Requires improvement

Sussex Partnership NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RX213	Millview Hospital	Adult Mental Health Services	BN3 7HZ
RX219	Trust Headquarters	Assessment and treatment services Cavendish House	TN34 3AA
RX219	Trust Headquarters	East Brighton Community Mental Health Centre	BN2 3EW
RX219	Trust Headquarters	Shoreham Assessment Treatment Service and Adult Mental Health Service	BN43 6GA

Summary of findings

RX219	Trust Headquarters	Lighthouse Recovery Support Service	BN3 4GH
RX219	Trust Headquarters	Adult Mental Health Services Linwood	RH16 4BE

This report describes our judgement of the quality of care provided within this core service by Sussex Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement 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.

Where applicable, we have reported on each core service provided by Sussex Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Sussex Partnership NHS Foundation Trust.

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 the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

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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Summary of findings

Overall summary

We rated adult community mental health services as requires improvement because:

However:

- The quality of risk assessments varied across teams.We reviewed 46 records and found six risk assessments missing. However, we observed staff regularly discussing risk during meetings in all teams visited.
- The quality and detail of care plans were inconsistent across the teams.In some of the records reviewed, it was unclear if the person was subject to a care programme approach of if a lead practitioner had been allocated. There was little evidence of staff explaining rights to people on a community treatment order.
- We reviewed the training records for six teams which showed an overall compliance with mandatory training. However, compliance with some training including the Mental Health Act, Mental Capacity Act and safeguarding adult's level two was low. Staff told us that it was difficult to access face-to-face training and they did not receive protected time to complete mandatory training.
- Staff told us that learning was not consistently shared across teams.
- There were effective internal meetings to monitor risk and discuss people with complex needs.The caseloads of the teams were monitored regularly in meetings and individually in supervision.
- The single point of access triage nurse booked new referrals into pre-arranged assessment slots, based on need and priority.The trust had met their target of referral to assessment and treatment times between April 2015 and March 2016.
- Staff were committed to creatively improving services to meet local need. This included the employment of peer support workers and employment advisors and the introduction of a daily clinic so that staff could respond quickly to people in crisis.
- The trust was a partner in the Sussex recovery college which offered mental health recovery focused educational courses to adults of all ages.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- There were inconsistencies in the quality and detail of risk assessments.We found missing risk assessments in six of the 46 risk assessments reviewed. However, we saw that one concerned a new referral where staff had contacted the person by phone and staff had reported another on the trust's incident reporting tool.
- We reviewed the training records of six teams and found that although staff had met the trust target of 60% overall, staff compliance with safeguarding adults level two training was low.
- Staff told us that although learning was shared about local incidents, they were not always aware of incidents that had occurred in other areas.This meant that opportunities to share learning could be missed.
- Staff used a plastic pocket to transport ampoules.Staff had not completed a risk assessment to ensure this was the safest way to transport medicine.
- A clinic room audit had found that many standards set out by the trust and the medicines and healthcare products regulatory agency (MHRA) were not being adhered to.

However:

- Caseloads were effectively managed through supervision and clinical meetings.
- All teams provided a daily clinic or duty worker to respond to people in crisis.
- Staff we spoke with were knowledgeable about safeguarding processes and how to raise an alert.
- Clinic rooms were all clean and tidy and contained appropriate equipment with robust systems in place to access medicine.
- Staff followed the trust's lone working policy and had created a 'buddy' system to make sure that staff were safe.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Psychiatrists did not complete electronic notes but wrote a summary in letters to GPs.Staff were responsible for uploading the summary onto the electronic record system.However, we saw paper summaries that had not been uploaded.This meant that electronic records were not always accurate and up to date.

Summary of findings

- The quality and content of the care plans were variable across the teams. Care plans at three of the teams were not always holistic or recovery orientated. Care plans did not always demonstrate that staff had given people who used services a copy of their care plan. It was not always clear if the person who used services was subject to a care programme approach (CPA) or if a lead practitioner had been allocated.
- We saw limited evidence of people having their rights, under the Mental Health Act or subject to a community treatment order, explained to them.
- We reviewed the training records of the services visited during our inspection.There was low compliance with training in the Mental Health Act and Mental Capacity Act and Deprivation of Liberty Safeguards.

However:

- There was a wide range of mental health disciplines in the teams which included psychiatrists, psychologists, nurses, occupational therapists and peer support workers.
- The teams had good access to psychiatry support and could arrange appointments at short notice, or get support from a doctor when they needed it.
- We saw effective multi-disciplinary meetings and handovers.Staff had the opportunity to discuss risk and complex needs in meetings, supervision and case review meetings with a consultant and team leader.
- All new staff, including bank staff and volunteers, completed a comprehensive induction programme.
- Staff received regular supervision and appraisals which were linked to the trusts values and behaviours.
- Employment advisors were integrated into two adult community teams.They provided support to people who used the service to access training and employment and maintain employment.

Are services caring?

Good

We rated caring as good because:

- The people we spoke with who used the service told us that staff were responsive, respectful and caring.
- Carers told us that staff were helpful, responsive and they felt listened to.
- We observed staff treating people who used the service with a high degree of skill, sensitivity, dignity and respect.
- We observed a good level of involvement of people who used the service during clinical reviews and appointments.

Summary of findings

- Staff used the triangle of care self-assessment tool to improve support for carers and recommended a carer's assessment to carers.
- People who used services at the Lighthouse recovery support service were involved in the reference group to set up the service. They were also involved in staff recruitment.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- There was a single point of access for referrals which were allocated to the next available assessment, dependent upon need.The trust had met their target of referral to assessment and treatment times between April 2015 and March 2016.
- All teams had a daily duty worker or clinic so that they could respond quickly to people in crisis.
- Staff demonstrated knowledge of how to access an interpreter if required.The rapid response service had a telephone interpreting service.
- The trust had introduced a recovery college. The college offered courses to staff and people using the service that were designed to increase their knowledge of recovery and support self-management.
- The Lighthouse personality disorder service had a lesbian, gay, bisexual, transgender, queer or questioning group and were reviewing how they could engage other minority groups.
- Peer support workers were part of the service development forum.The forum held regular meetings and consulted with people who used the service so their voice could be heard.
- Teams had regular contact with inpatient wards to monitor discharge.However, staff told us that sometimes there was a breakdown in communication between the services.

However:

- Data provided by the trust documented that between June 2015 and May 2016 the adult community based teams received the highest number of complaints. Most of the complaints concerned inadequate overall care and treatment and poor staff attitude.Of the complaints 95 of 241 were upheld.We case tracked three complaints and found that staff had responded promptly and comprehensively.

Are services well-led?

Good

We rated well led as good because:

Summary of findings

- Staff reported good morale and feeling supported by their immediate managers.
- Managers told us that they had autonomy at a local level so that services could be tailored to best meet the needs of adults with mental health problems in their demographic area.
- There were structures in place to support staff which included meetings and supervision.
- Managers were confident that team leaders had a good grasp of the needs of staff and people who used the service.
- Staff had attended specialist training which included family therapy in psychosis, nurse prescribing, perinatal care, carers' awareness and eating disorders.Managers and team leaders had completed, or were due to complete, a leadership course to support their development and better meet the needs of the service and staff.
- Staff at Cavendish House adult community team had set up a 'Wisdom on Wednesdays' medic's academic session. This was linked to the National Institute for Health and Care Excellence guidance.

However:

- There was low compliance with mandatory training in the Mental Health Act, Mental Capacity Act and safeguarding adults level two. Staff told us there was poor availability of face-to-face training and they did not have protected time to complete training.
- Staff told us that they received feedback about local incidents; however, they were often unaware of learning from incidents from other areas.

Summary of findings

Information about the service

Sussex Partnership NHS Foundation Trust adult community based mental health services offered a range of community based treatments. These included psychological support, medication and advice for people experiencing mental health problems. People could access adult services from the age of 18 years.

The community services we inspected were based in a variety of urban and rural settings, within a wide geographical area. The population served was diverse and included significant areas of deprivation. The teams we visited were made up of a range of disciplines which included psychiatric nurses, consultant psychiatrists, psychologists, occupational therapists, social workers, support workers and peer support workers.

We also inspected the Lighthouse recovery support service, which opened in May 2013. The Lighthouse is a non registered service which provides support to adult community services. The service is a group-based service for people in the Brighton and Hove area aged 18 and over, who are experiencing personality disorder or emotional intensity problems. The service operated as an integrated service, jointly run by Sussex Partnership NHS Foundation Trust and Sussex Oakleaf. The service was commissioned for 60 members as a pilot to see how the needs of people with personality disorder in the Brighton and Hove area could be met more effectively. The service was open seven days a week. Lead practitioners and specialist services could make referrals for clinical support and staff from the wellbeing service could make referrals for non-clinical support. The programme delivered at the service was based on three phase attachment theory. The team used psycho-educational groups supported by activities to deliver outcomes.

The rapid response service provided an assessment service and an enhanced duty for assessment and treatment teams outside normal working hours. Staff worked closely with crisis teams, the ambulance service and the police. The service wa linked to the Stay Alive app, which was a pocket suicide prevention resource with useful information to help people stay safe.

CQC last inspected the adult community mental health service inspected in January 2015 when we rated it 'Good' in all five domains. The services visited during the inspection in January 2015 were: trust headquarters Swandean, East Brighton community mental health centre, Chapel street clinic Chichester, Adur, Aran and Worthing treatment team, East Brighton assessment and treatment team and Western assessment and treatment team.

Our inspection team

The team was led by:

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

Head of Inspection: Natasha Sloman, Care Quality Commission.

Team Leader: Louise Phillips, Inspection Manager, Care Quality Commission.

The team that inspected the community-based mental health services for adults of working age comprised one CQC inspector, one inspection manager, one head of hospital inspections, and five specialist advisors including a doctor, two nurses, one psychologist and one social worker.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

To fully understand 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 the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients and staff at focus groups.

During the inspection visit, the inspection team:

- visited six team bases, looked at the quality of the team environments and observed how staff were caring for people who use services
- spoke with the managers of each of the six community teams
- spoke with 21 people using the service
- spoke with four carers
- spoke with 53 members of staff including consultant psychiatrists, associate specialist doctors, nurses, occupational therapists, psychologists, administrators, social workers, support workers and peer support workers
- reviewed 46 care records which included 17 for people subject to a community treatment order
- reviewed five medicine charts
- observed six home visits
- observed one clinical review, one community treatment order (CTO) review and a one to one appointment with a nurse
- observed 11 meetings including zoning meetings, clinical meetings, triage meetings, leadership meetings, service development meetings, clinical formulation meeting and team meetings
- reviewed information relating to the service
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 21 people who used the service who all spoke positively about the support provided by the adult community mental health teams. People told us that they felt involved in their care and staff were respectful and caring. They told us that staff were responsive to their needs and made arrangements for regular reviews with consultants.

The four carers we spoke with told us that they felt listened to and valued the care and support provided to them and their relative.

However, one of four comments cards reviewed contained negative comments about the support they had received.

Good practice

- Shoreham assessment treatment services were in the process of incorporating a physical health wellbeing clinic with their depot clinic, to improve access to physical health monitoring for people who used their service.
- We saw data that demonstrated there had been a significant reduction in the use of crisis services since the Lighthouse service had opened three years ago.The service had a lesbian, gay, bisexual, transgender, queer or questioning (LGBTQI) group and were reviewing how they could engage other minority groups. People who used the service were involved in the reference group to set up the service and were involved in staff recruitment.

Summary of findings

- Teams used a buddy system as part of the lone working policy.Staff were responsible for contacting their buddy if they had not received a call at an agreed time.
- Cavendish House adult community team had set up a 'Wisdom on Wednesdays medic's academic session for staff. This was linked to the National Institute for Health and Care Excellence guidance.Topics discussed included managing expectations and good endings, family interventions and personality disorders.
- The group treatment service had links with LGBTQI community groups.
- The rapid response service is linked to the Stay Alive app. The app is full of information to help people stay safe.

Areas for improvement

Action the provider MUST take to improve

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

Action the provider SHOULD take to improve

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

Sussex Partnership NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Assessment and treatment services Cavendish House	Trust Headquarters
Adult Mental Health Services Linwood	Trust Headquarters
East Brighton Community Mental Health Centre	Trust Headquarters
Lighthouse recovery support service	Trust Headquarters
Brighton & Hove group treatment service	Millview Hospital
Mental health rapid response service	Millview Hospital
Shoreham Assessment Treatment Service and Adult Mental Health Service	Trust Headquarters

Mental Health Act responsibilities

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

The trust had launched bespoke Mental Health Act e-learning training in May 2016. The trust had a target of 60% compliance rate for completion of mandatory and statutory training. We reviewed the training data for six teams and saw a low compliance with training in the Mental Health Act. Staff from Shoreham, the Lighthouse service and the rapid response service had met the trust target for completion of training in the Mental Health Act. The remaining adult community teams inspected had not met the target for completing training in the Mental Health Act.

Detailed findings

We reviewed the care records for 17 people who were subject to a community treatment order. We found missing documentation and inconsistent evidence in 12 records. Staff had not recorded that they had explained section 132 rights to people subject to a community treatment order in 10 records. The Mental Health Act Code of Practice states that there is a legal requirement to provide information concerning their rights under the Mental Health Act, whilst they are subject to a community treatment order.

We spoke to a person subject to a community treatment order who told us they felt listened to and that they had been involved in their care planning. However, they told us that they were unware of advocacy support and did not know how to complain.

Staff in some teams were dual qualified as an approved mental health professional and completed Mental Health Act assessments for people who used their service.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had launched bespoke Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) e-learning training in February 2016.

We reviewed the training data for six teams and saw a low compliance with training in the Mental Capacity Act. Staff from Shoreham, the Lighthouse service, the group treatment service and the serious mental illness local enhanced service had achieved the trust target for completing training in the MCA and DoLS. The remaining adult community teams inspected had not met the target for completing training in the MCA and DoLs.

Staff had recorded assessing capacity in 24 records reviewed. The Mental Capacity Act code of practice states that it should always be presumed that people have capacity to make their own decisions until there is proof that they don't.

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

Our findings

Safe and clean environment

- All sites were clean and tidy, although the environments varied. For example, the assessment and treatment services at Cavendish House were located in a large, welcoming, open plan space, whilst the assessment and treatment services at Linwood were in an old building. The Linwood team had asked for people's experience of their first '15 steps' on accessing the service. The feedback concluded that people did not feel the building valued staff or service users. The service manager had attended meetings with senior managers from the trust to consider alternative venues, although little progress had been made.However, the service had recently received funding from the local Rotary club to purchase new furniture and create a welcoming reception space.
- All services had alarms in the interview rooms. The alarms at Cavendish House were connected to a panel located in the reception area which identified where the alarm had been set off.Five of the 10 interview rooms at Cavendish House had two doors to enter and exit the rooms, which provided additional security.
- The lift at Mill View Hospital was not working at the time of our inspection. This meant that staff had to escort people who used services through a ward in order to reach therapy rooms. Staff told us that this had been reported for repair and that the lift regularly broke down.
- The clinic rooms were all clean and tidy and contained appropriate equipment with robust systems in place to access medicine. Staff from East Brighton and Cavendish House recorded fridge temperatures daily, in line with national guidance. However, the fridge temperature at Linwood had been recorded weekly and staff had only documented readings for the previous month.
- Staff from the East Brighton community mental health centre had added an anaphylaxis kit during our inspection. Staff from Cavendish House had ordered an anaphylaxis kit the day before our inspection. We saw an infection control audit completed by the trust which had recorded 71% compliance by Cavendish House Assertive Outreach Team and Mill View Hospital.The Lighthouse service and assessment treatment team at Cavendish House recorded 81% and 77% respectively. The remaining teams were not on the trust audit schedule for 2015/2016.

Safe staffing

- Data provided by the trust showed in the 12 months up until May 2016, there was a higher than trust average nursing vacancy rate of 37% at the Hastings and Rother assessment treatment team. There was a higher than trust average of overall vacancies of 13% at Brighton and Hove rapid response team between April 2015 and March 2016. However, the rapid response team was a small team of only 12 people, therefore one vacancy would have a significant impact on the percentages.
- Between 1 April 2015 and 31 March 2016 the average staff turnover across the six teams was 46%. The highest rate of turnover was mid Sussex liaison practitioners at 68%.Managers told us the reasons that staff had left were mainly due to promotion or moving to another team in the trust. Staff from East Brighton community mental health centre told us that a number of staff had recently left. This had increased pressure and caseloads for the remaining staff.
- There was a rolling recruitment programme to fill vacancies at the earliest opportunity.Managers had autonomy to make decisions to improve service delivery, which included being creative with vacancies. For example, identifying if the salary band or discipline could safely be changed to encourage applications, while making sure there were sufficient nurses.
- The average sickness level across the teams was 5%. The highest staff sickness level was 7% at Hastings and Rother wellbeing team.
- Managers used regular bank and agency staff, which included previous employees, to cover vacancies and long term sickness. Short term sickness was absorbed into the team.

Requires improvement

Are services safe?

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

- Caseloads were consistent across the teams. The caseload for assessment and treatment teams averaged between 30 and 35. We saw that a number of people on caseloads were seen once a month for a depot injection only. The caseload for assertive outreach teams averaged between 10 and 12. We saw that approximately 40% of the caseload for the assertive outreach team at Cavendish House lived in supported or residential accommodation. This meant that they received additional support.
- Caseloads for recovery and wellbeing teams varied across teams. For example, at Cavendish house, caseloads averaged between 20 and 25 and at Shoreham, caseloads averaged between 25 and 35. To manage caseloads, staff at Shoreham had been asked to identify 15 people who used services that could safely be managed by self-help, voluntary or community groups.
- Caseloads and risk was reviewed during supervision and meetings. Linwood had introduced a dedicated case review slot where staff could discuss concerns about their caseload with a team leader and consultant.
- All teams had access to a consultant psychiatrist. Staff told us that access to psychiatrists was good and that doctors in the teams were approachable and flexible. There was no direct medical input into the Lighthouse recovery support service, as it was a psychology led service. However, staff were able to access consultants from the adult community teams.
- Data provided by the trust showed that there had been an improvement for staff completion of mandatory training since June 2016. However, staff had not completed appropriate rates of mandatory training in all subjects. Data provided during our inspection showed a low compliance for staff completing safeguarding adults level 2 training.

Assessing and managing risk to patients and staff

- Overall, we found risk assessments to be comprehensive and holistic. However, risk assessments were missing in six of the 46 risk assessments reviewed.We saw that staff had only just received a referral for one person and had recorded another on the incident reporting tool which meant there were five unaccounted for.
- The risk assessments reviewed at the assessment and treatment team and assertive outreach team in East Brighton and the group treatment service at Mill View Hospital were all present and up to date.
- Of two risk assessments reviewed at Linwood, one did not have a risk assessment and another had been completed on the day of our inspection, despite the person having been in the service for some time.
- At Shoreham assessment and treatment service, three of the eight records reviewed did not have a risk assessment. This was escalated to the manager.Staff were in the process of assessing the suitability of one person who did not have a risk assessment.Two records did not contain a risk assessment or a crisis contingency plan. However, all nine records reviewed for people on a community treatment order at Shoreham contained a risk assessment, although one was dated September 2015 and another December 2015.
- All five risk assessments at the group treatment service at Mill View Hospital were up to date, comprehensive and holistic. Four records contained a crisis contingency plan.One of the five risk assessments at the rapid response team was missing. All five records for the rapid response team had a crisis contingency plan.
- Five of six records reviewed for the assessment and treatment service at Cavendish House contained risk assessments of which four were up to date. However, all contained a comprehensive crisis contingency plan. We case tracked two records for the assertive outreach team and found that one had not been updated since 2015.
- All except one of ten records for the group treatment service and rapid response service contained an up to date crisis plan.
- Staff from all disciplines attended regular zoning meetings to review risk. Zoning meetings took place at least weekly in each of the teams. Risks were given a risk rating of red for imminent risk, amber for increased concerns and green for low risk. We observed staff discussing risks at cluster meetings, team meetings and allocation meetings.
- Most services offered a daily duty worker, although the team at Cavendish House offered a daily clinic for staff

to see and respond to people in crisis. The team at Linwood had introduced daily medical assessment slots for people in crisis, as part of learning from a serious incident.

- Staff from the Lighthouse service had not met the trust target for completion of safeguarding adults level one training. Staff from the Lighthouse service had developed links with the local authority and arranged specialist safeguarding training for staff. Staff from Linwood had attended level three safeguarding children training the day before our inspection.
- Data provided during our inspection showed that 17% of staff from the assertive outreach team at Cavendish House had completed safeguarding adults level two training.
- Staff we spoke with were knowledgeable about safeguarding processes and how to raise an alert. Staff discussed potential safeguarding issues during meetings and with the local authority prior to submitting an alert. Staff used 'Framework I' to complete a safeguarding enquiry. The enquiry was submitted to the safeguarding lead at the local authority who managed the alert. Staff uploaded all relevant documents to the framework. The social workers within teams were the safeguarding leads.
- Staff followed the trust and local lone working policy. All staff were provided with mobile phones. Staff recorded their external visits in a central place and there was a known hostage phrase if they believed that they were in danger. There was a buddy system in place whereby staff were responsible for contacting their buddy if they had not received contact at an agreed time.
- We observed good documentation of medicines management. However, staff from East Brighton told us they used a plastic pocket to transport medicine ampoules. Staff had not completed a risk assessment to ensure this was the most secure way to transport medicine.
- We looked at five medicine charts during our inspection which were generally in good order. However, we found that zopiclone had been prescribed for longer than recommended on one chart. Another chart was brought to the attention of the manager to confirm that the physical health was being monitored of a person who used services that had diabetes.

Track record on safety

- There were 105 incidents which involved adult community teams reported to Strategic Executive Information System, between June 2015 and May 2016. Of these, 39 incidents related to the teams inspected.
- The adult community teams had reported 113 serious incidents that required investigation between 1 June 2015 and 31 May 2016.Thirty eight incidents related to the teams inspected.Twenty six incidents concerned unexpected or avoidable death or severe harm.The assessment and treatment teams in Brighton and Cavendish House had reported the highest number of serious incidents of 10 and six respectively.
- Examples of learning from serious incidents included clarification for staff on how to access a doctor and the introduction of urgent daily medical slots. Another example was the development and implementation of a service wide protocol to record consent to share information. Following a serious incident, there was a greater emphasis on staff encouraging family and carer involvement.
- Two of the five prevention of future death reports in the 12 month period up to 30 April 2016 related to this service. We saw that the trust had identified learning from both of these incidents. This included an emphasis on staff awareness and recording of significant events and anniversary's for patients and a review of meeting structures so that staff discussed concerns in a multi-disciplinary format.

Reporting incidents and learning from when things go wrong

- Staff were competent in using the trust's electronic incident reporting tool. We reviewed incidents reported on the electronic incident reporting tool which demonstrated that staff reported incidents appropriately. Incidents were cascaded to managers to review and action.
- Incidents and lessons learnt were discussed during handovers and meetings. Staff told us that although they were aware of local incidents, they were not always aware of incidents that occurred in parts of the services. However, we saw a learning bulletin that was sent to all staff which included information regarding recent incidents across the trust.

Requires improvement

Are services safe?

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

- Staff told us that they received appropriate debrief and support following incidents. This included support from the psychology team both as a team, and individually where requested.
- Managers attended a monthly clinical meeting where incidents were reviewed, themes identified and solutions considered to prevent future incidents.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The incident reporting tool captured complaints and staff responsibilities regarding duty of candour. Information from the tool was used at team level to show incidents, complaints and when a duty of candour letter was required.This meant that staff were able to ensure that they met the duty of candour.

Are services effective?

Requires improvement

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.

Our findings

Assessment of needs and planning of care

- We saw a range of recovery orientated services that provided assessment, treatment and recovery support for people who used the service.For example, staff from the assertive outreach team worked with people which services found hard to engage.Staff from the assessment and treatment team were the entry point to specialist mental health services.Staff from the recovery and wellbeing team worked with people who needed longer term support. Staff from the 'serious mental illness local enhanced service' worked with people with enduring mental illness as a step down from secondary care.
- The trust had reviewed their care programme approach policy in January 2016.Key points included the introduction of personal support plans for everyone who received care and the use of the term 'lead practitioner' for everyone who used services whether they were on standard or care programme approach levels of care. The policy stated that people whose needs could be met by a single practitioner received a standard level of care.People assessed as having more complex needs, which required the need for a higher level of engagement, co-ordination and support were placed on a care programme approach.
- In the records reviewed, staff had not always recorded if the person was subject to a care programme approach or if a lead practitioner had been allocated. Staff told us that since the trust had replaced the term care co-ordinator to lead practitioner, it was difficult to identify who was on a care programme approach or to check the status on the electronic care notes system, which had been introduced in February 2016.
- Information including care plans and progress notes was securely stored on the trust's electronic care records system. All staff had access to this system via desktop computers. Staff also had laptops because of their work in the community and the need for hot desking which meant that staff could not always access a computer.Staff told us that hot desking meant that teams could sometimes feel like 'virtual teams' and that this could affect opportunities to share information.
- We reviewed 46 care plans during our inspection. The care plansat the assertive outreach team in east Brighton, the group treatment service and the rapid response service were comprehensive, holistic, personalised and recovery orientated.All care plans were present at Cavendish House assessment and treatment team, although were inconsistent in their detail. Two of the three care plans reviewed at Linwood were present, although were not personalised and contained a generic support plan. Linwood provided two further care plans which were comprehensive, detailed and demonstrated evidence of people involved in their care.Care plans in three of the five records reviewed at East Brighton assessment and treatment team were missing. The two care plans reviewed were not personalised or recovery orientated. Two of the eight care plans reviewed at Shoreham services had not migrated properly.
- We reviewed 17 community treatment order records. All were holistic, contained clear outcomes and demonstrated good physical health care monitoring. However, one care plan did not record that the person was on a community treatment order or what was required to enable discharge.
- Psychiatrists did not complete electronic notes but wrote a summary in letters to GPs. This meant that staff did not always have up to date information on the electronic record of people who used services.
- We saw plans to pilot a dashboard for team leaders at the mid Sussex team. The dashboard allowed staff to access reports about staff caseloads and identified where a care plan, risk assessment and care plan assessment was due. The report was due to be piloted the day after our inspection.

Best practice in treatment and care

- There was evidence that staff had considered the National Institute for Health and Care Excellence (NICE) when planning and delivering treatment. This included care pathways which incorporated NICE guidance. An example of this was delivery of psychological treatment using systems training for emotional predictability and problem solving group. We observed staff awareness of NICE guidelines during meetings, appointments and home visits.

Are services effective?

Requires improvement

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.

- All teams had psychologists who were involved in one-to-one work and facilitating groups to people who used the service. One to one psychology support was available from the assessment and treatment team for people who used the Lighthouse service. People who used services at Mill View Hospital were able to access individual cognitive behavioural therapy or trauma work with a psychologist.
- Groups delivered across the services inspected included:hearing voices, coping strategies, dealing with change, creative exposure and mindfulness.
- Psychologists throughout the service were involved in case formulation and clinical supervision for staff. The psychologists at Linwood had lead roles which included the suicide prevention strategy and mood and disorder strategy.
- Employment advisors were part of the teams at mid Sussex and Shoreham. They supported people who used the service to access training or employment.
- The trust were a partner in the Sussex recovery college which offered mental health recovery focused educational courses to adults of all ages. Courses included: understanding psychosis, managing anxiety, skills for emotional wellbeing, understanding me and building resilience for wellness and recovery. Some of the courses were delivered from the offices of the adult community team in Cavendish House. We spoke with a peer support worker who was a trainer for the recovery college and had recently received an award for outstanding contribution to the recovery college.
- The adult community teams were involved in regular audits which included response times to referrals, clozapine prescribing and an annual schizophrenia audit. Shoreham services were involved in several audits which included capacity to consent and physical health care for people in clusters 10-17 who had a care programme approach. Clustering was used to determine the required level of care.
- The trust had not completed a care plan audit for the previous year due to changing the system for electronic care records. The trust were designing an audit and will be using a tool developed by the care plan approach association. This means that the trust will be able to compare results with other trusts. The trust planned to audit records of people on standard care and the care programme approach so that they have a more comprehensive understanding of care planning.
- Managers completed regular audits for follow up contact with people who used the service, which was a commissioning for quality and innovation (CQUIN) target. CQUIN's were introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.
- We saw good evidence of staff meeting the physical health care needs at Shoreham. Staff had developed the depot clinic into a wellbeing clinic, to include physical health care, similar to the modified early warning score system. The clinic provided blood testing, blood pressure, height and weight. Physical health care was also monitored at the assessment treatment service in Cavendish House.
- Assertive outreach teams and tier two workers supported people who used the service to attend GP appointments. Staff from the group treatment service captured information about physical health as part of the screening process and supported people to attend physical health appointments.
- The teams used a range of multidisciplinary assessment tools to measure the outcomes for the people using the services and promote their recovery, such as Health of the Nation Outcome Scale (HoNOS) and the patient health questionnaire (PHQ)

Skilled staff to deliver care

- All of the services inspected had a range of disciplines in their staff teams, as recommended by the Department of Health mental health policy implementation guide for community mental health teams.
- Teams used a fully integrated health and social care model that included some teams having a nurse or social worker who was also a qualified approved mental health professional.
- All new staff completed a comprehensive induction programme which included welcome and orientation, security, wellbeing, health and safety, policies and

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training information. All staff, including bank staff and volunteers, were expected to complete the induction. The induction included timeframes for staff to complete the various elements of the induction.

- The service employed peer support workers who had experienced mental health problems.They provided support which included budgeting, life skills and advocacy for people who used the service.
- Tier two workers worked with people with low risk and worked closely with organisations in the independent sector. Their role was to support people who had been discharged from more intensive support, to living back in the community.
- Employment advisors were based in some teams and provided support for people to gain paid employment, access training or retain existing employment.
- We spoke with a band five nurse who had been employed since October 2015 and was in the final stages of their preceptorship. They told us that they had received support from senior staff but did not have protected time to complete e-learning.
- We saw evidence that staff received regular supervision. Managers used a standard supervision record form, although the level of detail recorded in supervision notes varied across the teams.
- We saw evidence that staff had completed appraisals.Managers and staff completed the appraisal which included a review of the previous year against the trust values and behaviours, confirmation of competence and planning for the future. However, the content of appraisals was variable across the teams. Not all staff had uploaded their appraisal and supporting paperwork onto the 'My Learning' framework, which meant that data for appraisals was inaccurate.
- Managers and team leaders could view training and appraisal information on the framework for members of staff that they supervised.
- Managers and staff told us that access to face-to-face training was difficult due to lack of resources, availability of training and staff unable to be released from clinical duties.
- Examples of specialist training for staff included eating disorders, substance misuse, perinatal care, conflict resolution and family therapy in psychosis. Three lead practitioners from mid Sussex had applied for the nurse prescriber training, after a pilot in Brighton which involved nurse prescribers completing medical reviews.The manager at mid Sussex was keen to replicate this system in order to free up medical staff.

Multi-disciplinary and inter-agency team work

- All of the adult community teams had regular and varied multi-disciplinary meetings.The meetings were attended by a range of disciplines and included psychiatrists, senior house officers, nurses, occupational therapists, psychologists, team leaders and peer support workers.
- We observed a multi-disciplinary meeting at the eating disorder service. The meeting was thorough and well planned. Staff discussed risk and had clear plans to support people who used the service.
- We observed a zoning meeting at Linwood and Cavendish House. The meetings were generally well co-ordinated and staff clearly presented the current issues and risks of people who used the service. Staff updated clinical records during the meeting.
- We observed a clinical team meeting where staff discussed topics using the five CQC domains of safe, effective, caring, responsive and well led. The care delivery service had introduced the tag of CREWS to support staff to relate to these domains when planning care.
- We observed a formulation meeting where staff discussed complex cases.Eleven members of staff from various disciplines attended the meeting which was facilitated by a psychologist.
- Staff from the crisis team attended regular meetings at the Lighthouse recovery support service.
- The mental health liaison professionals at mid Sussex were aligned to GPs and based in surgeries and acted as a buffer between primary and secondary care.If people's needs were more complex or longer term, staff referred them to the assessment and treatment service.
- We spoke with social workers who were integrated into the community teams. They told us they felt supported by team managers. Social workers were responsible for safeguarding referrals in the teams

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

- There were staff who were trained as approved mental health professionals (AMHPs)at Linwood, Cavendish House, Shoreham and east Brighton adult community teams. Staff who were also a qualified AMHP were on a rota to complete Mental Health Act assessments. Staff tried, where possible, to complete assessments for people on their caseload who used their service. This meant that the person undergoing the assessment was known to the AMHP.
- The speciality doctor at mid Sussex was section 12 approved..
- We saw poor compliance with staff completing training in the Mental Health Act. Data provided by the trust showed that staff from Shoreham, the Lighthouse service and the rapid response service had met the trust target for completion of Mental Health Act training. The remaining teams inspected had not met the trust's target for completing this training.
- Staff had not recorded explaining people's rights under the Mental Health Act for people on a community treatment order in two of six records reviewed in the assessment and treatment team in Cavendish House or in any of the nine records reviewed at Shoreham.
- People on a community treatment order were invited to review meetings. We observed staff provide clear discussion and reasons for a community treatment order during a CTO review. Discussions included treatment, contact and the likely length of the order.Staff involved the person in the decision making during the review. The Mental Health Act administration team alerted staff when a CTO needed review.
- We spoke with a consultant psychiatrist at Shoreham, who acted as an informal Mental Health Act lead. We saw a copy of a community treatment order audit which was completed every two years. The audit comprised the numbers of community treatment orders for each team, but no further breakdown. For example, new community treatment orders, recalls or discharges.
- We saw information concerning advocacy displayed on notice boards at the services visited.

Good practice in applying the Mental Capacity Act

- We saw low compliance with staff completion of training in the Mental Capacity Act. Data provided by the trust recorded that staff from Shoreham, the serious mental illness local enhanced service, the group treatment service and the Lighthouse service had met the trust target for completing Mental Capacity Act and Deprivation of Liberty training. The remaining teams inspected had not met the trust's target for completing this training.
- We saw leaflets about the Mental Capacity Act in the waiting areas of services.
- The social worker at Cavendish House was the local Mental Capacity Act and Mental Health Act lead because of their safeguarding knowledge and approved mental health professional (AMHP) role.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed staff demonstrating a high degree of skill and sensitivity and care to people during home visits and appointments. Staff were respectful and involved people in making decisions about their care. Staff were skilled in managing the needs of the family and used a problem solving approach.
- We observed a good level of involvement of people who used the service during clinical reviews and appointments. There were clear discussions about plans for the short and longer term for people. Staff discussed medication, needs and risks whilst maintaining a focus on recovery.
- We saw evidence of carers being offered a carers assessment. Staff used the triangle of care self-assessment tool to improve support for carers. The assessment tool enabled individual teams to assess how they met the needs of carers.
- Staff spoke about people who used services with respect during meetings.
- In May 2016, 85% of the patients' friends and family survey would recommend the trust as a place to receive care. This was below the national average of 88%. However, we spoke to 21 people who used the service and four carers, whose comments were positive about the care they had received. They told us that the service was responsive and they were able to access the service immediately.A carer told us that staff had quickly arranged a doctor's appointment to review medication.
- We saw letters and compliments from people who used the service at Linwood including a letter of thanks for the care they had received which had been sent to the chief executive.
- People who used services and their carers told us they were confident in their care, felt in safe hands and their views were taken seriously.

The involvement of people in the care they receive

- We saw inconsistencies in care records of staff recording a person's involvement in their care planning. Care records at the group treatment and rapid response service and Cavendish House demonstrated involvement of people who used services. However, four of the five care plans at the assessment treatment service in East Brighton did not evidence any involvement from the people who used services.
- We reviewed 17 records of people on a community treatment order. Five records did not reflect the person's views and those that did, were variable in their detail.
- All except two people who used services told us that they felt listened to and had been involved in decisions about their care and treatment and had been given information which allowed them to make choices and changes.
- Staff encouraged carers to receive a carer's assessment. Staff from the Linwood assessment and treatment service and rapid response service had attended carers training based on the triangle of care principle in March. The purpose of the training was to raise staff awareness of the value of carer involvement and develop skills to improve engagement with carers.
- We saw advocacy services information displayed in all services.
- We saw a patient feedback survey at mid Sussex which had received 82 responses between May and August 2016, with a monthly increase in the number returned. Feedback in the survey was overwhelmingly positive.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The rapid response service provided an assessment service and an enhanced duty service for assessment and treatment teams outside of normal working hours. Staff completed a face-to-face initial assessment and then referred to the appropriate team. Staff worked closely with crisis teams, the ambulance service and the police.
- The rapid response team received an average of 700 calls per month. People could contact the service between 8am and 10pm Monday to Friday and 10am to 10pm on Saturdays and Sundays.People who phoned after 10pm were redirected to the accident and emergency department.
- All referrals were triaged through a single point of access. There were two triage nurses for the adult community teams whose role was to act as the single point of access for referrals and prioritise assessments according to need. The triage nurses manned a telephone pathway for referrals between 8am and 6.30pm Monday to Friday.
- Teams were commissioned to respond to urgent referrals within four hours, priority referrals within five days and routine referrals within 28 days. Data provided from the trust recorded that all teams inspected had met the trust target of 28 days for referral to assessment between April 2015 and March 2016.Managers completed audits to monitor targets and told us these were rarely breached.
- One of the key performance indicators for the rapid response service was for staff to complete an assessment within four hours. The clinical commissioning group had agreed a clear set of exclusion criteria. Information provided by the trust recorded that the team completed 100% of assessments within four hours, taking the agreed exclusions into account. Staff had achieved targets concerning sending an assessment summary to GPs within 24 hours. Staff had met the target for providing a care plan within 24 hours to people who contacted the service.
- Staff recorded available assessment slots on shared electronic calendars. The triage nurse booked an assessment based on need and priority. The triage nurse or duty worker telephoned to arrange an assessment for those who met the criteria for urgent or priority appointment. An appointment letter was sent within 28 days to people who had been assessed as a routine referral.
- Referrals were discussed during meetings and assigned to an appropriate member of staff.People could be stepped across teams in order to facilitate demand and meet individual need. For example, where appropriate, the assessment and treatment team could transfer somebody with less complex needs to the tier two services for ongoing support.
- There was a three week waiting list for the group treatment service in the east and a six week waiting list for the service in the west.
- All teams except Cavendish House had a daily duty worker who responded to people who presented in crisis and where the lead practitioner was not available. Staff from Cavendish House had replaced duty with a daily clinic which they felt was more appropriate and better met the needs of people who used the service. Following a serious incident, the mid Sussex service had introduced a daily one hour slot for urgent medical reviews.
- Carers and people who used the service told us that staff were responsive and appointments could be made at short notice.
- It was the responsibility of the lead practitioner to be actively involved in the planning of discharge of a person leaving hospital and to make contact with that person within seven days of discharge. There was a commission for quality and innovation (CQUIN) for follow up contact with people who used the service.
- Teams in East Sussex took part in a daily beds management telephone conference.In West Sussex, the team leader attended a monthly discharge planning meeting. Both meetings included attendance from a nurse from the ward, community teams and crisis resolution home treatment teams. Staff provided updates of people on the wards and expected discharge dates so that the appropriate community team could arrange contact and support. We were told that the wrong community team had recently been informed of a patient who was discharged from hospital. Because of

Are services responsive to people's needs?

Good

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

this, the person was not seen for several weeks following discharge. Team leaders had requested that all teams were copied into emails from the hospital to avoid a repeated incident.

- Teams had regular contact with inpatient wards to monitor discharge. However, a member of staff told us that sometimes there was a breakdown in communication between the services. For example, a hospital ward had not communicated a discharge to the service or had told the wrong team that somebody had been discharged. This meant that there was a delay in adult community teams seeing the person.
- We saw minutes of a discharge meeting which contained comprehensive details including concerns, prescribed medicines, plans, delays and a summary for each person.
- Staff told us that there were issues accessing beds for people who used the service. This was because bed occupancy was high. Staff were concerned that difficulties in accessing beds for people were leading to a high threshold for staff to manage risks.
- The Lighthouse recovery support service had a lesbian, gay, bisexual, transgender, queer or questioning group and were reviewing how they could engage other minority groups.
- Managers told us there were barriers to discharging people back to primary care.For example, there were approximately 50-60 people who used services at Shoreham who could be managed within primary care. We saw that a number of people who used the service received a depot injection only. Some GP surgeries administered depot injections but the service were unable to discharge care to the GP. Managers told us they were working hard to improve discharge back to primary care. There were plans to introduce depot clinics in GP surgeries with support and advice from tier two workers in the community mental health teams. Staff in Worthing were involved in a pilot that involved providing advice to general practitioners and identifying appropriate referrals.
- Mental health liaison professionals at mid Sussex were aligned to GP surgeries and acted as a buffer between primary and secondary care.
- Staff telephoned people to arrange appointments at a convenient time and sent a text to remind people of their appointment. The assertive outreach teams worked with people who services found hard to engage, to encourage contact with services.
- Staff were flexible in the times and location of appointments. Staff offered flexibility of appointments which considered children and sensory animals. The times of groups at the group treatment service were within school hours to encourage attendance. Staff at Cavendish House had introduced four clinician care teams who had a good level of knowledge of individuals circumstances. This meant that there was a consistent response to people who used services.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a full range of rooms and equipment at all services inspected and areas were clean and well furnished. However, there was variability on the quality of the environment and the space available between teams. For example, the mid Sussex team were located in an old building that had narrow corridors and lots of stairs. Interview and group rooms were located on the ground floor to make access as easy as possible for people who used the service. The interview and group rooms at Cavendish House were large and bright.Interview rooms were adequately sound proofed to provide a degree of privacy.
- We reviewed the clinic rooms at Linwood, Hastings and Rother and east Brighton.We found all clinic rooms to be well run, tidy and organised.
- Reception areas of all services were generally bright and welcoming with a range of information available for people who used services.Services displayed a 'you said, we did' board in the reception area.

Meeting the needs of all people who use the service

- Staff demonstrated knowledge of how to access an interpreter if required.The rapid response service had a telephone interpreting service.
- The buildings used by the community teams varied in their ability to accommodate people with disabilities. For example, the assessment and treatment services at Cavendish House were located in a large, welcoming open plan space which met the needs of those with

Are services responsive to people's needs?

Good

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poor mobility, whilst the assessment and treatment services at Linwood were in an old building with narrow corridors that were not conducive for those with disabilities.

- The trust had introduced a recovery college, which offered courses to staff and people using the service designed to increase their knowledge of recovery and support self-management.
- We spoke with a peer support worker who told us about their ongoing support and development within their role. The peer support workers were part of the service development forum. The forum held regular meetings and consulted with people who used the service to allow them to have a voice.

Listening to and learning from concerns and complaints

- Data provided by the trust documented that between June 2015 and May 2016, the adult community based teams received the highest number of complaints. The service had received 85 complaints about inadequate overall care and treatment.Forty two complaints concerned poor staff attitude and 34 complaints concerned poor communication.Of the 241 complaints received, 95 were upheld.Complaints were discussed during business meetings. Staff were asked to reflect on complaints and consider the expectations of people of used services and how staff could better meet their needs.
- Complaints were recorded on the trust's electronic incident reporting tool. All complaints were logged with the trust complaints team who completed a thematic analysis of complaints and disseminated findings to managers.
- Managers attended a monthly operational leads meeting and shared feedback about complaints and lessons learnt during team meetings.
- We reviewed and tracked three complaints. We saw that responses to the complaints had been prompt and comprehensive. We saw that the complainant had been provided with the details of who they could contact if they were unhappy with the outcome of their complaint.
- The service received 77 compliments between June 2015 and May 2016. The compliments concerned thanks to staff.
- We spoke to 21 people who used the service and four carers. Most told us that they would speak to their worker if they had any concerns. Two people told us that they did not know how to complain. We saw information about how to complain displayed in the services visited.

Are services well-led?

Good

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.

Our findings

Vision and values

- Overall, staff reported good morale and feeling supported by their immediate managers.We saw plaudits from staff at mid Sussex which included support in finding solutions to increasing workload, encouragement, mutual respect and inspiration. Staff spoke positively about the board and its direction.
- Managers told us that the care delivery service promoted more autonomy at a local level so that services could be tailored to best meet the needs of the demographic area.
- Staff knew most of the senior management team and were aware of the trust's values and behaviours. The clinical delivery service had introduced the term CREWS, which stood for caring, responsive, effective, well led and safe, as a way to support staff to consider the CQC key lines of enquiries when working people who used services.

Good governance

- There were regular and varied focussed meetings to support staff. Staff had the opportunity to discuss people with complex needs, risk, incidents, performance, caseloads, safeguarding and learning. Managers felt confident that team leaders had a good grasp of the needs of staff and people who used the service.
- There were systems in place to monitor team performance. This included regular supervision, case review meetings, cluster group meetings, team meetings, case formulation meetings, clinical meetings and a monthly operational leads meeting.
- Data provided by the trust demonstrated that some teams had not achieved compliance targets for some courses. Staff told us they did not have protected time to complete e-learning or face to face training. Staff told us that face to face training was seldom available and difficult to book. Staff levels for completing training in safeguarding adults level two, the Mental Health Act and Mental Capacity Act and Deprivation of Liberty was particularly low.
- Managers told us they tried to allocate staff to attend training geographically in order to reduce travel time. Other initiatives to improve completion of training included arranging for protected time for supervisors to spend a day off site with supervisees. Managers told us they were aware of issues with staff completing training but the CQC inspection had helped teams to focus.
- We saw that staff received regular supervision, although the content and detail of supervision notes was variable across teams.
- We saw that managers had completed appraisals with staff, although the content and detail was variable across teams. For example, the detail recorded for staff at Cavendish house was limited whereas there was comprehensive and relevant detail in staff appraisals in Shoreham. Appraisals were linked to the trust's values and behaviours. Staff told us there were issues with uploading information, including appraisals, onto the 'my learning' framework which had affected training and appraisal data.
- The assessment and treatment teams had met their key performance indication (KPI) target regarding access to the service.
- We saw that the police had made six referrals to the rapid response service which had prevented a detention under section 136 of the Mental Health Act 1983. A section 136 means that the police can take a person to a place of safety to be assessed for a mental illness.
- All staff had access to the trust's electronic incident recording tool, Ulysees. Managers discussed incidents and complaints at the operational leads monthly meeting and local team meetings. Staff told us that although they received feedback concerning local incidents, they were often unaware of learning from incidents from other areas. The trust had developed a serious incident learning bulletin which was posted on the intranet.However, staff knowledge of this was variable.
- The trust had a clinical academic group whose role was to provide clearer pathways for people whose mental health problem was difficult to diagnose.
- All audits had to be approved by the clinical audit team. Teams were involved in regular case load audits which were discussed during meetings and supervision.

Are services well-led?

Good

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.

- The manager of the Shoreham assessment and treatment service attended a monthly audit group meeting.Clinical audits included a commission for quality and innovationfor physical health, food and nutrition; follow up, clinical risk and discharge letters.
- We saw a clinic room audit to ensure that clinic rooms across all four community mental health teams were maintained and monitored to the standards recommended by the medicines and healthcare products regulatory agency (MHRA) for the safe and appropriate storage of medicines.The audit was completed in April 2016.The audit found that many standards set out by the trust in the medicines code and MHRA standards for storing medicines and monitoring fridge temperatures were not being adhered to.An action plan had been developed for each locality to highlight areas of principle concern so that staff could address the issues and meet the standards for the next audit in October 2016.
- Managers told us they had sufficient authority to make changes to improve the service at a local level.For example, to change the skill set of the team and introduce care groups for lead practitioners.
- We saw a dashboard report that was due to be introduced into the mid Sussex team.The report enabled team leaders to view staff caseloads and see where care plans, risk assessments and care programme approach was due.

Leadership, morale and staff engagement

- Results of the staff friends and family test said that 53% of staff would recommend the trust as a place to receive care and 23% would not recommend. This is below the England average of 79% and 7% respectively. However, staff we spoke with told us they felt supported by their managers and morale was high. We saw plaudits sent by staff which included comments about support and encouragement received.
- Sickness levels at the mid Sussex recovery and wellbeing and admin team and Cavendish House assertive outreach team were higher than the trust average. Managers followed policy to manage long term absence.
- Staff told us that they felt the service was well led at a local level and there was a clear managerial structure for each team. Staff spoke positively about the senior management team.
- Specialist training for staff included family therapy in psychosis, nurse prescribers, perinatal care, carers' awareness and eating disorders.
- Managers and team leaders had completed or were due to complete a leadership course.Part of the course involved staff completing a work based project which included a project to improve staff engagement and wellbeing. As part of the leadership course, managers at Linwood had completed projects concerning staff engagement and caseload capacity which they used to support staff and improve processes.

Commitment to quality improvement and innovation

- The trust were a partner in the Sussex recovery college which offered mental health recovery focused educational courses to adults of all ages. A peer support worker employed by the trust had recently received an award for outstanding contribution to the college.
- Staff at Cavendish house adult community team had set up a 'Wisdom on Wednesdays' medics academic session which was linked to national guidance including the National Institute of Health and Care excellence. Topics discussed included managing expectations and good endings, family interventions and personality disorders.
- Staff commitment to be creative in improving services to meet local need included the employment of peer support workers and employment advisors and the introduction of a daily clinic so that staff could respond quickly to people in crisis.
- There was a commission for quality and innovation for follow up contact with people who used the service.
- There was a commission for quality and innovation for physical 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 The trust did not make sure that people who used services had a comprehensive risk assessment. The trust did not make sure that risk assessments for people who used services were regularly reviewed so that they were accurate and up to date. This was a breach of Regulation 12(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The trust did not ensure that staff completed training in the Mental Capacity Act and Depriviation of Liberty Safeguards. The trust did not ensure that staff completed training in the Mental Health Act. There was evidence of an impact with regard to documentation and people not being read their rights. There was limited evidence of people having their rights, under the Mental Health Act or subject to a community treatment order, explained to them. This was a breach of Regulation 9(1)(2)(3)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Staffing Staff had not completed appropriate rates of mandatory safeguarding adults level two training. The trust did not provided sufficient availability of face to face mandatory training. This was a breach of Regulation 18(2)(a)

This section is primarily information for the provider

Enforcement actions

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.