of services in the community.

There was an elevated risk of suicide within 3 days of discharge and within 3 days of being admitted to an acute setting. In total there were 80 deaths in the period from 1 November to 31 October 2014. Whilst we recognise that it is not just the trust's responsibility to develop a suicide prevention plan, we would urge the trust to initiate urgent work with public health and community agencies to address this.

We were concerned that staff were not receiving timely feedback in relation to serious untoward incidents. We therefore asked the trust to supply us with details of length of time it took from notification of a serious untoward incident to time the report and action was completed and circulated. From the data supplied to us from the trust, it is struggling to meet timescales, with some investigations taking 220 days from start to finish. This may impact on their ability to close the loop on serious incidents and ensure that learning to avoid / prevent similar incidents from emerging is shared. The current average time taken to complete reports ofserious untoward incidents is about four months. The trust must work to address this.

The staff survey identified that there was an elevated risk to staff working extra hours and feeling stressed. The trust has a clear action plan to address this. This includes reviewing the staffing levels and skills mix on inpatient units and reviewing the use of three-day 12½ hours shift rotas.

At the time of the inspection, the Trust acknowledged that there was not a system in place to identify clearly where ‘agency’ staff were used. The Trust raised this with CQC prior to the inspection.

Overall, caring was rated as good, achieving outstanding in community child and adolescent services and forensic services. This was because staff were found to be compassionate, kind and motivated to go an extra mile for the people they served. We also found good solid

Summary of findings

evidence that the trust was sensitive to individual needs, taking cultural, religious and spiritual needs into account. They also provided good information to people and this was available in a variety of languages and formats.

The trust is a place where innovation is given priority and this enables them to seek new ways of working and bring about change to service delivery. There is much creativity at a senior level. We would urge the trust to continue to ensure that the quality of more traditional services ismaintained and that the desire to seek new and innovative ways of working is not at the expense of those services.

The senior management team were very positive about the new Chief Executive Officer (CEO). They felt that having been through a difficult and challenging period and that the culture of the board had changed for the better. We found the senior team to be open and transparent in their discussions with us. The CEO was able to describe the challenges facing Sussex.

It was clear that the trust were in a period of some significant change, including a cultural change. We heard from staff and stakeholders that relationships with the trust had been difficult to manage at times but that this was becoming more positive. Many felt that the new CEO was responsible for bringing in a more visible and open approach. The trust did not have a clear strategic direction thatwas written down and understood by staff. The trust also lacked a framework toensure that the board were clear about and understood the more detailed risks and challenges facing the organisation. It had identified the principal risks faced by the organisation.

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 overall as requiring improvement because;

In rehabilitation services and older people's inpatient services safe was rated as inadequate becausewe found that people were not always adequately protected from risks of inappropriate or unsafe care and treatment. This was because:

- We found examples where standards of hygiene and cleanliness were poor and infection control processes had not been followed.
- Although ligature risk assessments had been completed on all the older adult admissions wards, some staff were not able to articulate how these risks were being managed or mitigated on a day to day basis. We reviewed audits that had been carried out in relation to ligature risks and found that not all risks had been identified. In child and adolescent services there were areas of concern in relation to ligature points in bathrooms. Although identified, they were not being addressed as a priority on the trust ligature audit and programme of works.
- The trust had a system for feeding back on serious untoward incidents but it was not effective. Incidents were not always fed back in a timely manner in order to make changes to people's care and to reduce future risks or harm to patients.
- Many staff across all areas of the trust had not completed the necessary mandatory training in safeguarding or in health and safety. Training figures received from the Trust showed that only 9% of staff had received safeguarding adults training.
- There was unsafe use and management of medicines. Medicines had not been routinely managed and stored correctly. There were out of date medicines in storage cupboards.
- Across many inpatient services there were breaches on wards of best practice in relation to gender segregation. Many wards did not separate men and women and were mixed. Some wards had separate corridors for men and women but women could access bathroom and toilet facilities only by passing through the male corridors. Doors were left open between male and female corridors.

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However:

Summary of findings

- There were other services we inspected which we found to be good under safe. This was because they had good systems in place to monitor risk; for instance a 'zoning' system in community services. Staff were able to articulate how to identify abuse and how to implement safeguarding procedures. Some wards had successfully reduced seclusion through implementing a reducing restrictive practices strategy.

Are services effective?

Requires Improvement

Overall, effective was rated as requires improvement because;

- There were many examples of care plans which did not fully identify people's needs.
- There were also delays in people accessing physical health care outside of the inpatient unit. For instance, accessing diabetic services and tissue viability services. The Trust had no service level agreements in place to ensure timely access for patients who might need this.
- Mandatory training and refresher training had not been completed in many areas.
- There was a lack of understanding of the application of the Mental Capacity Act 2005. Consent to treatment decisions were not always adequately recorded and capacity was not always adequately assessed.
- There were issues across older peoples inpatient services in particular, highlighting serious gaps in training, supervision and appraisal.
- However; the trust consistently demonstrated a good awareness of best practice. Staff were able to articulate how NICE guidelines were used. The trust is clearly committed to using audit as a measure of how services were performing. The trust has participated in seven national audits and have undertaken a number of local audits. The trust are creative and keen to innovate and are taking part in national pilots. They are currently participating in the 'Street Triage' pilot, which aims to reduce the number of people detained inappropriately under S136 of the Mental Health Act 1983.
- They are also expanding their forensic and secure services. These services were noted for the initiatives they have implemented on patient involvement and improving patient experience.

Summary of findings

- The Harold Kidd Unit, Pavillion Ward and the electroconvulsive therapy department are all accredited by the Royal College of Psychiatry.
- Child and adolescent mental health services (CAMHS) and forensic services belong to the Quality Network for Inpatient Care (QNIC) The network aims to demonstrate and improve the quality of inpatient care through a system of review against the QNIC service standard. We saw that forensic services had implemented changes based on recommendations from the QNIC peer review.

Are services caring?

Good

Caring was rated as good;

- This was because staff were found to be compassionate, kind and motivated to make a difference. Caring was rated as good across all core services. In some areas this was rated as outstanding.
- The Community Mental Health Patient Experience Survey did highlight two areas of worse than average performance, which the trust should note, particularly in view of the inspection team findings. This was under 'planning your care' and' getting support with finding or keeping accommodation.'
- Whilst there were many examples of good care planning, older people's inpatient services and some acute wards did not demonstrate a consistent approach to involving people in the planning of their care. There were also very few examples of patients having 'advance decisions' recorded in their care records.
- However, we received positive feedback from patients and their carers and observed many instances where staff were kind and compassionate.

Are services responsive to people's needs?

Requires Improvement

Responsive was rated as requires improvement;

- This was because in child and adolescent services there were significant delays in accessing services, although the trust has been working to reduce this. Average number of days between referral and assessment breached targets. Monitoring carried out by Hampshire CAMHS showed that from April to September 2014 young people received their first assessment approximately 41 days following referral, with urgent referrals seen within timescale.

Summary of findings

- Hampshire CAMHS had a target of treatment taking place within 84 days of assessment, where at 70 days this would be flagged up and acted upon. We were informed that waiting times for routine treatments in relation to anxiety, low mood and autistic spectrum conditions could take up to a year. However, we found examples where young people had been waiting up to 18 months for routine treatments. Managers told us that the waiting lists resulted initially from when SPFT took over the Hampshire CAMHS and there was no clarity who was responsible for different assessments, with all teams doing different things.

The risk register for Hampshire CAMHS identified the waiting times as the highest risk level of severity, which was 'catastrophic'.

Inspectors visiting these services found;

- Across both adult and older peoples wards there was a shortage of beds. This meant that often it was necessary for patients to access inpatient care some distance from their home.
- Patients could also be transferred from one inpatient bed to another in order to manage bed shortages. We noted that this had occurred on 194 occasions during July/September 2014. Mental Health Act Co-ordinators here raised this with the trust as a concern.
- The Trust has a bed occupancy rate of 93%. The Royal College and Psychiatrist recommend an average occupancy of 85%.
- In between April and September 2014 there were 346 readmissions across 14 locations within 90 days of discharge. It is possible that this may indicate that discharge in some instances may be happening too soon.
- Discharge was often delayed because of lack of suitable accommodation. In the six months to September 2014 the Trust reported 132 delayed discharges from 22 wards.
- There were restrictions in place on some wards. This had an impact on patients' rights and freedom. For instance, some informal patients were not allowed to leave the ward for 24 hours and on the learning disability ward some patients could not access hot drinks or snacks.
- However, positively, the proportion of patients followed up within 7 days of discharge was in line with the England average of 97%.

Summary of findings

- Review of prescriptions charts showed that intra-muscular medications were prescribed routinely and the care records could not give a clear rationale for this. This was contrary to the trust policy on medication.

Are services well-led?

Requires Improvement

The trust was rated overall as requires improvement;

- The trust had no formal strategy at the time of the inspection. The chair described two broad strategic aims:
- 1. To continue to develop and expand the specialist services to become the biggest provider in the south-east. To further develop links with the criminal justice system and develop more joint ventures.
- 2. To consolidate the quality of the local adult services; levelling up to that of the best by identifying what services are good and encouraging sideways transmission of good practice.
- Governance of the trust had some gaps, particularly in relation to the flow of information. The trust collated a lot of data, particularly around performance, serious incidents and complaints but this did not always get fed back to the local teams and services in a timely manner. We heard this consistently from staff across many services.
- There were also significant issues around capturing information centrally on training and appraisal.
- We noted that the assurance framework to the board was not robust, so capturing information on quality, performance, finance and safety was not joined up. The CEO had already identified this as an issue and had commissioned a governance review. Action to address this gap was being taken with an additional committee scheduled for early February.
- It was clear that there have been some significant changes at a senior level of the organisation. Work has been started to ensure that the trust is open and transparent. The CEO was in the process of developing his team.
- The trust has a set of values and these were set out in the 'better by experience' booklet that lists and describes the five values: We welcome you. We hear you. We work with you. We are helpful. We are hopeful for you.
- There was good financial management in place and the trust had devolved budgets to the level of the clinical team.

Summary of findings

- It was not clear whether any in-depth analysis of the executive team's strengths and weaknesses had taken place.
- Staff overall were very positive about their managers and most core services were rated as good. However because we found significant issues relating to ligatures, training, supporting staff, lack of supervision, particularly in older peoples services, these were rated as requires improvement.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Paul Lelliott, Deputy Chief Inspector of Hospitals at the Care Quality Commission.

Team Leader: Natasha Sloman, Head of Hospital Inspection for the South East region at the Care Quality Commission.

The team included CQC inspectors and a variety of specialists and experts by experience. The team was joined by our national professional advisor on substance misuse, as this was the first comprehensive inspection which inspected substance misuse services. These services will not be rated at this stage.

Why we carried out this inspection

We inspected these core services as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of the experience of people who use services', we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about Sussex Partnership Foundation Trust and asked other organisations to share what they knew. We carried out an announced visit between 12th and 16th of January 2015. We also carried out an unannounced visit to Rutland Gardens on Friday the 23rd of January 2015.

During the visit the team;

- Sent out questionnaires to gather the views of people who use services.
- Collected feedback from people who use services using comment cards
- Talked with over **240** patients, carers and family members.
- Observed how staff were caring for people.
- Carried out **8** home visits with staff to people receiving care.
- Looked at the personal care or treatment records of over **300** patients.
- Interviewed over **360** individual frontline members of staff.
- Held focus groups at each location with different staff groups..
- Attended multi-disciplinary team meetings.
- Observed handovers.
- Reviewed information we had asked the trust to provide.
- Met with local stakeholders, commissioners and Local Authority representatives.
- Interviewed over **25** corporate staff and members of the board.
- Met with staff side union representatives
- Met with trust governors.

We visited all of the trust's hospital locations and sampled a number of community mental health services. We inspected all wards across the trust, including adult acute services, psychiatric intensive care units (PICUs), secure wards, older people's wards, specialist wards for people with learning disabilities, and child and adolescent wards. In total we inspected 41 wards and we visited 13 community teams. We also visited and inspected 5 S136 places of safety and 6 crisis services.

On the 8th and 9th of January 2015 we visited community child and adolescent services in Hampshire and Kent, as these are now managed by the trust.

Summary of findings

The team would like to thank all those who met and spoke to inspectors during the inspection. We were impressed by the honesty and willingness of patients and staff to come forward and share their experience with us.

Information about the provider

Sussex Partnership NHS Foundation Trust delivers a range of mental health, learning disability, substance misuse and prison services across Sussex. It is developing specialist services across the south east of England. It also provides primary mental health services in partnership with social enterprises and independent sector organisations. Adult services have no upper age limit and specialist mental health services include eating disorders, personality disorder and psychological therapies services. The trust is a teaching trust for Brighton and Hove medical school.

Sussex Partnership Foundation Trust achieved foundation trust status on 1st August 2008. The trust headquarters are located at Swandean, Arundel Road, Worthing, West Sussex, BN13 3EP.

It covers a large geographical area, and it serves a population of approximately 1.8m. Its reach extends into both Kent and Hampshire where it delivers community mental health services for children and young people. The county of Sussex is divided into 3 areas, West Sussex, East Sussex and Brighton and Hove. Each has a different health profile and therefore each area has its own priorities relating to the health agenda. Brighton has a higher than average proportion of young people and has a higher rate of deprivation and homelessness than the national average. East Sussex and West Sussex stand lower than the national average in relation to social deprivation. East and West Sussex both have high rates of self harm and suicide.

The trust has 657 beds and manages 5,000 staff. It has an annual income of around £2.5 million .

Sussex Partnership Foundation Trust has a total of 30 locations registered with CQC and has been inspected 17 times at 10 locations in total. At the time of our visit there were a number of compliance actions in place. These were at the Chichester Centre, Amberstone Hospital and Langley Green Hospital. The findings of our previous recent inspections were;

- In July 2013, Amberstone Hospital was inspected and found to be non-compliant in relation to the safety and suitability of premises and supporting workers. This is a breach under regulation 15 and 23 of the Health and Social Care Act 2008.
- In November 2013 The Chichester Centre was inspected and found to be non-compliant with staffing and supporting workers. This is a breach under regulation 13 and 23 of the Health and Social Care Act 2008.
- In March 2014, Langley Green Hospital was inspected and found to be non-compliant in relation to respecting and involving people who use services, care and welfare of people who use services, safeguarding people who use services from abuse, management of medicines, staffing, assessing and monitoring the quality of service provision and records. Tthis was a breach of regulation 17, regulation 9, regulation 11, regulation 13, regulation 22, regulation 10 and regulation 20 of the Health and Social Care Act 2008.

We inspected these services again and found that Amberstone Hospital is now compliant with regulation 15 but remains non-compliant with regulation 23, supporting workers in relation to their responsibilities. The Chichester centre is now compliant. Langley Green is now compliant with these regulations.

The Trust had recently appointed a new chief executive who was developing a cohesive top team.

Summary of findings

What people who use the provider's services say

We received much positive feedback from the interviews that were carried out by our experts by experience and inspection teams. We also collected comment cards and had asked people to complete a questionnaire on their experiences. We received 55 responses to the questionnaires that were sent. The cards and questionnaires gave us a more mixed and varied view on the care and treatment received. Some people who use services described feeling unsafe at times and felt that services were not as responsive as they should be. However, more people described the opposite and were very positive about the care provided by Sussex partnership. Feedback from the inspections of frontline services gave a consistent message that people were, overall, pleased with the standard of care received. Patients and their carers felt that the care they received was kind and compassionate. They were impressed with the activities provided and pleased that patients were supported to learn practical living skills on inpatient units. Carers told us that visiting times were flexible, which allowed them to keep in regular contact with their loved ones. Some people who use services said that these services saved them and described staff as brilliant.

Good practice

- The trust was participating in the "Street Triage" initiative, and had been effective in reducing the number of people detained under Section 136 of the Mental Health Act and the number of people referred to the crisis response team.
- The A&E liaison team and the Brighton urgent response team won the 2013 Guardian Healthcare Innovation award for the Brighton urgent response project in both A&E and in responding to GP referrals in the community. The project led to a 50% reduction in the number of patients with mental health problems being admitted to the observation ward at the Royal Sussex County Hospital.
- Brighton and Hove recovery college prospectus was available to all patients. Recovery colleges being rolled out across the trust.
- Reduction in use of seclusion from 2011-2014. Department of Health appointed Pavilion ward positive and pro-active champions.
- A staff member at Shepherd House had set up a football team, which involved in-patients, patients in the community and staff. They used training facilities at the local professional football club and had organised a tournament involving 16 teams from different mental health services in the local area.
- Most rehabilitation services employed peer support workers for several hours a week. They often facilitated community meetings with patients. Peer support workers provided a unique perspective on the service provided and worked well with patients to support their rehabilitation.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure medicines management is conducted in accordance with trust policies. For example on Oaklands ward a detained patient had been administered medication without lawful authority for ten days; on Oaklands ward we found patients' prescription-only drugs were not held securely; on Maple ward patients were routinely prescribed intra-muscular injections on admission to be given when required regardless of their individual needs or presentation.

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- The trust must ensure staff are appropriately trained. Staff had not received mandatory training within the timescales set by the trust. This included basic life support training and safeguarding training

Summary of findings

- The trust must comply with standards of hygiene and cleanliness in all areas.
- At Hanover Crescent Individual risk assessments must be comprehensive and reflect shared input from the individual, the referrer and staff. The service needs clarity and a clear sense of operational purpose and recommendations, to make sure that it can safely meet the needs of people. There are a number of serious concerns about the safety and suitability of the building, risk assessment processes and current staffing arrangements. Since the inspection Hanover Crescent is now closed to admissions.
- The trust must ensure staff are appropriately supported and supervised. Staff had not received supervision, appraisals or undertaken reflective practice in line with the trust's policy. Many staff had not received any formal support in the past year.
- The trust must ensure that informal patients are not prevented from leaving the ward. On Oaklands ward we found patients who were not detained were prevented from leaving the ward for 24 hours or longer.
- The trust must improve the recording and analysis of incidents and complaints, and how lessons are learnt from this.
- The trust and the local service must improve the effectiveness of the links between the corporate and local governance processes.
- The trust should review provision of gender segregated facilities on the wards.
- The trust must ensure safe staffing with appropriately qualified staff on the child and adolescent unit. The staffing returns on the child and adolescent unit showed that there was a shortage of qualified nurses on the majority of shifts throughout the day and night. The records indicated that some of these were covered by healthcare assistants. The covering of shortfalls of qualified nursing staff with healthcare assistant staff did not promote the health, safety and welfare of people who use the service, and put young people at risk of inadequate care.
- The trust must ensure appropriate actions are taken to mitigate the ligature risks to young people.
- The trust must identify and take action to mitigate risks on the older people's inpatient unit. On the older people's inpatient unit there were ligature risks that had not been identified.
- The trust must remove blanket restrictions in some areas.
- The trust must meet the Fit and Proper Person Test.
- The trust must take action to bring the seclusion rooms up to required standard in the inpatient unit for people with a learning disability and address use of seclusion in the inpatient unit for people with a learning disability.

Action the provider SHOULD take to improve

- The purpose of the de-escalation room should be confirmed and designed as appropriate to ensure that young people at risk to themselves or others were not nursed in this area.
- The trust should ensure consistent use of the Fraser Guidelines. There was inconsistent use of the Fraser Guidelines/ being Gillick Competent for use with young people under 16 years. The nine care records we viewed stated that many young people were treated under 'parental responsibility'. This did not fully take into account the capacity of the young person, or use of the Fraser Guidelines or Mental Capacity Act.
- The care plans on the child and adolescent ward should demonstrate the active involvement of young people in identifying their needs and goals for treatment.
- Discharge planning should be carried out as part of the assessment and care planning of the young people.
- The provider should ensure that all Section 17 leave forms are completed correctly and specify the frequency and duration of leave.
- In rehabilitation services the provider should ensure that all patients are seen and reviewed by a consultant psychiatrist regularly.
- The provider should ensure that the controlled drugs storage facility meets with legal requirements.

Summary of findings

- The provider should ensure that patients taking care of their own medicines can safely secure and store medicines in their bedrooms.
- The provider should ensure that an Independent Mental Health Advocacy service is put in place promptly and that all detained patients have access to an Independent Mental Health Advocate.
- The trust should review its collection and use of information about patients assessed in the 136 suites, and ensure that patients are not held in the suites for longer than necessary.
- Monitoring of the use of the 136 suites should be reviewed, so that the information produced is correct and can be used to improve the experience of patients brought to the suites, and ensure they are not subject to unnecessary delays.
- On Maple ward not all restraint incidents were reported. The trust must review this and take steps to ensure all restraints are recorded.
- The trust should ensure that there are systems in place for sharing learning following reports into serious untoward incidents. Staff involved in reporting incidents did not receive timely feedback.
- Risk assessments on Maple ward were generic in nature and were not person centred.
- The trust should ensure that staff are clear about what constitutes seclusion. When patients were restrained in their rooms this was not considered by the wards to be a form of seclusion. This meant that patients were not afforded the monitoring and review safeguards defined in the trust's seclusion Policy.
- The soft furnishings on Maple ward were in poor condition, which presented an infection control risk.
- The trust should ensure that the induction programme prepares people adequately for their role.
- The quality of assessment and care planning was variable. We found the care plan documentation did not always reflect the quality of care given and was not recovery focused.
- In Meadowfield Hospital patients did not always have access to prompt specialist nursing services such as nutritional support, tissue viability, podiatry or diabetic services as the trust did not have a service level agreement with the local community NHS trust.
- Patients were not always able to access care as close to home as possible. Bed shortages across the trust meant that patients from other areas were often accommodated in Maple, Rowan and Oaklands wards. Patients were often transferred several times before accessing care close to their home.
- Discharge was often delayed because of lack of suitable accommodation. We saw little active engagement with stakeholders to resolve the issues or establish co-ordinated pathways of care.
- On Maple ward the environment required refurbishment and redecoration.
- The trust should review privacy for people wishing to make private telephone calls. The ward payphones were situated in communal areas of the wards, which meant that patients could not make phone calls from these payphones in private.
- The trust should ensure that staff receive feedback from complaints on some wards. There was little analysis of themes or trends at ward level.
- Care record documentation should reflect a holistic, person centred, recovery approach highlighting strengths of patients.
- The trust should resolve its staff shortages.
- The trust should review staff understanding and monitoring of the Modified Early Warning Score (MEWS) records, where routine physical records, where routine physical observations of patients are recorded (such as blood pressure and pulse).
- The trust should review access to psychology within the service.
- The trust should consider adding shower facilities to the seclusion rooms at The Hellingly Centre, to preserve the dignity and respect of people and to reduce the risks posed by bringing people out of the seclusion room to use shower facilities.

Summary of findings

- The trust should ensure staff are confident regarding the location of ligature cutters and that this location is consistent across wards.
- In community learning disability services the trust should consider their arrangements for parking on the site as it was reported that people attending appointments had to wait for up to an hour to find a suitable parking space that would allow parking of a converted vehicle.
- All hospital staff should undergo breakaway and de-escalation of violence training to make sure that they are aware of the latest guidance and techniques to keep them and patients safe.
- Slips, trips and falls training should be cascaded across all older adult wards to support the pilot project on falls reduction.
- The fire evacuation timetable for 2015 should be planned and implemented at Millview Hospital.
- In the Bognor Regis team there is additional pressure on staff and their caseloads because of sickness and increasing number of care homes opening in the area. This has resulted in a rising number of people requiring community mental health services. The service needs to have support in place whilst the situation is addressed.
- Caseloads of all community teams need to be carefully managed to ensure they are in line with Department of Health guidance, to maintain effective services.
- The information technology provision is sporadic across the team basis with staff not having easy access to computers to access or record notes. This is time consuming and may lead to a loss of information.
- Medical and nursing records are currently used in either paper or electronic format. There is no consistency across the teams and this could lead to a potential loss of information.

Sussex Partnership NHS Foundation Trust

Detailed findings

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

Key findings in safe;

- In rehabilitation services and older people's inpatient services safe was rated as inadequate as we found that people were not always adequately protected from risks of inappropriate or unsafe care and treatment.
- There were concerns raised about ligature risks across older adult admissions wards and on child and adolescent inpatient services.
- The Trust had a system for feeding back on serious untoward incidents but it was not effective. Incidents were not always fed back in a timely manner in order to make changes to people's care and to reduce future risks or harm to patients.
- Many staff had not completed the necessary mandatory training in safeguarding or in health and safety.
- In some areas there was unsafe use and management of medicines.
- Across both inpatient services there were breaches on many wards of best practice in relation to gender segregation.

Our findings

Safe and clean environment

Across rehabilitation and older peoples inpatient services we found wards which were not clean and had unsafe standards of hygiene. At Hanover Crescent infection control and cleaning standards were poor. The environment was generally quite unclean and areas were in poor decor. The

kitchen in particular had ripped and dirty flooring. Food in the fridge was not clearly labelled and dated. Infection control processes had not been followed in line with trust policy on cleaning up blood spillages on soft furnishings.

Cleaning schedules at Rutland Gardens lacked detail and there had been no infection control audit. This was contrary to the Trust's own infection control policies.

A number of inpatient services both in acute, older people and rehabilitation services did not comply with guidance on same sex accommodation. This meant that staff could not effectively monitor and supervise patients, ensuring their safety. We saw that a woman had made an allegation relating to sexual assault whilst in the rehabilitation service and it was not clear what actions had been taken to minimise the risks of this or lessons learnt from this incident.

On the learning disability inpatient ward the separating door into the male/female was propped open and the window of the interconnecting door allowed males to observe female areas. In acute services we found that female-only lounges were locked and not often used. Staff said that it was not always possible to separate men and woman into different corridors and on some older people's wards not all bedrooms were en-suite and female patients had to walk through male areas to access bathroom and toilet facilities.

Although the Trust had an active plan for the management of ligature points, by which a patient at risk from self harm or suicide might hurt themselves, it had not identified all risk areas. We found ligature risks on Brunswick ward which had not been identified in the risk assessment. This included risks on door closures, cables in bedrooms, handrails and door frames. Some staff did not recognise that these could be potentially unsafe.

We also found ligatures presented a risk in rehabilitation inpatient services and in inpatient adolescent services.

Safe staffing.

Overall we found adequate levels of staffing. The inpatient service for children and adolescents at Chalkhill and at Hanover Crescent were an exception. At Chalkhill, we found evidence that there was only one qualified member of staff on duty. We examined the staffing returns for the period July 2014 – end of December 2014 and found that there had been a shortage of qualified nurses throughout the day and night. The records indicated that some of these gaps had been filled with healthcare assistants.

At Hanover Crescent, there was only one qualified nurse as part of the staff team establishment, therefore the service was frequently managed solely by support staff. There was one sleep-in member of staff at night and at times during the day there was only one member of staff. There was no dedicated medical or pharmacy cover. Staff told us and we reviewed rotas and the staff vacancy list which showed that there was not enough staff in establishment to cover all the shifts. Shifts were usually covered by regular bank staff.

The trust did not have an adequate system in place to monitor the use of bank or agency staff. The trust was not able to tell us what the use of agency staff was.

Assessing and managing risk to patients and staff.

The trust for the most part managed and assessed risk well and we found many examples of patients having detailed risk assessments which were comprehensive and up to date but this was not consistent. In acute inpatient services there were also risk assessments which were not person centred and detailed enough. Many of the these assessments had not had any recent updates.

We were also concerned about the risk assessment and management processes at Hanover Crescent particularly in relation to the environment and lack of clarity around purpose of the service. The ligature audit undertaken in November 2014 states throughout the document, in response to all identified risks, that the following actions will protect patients: "Hanover Crescent is staffed during the day and one sleep-in member of staff at night, patients are risk assessed daily for risk to self, where risk increases from low to medium risk the MDT will review suitability for the recovery house".

The trust states that only individuals assessed as `low risk` would be admitted to Hanover Crescent and that potential risks were managed through individual risk assessments. We found that risk assessments were not undertaken daily at Hanover Crescent and the service was dependent on the referral risk assessments of patients undertaken by the ward or care co-ordinators. We were informed that there had been occasions that staff had felt pressured to accept people who may not be suitable.

Detailed findings

There were some concerns about medicines management, for instance, the cabinet for storing controlled drugs at Rutland Gardens Hostel – Community Wards and Hanover Crescent did not comply with legal requirements. We informed the manager of this during our visit. There were no controlled drugs being stored in the cabinet at the time of our visit.

There were blanket restrictions in place on some wards. This had an impact on patients' rights and freedom.

Track record on safety.

In the past year the Trust reported 196 serious untoward incidents over 89 separate sites. 80 concerned patients' death (suicide). The numbers of incidents reported to the National Reporting and Learning System (NRLS) was lower than expected (75). This may indicate a less well developed safety culture.

The Trust was identified as having an elevated risk of suicide within 3 days of admission and within 3 days of discharge. There was no overall strategy to manage this. The trust, despite having a high rate of suicide, did not have a suicide prevention plan in place.

Learning from incidents

Across services we were told by staff and inspectors found that whilst incidents were reportedlearning from these incidents was not always robust. For instance, there had been a previous serious untoward incident at Hanover Crescent in 2013. We reviewed the root cause analysis report that was completed in November 2014. It was not clear that any actions had been identified in relation to the building or the risk management processes within the service. The trust advised us that they were reviewing the future of the service with the Brighton and Hove Clinical Commissioning Group.

In some areas staff did not feel that they received clear feedback about the outcomes and actions arising from serious untoward incidents. This was particularly notable in some inpatient areas.

Safeguarding.

Overall staff were able to clearly articulate what would constitute abuse and what they needed to do to protect vulnerable people. Howeve,r many staff reported having not had their mandatory training in safeguarding, trust figures showed that only **11%** of staff had received training.

Duty of Candour

The trust were meeting the requirements of Duty of Candour. The trust supplied data demonstrating how they complied with this duty. The trust has implemented best practice in relation to notifiying patients and relatives of serious untoward incidents, meeting with them and keeping people involved in the developments of reports and action plans.

Use of restraint and seclusion.

When patients were restrained in their rooms in older people's inpatient wards, this was not considered by the wards to be a form of seclusion. This meant that patients were not afforded the monitoring and review safeguards defined in the trust's seclusion policy.

Between the 1st April 2014 and the 1st of September 2014 there were 120 recorded episodes of seclusion; 57% of these happened in 3 locations, Amber ward, Pavillion ward and Willow ward. There were 384 incidents of restraint with 14% restrained in the prone position, of which 31 resulted in rapid tranquilisation.

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

Key findings in effective;

- There were delays in people accessing physical health care outside of the inpatient unit.
- Mandatory training and refresher training had not been completed in many areas. There was a lack of understanding of the application of the Mental Capacity Act 2005. Consent to treatment decisions were not always adequately recorded and capacity was not always adequately assessed.
- There were significant gaps, particularly across older people's inpatient services in relation to training, supervision and appraisal.

Our findings

Assessment of needs and planning of care.

Care plans were not always personalised and recovery focused. There were many examples across older people's rehabilitation and acute inpatient services of inadequate care plans which had not captured needs. In some care plans there was no evidence that patients had been actively involved in developing their care plan.

In the learning disability inpatient services not all patients had physical health action plans in place.

On older people's inpatient wards there were delays in accessing prompt medical care outside of the hospitals such as tissue viability services and diabetic support. This was because the trust has no service level agreement with the general acute services. This meant that access was more difficult and could impact on people getting their physical health care needs met.

Best practice in treatment and care

The Trust demonstrated good and consistent understanding of what was best practice in most areas.

Staff were aware of the National Institute for Health and Care Excellence and were able to articulate how they used these guidelines. Patients were assessed using Health of the Nation Outcome Scale (HoNOS).

There were examples of robust clinical audit taking place across all services.

There was good access to psychological therapies.

However, at Meadowfield Hospital we found through the examination of prescription charts on Larch, Maple and Rowan wards that patients were being routinely written up for intra-muscular medications (mostly lorazepam) as a matter of course on admission. Nursing staff were aware of this practice and said that this was routine. We were not able to see the clinical rationale for prescribing these medications as this was not documented in patients' notes. We raised this issue with ward managers, who said that they were not aware of this practice as this was contrary to the trust policy on prescribing medicines.

Skilled staff to deliver care

Across inpatient and community services, staff had not completed mandatory training. At Amberstone Hospital and Hanover Crescent we identified that the majority of staff were not up to date with basic life support or safeguarding training.

In some areas of the Trust, in particular at Meadowfields Hospital, staff had not received any supervision and had not been appraised.

Training records were not always available or up to date and data received from the trust showed very poor compliance. We were told that spreadsheets were kept locally to monitor training but this was not consistent across the trust. The trust is implementing a new electronic record system which will capture all training and monitor when mandatory training needs to be completed.

Across many inpatient services staff had not received refresher or mandatory training, for instance at Amberstone Hospital, staff had not received basic life support training or safeguarding training. In other areas of the trust staff had not received basic training in the Mental Capacity Act 2005

Are services effective?

and Deprivation of Liberty Safeguards. Figures from the trust showed that only 23% of staff had received training. We found that this impacted on patients' assessment of need and resulted in a lack of clarity of the legal framework in which treatment was taking place. (Quote MCA COP here)

Multi-Disciplinary and Inter-agency team work.

Overall, the Trust was able to demonstrate a robust approach to multi-disciplinary working.

Almost every area of both inpatient and community services had the necessary professionals from all disciplines – social work, occupational therapy, nursing, psychology and medical input.

Relationships between community and inpatient services were good, with the regular communication between services.

There was also good solid evidence of good working relationships with other agencies such as the police and ambulance services. There were meetings in place to discuss and share common objectives between agencies. The trust were taking part in joint initiatives to improve access for people with mental health problems with both police and ambulance services such as the 'Street Triage' service.

There were two exceptions to this overall. There was a lack of a multi-disciplinary approach at Hanover Crescent. Concerns were expressed by staff that because of staffing problems, community CAMHS services were more difficult to engage and did not always attend ward rounds/ meetings etc.

Adherence to Mental Health Act 1983 and Code of Practice.

We found good evidence that overall the trust applied the Mental Health Act 1983 correctly. It had a robust mental health act administrations department, who were knowledgeable and experienced in the Mental Health Act 1983.

However, when looking at patients notes there were some examples of inadequate recording of capacity and consent to treatment.

In rehabilitation services staff were using a form to record S17 leave. This form did not use the accepted terminology of the 'Code of Practice' It specified only two types of leaves 'accompanied' and 'unaccompanied'. The Code of Practice specifies that patients may be 'escorted' (in the company of staff). Accompanied leave generally refers to patients being accompanied by family members or carers.

Good Practice in applying the MCA.

The Trust was not always adhering to the principles of the Mental Capacity Act 2005. This was because we did not find a consistent approach to the assessment of mental capacity. Where assessments of capacity had been completed, these were not thorough. This was particularly poor in older people's inpatient services.

Figures supplied by the trust showed that only 23% of staff had received training in the MCA 2005 and did not understand when and how to apply for an authorisation to deprive someone of their liberty (DOLS). Our inspection team found 3 people who were deprived of their liberty and had been treated without the proper legal authority to do so.

However, e met many staff who were able to clearly describe their responsibilities under the MCA 2005.

Good

Are services caring?

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

Summary of findings

We rated caring as good because we met with staff who were very compassionate and kind. We received positive feedback from patients and their carers.

- Forensic services were rated as outstanding because the inspection team found instances of excellent practice in relation to patient involvement and feedback from people using services and their carers. The Hellingly Centre had recently won an award for the work staff had carried out in order to reduce incidents and use of seclusion and restraint.
- We found many examples across all services of people being involved in their care. The Trust has a well-developed strategy for 'involvement' which aims to involve people strategically as well as involve people in their one-to-one care. This strategy co-exists with the work the trust is undertaking with their equality agenda and patient experience work. These commitments are clearly set out in written guidance and are well triangulated.
- Most services had written information available and these were in different languages. Patients were all given welcome packs or leaflets describing services on offer. Advocacy services were available to patients.
- Some of the inpatient wards for adults and older people were not able to show a consistent approach to people's involvement in care planning. Very few patients had 'advance decision' in their care records.

Our findings

Dignity, respect and compassion

Across all services we found that staff were caring, compassionate and empathic. In two areas we found that staff were outstanding in the care and passion they clearly demonstrated for their work. People were treated with respect and dignity, although in learning disability inpatient services we were concerned to see that information about patients was visible to other patients. This was raised with the trust at the time of the inspection. We observed many instances where staff were kind and caring towards patients, despite staff working with increased levels of stress due to lots of demand for services.

Involvement of people using services

The trust stated it is committed to involving people in all aspects of trust business and has a good strategy for 'involvement'. The introduction of co-production and the recovery colleges and peer support is testimony to this approach. However, the inspection teams found areas where care planning was not robust and the basics of involving people in the care planning process were not followed, particularly on older people's inpatient services. We found good evidence in forensic services of people being involved in their care and in child and adolescent services there was innovative user engagement approaches across the services. This ensured that young people and their families had a say in how the service was run and how to reduce the stigma of mental illness.

Staff involved patients' carers and families where appropriate, and the crisis teams carried out or referred people for carer's assessments. Families and carers were also given information about carers' support groups.

Requires Improvement

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as requires improvement because;

- There were differences in the levels of responsiveness across the trust. We found that on older people's inpatient services there were delays in discharge and child and adolescent services there were long waiting lists for access to services. Overall, community services responded well to referrals and there were good links with primary care services and general practitioners.
- Across both adult and older people's wards, there was a shortage of beds. This meant that often it was necessary for patients to access inpatient care some distance from their home.
- Patients could also be transferred from one inpatient bed to another to manage beds. Patients were transferred between trust wards on 194 occasions during July/September 2014. Mental Health Act Co-ordinators here raised this with the trust as a concern.
- The Trust has a bed occupancy rate of 93%. The Royal College and Psychiatrist recommend an average occupancy of 85%.
- In between April and September 2014 there were 346 readmissions across 14 locations within 90 days of discharge.
- Discharge was often delayed because of lack of suitable accommodation. In the six months to September 2014 the Trust reported 132 delayed discharges from 22 wards.

Our findings

Access, discharge and bed management

Across all inpatient services there was variability in how discharge was planned from the wards. Rehabilitation services and older people's services had particular problems discharging people in a timely manner. This was because of lack of multi-disciplinary input and lack of suitable accommodation for people to move into.

However, in substance misuse services we saw good discharge planning, which was co-ordinated and had involved the whole multi-disciplinary team. Inpatient and community services worked well together.

The number of patients placed out of area for urgent treatment of mental health problems has risen considerably. In 2012/2013 there were 90 admissions out of local area. In 2013/2014 there were 227.

The ward environment optimises recovery, comfort and dignity

In some cases on the older inpatient units rooms were not personalised. Some of the bedrooms had no en-suite facilities. Visiting times across all wards was from 10am to 8pm seven days a week.

Many patients told us that the food was good and that was a range of meals to choose from, including food appropriate to meet the needs of different cultural and religious groups.

All acute wards had a welcome pack and relevant information was displayed and available.

On Oaklands ward we found a local policy which stated that informal patients could not leave within 24 hours without having a risk assessment completed. The trust must address this as it could constitute a de facto detention.

In learning disability inpatient services patients had no access to equipment or tools to support them to be independent in the kitchen. Patients also had no individualised plan of activities.

Meeting the needs of all the people who use the service.

Acute inpatient services offered information in a variety of languages. There was good access to spiritual support with multi-faith rooms. Staff were sensitive to culture and diversity.

Requires Improvement

Are services responsive to people's needs?

Interpreters were available when needed and staff knew how to access this service.

Menus offered a range of food which met the dietary requirements of religious and ethnic groups. On older people's wards menus were dementia friendly.

Listening to and learning from complaints.

Overwhelmingly, the Trust listened to and responded to complaints. Information was readily available on how to make a complaint. Patients were aware of the complaints process and felt that the Trust responded in a timely way. The majority of staff said that the outcome of complaints was discussed at team meetings. The exception to this was staff in older people's inpatient services, who said they rarely received feedback from complaints.

The Trust data indicated that the number of complaints hadincreased during 2013/14. The number of complaints upheld had decreased. The number of complaints received in relation to the medical profession doubled in the past year. 738 complaints were made in the last 12 months. 359 (48%) of these were upheld. Of the 738 complaints received, 14 have been referred to the Parliamentary and Health Service Ombudsman and one was partially upheld.

Across all services there was good support for people in relation to spiritual support and meeting cultural and diverse needs. Inpatient units all had access to multi-faith support. There was good access to psychology and the triangle of care was being implemented to ensure better access and communication with carers and family members.

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

We rated well-led as requires improvement/good because

- In some services there were gaps in relation to training and supervision.
- There were some services rated as inadequate in safe due to not meeting best practice in gender segregation, infection control and management of ligature points.
- The trust had no comprehensive assurance framework to the board.
- The trust had no written strategy to set the direction of travel for mental health services in Sussex.
- The trust had not responded to the need for a clear and comprehensive strategy to tackle suicide and self harm.

However;

- There was clear evidence of a significant cultural change happening under the leadership of the new CEO and many of the issues identified by the inspection team had been identified by the CEO and the senior team.
- There was a lot of evidence of good practice creative thinking and innovation taking place. There was good compliance with the Mental Health Act 1983. Patients and their relatives were very positive about their experiences of care.

Our findings

Vision and values

Most services, both inpatient and community, were clear about the Trust's vision and values. Staff were able to articulate these and these were clearly displayed in many communal areas and offices.

However, on older people's inpatient wards, staff we spoke to were not aware of the Trust's vision and values. Staff on these wards did speak highly of the support they received from their teams.

The trust was working to a set of values that had been launched in April 2011. This is called 'Better by experience' This describes the five values:

• We welcome you

• We hear you

• We work with you

• We are helpful

• We are hopeful for you

The trust had no formal written strategy at the time of the inspection. The chair described two broad strategic aims:

1. To continue to develop and expand the specialist services to become the biggest provider in the south-east. Wants to further develop links with the criminal justice system and to develop more joint ventures.
1. To consolidate the quality of the local adult services; levelling up to that of the best by identifying what services are good and encouraging sideways transmission of good.

The trust was in the process of developing a strategy. It was doing this by asking the separate services within the trust to develop a five-year plan. These service development plans, which would be assured for quality and feasibility, would form the basis of the wider trust strategic plan. The initial plan was to divide the trust into 'care delivery units', which would reflect either geography (for local adult services) or service line (for specialist services). The care delivery units would earn a greater degree of autonomy over their own budget and future direction and as they demonstrated their effectiveness and quality against a scorecard of performance measures.

The trust executive hoped that the establishment of care delivery units would encourage greater engagement in

Are services well-led?

service management and development by senior clinicians, particularly consultant psychiatrists. It also hoped that it would lead to better engagement with individual CCGs than was the previously the case.

The financial priority for 2015/16 was to gain better control of the variation in spend between the different teams in the adult services division. The director of finance and performance believed that the principal means of achieving this was to help every service improve to the level of the best performing service. The trust was required to make 5-6% savings in 2015/16 with 1.5% income deflation.

Good governance.

The majority of services had good local governance arrangements in place. This meant that teams were able to monitor the performance of services, review the quality of the service and understand people's experience of the service.

However, we found significant gaps in the recording of training and the trust has some outdated patient information systems. We also found that learning from serous untoward incidents did not happen in a timely way. The Trust has a bulletin called 'Report and Learn' but these did not always reach frontline staff and when they did the incidents described might have happened some time previously.

In 2014 there was a dip in the number of serious incidents reported by the trust. During this period the trust was the third lowest reporter of serious incidents of all trusts. When preparing for the inspection, the CQC discovered a discrepancy between the number of serious incidents recorded on the trust system and the number reported to the national reporting and learning system. The trust acknowledged that there was a 'backlog' of unrecorded incidents. We were assured that these would be cleared within two weeks of the end of the inspection.

Despite all of this the CEO felt confident that staff were aware of the process for investigating and escalating serious incidents. Overall, we found that this was the case and that staff knew how to do this.

There is an active programme of local clinical audit that junior and senior medical staff participate in. We found good evidence of audit happening across services.

We identified that there was a gap relating to how the trust assured itself that quality, performance, finance and safety was being monitored and fed up to the board of the trust. This meant that not all relevant information from key areas such as safety, performance, finance and patient experience data was brought together for scrutiny.

The two divisions compiled risk registers from submissions of risks identified by clinical services. We concluded that this was comprehensive and that staff throughout the trust were engaged with identifying risk. This resulted in a trust-wide risk register that ran to 240 pages. The CEO described the process as being "clunky and bureaucratic" and did not think that there was a proper process for escalation of risk in a way that resulted in the board fully understanding the risk priorities. This was in the process of being addressed.

The trust had devolved budgets to the level of the individual clinical teams.

The trust started the year with the plan to deliver a £1.2Million surplus, but was predicting a best case position of breaking even. The high spend on bank/agency nurses on adult admission wards and out of area treatments were the two largest contributors to the mid-year deficit.

Leadership and staff engagement

There was a high degree of autonomy and an open and transparent culture. Staff morale was good and staff spoke positively about local leadership. Staff said they were able to raise concerns without fear of victimisation The board regularly visited services and the Nursing Director did regular shifts on duty on an inpatient ward. The CEO had been visiting services, as had the non-executive directors.

Leadership and culture

In response to a poor performance in the 2013 NHS staff survey, the trust commissioned 'the Survey Initiative' (TSI) to conduct a series of focus groups with trust staff. The TSI report revealed some serious problems with the culture of the trust. Despite the critical nature of the report, the trust shared the findings with trust staff.

We concluded that the trust had gone through a difficult period of change within the organisation and that there were some cultural systemic problems which needed addressing. We also heard reports of a culture that was not always conducive to being open and transparent and was not always receptive to feedback and learning from complaints and serious incidents.

Requires Improvement

Are services well-led?

The new CEO informed us that he was aware of these cultural problems and described his attempts to engage with staff throughout the organisation; including attendance at a series of listening events. He told us that he planned to enrol the trust in the next cohort of 'listening into action'.

Since his appointment, the new CEO had worked to develop a cohesive top team and to support the development of the individual executives. This included facilitated away days to 'look at team dynamics', the introduction of a directors' development programme and a board development programme and the agreement of a set of board team objectives.

The non-executive directors had a range of relevant skills. These included banking, law, management consultancy, staff communications, customer relations and estates.

Fit and Proper Person Requirement (from implementation likely mid-November 2014)

The trust was in breach of this regulation due to insufficient checks on DBS with the board members and Governors. It was found that these checks had not happened in some cases and that DBS checking did not comply with best practice guidelines of checks being carried out every three years.

Engagement with people and staff

Staff were positive about how the trust engaged with staff, the governing body and patients andtheir carers. The governors told us that since the arrival of the new company secretary engagement with the trust is better. A staff engagement survey was commissioned by the trust and it was thought to be a real wake-up call to the board. This facilitated a much more proactive approach to engagement.

For senior recruitment and clinical staff patient /carer focus groups are asked to sit in on the interview process, which focusses on customer improvement.

Governors made the appointment of the new Chief Exec and the new Chair.

Regular Council of Governors meet and part of the agenda is update from the CEO and hot topics so governors have covered issues from Langley Green, to recruitment and use of agency staff etc.

The trust is taking part in 15 steps program (PLACE) environmental visits. Patients and Governors are encouraged to take part in this program, which happens yearly.

Relationships between the trust and CCGs varied. The trust adult services related to seven 'core' CCGs within Sussex. In addition, the dispersed specialist services related to a larger number of CCGs in neighbouring counties. Each CCG had its own type of relationship with the trust. For instance, CCGs in Kent and Hampshire had relatively new relationships and were commissioning child and adolescent services only. They were more positive about the trust than commissioners of adult services.

The trust CEO acknowledged that there has been a lot of criticism about the trust from local people and local politicians (reflecting an increased number of complaints to MPs about the service). Since his appointment, the CEO had met with many of the local MPs and with Healthwatch groups. He believed that many of the complaints are about people who did not get a service (that is, who fell between the gaps in primary care and secondary).

Continuous Improvement

The trust has participated in a number of national clinical audits including the national audit of schizophrenia, the audit of prescribing for ADHD and the audit of monitoring of patients prescribed lithium.

The trust is accredited by the Royal College of Psychiatist for Accreditation for Inpatient Mental Health Services/Aims Schemes

- The electro convulsive therapy accreditation services (ECTAS)
- The Memory Services National Accreditation Programme (MSNAP)
- The Psychiatric Liaison Accreditation Network (plan) – (Accreditation is at review stage)
- The Harold Kidd Unit also has accreditation for acute inpatient mental health services on wards for older people (AIMS-OP)

The trust is also part of the quality network for;

- The Quality Network for Community child and adolescent services (QNCC)
- The Quality Network for Inpatient child and adolescent services (QNIC)
- The Quality Network for Forensic Mental Health)

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12: Safe care and treatment** **The trust had not protected service users against the risks associated with unsafe use and management of medicines.** • On Oaklands ward we found patients' prescription-only drugs were not held securely; • On Maple ward patients were routinely prescribed intra-muscular injections on admission to be given when required regardless of their individual needs or presentation. • On Oaklands ward a detained patient had been administered medication without lawful authority for ten days. **This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

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 **Regulation 18: Staffing** **The trust did not have suitable arrangements in place to ensure that persons employed received appropriate training, professional development, supervision and appraisal to enable them to deliver care and treatment to service users safely and to an appropriate standard.** • Staff had not received mandatory training within the timescales set by the trust.

This section is primarily information for the provider

Requirement notices

- Staff had not received supervision, appraisals or undertaken reflective practice in line with the trust's policy.

This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11: Need for consent The trust did not have suitable arrangements in place for obtaining consent and acting in accordance with the consent of service users in relation to the care and treatment provided for them. On Oaklands ward we found patients who were not detained were prevented from leaving the ward for 24 hours or longer. There was no information available to support patients had consented to this arrangement. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Regulation 18: Staffing The trust had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

This section is primarily information for the provider

Requirement notices

At Chalkhill the covering of shortfalls of qualified nursing staff with healthcare assistants over long periods of time did not promote the health, safety and welfare of people who use the service, and put young people at risk of inadequate care.

This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 **Regulation 12: Safe care and treatment**

We identified a number of ligature risks within the environment at Chalkhill. The ligature risk assessment showed the provider was aware of these, though had not taken appropriate action to mitigate the risk to young people.

This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 18: Staffing**

This section is primarily information for the provider

Requirement notices

Staff did not receive regular mandatory training updates and lacked training in physical health issues to meet the needs of the high number young people with eating disorders nursed at Chalkhill.

This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 15: Premises and equipment**

The trust did not ensure that service users were protected against the risks associated with unsafe or unsuitable premises. At the Seldon Centre, the service was using quiet rooms to seclude people that did not meet the standards of seclusion as written in the National Institute of Clinical Excellence and guidance from the Royal College of Psychiatrists.

This was in breach of regulation 15(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 15: Premises and equipment**

This section is primarily information for the provider

Requirement notices

The trust did not ensure that service users were protected against the risks associated with unsafe or unsuitable premises. The layout of the ward at the Seldon Centre did not ensure that the privacy and dignity of service users was protected because there was not an adequate and permanent way to divide the sleeping areas of men and women on the ward.

This was in breach of regulation 15(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 9: Person-centred care**

The trust did not ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. The planning and delivery of care and treatment at the Seldon Centre did not meet the service users' individual needs because there were blanket restrictions on the ward limiting patients' access to the garden, choice of meals and ability to access freely hot drinks and snacks.

This was in breach of regulation 9(1)(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

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Requirement notices

Treatment of disease, disorder or injury	Regulation 9: Person-centred care The trust did not take proper steps to ensure that each service user was protected aginst the risks of receiving care or treatment that was inappropriate or unsafe. At Rutland Gardens Hostel – Community Wards patients were not being protected against the risks of receiving care or treatment that was inappropriate or unsafe. Care plans were generic and did not always reflect patients' current individual needs. For one person there was no care plan in place to address a serious risk to the individual. At Hanover Crescent individual risk assessments did not contain the detail required in order to make a comprehensive assessment of risk or assess whether Hanover Crescent was an appropriate and safe placement for the individual. At Hanover Crescent, there was not clear gender separation in the house. Due to the layout of the property staff could not effectively monitor and supervise individuals, particularly at night when there is no waking member of staff in the house. This was in breach of regulation 9(1)(a)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Regulation 12: Safe care and treatment

This section is primarily information for the provider

Requirement notices

The trust did not ensure that people who use services, staff and others were protected against identifiable risks of acquiring a health care associated infection.

At Rutland Gardens Hostel – Community Wards people were not adequately protected against identifiable risks of acquiring a health care associated infection by means of an effective system of infection prevention and control. The kitchen in particular was dirty. Standards of cleaning and hygiene were not clearly specified and in practice were not adequate to protect people against the risk of infection.

At Hanover Crescent infection control and cleaning standards were poor. The house was generally quite unclean. The kitchen in particular had ripped and dirty flooring. Food in the fridge was not clearly labelled and dated. Infection control processes had not been followed in line with trust policy on cleaning up blood spillages on soft furnishings.

This was in breach of regulation 12(1)(a)(b)(c)(2)(a)(c)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 18: Staffing**

The trust did not have suitable arrangements in place in order to ensure that staff at Amberstone Hospital were appropriately supported in relation to their responsibilities. Significant numbers of staff had not completed mandatory training. Most staff had not received training or refresher training in basic or intermediate life support and less than half of nurses

This section is primarily information for the provider

Requirement notices

were up to date with medicine management training. As a result there was a risk that staff would not be able to provide care and treatment to people that was safe and of an appropriate standard.

This was in breach of regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Regulation 15: Premises and equipment

The trust did not ensure that service users were protected against the risks associated with unsafe or unsuitable premises.

At Hanover Crescent, we identified some areas of serious concern from observations of the premises and our review of the trust ligature audit and service information. We were concerned about the safety and suitability of the property layout (including access to heights), fixtures, fittings; the lack of clarity in relation to the purpose of the service and patient group; and the culture of risk within the service. There was a reliance on individual risk assessments to manage potential environmental risks. We reviewed risk assessments and found these were incomplete and lacked detail.

Hanover Crescent did not have clear plans in place to respond to emergencies, such as power failure or needing to evacuate the building. There was no system in place at Hanover Crescent to be aware of who was present in the house, for example, in case of fire.

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Requirement notices

This was in breach of regulation 15(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 18: Staffing**

The trust had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

Staffing levels did not ensure that young people in need of child and adolescent community mental health services received a timely service for their needs, which could put young people at risk.

This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 9: Person-centred care**

The trust had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. The waiting times for assessment and treatment across all the CAMHS services were significantly high which meant that young people did not receive a timely service and could be at risk of harm to themselves or others.

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Requirement notices

This was in breach of regulation 9(1)(a)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(a)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 9: Person-centred care** The trust had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. The risks to young people on the waiting list were not monitored, which put young people at risk of harm to themselves or others. This was in breach of regulation 9(1)(a)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(a)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 9: Person-centred care** The trust had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. The assessments of young people in community child and adolescent services did not include a developmental history, which meant that important information was not routinely captured and assessed.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 9(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 9: Person-centred care**

The trust had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. The physical health of young people in community child and adolescent services receiving psychotropic medications was not always monitored.

This was in breach of regulation 9(1)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 18: Staffing**

In community child and adolescent services, the trust did not make suitable arrangements to ensure that persons employed for the purposes of carrying on the regulated activity received appropriate training. Staff did not receive regular mandatory training updates.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 17: Good governance**

In community child and adolescent services young people were not being protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to identify, assess and manage risks to people. Risk assessments were not always up-to-date. They were not easily accessible to staff due to a transition between paper and electronic records.

This was in breach of regulation 10(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 18: Staffing**

There were not suitable arrangements on Dove ward to ensure persons employed for the purpose of delivering the regulated activity received appropriate training, professional development and supervision.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 17: Good governance**

The trust did not regularly identify, assess and manage risks on Dove ward relating to the health, welfare and safety of service users and others.

This was in breach of regulation 10(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 17: Good governance**

People were not being protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to identify, assess and manage risks to people. Although numerous ligature risks had been identified on all the older adult admission wards some staff were not able to articulate how they were being managed or mitigated on a day to day basis. Audits did not capture all potential ligature risks. Trust governance systems had not effectively assessed and monitored the quality of services provided.

This section is primarily information for the provider

Requirement notices

The trust did not have an effectively operating system to share learning from incidents in a timely manner in order to make changes to peoples care in order to reduce the potential for harm to service users.

Relates to Grove, Iris, Larch, Brunswick and Burrows wards.

This was in breach of regulation 10(1)(a)(b) (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Regulation 9: Person-centred care

The trust had not taken proper steps to ensure that each patient using the service was protected against the risks of receiving care or treatment that was inappropriate or unsafe. On Larch ward, all patients were routinely prescribed intra-muscular injections on admission to be given when required regardless of their individual needs or presentation.

This was in breach of regulation 9(1)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

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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 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11: Need for consent** The trust did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people or, where that did not apply, for establishing and acting in accordance with people's best interests. Mental capacity assessments lacked explanation of how capacity had been assessed. Many staff had little or no knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Relates to Grove and Iris wards. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13: Safeguarding service users from abuse and improper treatment** The trust did not have suitable arrangements in place to protect patients against the risk of unlawful control and restraint. On two wards patients were being unlawfully deprived of their liberty. Relates to Grove and Iris wards.

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Requirement notices

This was in breach of regulation 11(1)(a)(2)(a)(3)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 12: Safe care and treatment**

The trust did not protect patients against the risks associated with unsafe use and management of medicines. Two wards had not been monitoring the storage of controlled drugs and one ward had not disposed of or returned out of date controlled drugs. One ward had not used covert medication in line with trust policy because a pharmacist had not been involved in the process.

Relates to Grove, Iris, Burrows and Brunswick wards.

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 15: Premises and equipment**

The trust did not ensure that patients were protected from the risks associated with unsafe or unsuitable

This section is primarily information for the provider

Requirement notices

premises. Five wards did not comply with Department of Health gender separation requirements. Two of the older adult inpatient wards had unsuitable garden designs and layouts for use by dementia patients.

Relates to Grove, Iris, Burrows, Brunswick and Larch wards.

This was in breach of regulation 15(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Regulation 17: Good governance

The trust did not ensure that patients were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them. Care plans were not signed by patients and there was no rationale given as to why they had not signed. It was not evident that copies had been given to patients. Diet and fluid charts were not completed clearly or consistently despite being identified as a clinical need.

Relates to Grove, Iris, Burrows and Brunswick wards. (The diet and fluid charts only relate to Grove ward.)

This was in breach of regulation 20(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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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 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18: Staffing** The trust did not have suitable arrangements in place to ensure that staff had received appropriate training, professional development, supervision and appraisal. Relates to Grove, Iris, Burrows, Brunswick, Meridian and Larch wards. This was in breach of regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Regulation 10: Dignity and respect** Informal patients were not always fully informed of their right to leave the ward and on one occasion an informal patient was advised that they could not leave the ward until they had seen a doctor. This would constitute as de facto detention. Other patients had not been supported to spend time off of the wards and they did not have care plans in place to ensure that staff provided people with an opportunity to leave the ward and access the community. Relates to Grove and Iris wards.

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Requirement notices

This was in breach of regulation 17(1)(a)(b) (2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 At Langley Green hospital the service must improve the recording and analysis of incidents and complaints, and how lessons are learnt from this. This was in breach of Regulation 10 (1)(a)(2)(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.