Sussex Partnership NHS Foundation Trust

Evidence appendix

Tel: 0300 304 0100

http://www.sussexpartnership.nhs.uk

Date of inspection visit:

2 October – 7 December 2017

Date of publication:

23 January 2018

This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Sussex Partnership NHS Foundation Trust is one of the largest mental health trusts in the country providing mental health, specialist learning disability, secure and forensic services for Brighton and Hove, East Sussex and West Sussex and specialist community child and adolescent mental health services reaching into Hampshire.

The trust was established as Sussex Partnership NHS Trust in April 2006 and became an NHS foundation trust with teaching status in August 2008. The trust is a teaching trust of Brighton and Sussex medical school and has a national reputation for research into mental health issues. The trust's research income exceeds £1.5 million.

The trust operates from over 260 sites including the community services and serves a population of 1.55 million people, employing approximately 3840 staff. There are 611 mental health inpatient beds.

Most of the registered locations are owned by the trust, however in some places the services are provided in hospitals managed by other NHS trusts (Acute hospital trusts). The areas covered by the trust are in line with local government social services areas of Brighton and Hove, East Sussex and West Sussex and Hampshire.

The trust also provides primary medical services for HMP Lewes and HMP Ford. The trust has two adult social care services – Lindridge (care home) and Avenida Lodge (domiciliary care service).

Registered locations

The trust had 28 active locations registered with the CQC (on 22 November 2017).

Registered location	Code	Local authority
Trust Headquarters	RX219	West Sussex
Rutland Gardens Hostel – Community Wards	RX202	Brighton and Hove
Millview Hospital	RX213	Brighton and Hove
Lindridge	RX214	Brighton and Hove
Shepherd House	RX232	West Sussex
Connolly House	RX237	West Sussex
Orchard House	RX239	West Sussex
The Harold Kidd Unit	RX240	West Sussex
Oaklands Centre for Acute Care	RX26N	West Sussex
Meadowfield Hospital	RX277	West Sussex
Salvington Lodge (The Burrowes)	RX2A3	West Sussex
Horsham Hospital – Iris Ward	RX2C8	West Sussex
Healthcare HMP Ford	RX2CY	West Sussex
HMP Lewes – Prison Healthcare Department	RX2DC	East Sussex
78 Crawley Road	RX2DX	West Sussex
Department of Psychiatry	RX2E7	East Sussex

The Hellingly Centre	RX2E9	East Sussex
Amberstone Hospital	RX2F3	East Sussex
Avenida Lodge	RX2G9	East Sussex
St Anne's Centre & EMI Wards	RX2K3	East Sussex
Woodlands	RX2L6	East Sussex
Beechwood Unit	RX2L8	East Sussex
Langley Green Hospital	RX2PO	West Sussex
Chalkhill	RX2X4	West Sussex
The Chichester centre	RX2X5	West Sussex
Hove community Learning Disability Team	RX2XD	Brighton and Hove
Lindridge	RX2Y5	Brighton and Hove
Selden Centre, Specialist Assessment and Intervention Service	RX2Y6	West Sussex

The trust had 611 inpatient beds across 40 wards, 16 of which were children's mental health beds. The trust had an average of 595 outpatient clinics a week and 6450 community appointments each week across all clinical specialties.

Total number of inpatient beds	611
Total number of inpatient wards	40
Total number of day case beds	0
Total number of children's beds (MH setting)	16
Total number of children's beds (CHS setting)	0
Total number of outpatient clinics a week	595
Total number of community clinics a week	6450

We carried out a comprehensive inspection of Sussex Partnership NHS Foundation Trust on the 6, 7, 12 – 16, 20, 22, 29 September 2016. Two focussed inspections to follow up Warning Notices were carried out on the 1 - 4 November and 7 December 2016. We told the trust they must make the following improvements:

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

We also told the trust they should make the following improvements:

- The trust should ensure staff are following trust policy around the checking of controlled drug stock balances.

- The trust should ensure that staff learn from incidents and change practice to reflect updated policies and procedures, by monitoring the effectiveness of their method of communicating those changes.

We have reviewed evidence in relation to these areas of improvement at this inspection (October - December 2017). The trust had taken action on each of these areas which resulted in overall improvements to the trust.

We also:

- Observed two trust board meetings (public and private meetings on both occasions).
- Observed two quality committee meetings.
- Spoke with six executive directors and the chief executive of the trust.
- Held focus groups with the five non-executive directors of the trust.
- Spoke with the interim chair of the trust.
- Spoke with trust leads in safeguarding, family liaison and physical healthcare, Mental Health Act, approved mental health professionals, serious incidents, pharmacy, complaints, governance, quality improvement, service users and carers, and training and development.
- Held two focus groups with black and minority ethnic (BME) staff.
- Held 19 focus groups with different disciplines of staff across the geographical footprint of the trust, (East and West Sussex, Brighton and Hove and Hampshire). These groups included allied health professionals, trade union representatives, qualified nurses, unqualified staff, corporate and estates staff, junior doctors and consultants.
- Spoke to the trust interim lead governor and observed one council of governors meeting.
- Undertook an online feedback survey with the trust governors.
- Involved volunteers from Healthwatch West Sussex, East Sussex and Brighton and Hove in our core service inspections.
- Attended an external carer's forum meeting.
- Reviewed trust policies and procedures.
- Reviewed four serious incident investigation reports.
- Reviewed six complaint records.
- Reviewed four death investigation reports.
- Spoke with the freedom to speak up guardian.
- Attended a trust BME network meeting, patient safety event and learning from incidents event.
- Received feedback about the trust from four clinical commissioning groups.
- Received feedback about the trust from NHS England specialised commissioning and NHS Improvement.

- Received feedback about the trust from Brighton and Hove overview and scrutiny committee and health and well-being board.
- Monitored social media for work undertaken by the trust and it staff.
- Received feedback from the CQC health and justice team regarding HMP Lewes and HMP Ford.
- Received feedback from the CQC adult social care team regarding Lindridge and Avenida Lodge.

Is this organisation well-led?

Leadership

The trust board had 16 members, made up of executive and non-executive directors. The board had undergone significant changes over the previous nine months. A new chief executive was appointed in March 2017, followed by new medical director, chief operating officer and an interim director of human resources. The trust chair left during this time and a non-executive director stepped into the interim-chair role.

The trust board and senior leadership team had a range of skills and experiences to enhance the senior leadership of the trust. The non-executive directors bought a range of expertise from their professional backgrounds, such as organisational and cultural change and financial performance. Fit and proper person checks were in place. Employment records of the five most recently appointed directors or non-executive directors provided evidence of meeting the requirement with the exception of occupational health screening, which was not present in two of the records. The remuneration committee or nominations committee depending on role monitored the requirements.

The chief executive and interim chair both had a clear understanding of the key challenges and strategic direction of the trust. Non-executive directors demonstrated they all identified challenges the trust faced across the services it provided, shortfalls and the increased need to work with partners to resolve these.

The trust board and senior leadership team displayed integrity on an ongoing basis. The feedback we received from stakeholders was that the trust and senior leadership team had an open, honest and transparent approach in their work with them. Similarly, the staff with spoke with during the focus groups and during the inspection of the core services was that they felt the new leadership team brought a fresh approach, underpinned by the trust values, which were demonstrated in their words and actions.

There was a programme of board visits to services and staff fed back that the trust senior leaders were approachable. The timetable of visits showed that different executive and non-executive directors had visited a variety of services. The direct engagement with staff enabled the board of directors, in particular the non-executive directors, to verify for themselves the intelligence being highlighted to them through board reports. The trust used a tracker to pro-actively identify services that required a site visit and the board has made a commitment that all inpatient and community services would be visited by the end of the 2017/18 financial year.

Two chief pharmacists led the department, which ensured the service had capacity to develop their medicines optimisation strategy 2016-20. A report detailing achievements and challenges faced by the service about medicines optimisation was produced annually.

The medicines optimisation team was represented on the medicines optimisation committee and clinical effectiveness group. The chief pharmacists were line managed by the medical director, which enabled communication directly to the board.

There were a number of leadership development programmes to support staff to progress within the trust. This included the trust's leadership development programme, emerging leaders programme and the black and minority ethnic (BME) staff mentorship initiative aimed at black and minority ethnic staff. Staff were aware of the mentorship and role modelling opportunities available to them to help them develop in their role and career. The trust race reference group took a lead on rolling this out and making BME staff aware of the opportunities available, as this had been identified this as a priority on the workforce race equality standard (WRES) action plan for the trust.

As at July 2017 the executive board had 16.7% black, minority ethnic (BME) members, and 83.3% women. The non-executive board had 16.7% BME members and 33.3% women. The chief executive chaired the quality committee of the trust.

	BME %	Women %
Executive	16.7%	83.3%
Non-executive	16.7%	33.3%
Total	**16.7%**	**58.3%**

The workforce strategy for the trust detailed the succession planning, which has been aligned to the trust leadership development and emerging leaders' programmes. The programmes were developed to drive cultural change at the trust, improve staff engagement and to develop the next generation of leaders who would be ready to take on more senior posts. Where staff are motivated to progress, and line managers felt they had the necessary competencies an internal or external development programme would be identified to support progression. These included the NHS leadership academy programmes in addition to the trust programmes.

The chief operating officer held a number of roles and responsibilities within the trust that included operational lead for the care delivery services, which included children and young people and learning disabilities. They were supported by a deputy director and the care delivery service leads.

Vision and strategy

The trust had a clear vision and set of values with quality and sustainability as top priorities. The trust values and associated behavioural expectations were described as their 'to be' list. They were linked to those of the NHS Constitution. The values were incorporated into various parts of the trust, such as staff appraisal and supervision, the development of services and working with others. The trust board meetings and governor meetings we observed all started with a reminder to those present of the trust values.

The trust had a clear vision and planned service to take into account local needs. Over the past three years the trust board had been implementing the overarching '2020 Vision' strategy to provide their vision of 'outstanding care and treatment you can be confident in'. The 2020 vision led to the development of eight care delivery services (CDS) across the trust, which provided overarching leadership of a particular care group and/ or geographical area. The aim of the care delivery services was for service lines to operate as separate business units through devolved leadership, whereby clinicians and managers could plan their service activities, set objectives and targets, monitor their service's financial and operational activity and manage quality and financial performance. The trust board was assured of the quality and financial performance of each CDS by an accountability framework which comprised of different forms of monitoring, such as monthly quality and financial performance reports that reported into the executive assurance committee and board.

The trust sat within East Surrey and Sussex sustainability and transformation plan (STP), which was made up of 24 organisations (local authorities and NHS) working in partnership to improve health and social care. Each area had developed proposals built around the needs of the whole population in the area, not just those of individual organisations. The trust chief executive was the STP senior responsible officer for the mental health work-stream of the STP. This enabled the clinical strategy to be aligned to, and directly link to the STP priorities in relation to mental health provision across the area. It also meant the senior leadership team were able to regularly monitor and review progress on the delivery of the STP. Some key focuses of the STP and trust clinical strategy were improved physical healthcare for people with mental health needs and the provision of a 24 hour crisis care pathway for the area. These were included within the top three priorities of the trust clinical strategy. Within each of the priorities there were a number of strategies to help drive the direction of the trust, such as more integration around mental health and physical healthcare, work towards zero suicide, new focus on team development and the implementation of quality improvement methodology.

Staff, patients, carers and external partners contributed to the clinical strategy. The achievement of the vision had more recently been enhanced by the implementation of the trust clinical strategy (2017-2020). The clinical strategy was implemented in 2017, having been developed in partnership with patients, carers, staff, commissioners and other key stakeholders via a hackathon. A hackathon is where people come together to bring practical solutions to a problem. The trust enabled this through a series of events and through the use of social media to gain as many views as possible in the development of their strategy. This involvement ensured that patient, carer, and local population needs were incorporated into the strategy, as well as that of different stakeholders.

The key priorities of the medicines optimisation strategy was described as separate visions, with a number of strategies to achieve these goals. The business case and staffing to support electronic prescribing had been agreed. However, for a number of reasons outside of their control the trust has been unable to implement electronic prescribing.

Culture

In the 2016 NHS staff survey the trust had better results than other similar trusts in six key areas:

Key finding	Trust score	Similar trusts

		average
Key Finding 20: Percentage of staff experiencing discrimination at work in the last 12 months	12%	14%
Key Finding 21: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	88%	87%
Key Finding 28: Percentage of staff witnessing potentially harmful errors, near misses of incidents in the last month	23%	27%
Key Finding 18: Percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	53%	55%
Key Finding 15: Percentage of staff satisfied with the opportunities for flexible working patterns	64%	59%
Key Finding 22: Percentage of staff experiencing physical violence from patients, relatives or the pubic in the last 12 months.	18%	21%

In the 2016 NHS staff survey: the trust had worse results than other similar trusts in six key areas

Key finding	Trust score	Similar trusts average
Key Finding 29: Percentage of staff reporting errors, near misses or incidents witnessed in the last month	89%	92%
Key Finding 16: Percentage of staff working extra hours	77%	72%
Key Finding 24: Percentage of staff/colleagues reporting most recent experience of violence	91%	93%
Key Finding 27: Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	56%	60%
Key Finding 14: Staff satisfaction with resourcing and support	3.19	3.36
Key Finding 2: Staff satisfaction with the quality of the work and care they are able to deliver.	3.71	3.85

Staff felt able to raise concerns and knew about the whistle-blowing process. The trust had relevant employment policies and procedures to support staff who wanted to raise any concerns about their work, such as those relating to raising grievances, whistleblowing, bullying and harassment. Staff we spoke with were aware of these policies and how to access them. Staff had raised concerns about bullying and harassment within the staff survey. We inspected core services leading up to the well led inspection and we found that teams had positive relationships, worked well together and addressed any conflict appropriately. In April 2017 trust appointed a freedom to speak up guardian (SUG) who worked part-time. Since this time the SUG had created five advocates in Sussex to help signpost staff to them and the support they offered. The trust had provided support to the SUG through displaying posters around the trust and messages on the trust intranet, to inform staff of the role and how to contact the SUG. The trust induction included a slot about the SUG. The SUG maintained a record of themes and staff groups and had a quarterly slot at the trust board meeting where they presented a report with a case study, in accordance with national guardian guidance. One of the non-executive directors was a link for the SUG if a concern was raised about a member of the executive team.

Staff felt respected, supported and valued. During the inspection period we held 21 focus groups with different disciplines of staff, across the geographical footprint of the trust, where we held these in East and West Sussex, Brighton and Hove and Hampshire. These groups included allied health professionals, trade union representatives, qualified nurses, unqualified staff, corporate and estates staff, junior doctors and consultants. In total 192 staff attended the focus groups to tell us what it was like working for the trust. This was in addition to approximately 280 staff we spoke with during the core service inspections. The feedback we received from staff was overwhelmingly positive. Staff spoke positively of the changes to the trust senior leadership team and how this had led to a revitalised and enthusiastic approach to the work, where they felt empowered to try out new ideas and were able to take more local initiatives bespoke to the patient groups they served. Staff spoke of a positive and open culture within the trust, and of feeling very valued due to the recognition and praise they received.

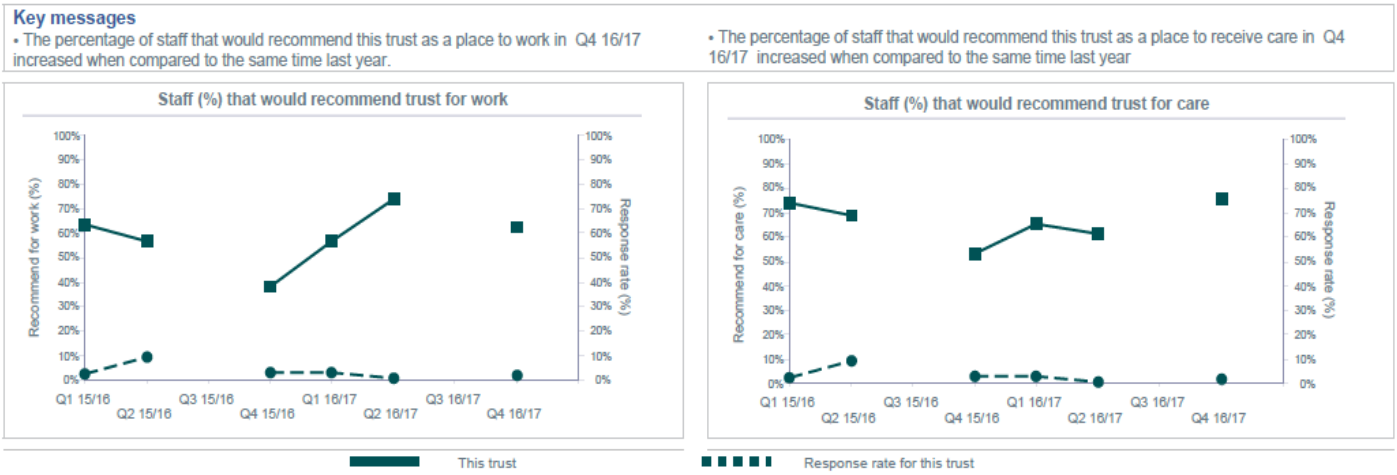
The patient friends and family test asked patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 1% and 6% worse than the England average for patients recommending it as a place to receive care for five of the six months in the period (April to September 2017). August 2017 saw the highest percentage of patients who would recommend the trust as a place to receive care with 89%.

The trust was worse than the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care in four of the six months.

	Trust wide responses				**England averages**	
	Total eligible	Total responses	% that would recommend	% that would not recommend	England average recommend	England average not recommend
Sep 17	17,818	316	84%	8%	89%	4%
Aug 17	20,252	197	89%	4%	88%	5%
Jul 17	21,222	187	83%	11%	89%	4%
Jun 17	24,777	257	84%	8%	88%	4%
May 17	21,896	223	83%	10%	89%	4%
Apr 17	19,628	194	88%	4%	89%	4%

From April 2014, NHS England introduced the staff friends and family test in all NHS trusts providing acute, community, ambulance and mental health services in England. Research has shown a relationship between staff engagement and individual and organisational outcome measures, such as staff absenteeism and turnover, patient satisfaction and mortality; and safety measures, including infection rates. The more engaged staff members are, the better the outcomes for patients and the organisation are generally.

The staff friends and family test asks staff members whether they would recommend the trust as a place to receive care and also as a place to work.



The trust showed an improving trend over the last six quarters. Quarter 4 2016/17 had the highest scores for staff recommending the trust as a place to receive care and Quarter 2 2016/17 had the highest scores for staff recommending the trust as a place to work. Response rates were the lowest in these quarters and are therefore less likely represent the staff views overall.
There was no reliable data to enable comparison with other individual trusts or all trusts in England.

The trust worked appropriately with trade unions. We met with some of the trade union representatives during the inspection. They generally spoke positively of relationships with senior trust leaders, who they said were personable, though some felt that further improvements could be made to meaningful staff engagement, also that some of the meetings they fed into could be better utilised, such as the partnership forum and health and safety meetings. However, all were positive on the new chief executive and of positive developments for staff going ahead.

Poor staff performance was addressed appropriately where needed. The trust had a disciplinary policy and procedure and a code of conduct policy. Processes were transparent and where staff were not performing at a reasonable standard action was taken.

The staffing levels of the trust were:

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 31 May 2017	2,419.84	N/A
Total number of substantive staff leavers	1 June 2016 – 31 May 2017	390.51	N/A
Average WTE* leavers over 12 months (%)	1 June 2016–31 May 2017	16%	N/A
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 31 May 2017	613.90	N/A
Total vacancies overall (%)	At 31 May 2017	20%	N/A

Total permanent staff sickness overall (%)	Most recent month (At 31 May 2017)	5%	N/A
	1 June 2016–31 May 2017	5%	N/A
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 31 May 2017	1239.89	N/A
Establishment levels nursing assistants (WTE*)	At 31 May 2017	799.80	N/A
Number of vacancies, qualified nurses (WTE*)	At 31 May 2017	264.47	N/A
Number of vacancies nursing assistants (WTE*)	At 31 May 2017	210.27	N/A
Qualified nurse vacancy rate	At 31 May 2017	21%	N/A
Nursing assistant vacancy rate	At 31 May 2017	26%	N/A
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 July 2016-30 June 2017	22910 (62%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 July 2016-30 June 2017	38264 (67%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 July 2016-30 June 2017	1793 (5%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2016-30 June 2017	9192 (25%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2016-30 June 2017	2811 (5%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 July 2016-30 June 2017	2419 (4%)	N/A

*Whole-time equivalent

Staffing was monitored daily by the charge nurses and matrons, and service directors, with any staffing concerns escalated in line with the trust safer staffing escalation policy. The board received a monthly safer staffing quality dashboard. The board also reviewed staff exit questionnaires for themes, and encouraged teams to focus on these during their development days to help improve retention. The board were fully aware of the staffing issues, and the hotspots where it was particularly hard to recruit staff, and this was referred to within the workforce and clinical strategies.

The trust had implemented a number of innovative ways to attract staff to working for the trust. These were well publicised, with a large recruitment campaign across different forms of social media, newspapers, the radio and television interviews. There were specific incentives for newly qualified nurses, such as a refreshed and more intensive preceptorship: a new band four role for healthcare assistants, where they could take on more responsibility; and also financial incentives for nurses returning to practice, similarly for attracting out of area nurses to work for the trust.

Staff felt quality and diversity were promoted in their day to day work. In the 2017 workforce race equality standard (WRES) it found that 12% of staff are black and minority ethnic (BME). The trust had an equality performance scheme 2014 – 2018 that provided a governance structure for tackling discriminatory practices across all the protected characteristics. The trust has a number of

initiatives to encourage BME staff development and recruitment, including the BME mentorship initiative and the emerging leaders programme.
There were a number of staff networks promoting staff diversity. The equality delivery system two (EDS2) framework was a national tool developed for the NHS by to aid the delivery of personal, fair and diverse services. The EDS2 was a quality improvement driver for staff and patient services. The most recent EDS2 provider by the trust was dated April 2016. It showed that equality reference groups for disability, race, sexual orientation and gender identity, religion and belief and gender groups were in the developing/ achieving stages. There was no information for the age reference group.

The trust's target rate for appraisal compliance was 90%. As at 31 July 2017, the overall appraisal rates for non-medical staff was 49%.

Core Service	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% of non-medical staff who have had an appraisal
MH - Wards for people with learning disabilities or autism	25	24	96%
MH - Child and adolescent mental health wards	27	25	93%
MH - Community mental health services for people with a learning disability or autism	74	53	72%
MH - Specialist community mental health services for children and young people.	550	390	71%
MH - Community LD / Autism	88	61	69%
MH - Community-based mental health services for older people	141	86	61%
MH - Mental health crisis services and health-based places of safety.	244	116	48%
MH - Wards for older people with mental health problems	281	129	46%
MH - Forensic inpatient	187	84	45%
MH - Acute wards for adults of working age and psychiatric intensive care units	304	131	43%
MH - Long stay/rehabilitation mental health wards for working age adults	82	35	43%
MH - Other specialist services	29	10	34%
MH - Community-based mental health services for adults of working age.	421	141	33%
Other	170	46	27%
Other (Care home - registered with ASC directorate)	83	1	1%
Total	**2706**	**1332**	**49%**

Two of the 15 core services (13%) achieved the trust's appraisal rate. The core services failing to achieve the trust's appraisal target were 'other (care home – registered with adult social care directorate) with 1%, 'other' with 27%, community based mental health services for adults of working age with 33%, long stay rehabilitation mental health wards for working age adults with

43%, acute wards for adults of working age and psychiatric intensive care units with 43%, forensic inpatient with 45%, wards for older people with mental health problems with 46%, mental health crisis services and health based places of safety with 48%, community based mental health services for older people with 61%, community learning disability and autism with 70% and specialist community based mental health services for children and young people with 71%. The rate of appraisal compliance for non-medical staff reported during this inspection is higher than the 45% reported the previous year. In December 2017 we were provided with refreshed appraisal data for the trust. This showed that the appraisal data was much improved. There were still only the same two core services meeting the trust target of 90%. However, the community based mental health services for adults of working age had improved to 62%, long stay rehabilitation mental health wards for working age adults to 60%, acute wards for adults of working age and psychiatric intensive care units 81%, forensic inpatient with 75%, wards for older people with mental health problems with 68%, mental health crisis services and health based places of safety with 70%.

We inspected four core services prior to the well led review and we found that the data held locally showed better compliance with appraisals than that held centrally. For example, in the specialist community mental health services for children and young people core service, in each service we visited, we saw evidence that all teams were at 100% compliance for appraisal rates. The reason given for the lowered submitted data was that staff were not routinely uploading and logging their completed appraisals onto the 'My Learning' platform, from which data was taken from. Also, the trust reports for appraisals included staff who had recently joined the trust and would not have yet qualified for an appraisal, and staff who had been seconded or who were absent, such as on maternity leave. Additionally, the data included staff members who were either on maternity leave or long term sick leave. During the inspection we spoke with approximately 472 staff. All staff told us they were offered an annual appraisal and that they had received this. However, non-nursing staff, such as corporate and estates staff said that they were put off being engaged in the process, due to their appraisal forms being nurse-orientated and now applicable to their role. Staff in the medicines optimisation team had regular appraisals, including the chief pharmacists. The trust did not provide any data in relation to their appraisal compliance for medical staff at the time of the original information request in August 2017. However, in December 2017 we were provided with figures that showed this was at 94%. The trust acknowledged that locally staff did not always upload onto the central system the appraisals that had been undertaken, and so this was not always accurately captured. There was a robust improvement plan in place to address this.

The clinical supervision compliance staff reported during this inspection was higher than the 73% reported the previous year.

Core Service	Formal supervision sessions each identified member of staff had in the period	Formal supervision sessions should each identified member of staff have received	Clinical supervision rate (%)
MH - Child and adolescent mental health wards	264	264	100%
MH - Forensic inpatient	1861	1861	100%
MH - Specialist community mental health services for children and young people.	1786	1984	90%
MH - Other Specialist Services	2850	3460	82%
MH - Community-based mental health services for older people	347	432	80%
MH - Wards for older people with mental	293	384	76%

health problems			
MH - Mental health crisis services and health-based places of safety	856	1168	73%
Other	2292	3352	68%
MH - Community-based mental health services for adults of working age.	1710	2695	63%
MH - Long stay/rehabilitation mental health wards for working age adults	525	842	62%
MH - Acute wards for adults of working age and psychiatric intensive care units.	810	1427	57%
TOTAL	**13594**	**17869**	**76%**

The trust's target rate for clinical supervision was 85%. As at 30 June 2017, the overall clinical supervision compliance was 76%. However, there was no standard measure for clinical supervision and trusts collect the data in different ways. Eight of the 11 core services (73%) achieved the trust's clinical supervision target. The core services failing to achieve the trust's target were 'acute wards for adults of working age and psychiatric intensive care units' with 57%, 'long stay/rehabilitation mental health wards for working age adults' with 62%, 'community based mental health services for adults of working age' with 63%, other with 68%, mental health crisis services and health based places of safety with 73%, wards for older people with mental health problems with76%, community based mental health services for older people with 80% and other specialist services with 82%.

We inspected four core services prior to the well led review and we found that the data held locally showed better compliance with supervision than that held centrally. In December 2017 the trust provided us with refreshed data which showed a much improved, and plans for future improvement, picture than that supplied by the centrally held data. The refreshed data showed that for the services identified above as failing to reach the trust's target, these had improved to 91%, 83%, 85%, 'other' subsumed within other core services, 81%, 80% and 95% respectively, with the overall supervision rate for December 2017 being at 89%. Staff also had group supervision and reflective practice sessions, which were not always recorded on the central system as being supervision.

At 31 July 2017, the training compliance for trust wide services was 82% against the trust target of 85%. Of the training courses listed 12 failed to achieve the trust target and of those, five failed to score above 75%. The five courses which failed to achieve the CQC recommended minimum threshold of 75% included; personal safety breakaway level 1 with 57%, adult basic life support and manual handling people both with 68% each, safeguarding children (level 3 additional) with 72% and personal safety managing violence and aggression with 74%. Training at the trust is reported on a rolling month on month basis. In December 2017 the trust provided refreshed information about the mandatory training rates. They were at 85% (trust target) for compliance across nine core mandatory training for all staff and 81% compliant across the wider mandatory course portfolio which consisted of 22 different subjects and levels figures to the end of November 2017. For the four core service we inspected, they were at, or over 85% for mandatory training, apart from the community-based mental health services for adults of working age and specialist community mental health services for children and young people, which were at 83% and 84% respectively.

We inspected four core services prior to the well led review and we found that the data held locally showed better compliance with mandatory training than that held centrally. The trust provided us

with this information which showed a much improved, and plans for future improvement, picture than that supplied by the centrally held data. For example, in the community-based mental health services for adults of working age core service it showed that for the sites we visited the overall mandatory training compliance ranged from 78% in West Brighton Community Mental Health service to 94% at West Hastings. However, the figures showed safeguarding level one for children and adults was 100%, equality diversity and human rights was 98% and clinical risk assessment and safety management was 97% across all sites. In areas where the training compliance was low, such as disengagement and conflict resolution, which was at 69% across all sites, the trust had provided a plan for when this training would be completed. For the acute wards for adults of working age and psychiatric intensive care units we found that some acute wards had 100% mandatory training compliance.

This trust received 681 compliments during the last 12 months from 1 July 2016 to 30 June 2017. The core service of 'community based mental health services for older people' had the highest number of compliments with 147, followed by 'specialist community mental health services for children and young people' with 111 and 'community based mental health services for adults of working age' with 103.

Governance

The trust had effective structures, systems and processes in place to support the delivery of its strategy including committees, sub-committees and team meetings. In 2015 the trust underwent an external review of its committees and their terms of reference. This led to the strengthening of these for a more robust governance structure and supporting the implementation and delivery of the trust 2020 vision and clinical strategy.

A clear framework set out the set out the structure of ward, team, divisional and senior trust meetings. The trust had an operational board, a council of governors and six committees. Each committee had its own reporting mechanism to ensure the dissemination of information to staff groups as well as oversight by the board members. The quality committee was chaired by a non-executive director and had four sub committees that fed up into this. Board and committee papers were in good order. There was a non-executive director (NED) and executive director Mental Health Act (MHA) lead on the trust board. There were concerns raised that the NED had little MHA experience, which meant that they could not challenge as the role required. However, the executive director had experience within MHA trusts and previously worked in the MHA Commission.

The governance framework addressed the need to meet people's physical health care needs. The quality committee received presentation and papers on the progress from the trust physical health care team, which in turn was fed into the trust board meetings. This was also monitored via the board assurance framework. The trust had a physical health strategy and a team of physical health leads with the necessary expertise to support this work. Physical health is a priority on the trusts board assurance framework under safe and effective care, as the trust recognised the need to improve outcomes on physical health for people with mental health conditions.

The trust provided details of its highest profile risks. Each of these had a current risk score of 15 or more.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

Opened	ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.	Last review date
1 April 2017	1.1	Care plans: Increase the quality of care plans through audit; 65% care plans signed/agreed with patients and/or carers; 95% care plan for people are reviewed as a minimum every 12 months.	16	16	4	1	9 November 2017
1 April 2017	1.2	Suicide prevention: 95% of patient discharged from hospital are seen within 7 days of discharge ad 95% patients have a risk assessment; we will aim to make a follow up call at 72jhrs following discharge, 90% of patients in COA have a crisis plan	20	20	4	1	9 November 2017
1 April 2017	1.3	Physical health: 90% of inpatients weight and height recorded and BMI calculated; 95% of patients admitted receive a physical health assessment	16	16	4	1	9 November 2017
1 April 2017	3.2	Focus on learning will be demonstrated by the trust achieving 95% compliance with mandatory training and launching Sussex Wellbeing and recovery College.	16	16	4	3	9 November 2017
1 April 2017	4.2	Sickness levels maintained at, or below 3.5%	20	20	4	4	9 November 2017
1 April 2017	4.3	80% staff received clinical and/or managerial supervision six weekly and 90% staff receive an annual appraisal	16	16	4	4	9 November 2017
1 April 2017	5.1	We will achieve financial breakeven or better by making best use of our resources and delivering our Service Improvement Plans (SIPs)	16	16	4	5	9 November 2017

1 April 2017	5.2	We will make sure their support services operate as effectively and efficiently as possible to help clinical services deliver the best possible care to patients. We will participate in national benchmarking to achieve high levels of efficiency for support services.	16	16	4	5	9 November 2017

The trust has provided documents detailing their highest profile risks. Each of these had a current risk score of 15 or higher.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

Opened	ID	Description	Risk level (initial)	Risk score (current)	Ward/Team	Last review date
19 October 2016	8194	Risk assessment forms, risk management and care plans are not uniformly and consistently being completed by clinicians across disciplines) in the appropriate fields in the carenotes system.	16	16	AMHS	Quarterly
24 October 2016	8199	Lack of space/environment	16	16	SOAMHS (W Brighton) / Mill view Hospital / Dementia	Quarterly
24 October 2016	8200	Impact of DoLS (which would include both those in residential settings and the community)	15	16	SOAMHS (W Brighton) / Mill view Hospital / Dementia	Quarterly
24 October 2016	8201	Impact & volume of social care demands (including statutory duties for S/W's) on both BHCC and SPFT staff.	15	15	SOAMHS (W Brighton) / Mill view Hospital / Dementia	Quarterly
24 October 2016	8203	Practitioners having little time (and maybe lack of awareness) to complete CPA review/s, clusters etc. in a timely manner.	15	15	SOAMHS (W Brighton) / Mill view Hospital / Dementia	Quarterly
15 November 2016	8241	The lack of space has resulted in higher levels of staff stress. At times team members cannot access a desktop PC and can't complete their clinical work. Musculo-skeletal issues due to lack of desks and staff 'perching' on end of desks. Staff also wasting time trying to find clinical space to see services users	15	15	ATS East Hub (EBCMHC) / East Brighton CMHS, BGH / AHMS	Quarterly

		and carers.				
15 November 2016	8242	Lack of time to compete the administration requirements of CPA and other aspects of patient care.	16	16	ATS East Hub (EBCMHC) / East Brighton CMHS, BGH / AHMS	Quarterly
15 November 2016	8245	The lack of space has resulted in higher levels of staff stress. At times team members cannot access a desktop PC and can't complete their clinical work. Musculo-skeletal issues due to lack of desks and staff 'perching' on end of desks. Staff also wasting time trying to find clinical space to see services users and carers.	15	15	ATS West Hib (MVH) / Mill View Hospital / AMHS	Quarterly
15 November 2016	8246	Lack of time to compete the administration requirements of CPA and other aspects of patient care.	16	16	ATS West Hib (MVH) / Mill View Hospital / AMHS	Quarterly
20 July 2015	7529	Proposed installation of patient sensor equipment OPMHS. This will alert staff when a patient gets out of bed to use the toilet. The bracket that houses the unit will be wall mounted at ceiling height. The Manchester audit score is expected to be a 54 dependent on the room height. It will be the responsibility of matrons to assess and include on their audit sheet.	15	15	Meridian Ward / Mill view Hospital / AMHS	Monthly 27 March 2017
5 May 2017	8551	Brunswick ward do not have an integrated alarm systems on the ward	15	15	Brunswick / Lindridge / Dementia	Quarterly
12 January 2017	8322	20% vacancy rate across Worthing recovery team, with a 90% nursing vacancy (4 WTE vacancies). 1 WTE consultant's vacancy with no cover and 0.5 consultant on at leave with no cover.	16	16	Recovery & Wellbeing (Worthing) Chanctonbury, Swandean / AHMS	Monthly – 11 August 2017
21 November 2016	8255	Iris ward patient room windows are without window restrictors in place. Estates team are to replace at no cost to SPFT. A full risk assessment is needed prior to any work commencing. Estates team have been informed that NO work is to commence until risk assessment of window restrictors to be used is completed. General manager is aware.	15	15	Iris Ward / Horsham Hospital / Dementia	Quarterly – 11 August 2017. Mental Health Act on Iris ward picked this risk and estates working with Propco to

						resolve.
12 February 2016	7711	There was a death in the inpatient unit at HMP Lewes on Friday 12th February 2016 following a ligature-tying incident. The young man who died was waiting for a secure mental health bed and had been since November 2015. Whilst in this man's case admission was complicated by one going discussion about the level of security and type of bed required (he had been assessed by both MSU and PICU several times and had been on the LSU men's waiting list for some time before the MOJ directed that he needed an MSU transfer on 10/2) the lack of availability of beds anywhere in the country delayed his admission. It is important to note that we still have 8 patients at HMP Lewes who are waiting in the inpatient unit for transfer to secure beds - 3 of whom do not yet have a bed identified.	15	15	HMP Lewes (Healthcare inpatients) Lewes Prison Healthcare / Forensic Healthcare Service	Quarterly – 29 March 2017
11 May 2017	8554	Prolonged difficulty in recruiting qualified nursing staff at The Hellingly Centre	20	20	Hellingly Centre	Monthly – 11 August 2017
2 June 2016	7858	Ligature risks on site	15	15	Crawley Road, 78 (Ward) / Forensic Health care Service	Monthly
9 August 2017	8713	Lack of capacity to allocate lead practitioners to cases requiring mental health intervention. Delay with patients receiving medical interventions. Patient safety – capacity issues with responsiveness to tribunals, and discharge planning for sec 117 status in-patients	16	16	Recovery & Wellbeing (Crawley) Ifield Drive, 218 / AMHS	Monthly

In addition to the board assurance framework and trust risk register, there was a risk register for each care delivery service, where the high risks also appeared on the overall trust register. The chief pharmacists managed the pharmacy risk register, which also hosted corporate medicines risks. National safety alerts were discussed at the drugs and therapeutics committee. Following the recent alert for valproate, the trust had reviewed its processes to ensure they reflected best practices and made a few changes.

Sussex Partnership NHS Foundation Trust has submitted details of six external reviews commenced or published in the last 12 months [2016/2017]. The six reviews included:

1. NHS England (NHSE) commissioned caring solutions – Independent review of the care and treatment provided by the trust to an individual - report not published by NHSE until October 2016

2. The trust and NHSE jointly commissioned caring solutions – to complete a thematic review of the care and treatment of 11 service users who became involved in serious incidents.
3. Soon to be published – NHSE commissioned Niche Mental Health Strategies to complete 'an independent investigation into the care and treatment of a mental health service user in Sussex – Sept 2016. Anticipated the report will be published in the autumn.
4. In the process of being investigated – NHSE appointed Niche Mental Health Strategies to review the care and treatment of a mental health service user. Publication date unknown.
5. In the process of being investigated – NHSE have appointed Niche Mental Health Strategies to review the care and treatment of a second mental health service user. Publication date unknown.
6. Prison and Probation Ombudsman Reports:

    - Date of incident 07.06.16 – serious incident - natural causes. Investigation completed
    - Date of incident 14.6.16 – incident - natural causes. Investigation completed.
    - Date of incident 16.06.16 – incident - natural causes. Investigation completed.
    - Date of incident 24.9.16 – incident - cause to be established. Investigation completed.
    - Date of incident 14.10.16 – serious incident - natural causes. Investigation completed.
    - Date of incident 9.11.16 – serious incident - natural causes. Investigation completed.
    - Date of incident 13.2.17 – serious incident - self-inflicted (by ligature). Investigation pending.
    - Date of incident 26.4.17 – serious incident - self-inflicted (by ligature). Serious incident review in progress and investigation pending.

Management of risk, issues and performance

Providers must report all serious incidents to the strategic executive information system (STEIS) within two working days of identifying an incident.

Between 1 July 2016 and 30 June 2017, the trust reported 204 STEIS incidents. The most common type of incident was 'apparent/actual/suspected self-inflicted harm meeting serious incident criteria' with 142. Of the incidents 113 occurred in community based mental health services for adults of working age.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Sussex Partnership NHS Foundation Trust reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the same period on their incident reporting system. The number of the most severe incidents was broadly comparable with the number the trust reported to STEIS. The trust provided 219 serious incidents and STEIS reported 204 incidents for the same period. From the trust's serious incident information, eight of

the 13 unexpected deaths were instances of sub-optimal care of the deteriorating patient meeting serious incident criteria and five of these occurred in wards for older people with mental health problems.

Type of incident reported on STEIS	MH - Acute wards for adults of working age and psychiatric intensive care units	MH - Child and adolescent mental health wards	MH - community based mental health services for older people	MH - Community mental health services for people with a learning disability or autism	MH - Community-based mental health services for adults of working age.	MH - Community-based mental health services for older people	MH - Forensic inpatient	MH - Long stay/rehabilitation mental health wards for working age adults	MH - Mental health crisis services and health-based places of safety.	MH - Other Specialist Services	MH - Specialist community mental health services for children and young people	MH - Wards for older people with mental health problems	Other	Other - Primary Medical Services	Grand Total
Abuse/alleged abuse of adult patient by staff	1				1							1			**3**
Abuse/alleged abuse of adult patient by third party	3											1			**4**
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	2				2										**4**
Apparent/actual/suspected homicide meeting SI criteria					2										**2**
Apparent/actual/suspected self-inflicted harm meeting SI criteria	6	2	2		97	5	3		14	3	4	2		4	**142**
Confidential information leak/information governance breach meeting SI criteria					3								1		**4**
Disruptive/ aggressive/ violent behaviour meeting SI criteria	2				5			1		1					**9**
Environmental incident meeting SI criteria							1								**1**
Failure to obtain appropriate bed for child who needed it	1														**1**
Pending review (a category must be selected before incident is closed)					1									1	**2**
Pressure ulcer meeting SI criteria	1											2	3		**6**

Slips/trips/falls meeting SI criteria				1	1		1					8	1		**12**
Sub-optimal care of the deteriorating patient meeting SI criteria									1			3		2	**6**
Unauthorised absence meeting SI criteria	4				1	1	2								**8**
Grand Total	**20**	**2**	**2**	**1**	**113**	**6**	**7**	**1**	**15**	**4**	**4**	**17**	**5**	**7**	**204**

Providers are encouraged to report patient safety incidents to the national reporting and learning system (NRLS) at least once a month. They do not report staff incidents, health and safety incidents or security incidents to NRLS.

The highest reporting categories of incidents reported to the NRLS for this trust for the period 1 July 2016 to 30 June 2017 were self-harming behaviour, patient accident and disruptive, aggressive behaviour (includes patient to patient). These three categories accounted for 3593 of the 5067 incidents reported. Self-harming behaviour accounted for 124 of the 133 deaths reported.

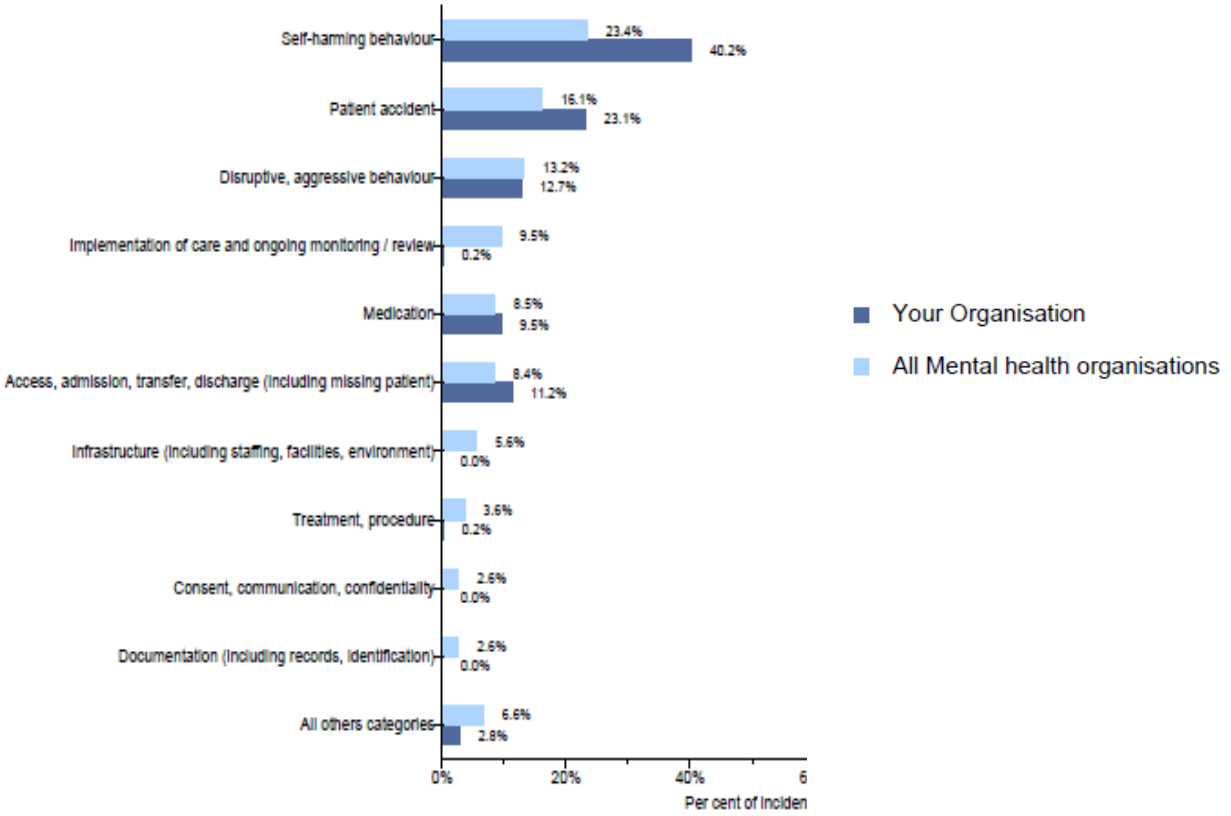
Ninety-five percent of the total incidents reported were classed as no harm (71%) or low harm (24%).

Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Self-harming behaviour	1071	587	55	8	124	**1845**
Patient accident	631	452	28	4		**1115**
Disruptive, aggressive behaviour (includes patient-to-patient)	508	121	3		1	**633**
Medication	625	5				**630**
Access, admission, transfer, discharge (including missing patient)	599	13	3			**615**
Other	89	12	4	1	8	**114**
Patient abuse (by staff / third party)	26	24	1			**51**
Infrastructure (including staffing, facilities, environment)	22	2				**24**
Implementation of care and ongoing monitoring / review	2	11	6			**19**
Clinical assessment (including diagnosis, scans, tests, assessments)	7		1			**8**
Treatment, procedure	4	2				**6**
Infection Control Incident	4	1	1			**6**

Consent, communication, confidentiality	1					**1**
Total	**3589**	**1230**	**102**	**13**	**133**	**5067**

According to the latest six-monthly national patient safety agency organisational report (1 October 2016 to 31 March 2017), the trust was in the lowest 25% of reporters nationally for similar trusts.

Self-harming behaviour and patient accident accounted for a higher proportion of the total number of incidents reported compared to similar trusts.



Organisations that report more incidents usually have a better and more effective safety culture than trusts that report fewer incidents. A trust performing well would report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death).

The trust reported more incidents from 1 July 2016 to 30 June 2017 compared with the previous 12 months. Compared to the previous 12 months, an extra 1,525 incidents have been reported in the most recent period. 'no harm' increased by 1270 incidents, low harm followed with an extra 228 incidents being reported in the current year. Severe and death incidents have increased by two and seven incidents respectively.

Level of harm	**1 July 2015 – 30 June 2016 (previous)**	**1 July 2016 – 30 June 017 (most recent)**	**Comparison to previous year**
No harm	**2319**	**3589**	**↑ 1270**
Low	**1002**	**1230**	**↑228**
Moderate	84	102	**↑18**
Severe	11	13	**↑2**
Death	126	133	**↑7**

Total incidents	**3542**	**5067**	**↑1525**

The trust had systems in place to identify learning from incidents, complaint and safeguarding alerts and to make improvements. The team overseeing serious incidents revisited action plans from previous serious incidents annually to ensure that actions were still embedded, and where not, review and re-introduce these. The trust had a clear framework to enable the passing of information and escalation of issues from ward to board, and board to ward level. For example, learning from serious incident reports went through the mortality scrutiny meeting to the safety committees, which fed into the quality committee and into the trust board meetings. These then fed down into the monthly clinical delivery service meetings and through to teams/wards so that relevant information and learning was shared. Staff at all levels of the organisation understood their roles and responsibilities and when to escalate issues to a more senior person. Outcomes of incident investigations were sent to service managers and matrons to share learning with their teams. All incidents were also uploaded onto the trust-wide interactive dashboard monthly to help team identify trends, themes and learning. The serious incident dashboard was presented at the public board meetings and also at the council of governors meeting.

The serious incident assurance report to the board of directors in November 2017 showed that the trust was not meeting their target of 90% of serious incident investigation reports being submitted within timescale. Up to the end of September 2017, only 49% of these were completed to timescale. The reasons given for this included staff annual leave and the involvement of families and needing to work at their pace. There were also some delays where the care delivery service leads were allocated as the lead reviewer, and their balancing this with their workload. The trust were monitoring this closely to ensure there was improvement in the timeliness of completion of serious incident reports.

There were two strategic leads for safeguarding, one for adults and one for children, who both reported to the chief nurse. There was a safeguarding lead nurse, named nurses and deputy named nurses for each area across the trust. We interviewed the trust safeguarding leads who outlined that the safeguarding structure had recently changed following a review led by the chief nurse, where it was found that there were gaps in safeguarding support and a lack of safeguarding presence on some senior trust meetings. The review also led to a safeguarding strategy which outlined key standards in accordance with the national framework and clear reporting structures from the safeguarding delivery group through to the trust board, via the quality committee.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

	In Days	**Current Performance**
What is your internal target for responding to* complaints?	Not currently in place	The trust are in the process of rolling out investigating an learning form complaints training and advise that complaint investigators should contact the complainant within 48 hours of receiving the complaint.

What is your target for completing a complaint?	25 working days or agreed timeframe	76%
If you have a slightly longer target for complex complaints please indicate what that is here	N/A	No data

* Responding to defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken

	Total	Date range
Number of complaints resolved without formal process*** in the last 12 months	511	1 July 2016 to 30 June 2017
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	21	1 July 2016 to 30 June 2017

**Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example PALS resolved or via mediation/meetings/other actions

The chief nurse was the board member with oversight of complaints. We met with the complaints lead and reviewed the summary report that looked at complaints responses to board and quality committee. The complaints team compiled monthly and annual reports for the trust board and quality committee so that there was clear oversight of trends, themes and learning that needed to be shared.

The trust applied duty of candour appropriately. The trust monitored the serious incidents and those that met the threshold for duty of candour and timescales for contacting the patient and or relative. The trust generally met these, and recorded reasons for breaches, for example, no next of kin details given for a patient who died, despite efforts to gain this through internal systems and from the patients' GP. Training in the duty of candour was provided to staff.

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. The trust audit committee monitored the clinical and internal audits that took place throughout the trust, along with any action that needed to be taken. The committee reported directly into the trust board. The trust submitted data that showed that a range of clinical audits took place, such as in relation to controlled drugs, and patient experience across a number of services. There was an internal audit programme for pharmacy management which included controlled drug audit checks and pharmacist intervention audit. We identified some best practice where the majority of ward and unit based audits had been successfully transferred from pharmacy to the wards for completion with pharmacy retaining an oversight of the audits. This is outstanding practice for wards to have ownership of the first level audits. In most trusts this is pharmacy led at this level.

The internal audit strategy for 2017-2020 identified a number of future audit priorities for the trust, such as risk management and governance.

The trusts bed occupancy rates were high, with some wards averaging at 105%. On occasion some wards had on occasion risen to over 140%. The trust was using out of area placements to manage beds at great cost. Approved mental health professionals (AMHPs) reported long waits in the community for beds and it was normal for AMHPs to go out and undertake assessments with no bed identified. This meant that they often experienced long waits in the community for beds to become available. Both medical director and chief operating officer recognised the bed pressures as a potential area that could impact on safety and quality. There was a good plan in place to both understand and improve patient flow, and this was worked into their clinical strategy. The medical director had made a very recent medical appointment for a patient flow expert. There was a daily bed management meeting in place and this looked at the daily bed situation, reviewed where patients were and length of stay and identified patients for discharge, or who were delayed discharges. The chief executive was assertively pursuing funding for a 24 hour crisis service through a business case. This had been promised by clinical commissioning groups but not forthcoming. This concern had also been raised at a national level through NHS England. We raised the concerns of approved mental health professionals with the trust and the trust took immediate steps to organise a meeting with AMHPs to explore how bed pressures were impacting on them.

Information Management

The trust was aware of its performance through the use of key performance indicators and other metrics. This data fed into the board assurance framework. Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust. Information was in an accessible format, timely, accurate and identified areas for improvement. Board meeting minutes showed a clear emphasis on quality and sustainability. Information was used to measure for improvement, not just assurance.

The trust had completed the information governance toolkit assessment. The trust was aware of its performance using key performance indicators. This data then fed into the board assurance framework. The toolkit performance was 93% for the trust.

Information technology (IT) systems and telephones were working well and they helped to improve the quality of care. Information governance systems were in place including confidentiality of patient records. The trust used and electronic patient record system that was password protected and only accessible to staff. The trust provided e-learning training to staff in information governance. This was provided for staff who were regular users. The final training rate was 97%.

An external review was undertaken in 2016 and an action plans developed to strengthen the governance processes. The majority of these had been met, though the actions relating to reviewing all policies and procedures was ongoing. We saw examples of where these had been updated, where they were up-to-date in referencing relevant current guidance.

Engagement

The trust had a structured approach to engaging with people who use service, those close to them and their representatives. Feedback was used to make improvements to the service. Across the trust staff held different events and used social media to engage with people who use services,

staff and the public and raise awareness of mental health and to reduce the stigma relating to this. The trust had further methods to meet with and receive feedback from patients, their carers and family members which included monthly carer meetings, annual patient experience conference and patient and carer stories were shared at board and council of governor meetings. The wards used "you said/we did" feedback tools in weekly community inpatient meetings. There was a service user leader and carer leader for the trust.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients, carers and staff had opportunities to give feedback on the service they received. Staff also received communications directly into their email accounts and through updates, such as 'patient safety matters' to help them learn from incidents and complaints to help them improve their services. During the core service inspections the staff fedback that these were very useful in helping them to look at their work and approach to situations, and make workable changes to improve the safety and experience of patients.

The trust was actively engaged in collaborative work with external partners. The trust actively collaborated with external partners with work around the sustainability and transformation plans. External stakeholders said they received open and transparent feedback on performance from the trust. The trust was also part of the south of England mental health quality and patient safety improvement collaborative to help develop the quality, safety, outcomes and experience of people using services. The trust has a well-established service level agreement with two local trusts for medicine supply and one trust for the provision of clinical pharmacy staff, medicines enquiries and out of hours provision. There were section 75 agreements between the local authority and the trust, but these worked in different ways across areas of the trust.

The trust offered governors training on appointment. Governors received a full day induction to their role, which included awareness training in from the Mental Health Act team and equality and diversity. Governors were invited to attend the NHS providers core skills course, of which seven were booked to attend in January 2018. They also had development days they could get involved in to help enhance their working as a team of governors. Governors had different areas of responsibility which linked into them being present on different quality committees, which helped increase their being able to hold non-executive directors to account. We carried out an online survey with the trust governors, of which 19 out of 32 responded. The majority of the feedback we received from the governors was that they had a positive relationship with the trust board and they felt able to question them. They also felt positive about the direction of travel of the trust.

Learning, continuous improvement and innovation

	Historical data		Projections	
Financial Metrics	Previous financial year (2 years ago) (31 March 2016)	Last financial year (31 March 2017)	This financial year (31 March 2018)	Next financial year (31 March 2019)
Income	£243,584,000	£253,133,000	£250,204,000	£252,248,000
Surplus	£3,158,000	-£3,465,000	£0	£0
Full costs	£240,426,000	£256,598,000	£250,204,000	£252,248,000
Budget	£239,439,000	£250,043,000	£250,204,000	£252,248,000

NHS Improvement (NHSI) provided information that the trust was in a relatively stable position and they had no concerns about the trust financial management. NHSI was working with the trust on a rapid quality improvement plan, which was designed to address quality issues and financial pressures in tandem and to achieve a breakeven position.

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed.

The table below shows services across the trust awarded an accreditation (trust-wide only) and the relevant dates.

Accreditation scheme	Core service	Service accredited
AIMS – WA (Working age adults)	Acute/PICU	Oaklands (22 November 2016)
AIMS – PICU (Psychiatric Intensive care Units)	Acute/PICU	None sought or achieved
AIMS – AT (Assessment and Triage)	Acute/PICU	None sought or achieved
AIMS – OP (Wards for older people)	Wards for older people	Orchard (21 March 2017) / Larch wards (not yet accredited)
Quality Network for Inpatient Learning Disability Services (QNLD)	Wards for LD & Autism	Seldom Unit – Member for two years and currently working towards full accreditation in year 3. Standards met in year 2, type 1 98% and type 2 93%.
Quality Network for Inpatient CAMHS (QNCC)	Child and adolescent mental health wards	Not provided
Quality Network for Community CAMHS (QNCC)	Specialist community mental health services for children and young people / MH - Other specialist services	Eastleigh CAMHS Peer Review (15 Sept 2016) Hampshire Eating Disorder Service (8 December 2016)
RCP Prison Quality Network	Forensic healthcare	Forensic healthcare – Lewes prison has completed two cycles of the peer review process, signed up for cycle three for accreditation.
CCQI Forensic services	Forensic inpatient	Pine, Fir and Hazel (February 2017) low secure units – t5th cycle peer review completed February 2017. Oak, Willow & Ash medium secure units – 23 March 2017. Elm ward low secure unit are engaged with the schemes but have not yet achieved accreditation.
RSQM Forensic services	Forensic inpatient	Forensic services are part of the Sussex restorative justice partnership (SRJP) which holds the accreditation for restorative justice services delivered in Sussex.
RCP Enabling environments award	Forensic inpatient	Elm ward – 26 June 2017

Quality Indicator for Rehabilitative care (QuIRC)	Long stay/rehab	Amberstone, Bramble Lodge, Connolly and Shepherd House and Rutland Gardens
ECT Accreditation Scheme (ECTAS)	Not provided	Eastbourne ECTAS achieved accreditation in July 2016 and Working in June 2017.
Psychiatric Liaison Accreditation Network (PLAN)	Crisis and HBPoS	Brighton mental health liaison team enrolled, awaiting accreditation – peer assessment completed and submission made.
Memory Services National Accreditation Programme (MSNAP)	Community based mental health services for older people	Memory assessment service, South West Sussex – 24 April 2016 / West Sussex – 24 June 2016 and North West Sussex – 15 September 2016

Effective systems were in place to identify and learn from unanticipated deaths. The trust 'incidents, serious incidents and learning from deaths policy and procedure' (May 2017) set out the framework for reporting, investigating, reviewing, monitoring and learning from deaths of people in receipt of treatment from the trust. The categories of what required investigation was in accordance with the NHS England serious incident framework (2015). Deaths were reported and subject to scrutiny at the recently implemented monthly mortality scrutiny group. The members of this included the associate director of nursing standards and safety, physical health lead and the clinical director for learning disability services. The group provided assurance to the safety committee that unexpected deaths would be reviewed in accordance with the national quality board 'learning from deaths' guidance. The safety committee reported to the monthly quality committee, which was chaired by a non-executive director. A report of incidents of mortality was also provided to the council of governor and board meetings. The chief nurse was the lead board member for serious incident investigations, prevention of future death reports from the Coroner and implementing learning from deaths work. The trust was the first in the country to be involved with Making Families Count (MFC). This is an award winning NHS England project, developed in partnership with a charity called 100 Families who support people who have lost loved ones as a result of suicide, or NHS homicides (where a patient with mental health needs kills a member of the public) or where a persons' relative has died whilst under the care of an NHS trust, as a result of a serious incident of avoidable harm. Through this work the trust was the first in the country to implement family liaison leads in August 2016. There were three dedicated family liaison leads and a further 13 staff who have been trained to provide family liaison. The family liaison leads sat as part of the serious incident team and also led on the review of serious incidents and provided root cause analysis training to band seven staff and above to enable them to also carry out reviews, whilst embedding the ethos of family liaison in this training. At the time of inspection they had provided this training to 60 staff across the trust.

We reviewed five serious incident investigation reports where people who use the service had died unexpectedly. The reports were detailed and clearly showed the steps taken in the investigation, which showed these were thorough and explored all angles. Since the implementation of the family liaison leads the serious incident reports have included family meeting details and views of the family. The serious incident reports were scrutinised to ensure the duty of candour requirement was met. All incident reports were sent to the local clinical commissioning groups to be approved. Learning from deaths were shared with staff through 'patient safety matters' briefings, patient safety events that took place across the trust and at the annual trust 'learning from incidents' event. During the core service inspection we found that there was good learning from incidents and staff could describe incidents that had occurred in other parts of the trust, and detailed improvements they had made in response to the learning from these. We have been monitoring the incidents of unexpected deaths over the past two inspections to monitor the effectiveness of the trust suicide prevention strategy (in 2015) and learning from deaths. Over the past two years

the number of deaths has reduced. Figures provided by the trust for 2016 show there were 104 from January to November. For the same period in 2017 this figure had dropped to 98.

The trust was actively participating in clinical research studies. The trust was a teaching trust of Brighton and Sussex medical school and has a national reputation for research into mental health issues. The trust's research income exceeds £1.5 million. League tables published on the 3 August 2017 by the national institute of health research showed that for 2016/17 the trust was the second highest recruiter to high quality research studies. This high level of activity has been maintained for many years. The trust had a dedicated research department and as at July 2017, the trust were carrying out 19 new studies (along with existing studies) that included some for people (and carers of people) with dementia, young people, adults with mental health needs and for trust staff well-being.

There were organisational systems in progress to support improvement and innovation work. The trust was in the process of implementing a three phased approach to quality improvement, following the institute for healthcare improvement model. At the time of the inspection they were in the first phase, the discovery module (which can take from 3-12 months), though entering into phase 2, of designing and developing a quality improvement model for the trust and training for staff so they could get involved. Work that had been undertaken across the trust was detailed in the 'quality and safety report', which included details of innovative practice.

Staff were encouraged to make suggestions for improvements and gave examples of ideas which had been implemented. The staff we spoke with during the inspection said that with the new trust leadership team and move towards quality improvement they felt more empowered and able to make improvements to their services. Staff spoke of being encouraged and supported to try out new and innovative ways of working to improve the services they worked in.

External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning. Some services within the trust had won some good practice awards in the year since the previous inspection of the trust. These included:

- The iROCK service in Hastings was a unique and innovative drop in clinic for young people to attend. The service aimed to engage young people who would not normally engage with formal services and to ensure young people were seen directly by the most appropriate service and not have to wait for intermediary. The service received 'Highly Commended' at a recent NHS Clinical Commissioners Healthcare Transformation Awards ceremony and was shortlisted for a Health Service Journal award in November 2017. The service was initially only commissioned for one year, however due to its success, was commissioned for a further two years and the service was planning ways in which to roll out similar schemes into other regions.

- The trust was part of the south of England NHS mental health collaborative which won two gold awards for best public sector programme and best operational programme in December 2017. They also won a bronze award for the best training partnership.

- Time for Dementia' was a joint initiative between the trust and Brighton and Sussex Medical School, working with University of Surrey, Alzheimer's Society and Surrey and Sussex Borders NHS Foundation Trust. This paired over 950 students training to be doctors/ nurses/ paramedics with families where a member had been diagnosed with dementia. Students visits several times over a two year period to gain real understanding of impact, knowledge, changes to attitudes and increased empathy. This programme was shortlisted in three categories at the national positive practice in mental health awards in October 2017.
- In August 2017 the people management journal featured article on positive work around organisational development that had been implemented by the then human resources and organisational development director. This was shortlisted for an award at the positive practice in mental health awards.

The trust also held an annual award ceremony called 'positive practice awards' to recognise and award staff members for outstanding contributions in their work.

Wards for older people with mental health problems

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Mill View Hospital	Meridian Ward (functional)	19	Mixed
Lindridge (formerly Nevill Hospital)	Brunswick Ward (dementia)	10	Male
Beechwood Unit	Beechwood (dementia)	20	Mixed
Department of Psychiatry	Heathfield Ward (functional)	18	Mixed
St Anne's Centre & EMI Wards	Raphael Ward - St Anne's (functional)	17	Mixed
The Harold Kidd Unit	Grove Ward (organic)	10	Male
The Harold Kidd Unit	Orchard Ward (functional)	12	Mixed
Meadowfield Hospital	Larch Ward (functional)	18	Mixed
Salvington Lodge (The Burrowes)	The Burrowes (organic)	10	Mixed
Horsham Hospital - Iris Ward	Iris Ward (organic)	12	Female
Langley Green Hospital	Opal Ward (functional)	19	Mixed

Is the service safe?

Safe and clean care environments

- All eleven wards had areas which were not clearly visible to staff and this presented some challenges for clear observation of the patients. Staff managed these challenges through individual risk assessments, having a presence in areas of the wards here they could view the bedroom areas and regular checks of patients. There were sufficient staff available to increase the observation of patients at a high risk of self-harming or falling over, for example.
- Staff carried out regular environmental risk assessments which were up to date and reviewed regularly.
- We identified concerns at our last inspection in September 2016 that the trust did not comply with the Department of Health Eliminating Same Sex Accommodation requirements and we issued a requirement notice. The guidance states that all sleeping and bathroom areas should be segregated and patients should not have to walk through an area occupied by another gender to reach toilets or bathrooms. Over the 12 month period from 1 August 2016 to 31 July 2017 there were three mixed sex accommodation breaches within this core service, one on St Raphael Ward, one on Orchard Ward and one on the Burrowes. Each of these wards were built prior to 2002, Orchard and the Burrowes were built on the 1930's. When we inspected, the trust was refurbishing St Raphael ward to avoid mixed sex accommodation breaches and planned to increase the number of bathrooms and toilets available on the ward. Staff mitigated risks by increasing staff observation if a breach occurred. All the mixed sex wards had female only lounges.
- There were ligature risk assessments for all 11 wards within this core service. These assessments were completed from August 2016 to present.
- The trust had taken actions to recently refurbish two wards in order to mitigate ligature risks. Refurbishment was underway in three other wards and was in planning stage in three further wards.
- We had concerns in our previous inspection in September 2016 that staff on Meridian ward had not taken adequate mitigation to manage ligature risks. During this inspection considerable improvements had been made. Staff had received training on managing ligature risks and staff knew where the high-risk ligature anchor points and ligatures were and how these risks were reduced and managed. Staff had carried out ligature risk assessments using the trust's ligature audit tool at least once each year. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Induction packs for new staff included clear guidance on how ligature risks were managed and how to report new risks. Staff had identified high-risk areas such as the bathrooms, lounges and dining rooms and ensured they regularly monitored these areas. Information sheets were available on the wards which highlighted all ligature anchor points, high, medium and low risk areas, locations for emergency equipment, fire alarms and ligature cutters.
- Alarms were available throughout the wards in bedrooms, bathrooms and toilets. Staff carried individual alarms. Staff and patients said that alarms were responded to quickly.

Maintenance, cleanliness and infection control

- Three locations scored better than similar trusts for all four aspects of the 2017 patient-led assessments of the care environment scores.
- One location (Department of Psychiatry) scored better than similar trusts for three aspects.
- There were two locations (The Harold Kidd Unit and Meadowfield) that scored worse than similar trusts for three out of four aspects of the care environment.
- Please note that some of the locations provide more than just this core service.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
MILL VIEW HOSPITAL	wards for older people with mental health problems	99.9%	94.1%	85.9%	83.1%
LINDRIDGE	wards for older people with mental health problems	100%	97%	87.7%	91.8%
THE HAROLD KIDD UNIT, CHICHESTER	wards for older people with mental health problems	93.6%	86.9%	80.2%	91.5%
MEADOWFIELD	wards for older people with mental health problems	96.6%	95.1%	-	80.1%
SALVINGTON LODGE - BURROWES WARD	wards for older people with mental health problems	97.6%	91.3%	85.6%	89.5%
HORSHAM HOSPITAL - IRIS WARD	wards for older people with mental health problems	98.7%	86.2%	79.1%	88.5%
DEPARTMENT OF PSYCHIATRY	wards for older people with mental health problems	99.7%	96.1%	79.8%	89.2%
ST ANNE'S CENTRE & EMI WARDS, ST. LEONARDS-ON-SEA	wards for older people with mental health problems	100%	90.4%	77.3%	90.1%
BEECHWOOD UNIT, UCKFIELD	wards for older people with mental health problems	100%	98.5%	91.5%	90.8%
LANGLEY GREEN HOSPITAL	wards for older people with mental health problems	99.2%	95.8%	-	82.3%
Trust overall		98.6%	94.7%	82.8%	86.3%

England average (Mental health and learning disabilities)	**98.6%**	**95.2%**	**84.8%**	**86.3%**

- We had concerns in our previous inspection in September 2016 that not all of the wards were clean. During this inspection all of the wards were clean. Cleaning schedules were available to guide staff. In addition there were audits of infection control and prevention and staff hand hygiene to ensure that patients and staff were protected against the risk of infection.
- Patients on St Raphael ward said chairs in the lounge area were heavily stained and when we checked, the chairs were soiled. We raised this with the trust senior managers who told us an order for new furniture had been made and the furniture arrived on the ward the week after our inspection. In addition there were no privacy blinds in the bedroom dormitory windows. This meant, throughout the ward, people in neighbouring office buildings could see into the ward both through the bedroom windows and in one of the bathrooms. We raised this with senior managers who undertook to resolve the problem immediately by fixing opaque film to the windows.

Clinic room and equipment

- Each ward had a clean and tidy clinic room. Staff kept appropriate records which showed regular checks took place to monitor the fridge temperatures for the safe storage of medicines. Emergency equipment and medicines were stored on the wards in the clinic rooms. An automated external defibrillator and anaphylaxis pack was in place on each ward to use in an emergency and staff knew how to use the equipment. The wards had access to an electrocardiogram machine. An electrocardiogram is a test which measures the electrical activity of the heart to show whether it is working normally. Equipment such as weighing scales and blood pressure machines were regularly calibrated and the equipment was checked on a regular basis.

Safe staffing

Definition

Substantive – how many staff in post currently.
Establishment – substantive posts plus vacancies, eg how many they want or think they need in post.

Substantive staff figures			**Trust Target**
Total number of substantive staff	At 30 June 2017	258	N/A
Total number of substantive staff leavers	1 July 2016 – 30 June 2017	53.6	N/A
Average WTE* leavers over 12 months (%)	1 July 2016 – 30 June 2017	21%	N/A

Vacancies and sickness			Trust Target
Total vacancies overall (excluding seconded staff)	At 30 June 2017	72.9	N/A
Total vacancies overall (%)	At 30 June 2017	21%	N/A
Total permanent staff sickness overall (%)	At 31 May 2017	7%	3.5%
Establishment and vacancy (nurses and care assistants)			**Trust Target**
Establishment levels qualified nurses (WTE*)	At 30 June 2017	137	N/A
Establishment levels nursing assistants (WTE*)	At 30 June 2017	157	N/A
Number of vacancies, qualified nurses (WTE*)	At 30 June 2017	43	N/A
Number of WTE vacancies nursing assistants	At 30 June 2017	23	N/A
Qualified nurse vacancy rate	At 30 June 2017	31%	N/A
Nursing assistant vacancy rate	Not provided	15%	N/A
Bank and agency Use			**Trust Target**
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 July 2016 – 30 June 2017	3355	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 July 2016 – 30 June 2017	3040	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 July 2016 – 30 June 2017	429	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2016 – 30 June 2017	7725	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2016 – 30 June 2017	989	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 July 2016 – 30 June 2017	611	N/A

*WholeTime Equivalent

This core service reported an overall vacancy rate of 31% for registered nurses at 30 June 2017.

This core service reported an overall vacancy rate of 15% for registered nursing assistants.

This core service has reported a vacancy rate for all staff of 21% as of 30 June 2017.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	Vacancies	Establishment	Vacancy rate	Vacancies	Establishment	Vacancy rate	Vacancies	Establishment	Vacancy rate

			(%)			(%)			(%)
Iris Ward	7.31	12.51	58%	1.35	15.15	9%	8.86	31.76	28%
Opal Ward	7.09	12.09	59%	2.31	15.43	15%	8.2	29.02	28%
Larch Ward	2.38	12.71	19%	1.14	12.74	9%	3.45	28.84	12%
The Burrowes	5.64	12.51	45%	0.02	15.15	0%	5.94	31.56	19%
Beechwood	0.77	12.57	6%	5.46	20.83	26%	8.36	38.2	22%
Brunswick Ward	3.8	13.6	28%	1.38	16.51	8%	6.49	32.96	20%
Orchard Ward	4.07	10.07	40%	2.35	14.15	17%	6.42	27.72	23%
Heathfield Ward	4.97	12.57	40%	0.85	9.25	9%	6.72	26.02	26%
Raphael Ward - St Anne's	1.18	12.57	9%	3.64	11.57	31%	4.85	27.25	18%
Grove Ward	4.22	12.51	34%	1.66	15.15	11%	5.78	30.56	19%
Meridian Ward	1.8	13.6	13%	2.67	11	24%	4.12	27.08	15%
Core service total	**43.23**	**137.31**	**31%**	**22.83**	**156.93**	**15%**	**69.19**	**330.97**	**21%**

NB: All figures displayed are whole-time equivalents

Between 1 July 2016 and 30 June 2017, bank staff filled 3355 shifts to cover sickness, absence or vacancy for qualified nurses. In the same period, agency staff covered 3040 shifts. An additional 429 shifts were unable to be filled by either bank or agency staff.

	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Opal	537	795	130
Meridian	303	117	15
Brunswick	285	186	37
Larch	483	252	69
Orchard	61	174	19
Grove	291	380	26
Iris	210	316	16

Burrowes	199	540	46
St Raphael	309	192	55
Beechwood	267	88	16
Heathfield	410	0	0
Core service total	3355	3040	429
Trust Total	**22910**	**9192**	**1793**

***Percentage of total shifts

- Between 1 July 2016 and 30 June 2017, 7725 shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants and 989 were filled by agency staff. There were an additional 611 shifts that were not filled by both bank and agency staff.

	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Opal	765	222	72
Meridian	627	12	43
Brunswick	822	32	69
Larch	529	87	63
Orchard	649	6	46
Grove	545	51	22
Iris	309	173	11
Burrowes	367	100	75
St Raphael	809	162	53
Beechwood	1635	144	151
Heathfield	668	0	6
Core service total	7725	989	611
Trust Total	38264	2811	2419

***** Percentage of total shifts

- The sickness rate for this core service was 7% between 1 June 2016 and 31 May 2017. This is lower than the sickness rate of 9% reported at the last inspection in September 2016.
- This core service had 53.6 (21%) staff leavers between 1 July 2016 and 30 June 2017. This is higher than the 17% reported at the last inspection (from 1 April 2015 to 31 March 2016).

	Substantive staff	Substantive staff Leavers	Average % staff leavers	Total % vacancies	Total % staff sickness	Ave % permanent staff sickness

						(over the past year)
Opal Ward	20.8	13	18%	28%	9%	14%
Larch Ward	23.0	5.2	23%	20%	6%	7%
The Burrowes	26.2	4	27%	17%	6%	9%
Grove Ward	23.8	7	26%	22%	15%	11%
Orchard Ward	20.3	4.8	21%	27%	9%	9%
Iris Ward	22.9	3.6	24%	28%	6%	5%
Brunswick Ward	25.7	4.1	27%	22%	2%	5%
Meridian Ward	23.1	1.8	23%	15%	3%	6%
Heathfield Ward	19.3	1.2	19%	26%	5%	4%
Beechwood	31.2	4.3	33%	18%	7%	9%
St Raphael Ward	21.8	4.6	21%	20%	6%	10%
Core service total	**258.1**	**53.6**	**21%**	**21%**	**7%**	**7%**
Trust Total	**2420**	**391**	**16%**	**20%**	**5%**	**5%**

- The below table covers staff fill rates for registered nurses and care staff during April, May and June 2017.
- Beechwood ward had not enough registered nurses for all night shifts over the three months and too many care staff for night shifts in May and June.
- Burrowes ward had not enough registered nurses for day shifts in May and and too many care staff for night shifts in May and June.
- Grove ward had not enough registered nurses for day shifts in April and May too many care staff for night shifts in June.
- Brunswick ward had not enough registered nurses for night shifts in June and too many care staff for night and day shifts in May.
- Iris ward had too many care staff for day shifts in all three months and too many care staff for night shifts in May.
- Larch ward had not enough registered nurses for day shifts in May.
- Meridian ward had too many care staff for all shifts in May and June.
- Opal ward had not enough registered nurses for day shifts in April and May, not enough care staff for night shifts in May and June and not enough care staff for day shifts in May.
- Orchard ward had not enough registered nurses for all night or night shifts over the three months, not enough care staff for day shifts in April and May and too many care staff for night shifts in all three months.
- St Raphael ward had not enough registered nurses for night and day shifts in April and too many care staff for day and night shifts in May.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff
	APRIL				MAY				JUNE			
Beech wood	98.6%	99.3%	71.0%	123.0 %	95.7%	98.9%	66.1%	146.0 %	92.4%	96.6%	70.2%	128.9 %
Burrowes Ward	98.1%	98.5%	103.2%	124.5 %	94.8%	113.4%	98.4%	138.2 %	85.1%	113.7 %	93.2%	142.7 %
Grove Ward	86.7%	106.1%	99.7%	100.0 %	88.1%	118.6%	96.6%	138.3 %	95.8%	99.9%	96.6%	112.5 %
Brunswick Ward	93.7%	133.3%	100.3%	170.2 %	95.7%	171.2%	100.0%	179.4 %	87.9%	119.5 %	108.3 %	126.8 %
Iris Ward	107.3%	134.9%	93.7%	104.8 %	100.4 %	150.4%	95.8%	125.8 %	95.9%	132.8 %	101.7 %	108.3 %
Heathfield Ward	93.4%	97.3%	100.0%	101.7 %	97.8%	100.9%	100.6%	101.7 %	95.3%	97.2%	111.1 %	95.1%
Larch Ward	95.3%	97.7%	103.2%	91.5%	100.6 %	95.5%	98.4%	93.4%	89.0%	97.8%	93.5%	93.3%
Meridian Ward	104.9%	104.1%	94.8%	117.6 %	104.7 %	143.6%	93.1%	139.7 %	107.0%	133.0 %	99.2%	165.2 %
Opal Ward	84.8%	113.6%	100.0%	100.0 %	88.8%	83.8%	95.2%	67.7%	108.3%	101.0 %	96.5%	69.0%
Orchard Ward	83.2%	88.9%	51.7%	197.1 %	75.5%	77.6%	53.4%	197.3 %	69.2%	96.8%	49.9%	200.3 %
St Raphael Ward	88.0%	95.1%	89.7%	113.1 %	93.4%	146.9%	101.1%	138.9 %	92.8%	120.3 %	101.8 %	114.7 %

- The number of nurses identified in the staffing levels, set by the trust's safer staffing tool, matched the number on all shifts across all wards. All staff told us there were sufficient staff to deliver care to a good standard and the staffing rotas indicated that there were sufficient staff on duty.
- The total number of substantive staff across the four wards was 258 and there had been an ongoing programme of recruitment which had seen a recent reduction in staff vacancies across the wards. For example staff vacancies on Opal ward had reduced from eight posts to six posts, vacancies on Orchard ward had reduced by three posts, vacancies on Grove ward had reduced by three, vacancies on St Raphael had reduced by three and Meridian ward had no staff vacancies.

- When required bank and agency staff were needed managers used temporary staff who were familiar with the wards.
- Staff told us senior managers were flexible and responded well if the needs of the patients' increased and additional staff were required. We saw examples during our visit of extra staffing being made available. For example, to provide one-to-one observation of patients in response to the changing needs of patients.
- Qualified nurses were present in communal areas of the wards at all times. There were sufficient qualified and trained staff to safely carry out physical interventions. All nurses were trained to deliver intermediate life support and all staff were trained in basic life support.
- Staff were available to offer regular and frequent one-to-one support to their patients. There were enough staff on each shift to facilitate patients' leave and for activities to be delivered. Staff and patients told us that activities were rarely cancelled due to staffing issues. Patients told us they were offered and received a one-to-one session with a member of staff most days. Information from the patients' daily records showed that this was the case.
- There was adequate medical cover over a 24 hour period, seven days a week across all of the wards. Out of office hours and at weekends, on-call doctors were available to respond to and attend the hospitals in an emergency. Consultant psychiatrists provided cover during the regular consultant's leave or absence.
- The compliance for mandatory training courses as of 31 July 2017 was 88%. Of the training courses listed five failed to achieve the trust target and two failed to score above 75%. These two were personal safety and management of violence (73%) and personal breakaway level 1 (54%).
- Rapid tranquilisation had the highest training compliance with 97%. There were 101 staff eligible for the training course trust wide and 98 were up to date with the course. Personal breakaway level 1 scored the lowest out of all the training courses with 54%. This was also the course with the lowest compliance trust wide. There were 39 staff eligible for the training course trust wide and 21 were up to date with the course. Managers told us this figure was low as staff on the wards, delivering direct patient care, covered breakaway training as part of the longer and more detailed personal safety management of violence awareness training course which achieved a compliance rate of 74%.

Key:

Below CQC 75%	Between 76% & 89%	**Above Trust target 90%**

Training course	This core service	Trustwide mandatory training total %
Adult Basic Life Support	78%	68%
Clinical Risk Assessment	96%	93%
Equality and Diversity	94%	93%
Health and Safety (Slips, Trips and Falls)	90%	84%
Infection Prevention (Level 1)	87%	95%
Infection Prevention (Level 2)	89%	75%

Information Governance	90%	88%
Manual Handling - Object	93%	87%
Manual Handling - People	77%	68%
Mental Capacity Act Level 1	93%	83%
Mental Health Act	90%	80%
Other (Please specify in next column)	88%	78%
Personal Safety - MVA	73%	74%
Personal Safety Breakaway - Level 1	54%	57%
Rapid Tranquilisation	97%	93%
Safeguarding Adults (Level 1)	81%	85%
Safeguarding Adults (Level 2)	94%	87%
Safeguarding Children (Level 1)	85%	93%
Safeguarding Children (Level 2)	90%	82%
Safeguarding Children (Level 3 Additional)	N/A	72%
Total %	**88%**	**81%**

Assessing and managing risk to patients and staff

- Risk assessments were completed for all patients on admission to hospital and followed the format in the electronic care record system. Staff used nationally recognised risk assessments and tools such as the 'historical, clinical and risk management scales'. This is a set of comprehensive guidelines for assessing risk of violence. Risk assessments were updated following any incidents. The percentage of clinical staff that had received risk assessment and management training was 96%, which was over the trust average compliance of 93%.

Management of patient risk

- Staff told us, where they identified particular risks, they safely managed these by putting in place relevant measures. For example, the level and frequency of observations of patients by staff were increased in response to increased risks. Risk assessments were detailed, complete and comprehensive. Assessments covered patients' mental state, skin condition, oral hygiene, continence, moving and handling and nutrition. Nationally recognised assessment tools were used such as the malnutrition universal screening tool, which is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. The Waterlow score was also used, which gives an estimated risk for the development of a pressure sore in a given patient.
- Staff discussed and shared risks in the daily handover meetings in a written handover to all staff. The handover was recorded on the electronic system. In addition each ward carried out a daily 'safety huddle' which is a nationally recognised good practice initiative to reduce patient harm and improve the safety culture on the wards. The meetings involve all available staff to discuss specific patients' risks and any potential harm that may affect patients.
- Staff on all wards followed the trust's observation policies and procedures to manage risk from potential ligature points.

- Blanket restrictions were kept to a minimum on all of the wards. Staff gave us examples when they had changed blanket restrictions. For example belts were banned on Orchard ward; however this in turn presented an increased risk of trips so belts were re-introduced and risk was individually assessed. Any restrictions had been thought through with staff and patients before implementation or had a clear rationale. For example, patients admitted to the wards underwent searches to ensure no contraband was brought into the ward. This was to ensure a safe environment for patients and staff and this had been put in place following incidents of contraband being brought onto the wards. Contraband is an item which is banned from the ward such as weapons, drugs or alcohol. A list was displayed showing these banned items. Staff told us that patient searches were done in a supportive and dignified way, ensuring it was conducted in a private area of the ward and by the appropriate gender of staff. Staff told us blanket restrictions were always revisited and reviewed.

- All wards followed best practice in implementing a smoke-free policy as the trust grounds were a smoke-free zone. Staff explained the policy to patients on admission and it was outlined in their ward welcome booklets. Staff offered patients smoking cessation support sessions, nicotine replacement therapy and they could purchase e-cigarettes if required.

- All staff we spoke to said that if patients were informal they were able to leave the wards. All informal patients we spoke with said they knew they could leave the ward should they wish to do so. There were notices by the ward entrance doors reiterating this point. Larch ward at Meadowfield Hospital operated an open door policy, which was least restrictive practice. The wards at this hospital had completed a literature review which had considered national research and guidance on open ward environments. This published literature review suggested that there was evidence of reduced complete suicides and absconsions without return to the ward for patients who were treated on open wards. The doors on Larch ward were open and patients requested to be risk assessed prior to leaving the ward. This was carefully managed by staff.

Use of restrictive interventions

- This core service had 198 incidents of restraint (on 100 different service users) and three incidents of seclusion between 1 July 2016 and 30 June 2017.

- Over the 12 months, there was a slight increase in the incidence of restraint in August 2016, in March 2017 and in June 2017. Brunswick ward reported both the most restraints and most uses of rapid tranquilisation. We discussed the higher level of restraints and rapid tranquilisation on Brunswick ward with the ward manager. The staff reported all occasions of restraint including gentle hands on restraint during personal care delivery. The rapid tranquilisation data included the administration of as and when oral medicines. Staff followed the trust rapid tranquillisation policy for prescribed medicines to be given in an emergency and followed the national institute for health and care excellence guidance.

- All staff received training which included the management of actual and potential aggression. Staff practiced relational security and promoted de-escalation techniques to avoid restraints where possible. Relational security is the way staff understand their patients and use their positive relationships with patients to defuse, prevent and learn from conflict.

- The below table focuses on the last 12 months' worth of data: 1 July 2016 to 30 June 2017.

	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Heathfield Ward	0	1	1	0	1
Grove Ward	0	24	10	0	9
Orchard Ward	0	6	3	1	5
Iris Ward	0	19	9	0	5
Opal Ward	0	10	7	0	5
Brunswick	1	77	26	2	19
Larch Ward	0	7	5	0	2
Meridian Ward	2	11	9	2	3
The Burrowes Unit	0	5	5	0	2
St Raphael Ward	0	18	11	3	12
Beechwood Unit	0	20	14	0	1
Core service total	**3**	**198**	**100**	**8**	**64**

- There were eight incidents of prone restraint which accounted for 4% of the restraint incidents.
- Over the 12 months, there was an increase in the use of restraint in August, where there were a total of 27 incidents and again in March 2017 and June 2017, when there were 21 in each month.
- Incidents resulting in rapid tranquilisation for this core service seem to have fluctuated over the year with the highest numbers in August 2016 (nine) and April 2017 (eight).
- Staff understood and worked within the Mental Capacity Act definition of restraint.
- There have been zero instances of mechanical restraint over the reporting period.
- The number of restraint incidents reported during this inspection is lower than the 229 reported at the time of the last inspection.
- Over the 12 months, there was a slight increase in the use of seclusion in May 2017, where there were a total of two instances.
- The number of seclusion incidents reported during this inspection was lower than the nine reported at the time of the last inspection.
- There have been no instances of long term segregation over the 12 month reporting period or the previous year.

Safeguarding

- All of the staff we spoke with knew how to raise a safeguarding issue or concern. Staff said they completed an electronic incident form and informed the nurse in charge or the ward

manager. All staff were aware of who the trust's safeguarding lead was and how to contact them. The safeguarding team contact details and flow charts of the safeguarding procedure were placed in all of the wards both in the nurses' office and also on the patients' notice boards. Over 94% of staff had up to date safeguarding children and adults training.

- Staff told us how they keep patients safe from harassment and discrimination by observing behaviours on the wards and between patients and visitors. All wards had strong working relationships with the local safeguarding teams and with the trust's safeguarding lead.
- All wards had access to family rooms where patients met family members, children and friends if it was risk assessed as safe to do so. All patients due for visits were risk assessed on the day to assess if the visit could take place safely. Family rooms were located off the wards.
- A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.
- Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to children's services, adult services or the police should take place.
- The trust did not supply safeguarding referral data at a core service level but have instead supplied the information at area level.
- Sussex Partnership NHS Foundation Trust has submitted details of zero external case reviews commenced or published in the last 12 months that relate to this core service.

Staff access to essential information

- Staff used an electronic care record system and information was available to all relevant staff when they needed it. Information was available between different teams across the trust.

Medicines management

- At our last inspection in September 2016 we had concerns that not all patients prescribed high dose anti-psychotic medicines were receiving the correct physical health care checks. In addition the required physical health checks were not always carried out for patients who had received rapid tranquilisation. We issued the trust with a requirement notice. During this inspection we found improvements had been made and did not identify any issues in relation to this.
- There were appropriate arrangements across all 11 wards for the management of medicines. Staff gave patients information about their medicines. There were no errors or omissions in the recording of medicines dispensed. If patients had allergies, these were listed on the front of the prescription chart. We looked at the ordering process and saw the process for giving patients their regular medicines. All medicines checked were available and in date. There were good processes and procedures in place on the ward in relation to medicines reconciliation. This is where the ward staff would contact general practitioners on admission, to confirm what medicines and dosages the patient was taking so that these medicines could continue while

the patient was on the ward. Staff discussed medicines in multidisciplinary care reviews. A pharmacist visited each of the wards daily and carried out routine audits to ensure that staff were managing medicines safely. Patients at risk of side effects from taking high dose antipsychotic medicines were monitored. Medicine to be given when required, were prescribed for patients appropriately and staff regularly reviewed and discontinued them if no longer needed. Medicines to be given to patients detained under the Mental Health Act were documented accurately. Forms were always signed by the consultant overseeing the patient's treatment, by the patient, if they had capacity to do so or by a second opinion appointed doctor.

Track record on safety

- Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.
- Between 1 July 2016 and 30 June 2017 there were 17 STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was slips, trips and falls meeting serious incident criteria with eight.
- A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.
- We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.
- The number of serious incidents reported during this inspection is lower than the 21 reported at the last inspection.

Ward	Abuse/alleged abuse of adult patient by third party	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Pressure ulcer meeting SI criteria	Sub-optimal care of the deteriorating patient meeting SI criteria	Slips, trips and falls	Total
Beechwood Unit				1	1	2
Grove Ward				1		1
Heathfields Ward					3	3
Iris Ward	1		1		1	3
Larch Ward	1				1	2
Meridian Ward		1				1
Opal			1			1
St Raphael Ward				3	1	4

Total	**2**	**1**	**2**	**5**	**7**	**17**

Reporting incidents and learning from when things go wrong

- The Chief Coroner's Office publishes the local coroners' reports to prevent future deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing future deaths.
- In the last two years, there have been nine 'prevention of future death' reports sent to Sussex Partnership NHS Foundation Trust. Two of these related to this core service, details of which can be found below.

Date of report: 6 March 2016

- Patient not known previously to mental health services. Admitted to Langley Green Hospital and then transferred to Mill View Hospital when a bed became available. The patient was at risk of aspiration pneumonia. The patient developed aspiration pneumonia and was transferred to an acute trust and died of pneumonia on 6 March 2016.

The Coroner's concerns were:

- The Transfer between Langley Green hospital and Mill View hospital was not considered in the patient's best interests and the patient's views were not considered.
- Poor documentation in relation to personal care, medication, observations, fluid and food intake.
- Physical disability not catered for (wheelchair bound, one side paralysed).
- Rapid tranquilisation policy not followed.
- Deterioration in physical health not detected.

The trust gave the following details of improvements made:

- Admission and internal transfer checklist developed and audited by matron. Internal transfer of patients highlighted in daily call. Carenotes used to record patient involvement.
- Rapid tranquilisation guidance from Chief Pharmacist strategy and governance developed and rolled out to staff. Updated policy.
- Audits of health records and care plans.
- Local improvement plan for compliance with the observation policy.
- Review of observation policy.
- Ordering of specialist equipment – needs identified prior to transfer and ordering information on intranet.
- Trust wide bed management being developed.

Date of report: 5 June 2016

- Patient was admitted to Brunswick ward in April 2016 with Parkinson's disease and Alzheimer's dementia. He died of natural causes.

The Coroner's concerns were:

- Medication regimen not effectively addressed / no reasons for changes in medicines recorded.
- Mental Capacity assessment forms not fully completed
- Falls risk assessment did not take into account information from family
- No Waterlow score until late in admission
- Thromboprophylaxis assessment not done until late in admission
- No bowel chart until late in admission
- Clinical recommendations and instructions not handed over, completed or documented
- Malnutrition universal screening tool score not reviewed
- Referrals to specialists not recorded / made
- Mobilisation not encouraged
- Delay in enema being given?
- Role of the primary nurse not clear / effective
- No review of care plan
- No appointment of care co-ordinator.

The trust gave the following details of improvements made:

- Multidisciplinary clinical care review template revised with audit
- Electronic records introduced
- Role of administrator on the ward enhanced
- Contact with family by senior doctor on admission
- Weekly track and trigger checklist introduced for multidisciplinary team
- Supernumerary nurse one day a week to carry out essential tasks from multidisciplinary team
- New falls proforma and audit
- Ward manager calls family and invites for introduction and info sharing
- Plan to visit at home before admission
- Training from nurse specialist
- Geriatrician attends ward weekly
- Weekly audit of waterlow and thromboprophylaxis assessments
- Enhanced physical health section on electronic care records
- Pressure ulcer pathway
- Equipment ordering system improved / possible equipment library going forward
- Training on bowel function

- Tabular list of diagnoses and common symptoms
- Briefing to staff with expected standards
- System of referrals to specialists reviewed
- Draft nutritional monitoring / food and fluid chart protocol
- Training on falls / audit and proforma
- Review of the role of primary nurse and guidance to staff and monitored in clinical supervision
- Improved multidisciplinary team clinical care review
- Care Co-ordinator requests to be in line with care programme approach policy, staff reminded and will be discussion in clinical supervision

- Staff knew how to recognise and report incidents on the providers' electronic recording system. Incidents and lessons learnt from incidents were shared at the wards' daily 'safety huddle' meetings. Incidents were presented in a monthly summary report which detailed when incidents took place and what had occurred. Staff gave us examples of incidents reported and lessons learnt relating to slips, trips and falls, safeguarding patients, the use of rapid tranquilisation, self-harm, assault, verbal abuse, and choking risks. Staff were able to discuss recent serious incidents and coroner concerns from across the core service, and action taken to avoid re-occurrences. The trust implemented a debriefing policy following incidents and staff confirmed these took place. Staff also debriefed patients following incidents. The trust sent a learning bulletin to staff each month, called 'patient safety matters'.

- Staff understood the duty of candour and told us they were open and transparent with patients and their families, if something went wrong. Managers said they had received training, paying particular attention to the quality of the incident investigations, how they engaged families and carers in reviews when things go wrong and then in how they identify lessons, share learning and demonstrate change in practice.

Is the service effective?

Assessment of needs and planning of care

- We reviewed 63 care records and all patients had detailed and timely assessments of their current mental state, previous history and physical healthcare needs. The care plans were recovery focused, however were of variable standards. Patients told us that they were included in the planning of their care. All patients, where possible, had a pre-admission physical health screening. All patients had a 72 hour care plan completed, following admission. A physical examination was carried out for all patients on admission and included a routine blood test and electrocardiogram. Care plans were updated in at least weekly clinical review meetings. Care plan surgeries were available across the wards and Grove ward held weekly care plan training sessions for staff and patients.

Best practice in treatment and care

- Staff followed national institute for health and care excellence (NICE) guidance when prescribing medicines, in relation to options available for patients' care, their treatment and wellbeing, and in assuring the highest standards of physical health care delivery. Staff also used NICE in the delivery of the therapeutic programme that included nationally recognised treatments for patients. During our last inspection in September 2016 we had concerns that Heathfield and St Raphael wards did not have access to psychology. During this inspection improvements had been made and all patients had access to a range of psychological therapies such as cognitive behaviour therapy, family therapy, occupational therapy, drama and movement therapy, music therapy, art therapy, dialectical behavioural therapy and these were delivered via one to one sessions and in groups. Patients told us therapies had helped to decrease their anxiety and had equipped them to address their issues and journey to recovery. Psychologists were helping staff set up behaviour support plans for patients who had challenging behaviour.

- Staff described how they developed complex physical health care plans and effectively managed physical health care needs. The trust's physical health care nursing team had offered training and advice across all of the wards. Training included topics such as dysphasia, diabetes and nutrition. Staff supported the integration of mental and physical health and staff developed comprehensive care plans that covered a range of physical health conditions such as diabetes, cardiac conditions, cancer, incontinence, addictions and breathing problems. Staff carried out physical health observations for all patients using the national early warning score. We had concerns during our last inspection in September 2016 that not all wards had access to external healthcare professionals. On this inspection improvements had been made and access to external healthcare professionals was evident on most of the wards and included tissue viability nurse specialists, speech and language therapists, dieticians and physiotherapists. We saw treatment plans had been drawn up by a visiting tissue viability nurse specialist and included guidance on re-positioning, dressings, elevation and pressure relieving equipment and photos to show correct use of the care plan. In another we looked at a care plan for catheter care which was detailed and gave staff clear guidance. However on Heathfield ward staff said there was still no agreement in place to access a tissue viability nurse specialist in a timely manner.

- Staff assessed patient's nutrition and hydration needs and developed care plans if needed. Health care assistants had received specific training to enable them to effectively monitor

nutritional and hydration needs. There were a range of specialist feeding aids available. Food choices included vegetarian and specialist food consistencies and supplements, for example, soft, pureed, finger and thickened food.

- Occupational therapists provided specialist psychological and social based educational groups. A wide range of activities were also available. At Langley Green Hospital audits of activities took place weekly to ensure there were sufficient activities provided. Health care assistants had been provided with training by occupational therapists to run a range of activities, such as breakfast clubs, reminiscence groups, quizzes, pampering sessions and a range of arts and craft sessions. Charts were produced monthly called, “how busy are we?” which showed each ward how many activities were being offered. This also incentivised staff to provide more activities.

- The trust was a smoke-free environment and staff supported patients with smoking cessation groups and nicotine replacement therapy. Staff also encouraged patients to improve their health by gentle exercising, pilates and eating healthily. Patients we spoke with told us they enjoyed local walks and exercise sessions as part of their weekly routine. Healthy living boards were displayed on the wards, offering information on healthy activities and food for patients. At Langley Green Hospital, Crawley wellbeing group attended weekly to offer educational sessions on healthy living and offering patients and staff additional health check-ups.

- Staff used the recognised rating scales known as the ‘health of the nation outcome scale’ to assess and record outcomes. These covered 12 health and social domains and enabled clinicians to build up a picture over time of their patients’ responses to interventions.

- Staff used laptops to take to their patients to run through and update care records. Staff also accessed advice for their patients on the trust intranet system, such as medication options and access to psychological therapy. On Burrows ward staff used iPads to play music and songs directly from the internet. Staff had also prepared individual playlists for patients to listen to on MP3 players.

- Staff engaged in clinical and management audits. These included ensuring good physical healthcare for patients, risk assessing ligature risks on the wards, reviewing enhanced observations, ensuring patients had positive behaviour support plans, medicine management and effective handovers. Staff audited risk assessments and care plans to ensure quality and completion.

- Staff representatives from each ward, senior clinicians and managers attended monthly meetings to review clinical effectiveness and looked at, for example, models of care, quality of care records, physical health promotion, consent, audit and research.

- This core service participated in five clinical audits as part of their clinical audit programme from 1 April 2016 to 31 March 2017.

Audit name/Title	Sites included	Date of Audit	Key actions following the audit
Place	Estates and Facilities & Health watch	01/05/2017	the audit scores are not published until august when an action plan to address any concerns raised with be implemented.
Venous thromboembolism risk assessment	Older peoples ward team	Not provided	Introduction of the new thromboprophylaxis risk assessment algorithm

& management - re-audit			
Integration of medical and nursing input to increase sleep monitoring in inpatients with dementia	Grove ward, Harold Kidd Unit	01/03/2017	Subsequent to the initial audit staff were made aware of poor documentation in clinical reviews. A review template document was made and placed on a secure shared drive. This resulted in significant improvement for ensuring good sleep hygiene.
Physical Health Monitoring	Beechwood Unit	01/12/2016	To undertake admissions during working hours 4.32 The admitting doctor to give clerking in top priority 4.33 To complete clerking in within 24 hours of admission where it has not been possible to do so on the day of admission
Post-Falls Assessments Documentation Audit	Beechwood Unit	01/01/2017	"Achieving change will require guidance from trust level through the design of a physician specific post-falls assessment document. This needs to be closely linked in with the existing guidance for nursing staff which is in progress through the physical health programme Designing and implementing a proforma on carenotes would be the most suitable way to ensure ease-of-use and therefore increase uptake of any proposed changes

Skilled staff to deliver care

- The staff across the wards came from various professional backgrounds, including medical, nursing, social work, occupational therapy and psychology. Staff were experienced and qualified to undertake their roles to a high standard.

- All staff, including bank and agency staff received a thorough induction into the service. The care certificate standards were used as a benchmark for health care assistants. These standards set out the skills and knowledge required by staff. Health care assistants completed a certificate in care. An apprenticeship scheme for health care assistants was also planned to start shortly after our inspection.

- Staff received appropriate training and professional development. Staff were encouraged to attend additional training courses. For example, ward managers were encouraged to undertake leadership courses and staff on the wards had received training on phlebotomy. All ward teams attended at least twice yearly development days. However, the trust did not offer dementia training as part of the mandatory training programme. Psychologists and staff who had received specialist dementia training told us they provided local, ward based dementia awareness sessions.

- The trust's target rate for appraisal compliance was 90%. As at 31 July 2017, the overall appraisal rates for non-medical staff within this core service was reported by the trust as 42%. All wards in this core service appeared to have failed to achieve the trust target, however during our inspection we asked ward managers for updated evidence and when this was provided, the compliance rate for appraisals was at the trust target of 90%. The trust was unable to split the data by staff group as such the analysis is based on findings for medical and non-medical staff combined. The rate of appraisal compliance for non-medical staff reported during this inspection is significantly higher than the 15% reported at the last inspection.

	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Heathfield	21	17	81
Raphael	21	17	81
Brunswick Ward	29	23	79
Meridian Ward	27	20	74
Grove Ward	26	13	50
Iris Ward	25	10	40
Opal Ward	21	7	33
The Burrowes	29	9	31
Orchard Ward	22	2	9
Larch Ward	27	1	4
Beechwood Unit	33	0	0
Core service total	**281**	**119**	**42**
Trust wide	**2713**	**1234**	**45**

- The trust's measure of clinical supervision data is sessions delivered.
- Between 1 July 2016 and 30 June 2017 the average non-medical clinical supervision rate across within this core service was 64%. We received refreshed data from the trust that showed that in December 2017 the core service had 80% compliance for staff receiving supervision. This is slightly below the trust target of 85%.

	Clinical supervision target	Clinical supervision delivered	Clinical supervision rate (%)
Meridian Ward (Functional)	85%	94	71
Brunswick Ward (Dementia)	85%	94	78
Opal Ward	85%	23	72
Heathfield Ward	85%	135	62

St Raphael	85%	122	54
Beechwood	85%	81	61
Core service total	**85%**	**549**	**64**
Trust Total	**85%**	**13594**	**76%**

- Ward managers told us they were performance managing a small number of staff for capability issues at the time of our inspection, and were well supported by their human resources staff.
- Preceptorship training was offered to newly qualified nurses. This helped ensure that they had the skills needed to complete their role and they were well supported.
- Volunteers and peer support workers were working with patients on the wards. For example at Langley Green Hospital a local charity had trained people with lived experience of mental ill health to be trainers. Volunteers provided sessions on the wards for example, guitar playing and music.

Multi-disciplinary and inter-agency team work

- Well-staffed multidisciplinary teams worked across the wards. Regular team meetings took place. We observed care reviews and staff handover sessions and found all of them to be effective. On Beechwood ward the consultant attended the nursing handover meetings to further improve communication.
- Staff worked with other agencies. There were links with primary care (doctors, pharmacists, speech and language therapists, physiotherapists, podiatrists, and dieticians), mental health crisis and home treatment teams older peoples' community mental health teams and housing organisations being particularly positive examples.

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

- We looked at care record files of patients who were detained under the Mental Health Act. The Mental Health Act documentation was present and available in the files. Each ward maintained an updated patient board that detailed when rights should be repeated for each patient. This information was audited every week.
- There was active involvement of the independent mental health advocacy service, and information about the service was displayed on information boards in communal areas.
- Patients were encouraged to contact the Care Quality Commission if they chose to about issues relating to the Mental Health Act. This was contained in the welcome folders given to all new patients.
- Each ward had access to Mental Health Act administrators who monitored requirements and compliance with the Act and Code of Practice.
- Copies of up-to-date section 17 leave forms were kept electronically and in files accessible in the nurses' offices. The forms were comprehensive, clearly detailing the levels, nature and

conditions of leave. These were regularly reviewed and updated. Staff recorded who had been given copies of the section 17 leave forms.

- Assessments of patients' capacity to consent to treatment were available. We found that both T2 and T3 certificates were reviewed in line with the trust's policy. These certificates show that patients detained under the Mental Health Act had the proper consent to treatment in place.

- As of 31 July 2017, 90% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every two years
- The training compliance reported during this inspection is higher than the 58% reported at the last inspection.

Ward	Eligible staff	Number trained	% Compliance
Larch Ward	10	10	100
The Burrowes	13	13	100
Grove Ward	9	9	100
Brunswick Ward	13	13	100
Heathfield	11	11	100
Iris Ward	10	9	90
Opal Ward	9	8	89
Meridian Ward	14	12	86
Beechwood Unit	15	12	80
Orchard Ward	9	7	78
Raphael	12	9	75
Core service total	**125**	**113**	**90**

Good practice in applying the Mental Capacity Act

- As of 31 July 2017, 89% of the workforce had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every two years.
- The training compliance reported during this inspection is higher than the 56% reported at the last inspection.

Ward	Eligible staff	Number trained	% Compliance
The Burrowes	28	28	100
Brunswick Ward	27	27	100
Heathfield	21	21	100
Iris Ward	24	23	96
Meridian Ward	24	23	96

Opal Ward	21	20	95
Larch Ward	25	23	92
Raphael	20	18	90
Beechwood Unit	31	27	87
Orchard Ward	20	17	85
Grove Ward	25	21	84
Core service total	**142**	**126**	**89**

- Sussex Partnership NHS Foundation Trust told us that 135 Deprivation of Liberty Safeguard (DoLS) applications were made to the local authority between April 2016 and March 2017. 124 of which were pertinent to this core service. Of the 124, 70 were approved.
- The greatest number of DoLS applications were made in March 2017 with 17.

Number of DoLS applications made by month

	April 16	**May 16**	**June 16**	**Jul 16**	**Aug 16**	**Sep 16**	**Oct 16**	**Nov 16**	**Dec 16**	**Jan 17**	**Feb 17**	**Mar 17**	**Total**
Applications made	15	7	13	3	10	11	7	2	12	15	12	17	124
Applications approved	5	7	2	4	3	6	5	2	6	11	10	9	**70**

- We had concerns on six of the wards (Grove, Orchard, Beechwood, Burrowes, Meridian and Iris) that there were a lack of capacity assessments/best-interests decision-making for decisions other than consent to treatment (such as medication) and admission. For example, this meant there were no capacity assessments or best interest assessments for personal care delivery.

- There were significant numbers of patients for whom Deprivation of Liberty Safeguard (DoLS) assessments had been requested but not carried out. Once the 14-day urgent authorisation had expired these patients were managed as though they had a DoLS authorisations but they were still waiting for assessments. The trust was chasing the local authority once a month to remind them the assessments were outstanding however staff said they did not always feel supported in managing this issue. For example staff were not aware of any escalation policy to follow once the urgent authorisation had run out of time.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

- Patients we spoke with on all of the wards were complimentary about the staff providing their care. Patients told us they got the help they needed. Patients told us they had been treated with respect and dignity and staff were polite, friendly, and willing to help. Patients told us staff were pleasant and were interested in their wellbeing.
- Patients said staff; whilst busy, were available for them most of the time. We saw staff treating patients with compassion and care. Patients told us staff were consistently respectful towards them. Patients said the staff tried to meet their needs, that they worked hard and had patients' best interests and welfare as their priority. During our inspection, we saw nothing other than positive interactions between staff and patients. Staff spoke to patients in a friendly, professional and respectful manner and responded promptly to any requests made for assistance or time.
- Staff assisted patients to access other services to help meet their needs. For example staff promptly referred patients to a variety of primary care healthcare professionals.
- Staff showed patience and gave encouragement when supporting patients. Patients told us they were the priority for staff and that their safety was always considered. When patients became distressed and agitated, staff intervened gently and in kind and pleasant ways. We saw these interventions calmed patients considerably.
- The atmosphere throughout the wards was calm and relaxed. Staff were particularly patient focused and not rushed in their work so their time with patients was meaningful. Staff were able to spend time individually with patients, talking and listening to them. All patients said they had regular one to one time with staff during the day and night and we saw staff were responsive when approached by patients.
- All staff we spoke with had an in-depth knowledge about their patients including their likes, dislikes and preferences. Staff understood the individual needs of their patients, including their personal, cultural, social and religious needs. We saw staff used the 'this is me' tool as recommended good practice by the Alzheimer's Society. This document was completed to let staff know about patients' needs, interests and preferences.
- Staff said they could raise any concerns about disrespectful, discriminatory or inappropriate attitudes or behaviour towards patients without fear of the consequences.
- Staff ensured information about patients was kept confidential.

- The 2017 patient-led assessments of the care environment score for privacy, dignity and wellbeing at four core service locations scored better than similar organisations.
- Six locations including Horsham Hospital, Iris Ward (79.9%) were worse when compared to other similar trusts for privacy, dignity and wellbeing.
- Please note that some of the locations provide more than just this core service:

Site name	Core service(s) provided	Privacy, dignity and wellbeing
MILL VIEW HOSPITAL	Wards for older people with mental health problems	96%
LINDRIDGE	Wards for older people with mental health problems	90.3%
THE HAROLD KIDD UNIT, CHICHESTER	Wards for older people with mental health problems	91%
MEADOWFIELD	Wards for older people with mental health problems	90.1%
SALVINGTON LODGE - BURROWES WARD	Wards for older people with mental health problems	87.5%
HORSHAM HOSPITAL - IRIS WARD	Wards for older people with mental health problems	79.9%
DEPARTMENT OF PSYCHIATRY	Wards for older people with mental health problems	90.9%
ST ANNE'S CENTRE & EMI WARDS, ST. LEONARDS-ON-SEA	Wards for older people with mental health problems	89.9%
BEECHWOOD UNIT, UCKFIELD	Wards for older people with mental health problems	84.4%
LANGLEY GREEN HOSPITAL	Wards for older people with mental health problems	92.7%
Trust average		89.3%
England average (mental health and learning disabilities)		**90.6%**

The involvement of people in the care they receive

Involvement of patients

- Patients received a comprehensive welcome pack on admission to the wards. The welcome pack gave detailed information to patients. This included information about health needs, the multidisciplinary team, care and treatment options, medication and physical health needs and care plans. We found the packs helped to orientate patients to the service and patients commented on them positively.

- There was evidence of patient involvement in the care records we looked at and all patients had either signed a copy of their care plans or said they did not want to sign the plans. Staffs' approach was person centred, individualised and recovery orientated. Patients reviewed their care plan at least once every week with the multidisciplinary team. Patients told us they were involved with their treatment and care planning. We attended 11 care reviews and patients were fully involved in discussions about their care and treatment.

- Staff communicated well with patients so that they understood their care and treatment. For example one of our inspection team was given a wipe board and pen to communicate with a

patient who was hard of hearing. In another example, Patients had raised a concern about staff coming into work and not acknowledging them on the way to the staff locker room. As a result staff acknowledged this concern and made a point of making eye contact and acknowledging patients on their way into work.

- Staff told us how patients were involved in service development. For example all wards had developed the, 'you said and we did' initiative. Staff and patients were assisted by the 'working together' engagement worker who we spoke with. Examples of changes made included updating welcome packs and co-producing the new version with patients and families, senior staff contacting families during the first 72 hours of patients' admission to aid good communication, installing draft excluders to the bottom of bedroom doors to reduce noise of doors opening during the night.

- Staff gained patient feedback from a variety of forums and methods. Every ward held a daily morning meetings where plans for the day were discussed and any issues could be raised. A charity had been commissioned by the trust to carry out patient satisfaction surveys. Staff had set up the therapeutic committee at Langley Green Hospital where patients, staff and carers reviewed and evaluated the effectiveness of the activities offered to patients. Peer support workers and the 'working together group' engagement worker carried out regular patient satisfaction surveys and encouraged the use of comment cards.
- We saw a number of examples of advance decisions made by patients for their future preferences in treatment and care.

- Local advocacy services were advertised on notice boards and in patient welcome packs.

Involvement of families and carers

- Patients told us that their families were included in their care planning. Each ward had an information board for carers that included, for example, information on how to raise a concern. Information leaflets were made available to relatives and friends and regular information sessions were available at all of the hospital sites. The wards had embedded the 'triangle of care' initiative that attempts to improve carer engagement in inpatient units by ensuring staff worked closely and in partnership with families and friends. An example of good practice on Orchard ward set the times and days of clinical reviews to suit carers and family so they could attend.
- Carers told us about the various ways they could give feedback on services. For example a carers' appreciation day was held at Langley Green Hospital. Staff offered carers' the opportunity to fill out 'family and friends' tests online. Staff encouraged the use of comment cards. Carer visiting times were unrestricted to enable visiting at times which suited families and friends. Carers' forums were available across all wards. On Iris ward the 'Improving carers experience project' produced a carers' information booklet which contained information covering common mental health conditions, managing day to day living, staying well and accessing local support across Sussex.
- A number of carers said they had been offered a carer assessment.

Is the service responsive?

Access and discharge

Bed management

- The trust provided information regarding average bed occupancies for 11 wards in this core service between 1 April 2016 and 31 March 2017.
- All of the wards within this core service reported average bed occupancies ranging above the provider benchmark of 85% over this period. Meridian Ward reported the highest individual bed occupancy during the period, at 120%. The lowest range was at Beechwood Ward, with a lowest bed occupancy of 68% and highest of 87%
- The previous inspection data was collected as average bed occupancy over six months, so is not comparable to recent data

Ward name	Average bed occupancy (1 Dec 2015 - 31 May 2016 (previous inspection)	Average bed occupancy range (1 April 2016 to 31 March 2017) (current inspection)
Beechwood Unit	72.5%	68%-87%
Brunswick Ward	86.9%	83% - 107%
Grove Ward	79.7%	69%-98%
Heathfield Ward	106.2%	91%-108%
Iris Ward	95.1%	71%-100%
Larch Ward	93.4%	86%-109%
Meridian Ward	110%	94%-120%
Opal Ward	101.7%	99%-111%
Orchard Ward	92.8%	77%-112%
St Raphael Ward	100.8%	92%-108%
The Burrowes Ward	98%	93%-107%
Core service wide	**N/A**	**68%-120%**

- The trust provided information for average length of stay for the period 1 April 2016 to 31 March 2017
- The information for this core service suggests that 11 wards in the core service presented a broadly similar length of stay for this period to the trust average and none of the wards were at the lower or higher end of the overall trust range.
- At ward level Brunswick ward and Grove wards were the wards with the highest reported lengths of stay and Orchard ward reported the lowest length of stay in an individual month
- When compared to the information provided at the time of the previous inspection, the length of stay was reported as an average over six months at that time rather than a range so is not comparable.

	Average length of stay range (1 Dec 2015 - 31 May 2016) (previous inspection)	Average length of stay range (1 April 2016 to 31 March 2017) (current inspection)

Beechwood Unit	29.9	29-94
Brunswick Ward	63.2	21-202
Grove Ward	62.3	44-228
Heathfield Ward	60.3	32-79
Iris Ward	71	49-101
Larch Ward	126.6	31-132
Meridian Ward	65.9	35-60
Opal Ward	66.5	24-82
Orchard Ward	25.6	15-77
St Raphael Ward	63.3	36-87
The Burrowes Ward	50.3	31-129
Core service total	**N/A**	**15-228**
Trust total	**N/A**	**10-1065**

- This core service reported no out area placements between 1 May 2016 and 31 July 2017.
- This core service reported 50 readmissions within 28 days between 1 April 2016 and 31 March 2017.
- 33 readmissions (66%) were readmissions to the same ward as discharge.
- The average of days between discharge and readmission was 11.7 days. There were no instances whereby patients were readmitted on the same day as being discharged but there were four instances where patients were readmitted the day after being discharged.
- At the time of the last inspection, for the period 1 December 2015 to 31 March, there were a total of 48 readmissions within 90 days. It should be noted that this data was over a shorter time period and the readmissions within 90 days was collected rather than 28 days, so it is not comparable.

Ward	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
Beechwood Ward	5	3	60%	3-23	9.6
Brunswick	6	4	67%	1-11	5.8
Grove Ward	2	2	100%	11-12	11.5
Heathfields Ward	3	2	67%	3-22	15.3
Iris Ward	1	0	0%	16	16
Larch Ward	6	4	67%	1-22	12.5
Meridian Ward	10	7	70%	1-25	11.6
Opal Ward	2	2	100%	3-4	3.5
Orchard Ward	5	2	40%	1-22	10.4

St Raphael	9	6	67%	9-27	16.9
The Burrowes	1	1	100%	17	17
Core service total	50	33	66%	1-27	11.7

- Staff told us that wherever possible they ensured beds were available for patients living in the catchment area. They worked with bed management co-ordinators to review if other patients were ready for move on or discharge to make beds available. It was rare for patients to be admitted out of area due to lack of beds, wards worked to ensure patients were admitted to their local ward as soon as a bed was available for them.
- Beds were always available when patients returned from leave.
- Staff we spoke with told us that patients were not moved between wards during an admission episode unless it was for a clinical reason, for example requiring more or less intensive nursing care.
- Staff told us discharge plans were discussed right from the admission date. Patients were preferably discharged in the morning or during the day once their discharge was approved and their medicines were ready for collection.
- If required beds could be made available for patients on psychiatric intensive care units, however this would be an extremely unusual occurrence, if a patient required more intensive nursing care. If required, staff arranged for patients to be more intensively nursed on their ward until a bed became available by increasing observation levels and carrying out a medicine review to consider appropriate adaptations to their treatment.

Discharge and transfers of care

- Between 1 April 2016 and 31 March 2017 there were 222 delayed discharges within this core service. This amounts to 53% of the total delayed discharges from the trust overall (426). The ward with the most delayed discharges was Beechwood unit with 48. Two wards (Heathfield ward and St Raphael ward) reported no delayed discharges.
- At the time of the last inspection there were 106 delayed discharges reported for this core service between 1 December 2015 and 31 May 2016. It should be noted that this was over a shorter time period of six months.

Team/ward/unit	Total discharges over the 12 months	Total delayed over the 12 months
Beechwood Unit	84	48
Brunswick Ward	50	24
Grove Ward	31	32
Heathfield Ward	111	0
Iris Ward	51	28
Larch Ward	144	9
Meridian Ward	161	32
Opal Ward	172	22
Orchard Ward	105	3
St Raphael Ward	112	0
The Burrowes Ward	47	24
Core service Total	**1068**	**222**

Trust total	**4064**	**416**

- Staff explained that delayed discharges were usually whilst alternative packages of care were set up, agreed and funded. For example transfers of care to either supported living, residential care or nursing home placements.
- Patients told us how staff helped them to achieve the goals set in their discharge plans. Examples included staff accompanying patients back to their homes to assess what additional support they may need to aid their recovery.
- Staff on all wards supported patients during transfer to acute hospitals and potentially to more intensive nursing wards. For example, the 'this is me' record was completed and accompanied patients, so staff at the acute hospital could see the patients' likes, dislikes and preferences.

Facilities that promote comfort, dignity and privacy

- St Raphael, Orchard and Heathfield wards had dormitory bedrooms and these areas were, in the main, not personalised. Grove and Iris wards had one shared bedroom each for two patients. On the remaining wards where patients had their own bedrooms, they were personalised if this is what patients wanted to do, with for example their photos and personal items on show. Patients could access their bedrooms at any time. Patients on all the wards, except St Raphael were able to securely store all of their possessions in their bedrooms in a locked cupboard. However, patients spoke to us positively about the dormitory wards. They said they enjoyed the company of other patients and felt less lonely.
- The trust had embarked on an extensive refurbishment programme across the older peoples' wards. Brunswick ward was due to move in November 2017 to a refurbished ward on the Millview hospital site. St Raphael was undergoing refurbishment at the time of our inspection.
- The wards had a variety of well furnished rooms for patients to use including quiet lounges. A selection of interview and group rooms were available.
- All of the wards had kitchen areas where patients could make hot drinks and snacks.
- All of the units had garden areas.
- Patients could make private phone calls and had access to their own mobile phones should they wish to have them. There was a policy available on mobile phone use and patients signed a contract, for example, agreeing not to use cameras. A communal phone was available for patients on all wards to use privately.
- The 2017 PLACE score for ward food at six locations scored better than similar trusts. There were four locations that scored worse when compared to other similar trusts for ward food.
- The sites with the highest scores (all scoring 100%) were Horsham Hospital, St Anne's Centre and Langley Green Hospital.
- The site with the lowest score was Millview Hospital with 81.3%.
- Please note that some of the locations provide more than just this core service:

Site name	Core service(s) provided	Ward food
MILLVIEW HOSPITAL	Wards for older people with mental health problems	81.3%

LINDRIDGE	Wards for older people with mental health problems	91.7%
THE HAROLD KIDD UNIT, CHICHESTER	Wards for older people with mental health problems	84%
MEADOWFIELD	Wards for older people with mental health problems	99.5%
SALVINGTON LODGE – BURROWES WARD	Wards for older people with mental health problems	94.5%
HORSHAM HOSPITAL – IRIS WARD	Wards for older people with mental health Problems	100%
DEPARTMENT OF PSYCHIATRY	Wards for older people with mental health problems	84.1%
ST ANNE'S CENTRE , ST LEONARDS ON SEA	Wards for older people with mental health problems	100%
BEECHWOOD UNIT, UCKFIELD	Wards for older people with mental health problems	91.4%
LANGLEY GREEN HOSPITAL	Wards for older people with mental health problems	100%
Trust overall		**92.1%**
England average (mental health and learning disabilities)		**91.5%**

Patients' engagement with the wider community

- Patients had access to psychological and social groups and training courses which had a focus on education, recovery and rehabilitation. For example, patients had access to courses at the recovery college, both as inpatients and also after discharge. The courses were co-facilitated between hospital staff and peer trainers who had lived experience of using mental health services. Staff encouraged strong community links. For example at Langley Green Hospital Crawley football club came into the hospital regularly to offer fitness educational sessions, pets as therapy trained dogs visited all wards every week, external pilates' trainers offered sessions both on the wards and in the community. Age UK were actively involved in falls prevention work at Langley Green Hospital. Patients were able to retain this network opportunity after discharge, including the group contacts & facilities. Another example was the 'wishing well' music sessions offered by musicians trained in mental health and living with dementia, on Grove, Burrowes, Iris & Brunswick wards. Patients on Brunswick and Meridian wards had access to a local community allotment project, both as inpatients and after discharge.
- Staff encouraged patients to develop and maintain relationships with people who mattered to them, both within the service and the wider community. Staff supported patients to maintain contact with their families and carers. For example restrictions on visiting times had been removed on all wards and on Iris ward pet dogs were actively encouraged to visit their owners.

Meeting the needs of all people who use the service

- Accessible bath, toilet, and shower facilities were provided on all wards. However on St Raphael ward this was limited to one.
- Staff told us that information could be made available in different languages as required by patients using the services. Information was available on interpreters, who could be requested if needed.
- There was information available on treatments, therapy, local services, patients' rights and how to complain. The information boards in all of the wards were displayed creatively and contained relevant and updated information for staff, patients and relatives. All wards had photographs of the staff to show patients who they were and what their roles were.
- Welcome packs of all of this information were available for patients. Some of the wards personalised information packs, others made a pack available in each bedroom. The welcome packs contained information about the various care pathways and treatment options available.
- Patient information leaflets on equality and diversity were available on all wards. Examples were given showing patients how their individual and unique needs could be raised and met. There were leaflets about how patients' needs could be supported with their religion, ethnicity, race, traditions, sexuality, disabilities and food preferences.
- A choice of food was provided to meet patients' religious and ethnic requirements.
- Patients had access to spiritual support. Staff would contact the spiritual support team if a patient wanted to see a priest or spiritual leader from another faith.

Listening to and learning from concerns and complaints

- This core service received 34 complaints between 1 July 2016 and 30 June 2017. Five of these were upheld, six were partially upheld and 12 were not upheld. Information was not provided on the number of complaints referred to the Ombudsman
- The number of either partially or fully upheld complaints reported during this inspection is lower than at the time of the last inspection. At that time five out of 22 complaints were fully or partially upheld.

Ward	Total Complaints	Fully upheld	Partially upheld	Not upheld	Under investigation	Withdrawn
Beechwood Unit	1	1	0	0	0	0
Brunwick Ward	2	0	0	1	1	0
Grove Ward	1	0	0	1	0	0
Heathfield Ward	3	0	1	1	0	1
Iris Ward	7	1	1	3	0	2
Larch Ward	2	0	0	2	0	0
Merdian Ward	4	0	2	1	0	1
Opal Ward	6	2	0	2	0	2
Orchard Ward	2	0	1	1	0	0
St Raphael Ward	6	1	1	0	4	0
Core service total	**34**	**5 (15%)**	**6 (18%)**	**12 (35%)**	**5 (15%)**	**6 (18%)**

Trust total	**772**	**103 (13%)**	**119 (15%)**	**448 (58%)**	**43 (6%)**	**56 (7%)**

- Staff met regularly to discuss learning from complaints. This informed a programme of improvements and training, for example, improving communication between staff and carers in relation to care planning. The trust sent staff a monthly publication, 'our patient safety matters' which also shared learning from complaints across the services.
- Copies of the complaints procedure were on display on the information boards on the wards and in the ward welcome packs. Patients we spoke with all knew how to make a complaint, should they wish to do so. Information was also available on how patients could contact the Care Quality Commission should the patients wish to do so.
- Staff knew how to handle complaints. Staff told us they tried to deal informally with concerns and to do this promptly in an attempt to provide a timely resolution to concerns. Informal complaints were logged and tracked as well as formal complaints.
- A community meeting was held every day on each ward and patients could raise any concerns they had. Staff were responsive to suggestions made by patients, for example through the 'we said you did' initiative.
- This core service received 68 compliments during the last 12 months from 1 July 2016 to 30 June 2017 which accounted for 10% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

- Ward managers and matrons had the skills, knowledge and experience to perform their roles to a high standard. The trust had introduced a new leadership approach through the introduction of 'care delivery services', designed to promote greater local autonomy and clinical decision making, closer to the wards and where patients were treated. Ward managers had successfully gone through the trust's leadership development and emerging leaders programme. This programme had been shortlisted in the 'National Training Journal Awards', due to take place in December 2017.

- The wards' senior management team had regular contact with all staff and patients. The senior management and clinical teams were visible to staff and staff said senior management regularly visited the services. All staff and patients knew who the senior management team were and that they felt confident to approach them if they had any concerns. Staff knew who the trust's executive team were and said they visited the wards.

Vision and strategy

- The trust's vision, values and strategies for the service were evident and on display on information boards throughout the wards. Staff we spoke to understood the vision and strategic objectives of the organisation. Staff said the trust's vision was to provide outstanding care and treatment across all services and that patients could have confidence in this. Staff felt very much a part of the service and were able to discuss the philosophy of the wards. Staff had opportunity to contribute to discussions about their service in regular team meetings and twice yearly development away days.

Culture

- Staff told us they felt respected, supported and valued in their work. They commented in particular about the support they received from their ward managers. Staff were proud about working for the trust, some staff had been encouraged to contribute to a new recruitment video, speaking about their positive experiences of working for the trust.

- All staff we spoke with felt confident to raise any concerns and they knew how to do this, including the availability of the whistle-blowing process should they want to use this.

- Managers dealt effectively with poor staff performance appropriately and in a timely manner.

- During the reporting period there were seven cases where staff have been either suspended or placed under supervision. Five staff have been suspended and two were placed under restricted practice.
- Of the six cases, three involved Band 2 staff group, two were suspended and one placed under restricted practice.
- Of the six cases, three involved Band 5 staff group. All three were suspended.
- Of the six cases, one involved Band 6 staff group. This staff member was placed under restricted practice.
- The number of staff placed under restricted practice or suspended during this inspection is worse than those reported at the last inspection when in a 12 month period there was one staff member suspended and no staff members placed on restricted practice

Ward	Restricted practice	Suspended	Total
Adult Services (AMHS) Inpatient Functional Older Adults (Opal Ward)	1	2	3
Adult Services (AMHS) Inpatient Functional Older Adults Larch Ward	0	1	1
Beechwood Specialist Dementia Treatment Unit	1	1	2
Brunswick Ward (Dementia)	0	1	
Total	2	5	7

- Teams worked well together for the well-being of patients, we saw this happening in clinical care reviews and discharge planning meetings.
- Staff appraisals included discussions on personal and professional development needs and action plans to achieve this development. All staff commented on how their professional development needs had been supported.
- Staff reported that the trust promoted equality and diversity in its day to day work and provided opportunities for career progression. For example, staff described being able to have flexible working practices which enabled them to maintain a good work life balance.
- The ward managers encouraged staff to recognise and celebrate their success. For example, on Burrows ward each staff handover started with staff saying, “what I am most proud of today”. In addition the trust ran the positive practice awards to thank members of staff who had gone the extra mile in supporting or delivering exceptional care.

Governance

- Ward staff provided clinical quality audits, human resource management data and data on incidents and complaints. The information was summarised and presented monthly in a report which all staff could see. These reports were looked at in regular team meetings. Ward managers, senior managers and senior clinicians attended meetings where they looked at patient safety, patient experience and staff management. This meant that the management teams were able to receive assurances and apply clear controls to make sure the services ran effective.
- Staff received their mandatory training, supervision and appraisals. There were sufficient suitably trained staff available on every shift in each ward to deliver good care to patients.
- Staff were confident that they learnt from incidents, complaints and patient suggestions and feedback.
- The trust have provided their board assurance framework, which details any risk scoring 15 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. None relate specifically to this core service.

- The trust has provided a document detailing their 15 highest profile risks. Each of these have a current risk score of 15 or higher. None relate to this core service.

Management of risk, issues and performance

- Staff showed us the ward operational risk registers. Staff told us they could submit items of risk for inclusion on the risk register. The risk register had inclusions from all the wards and support services, which showed that risks were escalated appropriately from all areas of the service. High risk entries on the risk register included recruitment and retention, ligature risks, risks of patient falls and risks of breaches of the single sex accommodation guidance.

Information management

- Staff had access to information and technology to support them in their work. Staff said that now the electronic care records system was embedded, they were seeing real improvements in the information accessible to them and their patients, for example the personalised care plan template.
- Information governance systems ensured of confidentiality of patient records across all wards.
- Ward managers we spoke with had access to information to support them in their role, for example clinical quality audits, human resource management data and data on incidents and complaints. We reviewed documents which indicated this information was being used across all wards to monitor provision and identify areas for improvement.
- Staff had processes in place to ensure that notifications were made to external bodies as required, for example to the Care Quality Commission and local authority.

Engagement

- Staff, patients and carers had access to timely and relevant information about the trust. For example via the trust's website, via social media and the quarterly publication, called, 'partnership matters'. In addition patients and carers were encouraged to, 'tell their story' on a website called, 'patient opinion'.
- Patients and carers had opportunities to give feedback through becoming members of the organisation, through regular surveys, satisfaction questionnaires, comment cards and via meetings arranged by managers.

Learning, continuous improvement and innovation

- Several research studies were underway across the older adult wards. These included a research project to find out about the best way to help people who have agitation and memory problems. Another project was developing new learning techniques in adults with memory problems. Time for dementia was a ground-breaking educational initiative to develop, deliver and evaluate an innovative approach to learning about dementia for undergraduate health professionals. The programme uses the longitudinal clerkship model which enhances undergraduate learning by providing on-going contact with an individual with a long term

condition. By regularly spending time with people with dementia and their carers, time for dementia aims to provide students with a unique opportunity to understand what it is like to live with dementia and from this develop a more positive attitude towards the illness as well as in-depth knowledge of the condition. Living well with dementia was a research project looking at maintaining family and carer wellbeing.

- Brunswick ward undertook improvement work to improve patient safety and experience on admission to the ward. This involved the ward manager or matron visiting the person in their home prior to admission to carry out a falls risk assessment and meet with the family to gain as much information as possible about the person. On agreement, they would also take some of the persons' personal items to put into their hospital bedroom to make them feel more comfortable when they arrived on the ward. Families received a phone call within 48 hours of admission and have the matron details as a point of contact.
- Opal ward developed a project to reduce patients' length of stay on the ward by improving communication with families, carers and external organisations such as the local authority and supported housing.
- Each ward carried out a daily 'safety huddle' which is a nationally recognised good practice initiative to reduce patient harm and improve the safety culture on the wards. The meetings involve all available staff to discuss specific patients' risks and any potential harm that may affect patients.
- Heathfield older people ward held a quality improvement session with staff, facilitated by the organisational development programme director and quality and safety assurance manager where staff gave 64 ideas of how to improve their ward, which will inform their quality improvement work going forward.
- Meridian older people ward at Millview Hospital were in the early stages of adopting a quality improvement model to tackle racially abusive language used from patients towards staff.

- NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.
- The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
Accreditation for Inpatient Mental Health Services (AIMS)	Orchard Ward	21 March 2017

- Larch ward was awarded the AIMS accreditation for inpatient mental health services in September 2017.

Community-based mental health services for adults of working age

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Lighthouse	Specialist psychological therapies WAMHS (Personality Disorder Service)	N/A	Not provided
East Brighton Community Mental Health Centre	AMHS Accommodation Team	N/A	Not provided
East Brighton Community Mental Health Centre	MH Homeless Team	N/A	Not provided
East Brighton Community Mental Health Centre	AMHS (SMILES)	N/A	Not provided
East Brighton Community Mental Health Centre	East Assessment and treatment Services (One team comprising of Assessment & Treatment (A&T) and one for Recovery & Wellbeing (R&W)	N/A	Not provided
East Brighton Community Mental Health Centre	Brighton and Hove Group Treatment Service	N/A	Not provided
East Brighton Community Mental Health Centre	AOT Brighton	N/A	Not provided
East Brighton Community Mental Health Centre	Depot Clinic	N/A	Not provided
Hove Polyclinic	West ATS (One team comprising of A&T and R&W)	N/A	Not provided
Hove Polyclinic	Depot Clinic	N/A	Not provided
Mill View Hospital	Mental Health Rapid Response Service (MHRRS)	N/A	Not provided
Mill View Hospital	Transition Team	N/A	Not provided
Mill View Hospital	SMILES Team	N/A	Not provided
Mill View Hospital	West ATS (One team comprising of A&T and R&W)	N/A	Not provided
Mill View Hospital	Brighton and Hove Group Treatment Service	N/A	Not provided

Avenida Lodge	Assessment & Treatment Service	N/A	Not provided
Battle Health Centre	Assessment & Treatment Service	6	Not provided
Cavendish House	Assessment & Treatment Services	160	Not provided
Cavendish House	Assertive Outreach Service	no clinics/ home visits only	Not provided
Crowborough Hospital (Grove House)	Assessment & Treatment Service	8	Not provided
Newhaven Rehabilitation Centre (Hillrise)	Assessment & Treatment Service	60	Not provided
St Anne's Centre & EMI Wards	Assessment & Treatment Service	N/A	Not provided
St Mary's House	Assessment & Treatment Service	132	Not provided
St Mary's House	Assertive Outreach Service	N/A	Not provided
Millwood Unit	Assessment & Treatment Service	44	Not provided
Woodside	Assessment & Treatment Service	32	Not provided
Bexhill Health Centre	Assessment & Treatment Service	25	Not provided
Horder Healthcare Seaford	Assessment & Treatment Service	8	Not provided
Rye, Winchelsea & District Memorial Hospital	Assessment & Treatment Service	2	Not provided
Acre Day Hospital	Day Services/Functional Group Offer Programme AMHS	4 clinics per week, plus daily assessment slots and group sessions	Not provided
The Bedale Centre	Bognor ATS Base (AMHS) Assessment & Treatment Team	N/A	Not provided
The Bedale Centre	ATS Adult Services (AMHS) Chichester & Bognor Recovery & Wellbeing	N/A	Not provided
The Bedale Centre	Adult Services (AMHS) Assertive outreach Team (Chichester & Bognor AOT)	N/A	Not provided
Chanctonbury Building	ATS Hub	N/A	Not provided
Highdown	ATS Services Triage	N/A	Not provided
Chanctonbury Building	ATS Service Adult Services (AMHS) - Assessment &	N/A	Not provided

	Treatment Team.		
Chanctonbury Building	ATS Service Adult Services (AMHS)- Recovery & Wellbeing Team,	N/A	Not provided
Chanctonbury Building	ATS Service Adult Services (AMHS) - Mental Health Liaison Practitioners	N/A	Not provided
Chanctonbury Building	Adult Services (AMHS) Assertive Outreach Team (AOT)	N/A	Not provided
Chapel Street Clinic	ATS Hub - Triage	N/A	Not provided
Midhurst	ATS Hub	N/A	Not provided
Chapel Street Clinic	ATS Hub, Adult Services (AMHS) Recovery & Wellbeing (Chichester & Midhurst)	N/A	Not provided
Chapel Street Clinic	ATS Hub - Adult Services (AMHS) Mental Health Liaison Practitioners Team	N/A	Not provided
Glebelands	Adult Services (AMHS)	10 clinics per week plus daily assessment slots (MHLP & R&W), plus psychology sessions, and group treatment programme sessions	Not provided
Highdown	Adult Services (AMHS)	2 clinics per week plus daily assessment slots (MHLP)	Not provided
16 Liverpool Gardens	Adult Services (AMHS)	15 clinics per week plus daily assessment slots (MHLP & R&W), plus psychology sessions	Not provided
Pepperville House	ATS Satellite Site Adult Services (AMHS) AAW Mental Health Liaison Practitioners (MHLPs)	No clinics - Daily assessment slots	Not provided
Pepperville House	AMHS psychology	No clinics - Daily assessment slots	Not provided
Pepperville House	AMHS Community Mental Health Teams	16 clinics per week, plus daily assessment slots (R&W), plus group treatment programme sessions	Not provided
The Laurels	Functional AMHS Groups	No clinics - 2 x weekly group sessions	Not provided
The Laurels	Medical Clinics	N/A	Not provided
Ifield Drive, Crawley	Adult Services (AMHS) ATS (Mental Health Liaison Practitioners)	N/A	Not provided

Ifield Drive, Crawley	Adult Services (AMHS) ATS (Recovery & Wellbeing)	54	Not provided
Langley Green Hospital	Adult Services (AMHS) Acute Day Hospital (Weald Day Hospital - Clinic)	N/A	Not provided
Linwood	Adult Services (AMHS) ATS HUB	780 (approx)	Not provided
Linwood	Adult Services (AMHS) ATS Triage	N/A	Not provided
Linwood	Adult Services (AMHS) - ATS Assessment & Treatment Team	N/A	Not provided
Linwood	Adult Services (AMHS) - ATS Recovery & Wellbeing Team	N/A	Not provided
Linwood	Adult Services (AMHS) ATS Mental Health Liaison Practitioners	N/A	Not provided
New Park House	Adult Services (AMHS) ATS Service Hub	62	Not provided
New Park House	Adult Services (AMHS) Triage	N/A	Not provided
New Park House	Adult Services (AMHS) - Medical	N/A	Not provided
New Park House	Adult Services (AMHS) ATS Assessment & Treatment Team	N/A	Not provided
New Park House	Adult Services (AMHS) ATS MHLP's (Horsham)	N/A	Not provided
New Park House	Adult Services (AMHS) ATS Recovery & Wellbeing Team (Horsham)	N/A	Not provided
New Park House	Adult Services (AMHS) Assertive outreach (AOT Northern)	N/A	Not provided
Springvale	Adult services (AMHS) ATS Assessment & Treatment	152 (approx)	Not provided
Springvale	Adult services ATS Recovery & Wellbeing	N/A	Not provided
Springvale	Adult Services (AMHS) ATS MHLP's	N/A	Not provided
Bluebell House	Bluebell House Recovery Support Centre	N/A	Not provided

Is the service safe?

Safe and clean environment

- All premises were well maintained, kept clean and had appropriate furnishings.
- Clinic rooms were clean and well-equipped. Each clinic room had the necessary equipment to carry out physical health examinations.
- Clinical equipment was clean and tested regularly. Pharmacists completed monthly audits of the clinic rooms to ensure all equipment was tested regularly and fridge temperatures checked.
- The clinic area at Hove Polyclinic that staff used for physical examinations was not fit for purpose when we initially inspected the site. There was no sink, the floor was carpeted, there was no pedal bin for waste and the surfaces were wooden. We raised this with the trust during the inspection and they assured us they would take measures to rectify this situation. Following the inspection the trust informed us that they took immediate action and re-sited this room. On the 27 November 2017 we re-visited the site. We found that the physical healthcare assistant was carrying out physical health checks in the depot clinic. This room was appropriately furnished for carrying out physical healthcare checks, and ensuring risks of infection were minimised. The use of the room was managed on a timetable basis between the physical healthcare assistant and the depot clinic nurses to ensure that they were using this at different times. This was a temporary measure, as the trust had identified a room close to this to be appropriately refurbished into a dedicated room for carrying out physical health checks.
- Interview rooms in the community sites were soundproofed well for confidentiality and had alarms. Staff at the Glebelands House site took alarms into the meeting rooms with them from the staff reception area. Staff signed to say which alarm they had taken and to which room they were going. All other sites had alarms in the interview rooms.

Safe staffing

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	30 June 2017	347.3	N/A
Total number of substantive staff leavers	1 July 2016 – 30 June 2017	42.4	N/A
Average WTE* leavers over 12 months (%)	1 July 2016 – 30 June 2017	12%	16%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	30 June 2017	47.8	N/A
Total vacancies overall (%)	30 June 2017	12%	N/A

Total permanent staff sickness overall (%)	30 June 2017	3%	3.5%
	1 July 2016 – 30 June 2017	3%	3.5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	30 June 2017	197.28	N/A
Establishment levels nursing assistants (WTE*)	30 June 2017	27.69	N/A
Number of vacancies, qualified nurses (WTE*)	30 June 2017	29.24	N/A
Number of vacancies nursing assistants (WTE*)	30 June 2017	5.67	N/A
Qualified nurse vacancy rate	30 June 2017	15%	3.5%
Nursing assistant vacancy rate	30 June 2017	20%	3.5%
Bank and agency Use			
Shifts filled by bank staff to cover sickness, absence or vacancies (qualified nurses)	1 July 2016 – 30 June 2017	3194	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 July 2016 – 30 June 2017	392	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 July 2016 – 30 June 2017	48	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2016 – 30 June 2017	1106	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2016 – 30 June 2017	119	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 July 2016 – 30 June 2017	17	N/A

*WholeTime Equivalent

- Team leaders had regular caseload supervision with practitioners to ensure that caseloads were manageable and shared equally between the team. Part time staff and social workers with responsibility for safeguarding had reduced caseloads to enable them to manage their time effectively.

- The trust reported an overall vacancy rate of 15% for registered nurses at 30 June 2017. The vacancy rate for registered nurses had steadily increased over the 12 month reporting period (1 July 2016 to 30 June 2017), rising from 9% in July 2016 to 16% in April 2017. The registered nurse vacancy rate had been static at 15% for the last two months reported (May and June 2017). The vacancy rate for registered nurses was not comparable to data reported at the last inspection.
- The trust service reported an overall vacancy rate of 20% for registered nursing assistants at 30 June 2017. The vacancy rate for nursing assistants has fluctuated over the 12 month reporting period (1 July 2016 to 30 June 2017), ranging from an over establishment of 9% in August 2016 to a 79% vacancy rate in March 2017. The vacancy rate for nursing assistants has been static at 20% for the last two months reported (May and June 2017).

- The vacancy rate for nursing assistants was not comparable to data reported at the last inspection.
- This core service had reported a vacancy rate for all staff of 12% as of 30 June 2017. The vacancy rate for all staff was not comparable to data reported at the last inspection.

	Registered nurses			Health care assistants			Overall staff figures		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Depot Clinic	2	2	100%	0	0	0%	2	2	100%
Transition Team	3	3	100%	5	5	100%	8	8	100%
ATS Adult Services (AMHS) Chichester & Bognor Recovery & Wellbeing	5	12.8	39%	0	0	0%	5	17.2	29%
Adult Services (AMHS) ATS (Mental Health Liaison Practitioners)	5.27	14.67	36%	0	0	0%	5.27	14.67	36%
Adult Services (AMHS) ATS HUB	2	6	33%	0	0.6	0%	5.59	19.29	29%
Assessment & Treatment Service	8.57	26.97	32%	-0.27	7.46	-4%	15.65	86.88	18%
Adult Services (AMHS) ATS (Recovery & Wellbeing)	1.53	7.13	21%	0	0	0%	1.53	8.13	19%
ATS Service Adult Services (AMHS) - Mental Health Liaison Practitioners	1.36	6.76	20%	0	0	0%	2.36	7.76	30%
AOT Brighton	2.01	11.32	18%	0.11	4.97	2%	2.23	18.8	12%
East ATS (One team comprising of A&T and R&W)	2.2	17.7	12%	1.5	3.93	38%	3.82	35.93	11%
West ATS (One team comprising of	1	14.29	7%	-0.87	1.73	-50%	-0.45	28.73	-2%

A&T and R&W)									
Brighton and Hove Group Treatment Service	0.5	9.2	5%	0	0	0%	-0.26	9.44	-3%
ATS Hub - Adult Services (AMHS) Mental Health Liaison Practitioners Team	0.2	7.72	3%	0	0	0%	0.2	8.72	2%
Assertive Outreach Service	0.15	8.16	2%	0	3	0%	0.15	14.96	1%
ATS Hub, Adult Services (AMHS) Recovery & Wellbeing (Chichester & Midhurst)	0.05	9.25	1%	0	0	0%	0.05	13.85	0%
AMHS Accommodation Team	0	0	0%	0	0	0%	0.6	4.6	13%
Adult Services (AMHS)	0	0	0%	0	0	0%	0	0	0%
Adult Services (AMHS) - ATS Assessment & Treatment Team	0	0	0%	0	0	0%	0	0	0%
Adult Services (AMHS) Assertive Outreach Team (AOT)	0	3.8	0%	0.2	1	20%	0.2	8.5	2%
Adult Services (AMHS) - Medical	0	0	0%	0	0	0%	0	0	0%
Adult Services (AMHS) Acute Day Hospital (Weald Day Hospital - Clinic)	0	1	0%	0	0	0%	1.49	4.29	35%
Adult Services (AMHS) Assertive outreach (AOT Northern)	0	5	0%	0	0	0%	0.61	7.4	8%

Adult Services (AMHS) Assertive outreach Team (Chichester & Bognor AOT)	0	3	0%	0	0	0%	0.45	6.45	7%
Adult services (AMHS) ATS Assessment & Treatment	0	0	0%	0	0	0%	0	0	0%
Adult Services (AMHS) ATS Mental Health Liaison Practitioners	0	0	0%	0	0	0%	0	0	0%
Adult Services (AMHS) ATS MHLP's	0	0	0%	0	0	0%	0	0	0%
Adult Services (AMHS) ATS Service Hub	0	0	0%	0	0	0%	0	0	0%
Adult Services (AMHS) ATS Triage	0	0	0%	0	0	0%	0	0	0%
Adult Services (AMHS) Triage	0	0	0%	0	0	0%	0	0	0%
Adult Services (AMHS) ATS Assessment & Treatment Team	0	0	0%	0	0	0%	0	0	0%
Adult Services (AMHS) ATS MHLP's (Horsham)	0	0	0%	0	0	0%	0	0	0%
Adult Services (AMHS) ATS Recovery & Wellbeing Team (Horsham)	0	0	0%	0	0	0%	0	0	0%
AMHS (SMI LES)	0	0	0%	0	0	0%	0	0	0%
AMHS psychology	0	0	0%	0	0	0%	0	0	0%
AMHS Teams	0	0	0%	0	0	0%	0	0	0%
ATS Hub	0	0	0%	0	0	0%	0	0	0%

ATS Hub - Triage	0	0	0%	0	0	0%	0	0	0%
ATS Satellite Site Adult Services (AMHS) AAW MHLPs	0	0	0%	0	0	0%	0	0	0%
ATS Service Adult Services (AMHS)- Recovery & Wellbeing Team,	0	0	0%	0	0	0%	0	0	0%
ATS Service Adult Services (AMHS) - Assessment & Treatment Team.	0	0	0%	0	0	0%	0	0	0%
ATS Services Triage	0	0	0%	0	0	0%	0	0	0%
Bognor ATS Base (AMHS) Assessment & Treatment Team	0	0	0%	0	0	0%	0	0	0%
Functional AMHS Groups	0	0	0%	0	0	0%	0	0	0%
Medical Clinics	0	0	0%	0	0	0%	0	0	0%
Neurobehavioural Service	0	4	0%	0	0	0%	0.4	6.8	6%
SMILES Team	0	0	0%	0	0	0%	0	0	0%
Day Services/Functional Group Offer Programme AMHS	-1.2	7.31	-16%	0	0	0%	-0.86	28.01	-3%
Specialist psychological therapies WAMHS (Personality Disorder Service)	-0.6	3	-20%	0	0	0%	-0.39	7.48	-5%
Adult Services (AMHS) - ATS Recovery & Wellbeing	-1.5	6.1	-25%	0	0	0%	-2.5	7.1	-35%

Team									
Adult services ATS Recovery & Wellbeing	-1.5	6.1	-25%	0	0	0%	-2.5	7.1	-35%
MH Homeless Team	-0.8	1	-80%	0	0	0%	-0.8	1.8	-44%
Core service total	**29.2**	**197.3**	**15%**	**5.7**	**27.7**	**20%**	**47.8**	**383.9**	**12%**
Trust total	**264.5**	**1239.9**	**21%**	**210.3**	**799.8**	**26%**	**598.6**	**3020.0**	**20%**

NB: All figures displayed are whole-time equivalents

- Between 1 July 2016 and 30 June 2017, bank staff filled 3194 shifts to cover sickness, absence or vacancy for qualified nurses.
- In the same period, agency staff covered 392 shifts for qualified nurses. 48 shifts were unable to be filled by either bank or agency staff.
- We do not have details of the number of total shifts possible over the 12 month period and are therefore unable to calculate the proportion of shifts filled by bank or agency staff compared to the permanent workforce. The bank and agency use data submitted by the trust was not comparable to data reported at the time of the last inspection.

Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
354 880930/931 WCC Assess & Recovery Teams Chichester & Bognor	609	0	10
354 880912 AEC Recovery & Wellbeing - Eastbourne	439	0	0
354 880946 WNC North West Sussex MHLP's	307	78	3
354 880940/1/2 AWC Mid Sussex Assess & Recovery	150	145	8
354 880945 WNC Crawley Recovery & Wellbeing	9	106	0
354 880911 AEC Assessment & Treatment - Uckfield	181	0	0
354 882641 WNC Horsham Recovery & Wellbeing	150	56	0
354 880195 WNA A&E Liaison North West Sussex	35	7	1
354 880960 ABC East B&H - Assessment & Treatment Centre	142	0	0
354 880020 WCC Assertive Outreach - Chichester & Bognor	3	0	0
354 882608 WCD Worthing Liaison	97	0	0
354 880966 ABC West B&H - Recovery & Wellbeing	18	0	2

Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
354 880921 WCC Recovery & Wellbeing - Worthing	125	0	0
354 883924 WNC NWS Tier 2	59	0	0
354 880944 WNC C&H Assessment and Treatment Centre	120	0	4
354 880961 ABC East B&H - Recovery & Wellbeing	93	0	0
354 880529 ABC Clinic Staff	113	0	3
354 880920 WCC Assessment & Treatment - Worthing	93	0	0
354 880537 ABC Accommodation Team	90	0	10
354 880913 AEC Recovery & Wellbeing - Uckfield	66	0	0
354 880919 WCC Tier 2 Services	0	0	0
354 880032 WCC Assertive Outreach - AAW	78	0	0
354 880054 WCA Senior Nurse Practitioners - West Sussex	66	0	1
354 880910 AEC Assessment & Treatment - Eastbourne	62	0	0
354 880057 WCA Mental Health Liaison	N/A	0	0
354 880070 WCA St Richards Liaison	N/A	0	3
354 880900 AEC Assessment + Treatment - Hastings	28	0	0
354 880621 AEC Assertive Outreach Eastbourne	30	0	0
354 880135 WNC Assertive Outreach Northern	0	0	0
354 880965 ABC West B&H - Assessment & Treatment Centre	8	0	2
354 880121 WNA Weald Day Hospital	9	0	0
354 880619 AEC Assertive Outreach Hastings	9	0	0
354 880940 WNC Mid Sussex Assessment & Treatment Centre	5	0	0
354 882633 WCD Chichester Liaison	0	0	0
354 880058 WCA West Sussex ECT Service	0	0	0
354 880901 AEC Hastings & Rother	0	0	0

Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Recovery & Wellbeing			
354 880538 ABC B&H Post Care Services	0	0	0
354 881056 WNC Personality Disorders	0	0	0
Core service total	**3194**	**392**	**48**
Trust Total	**22910**	**9192**	**1793**

- Between 1 July 2016 and 30 June 2017, 1106 shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.
- In the same time period, agency staff covered 119 shifts. 17 shifts were unable to be filled by either bank or agency staff.
- We do not have details of the number of total shifts possible over the 12 month period and are therefore unable to calculate the proportion of shifts filled by bank or agency staff compared to the permanent workforce. The bank and agency use data submitted by the trust was not comparable to data reported at the time of the last inspection.

Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
354 880900 AEC Assessment + Treatment - Hastings	21	0	1
354 880930/931 WCC Assess & Recovery Teams Chichester & Bognor	475	0	5
354 880901 AEC Hastings & Rother Recovery & Wellbeing	0	0	0
354 880921 WCC Recovery & Wellbeing - Worthing	6	0	0
354 880945 WNC Crawley Recovery & Wellbeing	5	2	0
354 880538 ABC B&H Post Care Services	143	0	0
354 881056 WNC Personality Disorders	123	0	2
354 880944 WNC C&H Assessment and Treatment Centre	102	0	0
354 882633 WCD Chichester Liaison	0	0	0
354 882608 WCD Worthing Liaison	99	0	0
354 880961 ABC East B&H - Recovery & Wellbeing	58	0	0
354 880057 WCA Mental Health Liaison	N/A	0	0
354 880619 AEC Assertive Outreach Hastings	0	0	0

354 880020 WCC Assertive Outreach - Chichester & Bognor	9	0	0
354 880121 WNA Weald Day Hospital	24	0	1
354 880195 WNA A&E Liaison North West Sx	1	18	6
354 880911 AEC Assessment & Treatment - Uckfield	12	0	0
354 880621 AEC Assertive Outreach Eastbourne	8	0	0
354 880919 WCC Tier 2 Services	0	0	0
354 880032 WCC Assertive Outreach - AAW	3	0	2
354 880960 ABC East B&H - Assessment & Treatment Centre	1	0	0
354 880054 WCA Senior Nurse Practitioners - West Sussex	0	0	0
354 880058 WCA West Sussex ECT Service	0	0	0
354 880070 WCA St Richards Liaison	N/A	0	0
354 880135 WNC Assertive Outreach Northern	16	0	0
354 880529 ABC Clinic Staff	0	0	0
354 880537 ABC Accommodation Team	0	0	0
354 880910 AEC Assessment & Treatment - Eastbourne	0	0	0
354 880912 AEC Recovery & Wellbeing - Eastbourne	0	0	0
354 880913 AEC Recovery & Wellbeing - Uckfield	0	0	0
354 880920 WCC Assessment & Treatment - Worthing	0	0	0
354 880940 WNC Mid Sussex Assessment & Treatment Centre	0	0	0
354 880940/1/2 AWC Mid Sussex Assessment & Recovery	0	0	0
354 880946 WNC North West Sussex MHLP's	0	0	0
354 880965 ABC West B&H - Assessment & Treatment Centre	0	0	0
354 880966 ABC West B&H - Recovery & Wellbeing	0	0	0
354 882641 WNC Horsham Recovery & Wellbeing	0	0	0

354 883924 WNC NWS Tier 2	0	73	0
Core service total	**1106**	**119**	**17**
Trust Total	**38264**	**2811**	**2419**

- The Linwood team was using one agency nurse to cover whilst there were two new starters in the team. Hove Polyclinic was using one full time bank nurse. No other team we inspected was using either bank or agency nurses.
- Team leaders at each team were aware that they had staff members who were approaching retirement age and had made provision for this. Team leaders had had discussions with these staff to see if they would return to work on a part time basis after their retirement. One consultant psychiatrist at Hove Polyclinic was already doing this.
- The team at Hove Polyclinic had student nurses on placement. The team leader was using part of the budget to retain a bank nurse that could then be used to employ a student nurse when they graduated. This would ensure that the team would be fully staffed and was evidence of forward planning.

- This core service had 347.3 (an average of 12%) staff leavers between 1 July 2016 and 30 June 2017. The turnover data submitted by the trust is not comparable to data submitted at the time of the previous inspection.

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
East ATS (One team comprising of A&T and R&W)	32.1	5.3	16%
Battle Health Centre Assessment & Treatment Service	31.1	3.6	12%
Day Services/Functional Group Offer Programme AMHS	28.9	2	7%
West ATS (One team comprising of A&T and R&W)	28.2	4.3	15%
Crowborough Hospital (Grove House) Assessment & Treatment Service	23.2	3.6	15%
Avenida Lodge Assessment & Treatment Service	18.3	1.5	7%
AOT Brighton	16.8	1	6%
Assertive Outreach Service	14.8	0	0%
ATS Hub, Adult Services (AMHS) Recovery & Wellbeing (Chichester & Midhurst)	13.8	0	0%
Adult Services (AMHS) ATS HUB	13.1	2.6	16%
ATS Adult Services (AMHS) Chichester & Bognor Recovery &	12.2	1	7%

Wellbeing			
Mental Health Rapid Response Service (MHRRS)	9.9	1.8	18%
Adult Services (AMHS) - ATS Recovery & Wellbeing Team	9.6	1	12%
Adult services ATS Recovery & Wellbeing	9.6	1	12%
Brighton and Hove Group Treatment Service	8.7	1.8	20%
Adult Services (AMHS) ATS (Mental Health Liaison Practitioners)	8.4	3.6	34%
Adult Services (AMHS) Assertive Outreach Team (AOT)	8.3	0	0%
Specialist psychological therapies WAMHS (Personality Disorder Service)	8.1	0	0%
ATS Hub - Adult Services (AMHS) Mental Health Liaison Practitioners Team	7.7	0.8	10%
Adult Services (AMHS) Assertive outreach (AOT Northern)	6.8	0	0%
Adult Services (AMHS) ATS (Recovery & Wellbeing)	6.6	2.5	37%
ATS Service Adult Services (AMHS) - Mental Health Liaison Practitioners	6.4	1.6	24%
Adult Services (AMHS) Assertive outreach Team (Chichester & Bognor AOT)	6	0.5	8%
Neurobehavioural Service	5.4	1	16%
AMHS Accommodation Team	4	0	0%
AMHS (SMI LES)	4	0	0%
Adult Services (AMHS) Acute Day Hospital (Weald Day Hospital - Clinic)	2.8	1	35%
MH Homeless Team	2.6	0	0%
Adult Services (AMHS) - ATS Assessment & Treatment Team	0	0	0%
Adult Services (AMHS) - Medical	0	0	0%
Adult services (AMHS) ATS Assessment & Treatment	0	0	0%
Adult Services (AMHS) ATS Mental Health Liaison Practitioners	0	0	0%
Adult Services (AMHS) ATS MHLP's	0	0	0%
Adult Services (AMHS) ATS Service Hub	0	0	0%

Adult Services (AMHS) ATS Triage	0	0	0%
Adult Services (AMHS) Triage	0	0	0%
Adult Services (AMHS) ATS Assessment & Treatment Team	0	0	0%
Adult Services (AMHS) ATS MHLP's (Horsham)	0	0	0%
Adult Services (AMHS) ATS Recovery & Wellbeing Team (Horsham)	0	0	0%
AMHS psychology	0	0	0%
AMHS Teams	0	0	0%
ATS Hub	0	0	0%
ATS Hub - Triage	0	0	0%
ATS Satellite Site Adult Services (AMHS) AAW MHLPs	0	0	0%
ATS Service Adult Services (AMHS)- Recovery & Wellbeing Team,	0	0	0%
ATS Service Adult Services (AMHS) - Assessment & Treatment Team.	0	0	0%
ATS Services Triage	0	0	0%
Bognor ATS Base (AMHS) Assessment & Treatment Team	0	0	0%
Depot Clinic	0	0	0%
Functional AMHS Groups	0	0	0%
Medical Clinics	0	0	0%
SMILES Team	0	0	0%
Transition Team	0	1	36%
Cavendish House Assessment & Treatment Services	0	0	0%
St Anne's Centre & EMI Wards Assessment & Treatment Service	0	0	0%
Bexhill Health Centre Assessment & Treatment Service	0	0	0%
Rye, Winchelsea & District Memorial Hospital Assessment & Treatment Service	0	0	0%
St Mary's House Assessment & Treatment Service	0	0	0%
Woodside Assessment & Treatment Service	0	0	0%
Newhaven Rehabilitation Centre (Hillrise) Assessment & Treatment Service	0	0	0%
Millwood Unit Assessment & Treatment	0	0	0%

Service			
Horder Healthcare Seaford Assessment & Treatment Service	0	0	0%
Glebelands Adult Services (AMHS)	0	0	0%
Highdown Adult Services (AMHS)	0	0	0%
16 Liverpool Gardens Adult Services (AMHS)	0	0	0%
Core service total	**347.3**	**42.4**	**12%**
Trust Total	**2419.9**	**390.6**	**16%**

- The average sickness rate for this core service was 3% between 1 July 2016 and 30 June 2017. The most recent data provided, for 30 June 2017, also showed a sickness rate of 3% The sickness data submitted by the trust is not comparable to data submitted at the time of the previous inspection.

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Adult Services (AMHS) Assertive outreach (AOT Northern)	0%	17%
Neurobehavioural Service	16%	11%
Adult Services (AMHS) ATS (Recovery & Wellbeing)	5%	10%
AOT Brighton	10%	9%
Avenida Lodge Assessment & Treatment Service	13%	9%
Mental Health Rapid Response Service (MHRRS)	0%	8%
AMHS Accommodation Team	6%	6%
ATS Adult Services (AMHS) Chichester & Bognor Recovery & Wellbeing	1%	4%
ATS Service Adult Services (AMHS) - Mental Health Liaison Practitioners	0%	4%
Adult Services (AMHS) ATS (Mental Health Liaison Practitioners)	0%	3%
Adult Services (AMHS) Acute Day Hospital (Weald Day Hospital - Clinic)	1%	3%
Assertive Outreach Service	1%	3%
ATS Hub, Adult Services (AMHS) Recovery & Wellbeing (Chichester & Midhurst)	15%	3%
East ATS (One team comprising of A&T and R&W)	2%	3%
Crowborough Hospital (Grove House) Assessment & Treatment Service	0%	3%
ATS Hub - Adult Services (AMHS) Mental Health Liaison Practitioners Team	0%	2%
Brighton and Hove Group Treatment Service	1%	2%
Transition Team	0%	2%
Adult Services (AMHS) Assertive Outreach Team (AOT)	1%	1%

Day Services/Functional Group Offer Programme AMHS	0%	1%
Specialist psychological therapies WAMHS (Personality Disorder Service)	0%	1%
West ATS (One team comprising of A&T and R&W)	3%	1%
Battle Health Centre Assessment & Treatment Service	2%	1%
Adult Services (AMHS) - ATS Assessment & Treatment Team	0%	0%
Adult Services (AMHS) - ATS Recovery & Wellbeing Team	0%	0%
Adult Services (AMHS) - Medical	0%	0%
Adult Services (AMHS) Assertive outreach Team (Chichester & Bognor AOT)	0%	0%
Adult services (AMHS) ATS Assessment & Treatment	0%	0%
Adult Services (AMHS) ATS HUB	0%	0%
Adult Services (AMHS) ATS Mental Health Liaison Practitioners	0%	0%
Adult Services (AMHS) ATS MHLP's	0%	0%
Adult Services (AMHS) ATS Service Hub	0%	0%
Adult Services (AMHS) ATS Triage	0%	0%
Adult Services (AMHS) Triage	0%	0%
Adult services ATS Recovery & Wellbeing	0%	0%
Adult Services (AMHS) ATS Assessment & Treatment Team	0%	0%
Adult Services (AMHS) ATS MHLP's (Horsham)	0%	0%
Adult Services (AMHS) ATS Recovery & Wellbeing Team (Horsham)	0%	0%
AMHS (SMI LES)	0%	0%
AMHS psychology	0%	0%
AMHS Teams	0%	0%
ATS Hub	0%	0%
ATS Hub - Triage	0%	0%
ATS Satellite Site Adult Services (AMHS) AAW MHLPs	0%	0%
ATS Service Adult Services (AMHS)- Recovery & Wellbeing Team,	0%	0%
ATS Service Adult Services (AMHS) - Assessment & Treatment Team.	0%	0%
ATS Services Triage	0%	0%
Bognor ATS Base (AMHS) Assessment & Treatment Team	0%	0%
Depot Clinic	0%	0%
Functional AMHS Groups	0%	0%
Medical Clinics	0%	0%
MH Homeless Team	0%	0%
SMILES Team	0%	0%
Cavendish House Assessment & Treatment Services	0%	0%
St Anne's Centre & EMI Wards Assessment & Treatment Service	0%	0%
Bexhill Health Centre Assessment &	0%	0%

Treatment Service		
Rye, Winchelsea & District Memorial Hospital Assessment & Treatment Service	0%	0%
St Mary's House Assessment & Treatment Service	0%	0%
Woodside Assessment & Treatment Service	0%	0%
Newhaven Rehabilitation Centre (Hillrise) Assessment & Treatment Service	0%	0%
Millwood Unit Assessment & Treatment Service	0%	0%
Horder Healthcare Seaford Assessment & Treatment Service	0%	0%
Glebelands Adult Services (AMHS)	0%	0%
Highdown Adult Services (AMHS)	0%	0%
16 Liverpool Gardens Adult Services (AMHS)	0%	0%
Core service total	**3%**	**3%**
Trust Total	**5%**	**5%**

Medical staff

- Each team had access to medical cover. There was at least one consultant psychiatrist available at each team. Staff could arrange out-patient appointments for people using the service or sooner appointments if they needed to see a psychiatrist urgently.

Mandatory training

- The compliance for mandatory training courses at 31 July 2017 was 72%. Of the mandatory and statutory training courses listed, 17 failed to achieve the trust target and of those, 13 failed to score above 75%.
- Although immediate life support, manual handling, people and personal safety are listed as mandatory courses, no figures were provided, but rather none applicable entered in each row of data.
- The trust has a rolling month on month training target.
- The training compliance reported for this core service during this inspection was higher than the 68% reported for the previous financial year (31 March 2016 to 1 April 2017).

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	**This core service**	**Trust target %**	**Trustwide mandatory training total %**
Rapid Tranquilisation	100%	85%	93%
Safeguarding Children (Level 3 Additional)	100%	85%	72%
Fire safety onsite- Inpatient	100%	85%	86%
Safeguarding Children (Level 1)	97%	85%	93%

Safeguarding Adults (Level 1)	95%	85%	85%
Clinical Risk Assessment	89%	85%	93%
Equality and Diversity	87%	85%	93%
Infection Prevention (Level 1)	83%	85%	95%
Information Governance	82%	85%	88%
Fire safety onsite - non inpatient	76%	85%	78%
Safeguarding Adults (Level 2)	75%	85%	87%
Health and Safety (Slips, Trips and Falls)	74%	85%	84%
Mental Capacity Act Level 1	74%	85%	83%
Mental Health Act	73%	85%	81%
Safeguarding Children (Level 2)	72%	85%	83%
Manual Handling - Object	70%	85%	87%
Fire safety Awareness (1year)	62%	85%	78%
Adult Basic Life Support	61%	85%	68%
Infection Prevention (Level 2)	59%	85%	75%
Medicines management	57%	85%	29%
Personal Safety Breakaway - Level 1	45%	85%	57%
Adult Immediate Life Support	N/A	85%	74%
Manual Handling - People	N/A	85%	68%
Personal Safety - MVA	N/A	85%	74%
Total %	**72%**	**85%**	**82%**

- The trust provided us with up to date training figures for the period up to 18 December 2017. This showed that for the core service there was 83% compliance with mandatory training. The figures showed safeguarding level one for children and adults was 100%, equality diversity and human rights was 98% and clinical risk assessment and safety management was 97% across all sites. In areas where the training compliance was low, such as disengagement and conflict resolution, which was at 69% across all sites, the trust had provided a plan for when this training would be completed. The trust also provided details to show when staff could take protected time to complete mandatory training or had booked training in advance.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We reviewed 51 care records of people using services. Staff had completed thorough risk assessments of each individual as part of the initial assessment and updated these regularly. All care records we reviewed showed that people using the service had an up to date risk assessment.

- Staff had made crisis contingency plans in collaboration with people using the service and these were easily accessible within the individuals electronic care record.
- Staff updated the risk assessment of people using the service after any incident or change in care plan.

Management of patient risk

- Each team had a duty system to respond to any sudden deterioration in the mental health of a person using the service. The Hastings service ran a daily clinic which enabled staff to prioritise individual people using the service depending on the presenting risk, which freed up practitioners time and reduced waiting lists. Staff would be on the daily clinic rota and would know in advance if they had any assessments to complete on that day. The team leaders and duty worker would have a daily morning meeting to discuss any planned assessments or contacts needed that day.
- Staff maintained contact with people on waiting lists to ensure they could respond to any increase in risk or individual need. Staff could prioritise and bring forward assessments if the need had changed, or risk increased.
- The Elm Grove service had three times weekly zoning meeting at which staff reviewed the risk of people using the service to ensure they were receiving the appropriate amount of contact from the team. At Glebelands House the assertive outreach team reviewed risks daily and adopted a collaborative approach to managing risk.
- The trust had a lone working policy which we saw followed at all sites apart from Linwood. At Linwood staff used a system whereby each practitioner would buddy up with another at the start of the day and would contact their buddy at the end of the day. This was reliant on individual staff agreeing to the buddy system and there was no oversight of these arrangements. All other teams operated a lone working system whereby each practitioner out on community visits at the end of the day would contact the designated duty worker for the day. If the staff member had not contacted duty by a specified time, the duty worker would contact them. This ensured someone always had oversight of where staff were and a main point of contact for all staff.
- The early intervention service in East Sussex held a twice weekly zoning meeting to discuss the risks of people using the service. The meant that the service could prioritise and offer more contact with those people considered to be at higher risk. The team used a traffic light system to indicate the level of risk.
- The assertive outreach team at Glebelands House had a daily zoning meeting, using the traffic light system to highlight those at highest risk. Staff could see people using the service who rated as a red risk daily until the risk had reduced.

Safeguarding

- A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or an adult at risk from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.
- Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or an adult at risk,

the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to children's services, adult services or the police should take place.

- This core service made four adult safeguarding referrals between 1 July 2016 and 30 June 2017. This core service made seven child safeguarding referrals between 1 June 2016 and 31 May 2017. The number of safeguarding referrals reported during this inspection is not comparable to data submitted at the time of the previous inspection.
- Teams had strong safeguarding links with the local authority and knew how to make a referral. In the trust services within West Sussex and Brighton & Hove there were integrated social workers who took the lead role in any safeguarding enquiry. In East Sussex there were no integrated social workers, although the social workers in East Sussex were co-located with the Hastings team so communication between the two services was good and easily facilitated.
- Training rates for safeguarding across the service was at the trust target of 85%. This varied in the teams we visited. Safeguarding adults level two ranged from 100% at Glebelands House to 81% at the Bedale Centre in Bognor Regis, and safeguarding children level three ranged from 100% at Linwood to 55% at West Brighton Community Mental Health Service. Level one safeguarding for both adult and children safeguarding was 100% across all teams. The trust provided a plan for when this training would be completed.
- Staff demonstrated good knowledge and understanding of safeguarding issues and when to raise concerns with either local authority social workers, or the social workers within the team.
- The trust had a detailed safeguarding policy which made reference to both adults' and children's safeguarding, which all staff could refer to inform decision making.
- The electronic recording system had an alert which showed whether a person was subject to either safeguarding or multi-agency risk assessment conference procedures. This enabled practitioners to see quickly the safeguarding status of people on their caseload, and helped them track progress.

Referrals		
Adults	**Children**	**Total referrals**
4	**7**	**11**

- The trust had submitted details of 13 external case reviews commenced or published in the last 12 months, however it is not possible to attribute to specific core services from the information submitted.

Staff access to essential information

- Staff stored all information relating to people using the service and their care records on an electronic system. All staff had access to this and in those teams in West Sussex and Brighton & Hove the staff also had access to the local authority electronic record keeping system. This ensured that staff could access relevant information in a timely manner, without having to request it from the local authority. However, it did also mean that staff had two systems to keep updated which took more time.
- Staff scanned and uploaded any paper documents so these were always available and accessible to all.

- Staff from teams across the mental health pathway used the same system so staff from crisis teams, inpatient services and community teams all had access to the same information. This helped to maintain effective communication between the various teams.

Medicines management

- The trust had a policy on transporting medicine safely in the community which staff adhered to. The trust had consulted with their Chief pharmacist about the most appropriate way to transport medicine and concluded that as long as the medicine was secure it did not need to be transported in a locked container. We saw no evidence to indicate that staff were not following this policy. However, staff from some teams used lockable containers to transport medicine, although this was not a compulsory requirement of the trust policy. All staff transporting medicine in the community had an appropriate licence to do so, in line with national institute for health and care excellence guidance.
- Staff monitored the effects of medicine on the physical health of people using services and reviewed this regularly in physical health clinics. This was in line with guidance from the national institute for health and care excellence.
- We saw evidence of good pharmacy and medicines reconciliation at Linwood, Elm Grove and Hove Polyclinic sites as well at the early intervention and assertive outreach services. Each team had weekly contact with the team pharmacist.

Track record on safety

- Providers must report all serious incidents to the strategic information executive system (STEIS) within two working days of staff identifying an incident.
- Between 1 July 2016 and 30 June 2017 there were 108 STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was the category 'Apparent/actual/suspected self-inflicted harm meeting serious incident criteria' with 92 incidents. Of the 108 incidents, 79 were classed on STEIS as unexpected or avoidable deaths. However, there were no unexpected deaths recorded for this core service within the serious incident requiring investigation data. In terms of the volume of incidents the highest number were reported by the assessment and treatment service East Hub with 12.
- A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.
- We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS (two more incidents were detailed in the trust data compared to the STEIS extract).
- The number of serious incidents reported during this inspection was lower than the 116 reported at the last inspection.

	Number of incidents reported on STEIS										
Teams	Abuse/alleged abuse of adult patient by staff	Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	Apparent/actual/suspected homicide meeting SI criteria	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Confidential information leak/information governance breach meeting SI criteria	Disruptive/ aggressive/ violent behaviour meeting SI criteria	Pending review (a category must be selected before	Slips/trips/falls meeting SI criteria	Unauthorised absence meeting SI criteria	Grand Total
A&T (Eastbourne, Hailsham & Seaford)				6						6
A&T (Hill Rise)				4						4
A&T (Worthing)			1	3						4
A&T Cavendish House		1		9						10
A&T Satellite (Uckfield North)				1						1
A&T Team (New Park House)				3		1				4
A&T Western (Chichester)				2		1				3
AOT (Brighton)		1		2						3
AOT (Crawley)				1						1
AOT (West) East Sussex					1					1
ATS East Hub (EBCMHC)				12						12
ATS West Hub (MVH)				7			1		1	9
Group Treatment Prog (Acre Day)				1						1
Health In Mind (ESH)				1						1
Health In Mind (HW,L&H)				2						2
Mental Health Liaison Practitioners (Bedale)						1				1
Mental Health Liaison Practitioners (Chapel St)				1						1
Mental Health Liaison Team (St Annes)				1						1
MH Team For Homeless People				1		1				2

MHRRS (MVH)				2						2
Neuropsychiatry CHP (PRH)	1									1
Recovery & Wellbeing (Arun)				1						1
Recovery & Wellbeing (Bedale)				2	1	1				4
Recovery & Wellbeing (Cavendish Hse)				4						4
Recovery & Wellbeing (Chichester & Midhurst)				1						1
Recovery & Wellbeing (Crawley)			1	4						5
Recovery & Wellbeing (East Grinstead)				1						1
Recovery & Wellbeing (Horsham)				4				1		5
Recovery & Wellbeing (Midsussex)				7						7
Recovery & Wellbeing (Worthing)				2						2
Recovery & Wellbeing Hillrise (South)					1					1
Recovery & Wellbeing Millwood (North)				5						5
Street Triage Eastbourne				2						2
Grand Total	**1**	**2**	**2**	**92**	**3**	**5**	**1**	**1**	**1**	**108**

- The trust had a high rate of suicide amongst people using services at a rate of 11.9 per 10,000 people using services compared to 7.13 per 10,000 as an average for all other mental health trusts. The trust had a safer communities suicide prevention strategy to work to try and reduce the numbers of death by suicide. As part of this the trust had a developed the Stay Alive app for mobile phones and tablets, which was free to download. This included a personalised safety plan, reasons to live and a section to store photographs important to the individual. The trust had further introduced family liaison posts; patient safety learning events for all staff; serious incident scrutiny panels and within West Sussex there was a suicide prevention champions' network. The trust were looking to develop their suicide prevention work further and adopt a zero suicide approach.

Reporting incidents and learning from when things go wrong

- The chief coroner's office publishes the local coroners' reports to prevent future deaths which all contain a summary of schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.
- In the last two years, there have been nine prevention of future death reports sent to the trust. Two of these related to this core service, details of which can be found below.

Date of report: 14 February 2017

Care transferred to Avon and Wiltshire Mental Health Partnership NHS Trust, and then later re-referred to the trust early intervention service. Died before contact made by the trust.

The Coroner's concerns were;

- No relevant policy, procedure or practice requiring faxes to be logged and scrutinised on receipt so it was not noticed that pages of referral were missing.
- No policy, procedure or practice requiring the referral to be read before the zoning meeting and initial risk assessment.
- No relevant policy, procedure or practice to confirm with the referrer the date on which contact with a newly referred patient will be.
- No serious incident review / effective joint learning from the other Trust's serious incidents.

The trust gave the following details of improvements made;

- Information governance training completed
- Posters with guidance on fax receipt
- Developed set of standards for accepting referrals with guidelines for staff
- Early contact with clients offering a choice around appointment times and venues
- Higher rates of engagement achieved
- Telephone contact with referred client the next working day and agree a date and venue for contact
- Transition proforma developed
- Retrospective serious incident review to be undertaken

Date of report: 20 April 2017

Patient was seen by mental health liaison team following an overdose. Family called mental health line and approved mental health professional wanting a Mental Health Act assessment.

The coroner's concerns were;

- Lack of a coherent and standard practice in the management of calls / referrals when a service user or family require a Mental Health Act assessment.
- Local authority and trust using different information technology systems.

The trust gave the following details of improvements made;

- Trust is working with commissioners to be able to accept self referrals and to have a single point of access.
- Access to both electronic systems permitted for those requiring access with the necessary training.

- All staff we spoke with knew how to report incidents and which incidents should be reported. All staff had access to the on line incident reporting system.
- Staff sent all reported incidents to the team leaders to review and sign off. If further review was needed, the team leader would send it on to the service managers for scrutiny.
- Staff received feedback and learning from any incidents at monthly team business meetings and via email communications including the trust Patient Safety Matters bulletin.
- Staff had the opportunity to de-brief after an incident and were offered reflective feedback sessions, often facilitated by the psychology team.
- The trust had a duty of candour policy to which staff adhered. This ensured that staff were open and transparent with those using services and their families and carers and kept them informed of any incidents that might have affected them. The duty of candour policy clearly set out the steps staff must take when informing others following an incident.
- Staff told us of changes in practice following incidents. At the Bedale Centre, for example, an individual known to services, but not receiving care was arrested and charged with offences. The learning and change in practice resulted in staff now referring those not willing to engage back to the original referrer with a recommended treatment plan and the option to re-refer when more appropriate. This means that people on the team caseload not actively receiving a service, but who other agencies may believe are receiving a service do not slip between agencies and miss out on a service.
- The early intervention service in East Sussex had an annual team away day to discuss any serious untoward incidents. This helped the team to review any themes and helped them in developing new ways of working.

Is the service effective?

Assessment of needs and planning of care

- We reviewed 51 individual care records. Each record showed staff had completed a comprehensive assessment including the physical health needs of people using services.
- Care plans clearly reflected the individual persons need's that staff had identified during the initial assessment. Care plans were personalised, holistic and recovery focused.
- We saw evidence at the Bedale Centre that staff had not stated why each person using services did not have a formal care plan in the electronic record system. People using services had a care plan recorded within the letters section which was sufficient, although staff had not always recorded this in the care plan section. We raised this with the trust at the time of the inspection and received assurances that staff would record why a person using services did not have a formal care plan.
- Staff reviewed their caseload with the relevant team leader every three months to ensure care plans of those using services were relevant and up-to-date. This ensured that both the individual and practitioner knew the current goal and any discharge plans that may be in place.

Best practice in treatment and care

- This core service participated in four clinical audits as part of their clinical audit programme 2016 – 2017 relating to this core service.

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Service Evaluation of client and staff satisfaction with the Chichester and Bognor Regis Family Intervention for Psychosis pilot service	Chichester & Bognor assessment & Treatment service	MH - Community-based mental health services for adults of working age	Quality Improvement Project (QIP)	01/01/2017	To improve service user access to Family Intervention for psychosis, staff from Chichester and Bognor Assessment and Treatment service, Assertive Outreach Team and Early Intervention in Psychosis set up a pilot project to provide Family Interventions for one day each month, providing direct Family Interventions for clients and their families, as well as providing consultation to staff.
An audit of an urgent referral service within an Assessment and Treatment Service	Hastings assessment & treatment service	MH - Community-based mental health services for adults of working age	Quality Improvement Project (QIP)	01/05/2016	Recommendations to the service included clarification around the referral process with GPs, further measures to ensure correct contact numbers are given and if possible more time for staff to spend on formulation and planning
Snapshot Audit of Community	Crawley, Horsham &	MH - Community-	Clinical audit	01/09/2016	• To review the community zoning systems and make

Contacts Prior to Referral to the Acute Care Services	Mid Sussex CMHT	based mental health services for adults of working age			these more robust. • Ensure that most patients are reviewed by a psychiatrist prior to being referred to the expensive acute care service • Repeat audit next year to complete the audit loop
Supervised Community Treatment Order Audit	Northern West Sussex Assertive Outreach Team	MH - Community-based mental health services for adults of working age	Clinical audit	01/03/2017	• We need to demonstrate that we are compliant with the legal CTO requirements by amending the non-compliant areas and re-auditing in 3 months' time. • To ensure that all staff within the team are aware of and familiar with Carenotes guidance for uploading MHA documents. • When SOAD requests are made via the online form, email receipts from the CQC are entered as a clinical note in Carenotes. • To look into current Trust CTO guidelines and inform the relevant people on updates (S61 form). • Where patients are being administered medication in the community, relevant capacity to consent documents are attached to the prescription card.

- Staff were able to provide a variety of treatment interventions including psychological therapy, medication and social support. Interventions such as family intervention therapy for those with psychosis were in line with National Institute for Health and Care Excellence guidelines. Staff offered psychological input to all people on the early intervention caseload.
- The psychology service in Hastings provided education to practitioners so all staff would think psychologically. This meant that staff felt confident to work with people in a psychological way, ensuring more suitable referrals to the psychology team. Psychologists would offer anyone referred to their service four sessions of formulation prior to any therapy. This ensured that the individual knew what was expected of them regarding their therapy, and gave the psychologist time to develop a formulation and treatment plan. This system had reduced waiting times for psychological intervention.
- The service based at Hove Polyclinic had an employment specialist and links with local colleges to support people using services find employment or work based training. The

employment specialist could also support people with their benefits claims to ensure they were claiming appropriate benefits.

- All teams visited had a physical health clinic to ensure those using services had access to physical health screening and regular health checks. Teams were actively promoting healthy lifestyles and provided information on smoking cessation and healthy living. Staff at Glebelands House and Hove Polyclinic had access to an electrocardiogram machine that was used by people putting their hands on an electronic plate. Staff could view the results immediately on a laptop and send this directly to the person's GP.
- The early intervention service in East Sussex had a physical health lead who had set up a spreadsheet to look at blood testing and physical health checks to identify which people using the service had received which check and to flag when individuals were due to have a check or screen. Assertive engagement with people using the service also happened, so staff could go to peoples' home to carry out the physical health checks. Over 90% of clients had had checks. Staff completed the checks for those using the service annually.
- The assertive outreach service managed physical health concerns as a team. For example, the team leader arranged for a care package for a person using services who had poor physical health care. The care agency later withdrew, so the team leader and other practitioners visited to clean the person's flat and raise a safeguarding concern against the care agency. The assertive outreach team now provide all the individual's care needs and prescriptions with support from the team pharmacist.
- Teams at Hove Polyclinic and East Brighton had strong links with local substance misuse services and offered joint assessments where appropriate. These teams also employed a learning disabilities specialist nurse who could offer joint assessments and joint working with the mental health practitioners.
- Staff used health of the nation outcome scales to monitor the impact of mental health problems on people using services and measure outcomes at the end of an episode of care.
- All teams had strong peer support who offered a variety of different groups including nature groups, fishing group, kickboxing and a wellbeing group.
- The trust had a recovery college which provided courses on mental health and recovery. The courses were designed for those using services to gain knowledge of their condition to enable them to take control of their own recovery. The ethos of the recovery college was for people to manage their condition without it taking over their life, allowing people to live a full life despite the challenges having a mental health condition can bring.

Skilled staff to deliver care

- The trust's target rate for appraisal compliance is 90%. As at 31 December 2016, the overall appraisal rates for staff within this core service was 39%. Please note there was no breakdown to ascertain whether this data related to non-medical or medical staff at the trust.
- All but three teams failed to achieve the trust's appraisal target (ABC Accommodation Team, 06-WA-HOME-Brighton and WNC Mid Sussex Liaison Practitioners)
- The rate of appraisal compliance for staff reported during this inspection was higher than the 26% reported at the last inspection.

Team name	Total number of permanent staff who have had an appraisal	Total number of permanent staff requiring an appraisal	% appraisals
ABC Accommodation Team	4	3	133%
06-WA-HOME-Brighton	3	3	100%
WNC Mid Sussex Liaison Practitioners	1	1	100%
02-WA-AOT-Worthing	8	10	80%
06-WA-AOT-Brighton	14	21	67%
ABC Brighton and Hove Group Treatment Service	6	9	67%
02-AM-MHLP-Adur Arun Worthing	5	8	63%
06-AM-AT-B&HoveWest	12	19	63%
06-AM-AT-B&HoveEast	16	27	59%
03-AM-AT-Crawley & Horsham	8	16	50%
01-AM-AT-Chichester & Bognor	12	26	46%
02-AM-AT-AAW	12	27	44%
01-WA-AOT-Chichester	3	7	43%
06-WA-ACCESS-B&H Urgt Resp	4	10	40%
01-AM-MHLP-Chichester & Bognor	3	8	38%
04-AM-AT-Hastings	15	39	38%
03-WA-DAYAC-Weald Day Hosp	1	3	33%
04-WA-AOT-Hastings	2	6	33%
06-WA-CMHT-SMILES	1	3	33%
02-AM-REC-AAW	4	15	27%
03-AM-REC-Mid Sussex	2	8	25%
05-AM-AT-High Weald, Lewes and Havens	8	32	25%
01-AM-REC-Chichester & Bognor	3	13	23%
05-AM-AT-Eastbourne, Hailsham Seaford	6	31	19%
03-WA-AOT-Northern West Sussex	1	6	17%
03-AM-REC-Crawley & Horsham	1	9	11%
05-WA-AOT-Amberstone	1	9	11%
03-AM-MHLP-Crawley & Horsham	1	11	9%
03-AM-AT-Mid Sussex	2	25	8%
Core service total	**159**	**405**	**39%**
Trust wide	**1234**	**2714**	**45%**

- Between 1 July 2016 and 30 June 2017 the average clinical supervision rate for non-medical staff across all teams where data was provided for in this core service was 72% compared to the trust target of 85%

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Location	Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Woodside, Cavendish House, Millwood, Avenida, Grove House	Health in Mind	449	311	69%
Lighthouse	Specialist psychological therapies WAMHS (Personality Disorder Service)	12	2	17%
East Brighton Community Mental Health Centre	MH Homeless Team	31	24	77%
East Brighton Community Mental Health Centre	AMHS (SMI LES)	32	10	31%
East Brighton Community Mental Health Centre	East ATS (One team comprising of A&T and R&W)	700	346	49%
East Brighton Community Mental Health Centre	Brighton and Hove Group Treatment Service	64	50	78%
East Brighton Community Mental Health Centre	AOT Brighton	60	39	65%
East Brighton Community Mental Health Centre	Depot Clinic	12	12	100%
Hove Polyclinic	Depot Clinic	12	12	100%
Mill View Hospital	Mental Health Rapid Response Service (MHRRS)	68	37	54%
Mill View Hospital	Transition Team	12	0	0%
Mill View Hospital	SMILES Team	0	0	n/a
Mill View Hospital	West ATS (One team comprising of A&T and R&W)	565	371.5	66%
Mill View Hospital	Brighton and Hove Group Treatment Service	0	0	n/a
East Brighton Community Mental Health Centre	AMHS Accommodation Team	No nursing staff	No nursing staff	n/a
Swandean,Worthing	LWWD South	103	77	75%
New Park House and Ifield Drive	Northern West Sussex Community Team MHLP	71	55	77%
New Park House	Adult Services (AMHS) ATS Recovery & Wellbeing Team (Horsham)	81	70	86%
Ifield Drive, Crawley	Adult Services (AMHS) ATS (Recovery & Wellbeing)	75	44	59%

Linwood and Springvale	Adult Services (AMHS) - ATS Assessment & Treatment Team	101	61	60%
Linwood and Springvale	Adult Services (AMHS) ATS Mental Health Liaison Practitioners	80	58	73%
New Park House	Adult Services (AMHS) Assertive outreach (AOT Northern)	31	15	48%
	Core service total	**2559**	**1594.5**	**62%**
	Trust Total	**16113**	**11734**	**73%**

No data has been provided for medical staff for this core service.

- Staff received a variety of supervision including managerial, clinical, reflective practice and peer support. Social workers and psychologists received professional supervision from outside the team to ensure their practice was current and up to date. We received refreshed data from the trust that showed that in November 2017 the core service had met the trust target of 85% for staff receiving supervision.
- Not all staff had received an annual appraisal. The trust provided annual appraisal data for the period up to December 2017 which showed an overall appraisal rate of 62% for the core service. However, some sites had achieved higher rates of staff appraisals including Glebelands at 100% and Cavendish House, Elm Grove and Hove Polyclinic all over the trust target of 90%. The trust acknowledged that locally staff did not always upload onto the central system the appraisals that had been undertaken, and so this was not always accurately captured. There was an improvement plan in place to address this. Staff who had had an appraisal reported that they were meaningful and included opportunities to discuss learning, future career development as well as challenges and successes.
- Each team had regular meetings to ensure staff were kept informed of any trust news, learning from complaints and incidents and any service developments. Staff were able to access specialist training for their role and we heard of staff attending family therapy training, psychological interventions training, suicide prevention and medicines management training, alongside their mandatory training.
- Each team had access to a full range of mental health specialists, including psychiatrists, psychologists, peer support workers, social workers, pharmacists and support, time and recovery workers. Staff could refer to additional specialist including dieticians and speech and language therapists as required.
- The service peer support workers were well linked in with the recovery college. The peer support trainer at the Hastings service saw eight peer support workers to provide supervision. Once every two months all peer support workers came together to talk about trust wide meetings, discuss systems, policies and processes along with educational issues. The peer support trainer was happy and motivated to do her job and felt well supported by management and said management was passionate about this model.

Multidisciplinary and interagency team work

- Staff attended weekly multidisciplinary clinical meetings to discuss new referrals and assessments as well as on going cases for additional support. Teams also held zoning meetings to discuss the risks of those using the service and monthly business meetings to discuss service developments and any trust issues.
- Teams had good links with other services within the mental health pathway. At Hove Polyclinic there were community mental health nurses that had a specific link role with the inpatient service to facilitate discharge, and pathways nurses that linked with primary care services such as GP practices. In Glebelands House staff had developed the pathfinder service which provided a link between community mental health services and non-statutory support organisations in the community. This way of working helped people newly referred to the service transition into mental health services more smoothly, or prevented a referral to secondary mental health services. This enabled the Glebelands House team to manage their waiting lists effectively and gave practitioners more time to work with those people on their caseloads.
- Those teams in West Sussex and Brighton and Hove council localities had integrated social workers. The teams in East Sussex had co-located social workers which ensured good communication between local authority and trust staff.
- The team at Hastings reported some issues with the volume of GP practices they were linked to and how this could affect the number and quality of referrals they received. Staff were working with GP practices to improve links and establish improved working relationships.
- Some teams shared buildings with crisis services which helped better communication between the teams.
- The Linwood team had developed strong links with primary care and had set up a primary care liaison post to ensure good, clear effective communication between GP practices and the mental health service.
- Linwood had established strong working links with other community teams in the area and crisis services.

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

- As of 31 July 2017, 73% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every two years.
- The training compliance reported during this inspection was similar to the 72% reported during the previous financial year.
- The trust provided training figures for the period up to November 2017. The Mental Health Act training compliance across the sites we visited was 90%, above the trust target of 85%.
- Staff had access to administrative support and advice on the implementation of the Mental Health Act.
- On our previous inspection we had seen that people using service who were subject to a community treatment order were not routinely being made aware of their rights, or paperwork was not kept up to date. On this inspection we reviewed community treatment

orders at Glebelands House, Hastings and Hove Polyclinic teams. These were all up to date and we saw evidence that staff were routinely reading individuals their rights under this legislation and gave those subject to the treatment order timescales for lodging an appeal against this.

- Staff at the Glebelands House assertive outreach team completed audits of community treatment order paperwork to ensure staff were applying the legislation correctly.
- The trust had a Mental Health Act policy and all staff had access to the Mental Health Act Code of Practice.
- The trust employed approved mental health professionals and many of these were based within the community teams. The approved mental health professionals carried out these duties on a rota system so everyone knew when they would be available for case work and when they were performing Mental Health Act duties.

Good practice in applying the Mental Capacity Act

- As of 31 July 2017, 74% of the workforce had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every two years.
- The training compliance reported during this inspection was similar to the 73% reported at the last inspection.
- The trust provided up to date training figures for the period to November 2017. Training compliance rates across the service for Mental Capacity Act training were 94%, above the trust target figure of 85%. The trust provided a plan for when staff would complete this training across all sites.
- The trust had an up to date Mental Capacity Act policy for all staff to refer to.
- Staff relied on the specialist knowledge of the social workers in the team to provide support regarding any issues pertaining to the Mental Capacity Act. This did not provide a consistent approach to issues of mental capacity and we did not see any evidence that staff routinely considered or assessed the mental capacity of people using the service. However, staff at Elm Grove had good Mental Capacity Act awareness and we saw evidence that staff routinely considered the principles of the Mental Capacity Act.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

- People using the service reported that staff treated them kindly, with respect and maintained their dignity. People told us that staff behaved appropriately towards them and did all they could to understand their needs and be empathetic to them. People using services told us they felt the variety of groups on offer beneficial and felt the level of support in these groups was good.
- People using the service told us they had were able to contact their lead practitioner at any time, and felt they got a good response.
- Staff were able to respond to sudden changes in the mental health of people using services and could provide advice and support at the time they needed it.
- Staff worked with people using services to help them understand their condition so that they could manage these themselves more effectively.
- Staff had good links with community services and were able to direct people using services to more appropriate services if required.

The involvement of people in the care they receive

Involvement of patients

- We saw evidence in care records of involvement of the people using services in their care planning. Care records showed that staff discussed care plans with those using services and offered them a copy of their care plan.
- People using services told us that they had been involved in developing their care plan, and that their families could be involved if they wished.
- Some people using services did not have a formal care plan, but their plan of care was detailed in practitioners' letters. This was the case when the person was not part of the care programme approach, but had only seen one practitioner in a clinic, for example out-patient appointments or the depot clinic.
- Cavendish House had recruited people using services to be part of the interview and recruitment panels for new staff.
- All services had display leaflets and information on how to access advocacy.

Involvement of families and carers

- Carers we spoke with told us they were kept informed and up to date with any changes in the care for the person receiving the service. Carers were invited to attend review meetings and care programme approach meetings.
- Staff recorded consent to share documentation to ensure that they did not give information about the individual to carers without their consent.
- Staff gave carers information on how to access a carers assessment and staff routinely offered these at the initial assessment stage.
- Staff at the early intervention service ran family and friends evenings and worked closely with the recovery and discovery colleges. The team also kept a database of family, carers and friends and staff also offered them psychological education.
- The assertive outreach team at Glebelands House had a link worker for carers and used the triangle of care model. The triangle of care model was set up by the Carers Trust in

2010 and focuses on keeping carers included, informed and supported when they are caring for an individual with mental health difficulties.

Is the service responsive?

Access and waiting times

- The trust has identified the below services in the table as measured on referral to initial assessment and assessment to treatment.
- The core service met the referral to assessment target in 22 of the targets listed (out of 25). The core service met the assessment to treatment target in 19 of the targets listed (out of 22).
- The number of days from referral to initial assessment and assessment to treatment during this inspection is not comparable to data submitted at the time of the previous inspection.

Name of hospital site or location	Name of team	Service Type	Days from referral to initial assessment		Days from assessment to treatment		Comments, clarification
			Local target	Actual (mean)	Local target	Actual (mean)	
Chapel Street Clinic	01-AM-AT-Chichester & Bognor	Adult Mental Health Services	28	20	98	8	SPFT wait times are collected as referral to assessment and referral to treatment, therefore the ' initial assessment to onset of treatment waits' construction has been calculated as the median referral to treatment less the median referral to assessment.
Chapel Street Clinic	01-AM-MHLP-Chichester & Bognor	Adult Mental Health Services	28	20	98	1	
The Bedale Centre	01-AM-REC-Chichester & Bognor	Adult Mental Health Services	28	21	98	1	
Chanctonbury, Swandean	02-AM-AT-AAW	Adult Mental Health Services	28	21	98	3	
Chanctonbury, Swandean	02-AM-MHLP-Adur Arun Worthing	Adult Mental Health Services	28	21	98	0	
Chanctonbury, Swandean	02-AM-REC-AAW	Adult Mental Health Services	28	19	98	-6	
Highdown	02-WA-AOT-Worthing	Working Age Mental Health Services	28	0	98	64	
New Park House	03-AM-AT-Crawley	Adult Mental Health Services	28	23	98	14	

	& Horsham					
Linwood	03-AM-AT-Mid Sussex	Adult Mental Health Services	28	21	98	7
New Park House	03-AM-MHLP-Crawley & Horsham	Adult Mental Health Services	28	22	98	6
Linwood	03-AM-MHLP-Mid Sussex	Adult Mental Health Services	28	20	98	4
Ifield Drive, Crawley	03-AM-REC-Crawley & Horsham	Adult Mental Health Services	28	23	98	5
Cavendish House	04-AM-AT-Hastings	Adult Mental Health Services	28	21	98	6
Cavendish House	04-AM-REC-Hastings	Adult Mental Health Services	28	22	98	11
St Mary's House	05-AM-AT-Eastbourne, Hailsham Seaford	Adult Mental Health Services	28	9	98	0
Newhaven Rehabilitation Centre (Hillrise)	05-AM-AT-High Weald, Lewes and Havens	Adult Mental Health Services	28	15	98	13
St Mary's House	05-AM-REC-Eastbourne, Hailsham and Seaford	Adult Mental Health Services	28	7	98	1
Newhaven Rehabilitation Centre (Hillrise)	05-AM-REC-High Weald, Lewes and Havens	Adult Mental Health Services	28	20	98	-8

East Brighton Community Mental Health Centre	06-AM-AT-B&Hove East	Adult Mental Health Services	28	17	98	7	
Mill View Hospital	06-AM-AT-B&Hove West	Adult Mental Health Services	28	16	98	8	
East Brighton Community Mental Health Centre	06-AM-REC-B&Hove East	Adult Mental Health Services	28	0	98	0	
Mill View Hospital	06-AM-REC-B&Hove West	Adult Mental Health Services	28	4	98	1	
Chanctonbury, Swandean	Urgent Care Pathway Service teams for Coastal West Sussex CCG	Adult Mental Health Services	5	100% seen within 5 days			Date period: April 16 to March 17 - Priority Referrals Assessed <5 working days is recorded manually by teams.
New Park House	Urgent Care Pathway Service teams for Crawley CCG	Adult Mental Health Services	5	100% seen within 5 days			
Linwood	Urgent Care Pathway Service teams for Horsham and Mid Sussex CCG	Adult Mental Health Services	5	100% seen within 5 days			

- The trust had a set target time for referral to assessment and referral to treatment times. Each service across the trust was meeting these timescales.
- Each team had a duty system which could see urgent referrals on the same day or within five days as appropriate. All routine referrals were seen within 28 days. The Hastings

service ran a daily clinic which was a more managed way of running duty, which both freed up the duty worker to complete assessments and kept the waiting lists down.

- The duty worker in each service could respond to people using services calling up and had capacity to see people on the same day.
- The service at Glebelands House retained an assertive outreach team to work with people who services had failed to engage. The team used a team approach model so each practitioner had a small caseload, but the work was shared between the staff. This ensured that people using service received the level of support that was appropriate for their need and any risks where held collectively as a team.
- Staff managed their own diaries and could be flexible in offering people appointment times.
- There was out of hours cover provided at each team. Hove Polyclinic had a mental health rapid response team who could see urgent referrals, and also took on the role of out of hours support.
- Each team followed a protocol of making follow up contact with people using services who did not attend appointments. Staff tried to contact them by telephone, and then wrote letters to the individual and referrer so that all relevant people were kept aware. If staff felt risks were sufficiently high they could attempt a cold call visit of anyone who did not attend their appointment.
- Teams that did not have an assertive outreach team worked to engage with people that services found hard to engage. . In Glebelands House this role was carried out by the assertive outreach team.

The facilities promote comfort, dignity and privacy

- All services had a wide range of rooms to see people using services, including clinic rooms. These were all soundproofed to maintain confidentiality.
- Waiting areas were spacious and well furnished, offering a wide variety of information leaflets.
- Staff reported there were enough rooms for them to book to see people at the service.

Patients' engagement with the wider community

- The Glebelands House service had developed an integrated service with people using services and non-statutory organisations in the area called the Pathfinder Alliance. This was a co-production between the trust, people using services and the third sector. The service had two pathways: a step down pathway for people nearing discharge; and a step up intervention to offer a service at point of referral. By working with those using services nearing discharge the service could offer a more joined up transition to community services which reduced the chances of a re-referral, and by offering interventions at the point of referral the service reduced the number of referrals that needed a specific mental health service. This not only reduced waiting times and caseloads for practitioners, but also freed up practitioners time to see existing people on their caseload.
- The Hove Polyclinic service had links with Southdown recovery service and Brighton and Hove Employment Service. This service offered support to maintain people using services' existing employment or help to find employment.
- Staff at all teams encouraged people using services to maintain healthy relationships with those people that mattered to them, be that family, friends or community groups.

- The Ifield service had developed a service to provide mental health support to armed services veterans. The service could take referrals directly from veterans, or from their GP. The service aimed to support veterans' transition into civilian life and had specialist practitioners who had an understanding of military culture and what the veterans may have been through. Veterans themselves have reported the service as being supportive and understanding.

Meeting the needs of all people who use the service

- All premises had a working lift for those unable to use the stairs.
- The teams at Hove Polyclinic and Elm Grove in East Brighton had employed learning disabilities specialist nurses to carry out joint assessments and joint working with mental health practitioners. This ensured that people using services with learning disabilities and mental health issues were seen by the most appropriate service for their needs.
- Each waiting area had a suitable supply of information on local community groups, advocacy and medicine information. We did not see these in any foreign languages, but staff told us they could request this for individuals if needed. Staff knew how to access interpreters if they were needed.
- Staff had flexibility to see people at their homes or away from the team offices if this was more suitable for the person using services.

Listening to and learning from concerns and complaints

- This core service received 300 complaints between 1 July 2016 and 30 June 2017. Thirty-eight of these were upheld, 44 were partially upheld and 181 were not upheld. The number of either partially or fully upheld complaints reported during this higher than the 189 reported at the last inspection.

Team name	Total Complaints	Not Upheld	Partially Upheld	Referred To Clinical Team	Suspended	Under Investigation	Upheld
A&T (Eastbourne, Hailsham & Seaford)	19		13	3			1
A&T (Hill Rise)	13		10	2			
A&T (HW,L,H) Newhaven Later Life	1		1				
A&T (Later Life Chichester)	1						
A&T (Worthing)	21		14	3			2
A&T Cavendish House	11	1	8				
A&T Satellite	1		1				

(Bexhill) Hastings & Rother					
A&T Satellite (Uckfield North)	3	1			1
A&T Team (New Park House)	30	15	5		5
A&T Western (Chichester)	10	3	1		
ADHD (West Sussex)	1	1			
Amberstone	3	1	2		
AOT (Bognor)	3	2	1		
AOT (Brighton)	2	2			
AOT (Crawley)	1	1			
AOT (H&R)	2	1			
AOT (West) East Sussex	2	2			
ATC (Arun House)	6	5	1		
ATS East Hub (EBCMHC)	17	12	3		1
ATS West Hub (MVH)	17	10	2		2
ATS West Hub (Poly	4	1	2		
Depot Clinic WA (Hove Polyclinic)	2	1	1		
Group Treatment Prog (Acre Day)	2	1			
Group Treatment Prog (Pepperville)	1	1			
Health In Mind (HW,L&H)	1	1			
LWWD West	1				
Mental Health Liaison Practitioners (Bed	1				
Mental Health Liaison Practitioners (Cha	2	2			
Mental Health	2				

Liaison Practitioners (Cra								
MHRRS (MVH)	2		1					1
Neurobehavioural Service	2		2					
Personality Disorder (Bluebell House)	1		1					
Recovery & Wellbeing (Adur)	1			1				
Recovery & Wellbeing (Arun East)	6		6					
Recovery & Wellbeing (Arun)	3		2					
Recovery & Wellbeing (Bedale)	32		18	8				1
Recovery & Wellbeing (Cavendish Hse)	3		2					1
Recovery & Wellbeing (Chichester & Midhurst)	6		4					
Recovery & Wellbeing (Crawley)	22		9	6				
Recovery & Wellbeing (East Grinstead)	4		3					1
Recovery & Wellbeing (Eastbourne)	2		2					
Recovery & Wellbeing (Horsham)	9		5					1
Recovery & Wellbeing (Midsussex)	10		5	2				1
Recovery & Wellbeing (Worthing)	5		5					
Recovery & Wellbeing Hillrise (South)	5		2	1	1			
SMILES	1						1	

Talking Therapies Service	1		1				
Transition Team	3		3				
Triage & Urgent Care (ATS)	2						
Core service total	**300**	**1**	**181**	**44**	**1**	**1**	**18**

- Staff provided people using services with information on how to make a complaint as part of the initial information pack. People using services told us they knew the process for how to make a complaint.
- Staff gave feedback to people who had made a complaint and told them what actions the service would take, if any, as a result.
- Staff received feedback from within the trust on the outcome of any complaint made by people using services.
- People using services reported knowing how to make a complaint and we heard of one complaint when an individual felt the service was not giving them enough information in the appointment letters they received. The service listened to this feedback and implemented a new process whereby a greater amount of useful information would be sent out with appointment letters.
- This core service received 103 compliments during the last 12 months 1 July 2016 and 30 June 2017 which accounted for 15% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

- There were clearly defined roles for team leaders and service managers within each team inspected. Team leaders had the necessary skills to perform their role and each said they felt well supported by the service managers.
- Team leaders demonstrated a clear understanding of the service they were providing and how it connected to the wider community service. Each team leader could explain how their team operated and fitted in to the community mental health pathway.
- Staff reported that team leaders and more senior managers were a visible presence in the service and they felt well supported and connected to the wider trust organisation.
- Staff had opportunities for development and taking on leadership roles.

Vision and strategy

- Staff were aware of the trust vision and values and how they could work towards these. Senior managers had communicated these to staff teams at team meetings and via trust bulletins. Staff knew how they applied to their day to day work.
- Staff contributed to the on-going development of services and implementations of new ways of working. Staff felt valued and listened to, which gave them more confidence to contribute new ideas.

Culture

- During the reporting period of 24 July 2016 to 25 July 2017 there were five cases where staff were either suspended or placed on restricted duties. Four staff were suspended and one was placed on restricted duties.

Caveat: Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted.

Location	Team name	Suspended	Restricted duties	Total
Aldrington Centre	Brighton Wellbeing		1	1
Newhaven Rehabilitation Centre (Hillrise)	Assessment & Treatment Service	1		1
The Bedale Centre	Adult Services (AMHS) Assertive outreach Team (Chichester & Bognor AOT)	1		1
Little Common Surgery, Bexhill on Sea	HiM	1		1
St Anne's Centre & EMI Wards	Assessment & Treatment Service	1		1
	Core service total	**4**	**1**	**5**

- All staff we spoke with said they felt proud to work for the team they did, and all emphasised the strong working relationships in the teams.
- Staff knew how to raise concerns and felt they could do this without fear of retribution. There was an open culture of honesty amongst the practitioners and all staff felt they could offer constructive challenge to one another.
- The staff appraisals which included conversations about career development, training opportunities and how these could be supported within the team.
- The trust provided an occupational health service for staff to access support for their own needs, both physical and emotional, to maintain their wellbeing.
- The trust 'positive practice awards' had taken place earlier in the month. These were awards which celebrated success and achievements within the trust. Several of the teams inspected had been nominated for these awards and a practitioner at the Hastings service was the current employee of the month for the whole trust.

Governance

- The trust provided their board assurance framework, which details any risk scoring 15 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. None relate specifically to this core service

- Each team had a clear framework for discussion and meetings which ensured staff at all levels were aware of any learning from incidents and complaints. Staff received updates through regular bulletins and the trust newsletter Patient Safety Matters.
- Staff had a good understanding of the role of other teams within the mental health pathway and worked well with these teams to provide people using services with a joined up integrated service.
- Staff had responded to risk incidents and changed working practice as a result. For example at the Bedale Centre staff changed practice to ensure they referred people who they were not actively working with back to the original referrer with a treatment plan an option to re-refer. This ensured that everyone knew who was involved in a persons' care and when and reduced the chance of people falling through the system. This was in response to a previous incident.
- Staff at the assertive outreach team had carried out an audit of their Mental Health Act paperwork in relation to people subject to a community treatment order. This had improved the team compliance with the legislation and ensured that people subject to a community treatment order where routinely notified of their rights under this section of the Mental Health Act.

Management of risk, issues and performance

- Staff knew of the trust risk panel and felt confident in submitting cases to this. The risk panel was a group of lead practitioners who discussed people using services who presented with particular or high risks. This supported the individual case holder in sharing the risk with reduced their individual responsibility.
- Staff felt able to escalate risks within their teams to the team leaders and service managers and reported being confident that something would be done.

Information management

- Staff had access to systems needed to do their work effectively. Staff in teams with integrated social workers had access to both the trust and local authority information systems.
- Information with details of people using services was secure and kept confidential at all times.
- Team leaders had access to their teams dashboards so could monitor their teams training and supervision records. Team leaders used the dashboard in supervision to ensure staff kept their training and supervision up to date.
- Information stored was current and easily updated to maintain currency.

Engagement

- Staff reported feeling connected to the wider trust and had access to up to date trust information via the regular trust bulletins.
- People using services had the opportunity to provide feedback and comment on the service by way of frequent questionnaires and surveys. Staff also provided these to carers for their feedback on how the trust ran services.
- The team at Hastings had recruited people using services to be involved in the recruitment and selection panel for new staff.
- Teams used peer support workers to enhance their interventions with people using the service. Peer support workers work with people using services to promote recovery and personalisation to help people understand their mental health problem and not as a barrier to living a full life.

Learning, continuous improvement and innovation

- NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited. There are no accreditations that have currently been awarded to teams within this core service.
- The trust was involved in numerous pieces of research for people using services, their carers and staff. These included the CIRCUITS study for people who may experience issues with cognition; the Voice Impact Scale for people hearing voices; BIO DEP for people with depression; studies into the genetic causes of mental illness and the use of mindfulness as an effective technique for managing obsessive compulsive disorder. For carers the trust was participating in Caring for Caregivers research and for staff the trust was involved in Mindshine3: Improving the wellbeing of NHS staff.
- Staff were encouraged to be involved in service development and quality improvement work. Staff at Hastings had reduced waiting times by use of the daily clinic, and at Elm Grove and Hove Polyclinic the teams were working innovatively with partners in substance misuse services and learning disabilities services.

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

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Mill View Hospital	Regency Ward (Male)	20	Male
Mill View Hospital	Caburn Ward (Female)	20	Female
Mill View Hospital	Pavilion Ward (Male)	10	Male
Department of Psychiatry	Amberly Ward (Female)	18	Female
Department of Psychiatry	Bodiam Ward (Male)	18	Male
Woodlands	Woodlands Centre for Acute Care (Mixed)	23	Mixed
Oaklands Centre for Acute Care	Oaklands Ward (Mixed)	16	Mixed
Meadowfield Hospital	Maple Ward (Mixed)	17	Mixed
Meadowfield Hospital	Rowan Ward (Mixed)	17	Mixed
Langley Green Hospital	Coral Ward (Mixed)	6	Mixed
Langley Green Hospital	Coral Ward (Surrey Placements) (Mixed)	13	Mixed
Langley Green Hospital	Jade Ward (Mixed)	19	Mixed
Langley Green Hospital	Amber Ward (Mixed)	12	Mixed

Is the service safe?

Safe and clean care environments

- Staff on most wards carried out twice daily environmental risk assessments to ensure that there were no areas or items of risk available to patients, that had not been mitigated, to maintain safety on the wards. However, records we reviewed in Woodlands showed that checks had not always been completed during the month of September. Staff in Woodlands did not use a check list to conduct their environmental risk assessments, unlike other wards such as Jade, Pavilion and Amber which had risk assessment check lists to guide staff and help them record their daily risk assessment checks.

- Nine out of 12 wards we inspected had blind spots. The associated risks were mitigated by staff patrols and observation levels which were adjusted depending on patient and ward risk. There were good lines of sight in Meadowfield and Oaklands which were monitored by staff stationed at central points on each ward.

- There was an uncovered gap in a window on Amber ward when it was opened. This window was on a ground floor corridor facing out onto the communal garden walk way. The walk way was also used by all patients including unescorted informal patients. This meant there was a potential risk that patients could pass contraband into the psychiatric intensive care unit unobserved.

- Patients on Amberley ward complained about lack of water pressure in the showers and we saw evidence of these issues noted in the ward's patient council meetings.

- The service had up to date ligature risk assessments for all twelve wards. Staff had identified risks in the gardens of Langley Green Hospital but had scored these risks lower than similar risks identified on the ward. We brought this to the attention of the ward managers who reported they would re-score the risks to bring them in line with similar risks within the ward environment .

- All of the wards reported risks that were assessed as being high. The trust had taken actions to mitigate ligature risks by use of staff observation and use of patient risk assessments. Staff displayed ward ligature risk maps (known as 'risk footprints') in the Coral, Pavilion, Woodlands and Caburn nursing offices as a visual reminder to staff of ward risk points.

- Over the 12 month period from 1 August 2016 and 31 July 2017 there was one mixed sex accommodation breach within this core service.

- The mixed sex breach occurred at Oaklands Ward on 4 March 2017. The breach type was recorded as an 'Adult bathroom/hygiene facilities breach'.

- One male patient was admitted to female corridor of Amber ward during our inspection. Staff had assessed this risk and managed his admission by increasing observations of him while in the female corridor.

- All wards we inspected had female-only lounges where appropriate. Woodlands was due to separate its mixed gender corridors into newly designed separate male and female corridors after our inspection. The separation of wards took place on 6 November 2017.

- Patients had access to nurse call alarms on all wards. All staff carried personal alarms. We observed staff responding to alarms in a timely manner across all wards during our inspection.

Maintenance, cleanliness and infection control

- Two locations scored better than similar trusts for three out of four aspects of the 2017 PLACE scores for the environment. These were Department of Psychiatry and Oaklands Centre (for which the Dementia aspect was not applicable).

- Three locations scored better than similar trusts for two aspects.

- Please note that some of the locations provide more than just this core service.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
MILL VIEW HOSPITAL	MH Wards for Older People with Mental Health Problems MH Acute wards / PICU Crisis / Health based places of safety	99.9%	94.1%	85.9%	83.1%
OAKLANDS CENTRE	MH Acute wards / PICU	99.5%	99.6%	-	91.6%
DEPARTMENT OF PSYCHIATRY	MH Wards for Older People with Mental Health Problems MH Acute wards / PICU Crisis / Health based places of safety	99.7%	96.1%	79.8%	89.2%
WOODLANDS, ST. LEONARDS-ON-SEA	MH Acute wards / PICU Crisis / Health based places of safety MH Long stay / rehabilitation wards	98.9%	94.4%	76.5%	91.8%
LANGLEY GREEN HOSPITAL	MH Wards for Older People with Mental Health Problems MH Acute wards / PICU Crisis / Health based places of safety	99.2%	95.8%	-	82.3%
Trust overall		98.6%	94.7%	82.8%	86.3%
England average (Mental health		**98.6%**	**95.2%**	**84.8%**	**86.3%**

- All wards were clean, well-furnished and were well maintained. We reviewed cleaning records on all wards which indicated that they were cleaned regularly.

Seclusion room

- There was a seclusion room in each of the psychiatric intensive care units at Langley Green (Amber ward) and Mill View (Pavilion ward) hospitals. We were unable to inspect the seclusion room on Pavilion ward as it was in use during our inspection. The seclusion room on Amber ward had a clock which also displayed the date. There was a bathroom with anti-ligature shower, sink and toilet adjacent to the seclusion room. A ligature point is a point which could be used to attach a cord, rope or other material for the purpose of strangulation. Staff had access to physical health monitoring equipment.
- However, the seclusion room on Amber ward did not allow clear observation. There were blind spots in the room and there was no closed circuit television monitor. The two-way communication intercom was broken during our visit, however the trust informed us that there had been intermittent problems with this, and it had been repaired on several occasions previously. The trust informed us this had been fixed following our inspection. We found these issues with the Amber ward seclusion room in both of our previous inspections in September 2016 and April 2017 and suggested that the provider make improvements to improve safety and communication for patients using the room. We brought this to the attention of the ward manager and service manager during our inspection. Following our inspection, the trust informed us that building work to improve the seclusion room will commence within the eight weeks following the inspection. We visited the ward again in December 2017 following our inspection and saw that the renovation works were underway to address these issues.

Clinic room and equipment

- Clinical rooms on all wards were fully equipped with accessible resuscitation equipment and emergency drugs which staff checked regularly. Staff in Meadowfield were scheduled to check their resuscitation equipment weekly, however we noted there were gaps in the weekly checks were not carried out in April, May and August 2017 on Rowan ward. Staff did not consistently carry out weekly checks during June, July, August and September on Maple ward. All clinic rooms were well maintained, organised, clean and equipment displayed labels to indicate they had been cleaned recently. On Regency ward we noted that the clinic room and fridge temperature had not been monitored between 23 and 31 September 2017, which could mean that medicines were potentially not stored at the correct temperature. Furthermore, staff identified in August 2017 that an iGel Airway 5 as part of the ward's resuscitation equipment expired, however it not been replaced. An iGel airway is used to maintain an open airway or to serve as a route through which to administer certain drugs in emergency resuscitation.

Safe staffing

Nursing staff

Definition

Substantive – how many staff in post currently.
Establishment – substantive plus vacancies, e.g. how many they want or think they need in post.

Substantive staff figures			**Trust Target**
Total number of substantive staff	At 30 June 2017	285	N/A
Total number of substantive staff leavers	1 July 2016 – 30 June 2017	57	N/A
Average WTE* leavers over 12 months (%)	1 July 2016 – 30 June 2017	20%	N/A
Vacancies and sickness			**Trust Target**
Total vacancies overall (excluding seconded staff)	At 30 June 2017	42.6	N/A
Total vacancies overall (%)	At 30 June 2017	23%	N/A
Total permanent staff sickness overall (%)	At 31 May 2017	6%	3.5%
Establishment and vacancy (nurses and care assistants)			**Trust Target**
Establishment levels qualified nurses (WTE*)	At 30 June 2017	392.64	N/A
Establishment levels nursing assistants (WTE*)	At 30 June 2017	166.55	N/A
Number of vacancies, qualified nurses (WTE*)	At 30 June 2017	104.49	N/A
Number of WTE vacancies nursing assistants	At 30 June 2017	58.02	N/A
Qualified nurse vacancy rate	At 30 June 2017	27%	N/A
Nursing assistant vacancy rate	At 30 June 2017	35%	N/A
Bank and agency Use			**Trust Target**
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 July 2016 – 30 June 2017	3868	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 July 2016 – 30 June 2017	3600	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 July 2016 – 30 June 2017	637	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2016 – 30 June 2017	10038	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2016 – 30 June 2017	752	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 July 2016 – 30 June 2017	752	N/A

*WholeTime Equivalent

- This core service reported an overall vacancy rate of 27% for registered nurses at 30 June 2017.
- This core service reported an overall vacancy rate of 35% for registered nursing assistants.
- This core service has reported a vacancy rate for all staff of 23% as of 30 June 2017.

	Registered nurses			Health care assistants			Overall staff figures		
Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Acute inpatient Adult Female (Amberly Ward)	2.37	13.57	17%	4.77	16.2	29%	7.65	34.78	22%
Acute inpatient Adult Mental Health (Bodiam Ward)	2.97	13.57	22%	3.1	14.47	21%	6.07	32.54	19%
Acute inpatient WAMHS (Oaklands Ward)	4.31	13.31	32%	2.2	12	18%	7.51	28.81	26%
Adult Services (AMHS) Acute inpatient Coral Ward	6.2	12.09	51%	4.86	13.47	36%	10.66	26.96	40%
Adult Services (AMHS) Acute inpatient Coral Ward (Surrey Placements)	0	0	0%	0	0	0%	0	0	0%
Adult Services (AMHS) Acute inpatient -	5.48	12.09	45%	4.93	13.69	36%	11.56	27.43	42%

Jade Ward									
Adult Services (AMHS) PICU - Amber Ward	5.35	15.56	34%	7.22	25.38	28%	12.57	42.04	30%
Adult Services (AMHS)Acute inpatient (Maple Ward)	3.3	10.3	32%	7.33	21.01	35%	10.63	34.31	31%
Adult Services Acute inpatient (AMHS) Rowan Ward	3.3	10.3	32%	2.62	15.15	17%	6.58	28.45	23%
Caburn Ward	1.8	14.6	12%	-0.17	10.03	-2%	2.54	30.45	8%
Pavilion Ward	2.31	13.6	17%	4.18	15.6	27%	7.74	32.25	24%
Regency Ward	3.47	14.6	24%	-0.3	10.3	-3%	2.37	28.9	8%
Woodlands Centre for Acute Care	17.16	22.96	75%	1.86	17.36	11%	18.61	45.72	41%
Core service total	**104.49**	**392.64**	**27%**	**58.02**	**166.55**	**35%**	**42.6**	**184.66**	**23%**

NB: All figures displayed are whole-time equivalents

- Between 1 July 2016 and 30 June 2017, bank staff filled 3,868 shifts to cover sickness, absence or vacancy for qualified nurses. In the same period, agency staff covered 3,600 shifts. An additional 637shifts were unable to be filled by either bank or agency staff.
- We do not have details of the number of total shifts possible over the 12 month period and are therefore unable to calculate the proportion of shifts filled by bank or agency staff compared to the permanent workforce.
- The data at the time of the last inspection for bank and agency is not comparable the way it is now collected.

	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Coral	302	588	88

Amber	792	224	96
Jade	239	773	133
Pavilion	252	102	30
Regency	246	37	46
Caburn	337	186	73
Maple	316	274	8
Rowan	347	334	30
Oaklands	682	19	11
Woodlands	101	929	117
Amberley	17	73	0
Bodiam	233	61	5
Core service total	3868	3600	637
Trust Total	**22910**	**9192**	**1793**

- Between 1 July 2016 and 30 June 2017, 10,038 shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants and 752 were filled by agency staff. There were an additional 752 shifts that were not filled by both bank and agency staff.
- We do not have details of the number of total shifts possible over the 12 month period and are therefore unable to calculate the proportion of shifts filled by bank or agency staff compared to the permanent workforce.
- The data at the time of the last inspection for bank and agency is not comparable the way it is now collected.

	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Coral	713	63	96
Amber	1457	182	140
Jade	765	201	182
Pavilion	914	18	48
Regency	416	4	38
Caburn	388	14	50
Maple	1533	116	30
Rowan	868	42	78
Oaklands	1057	0	19
Woodlands	1248	105	64

Amberley	164	4	0
Bodiam	420	3	6
Core service total	9943	752	751
Trust total	38264	2811	2419

***** Percentage of total shifts

- The sickness rate for this core service was 6% between 1 June 2016 and 31 May 2017. The most recent staff sickness rate was 8% as of June 2017. These are both higher than the overall trust rates.
- The service manager at Langley Green Hospital joined the service in October 2016. Since that time they have engaged with staff to review and reduce sickness levels. During the inspection we saw data to indicated this had reduced from 6.3% in June 2017 to 4.6% in August 2017.
- This core service had 57 staff leavers between 1 July 2016 and 30 June 2017 and an average annual turnover of 20%.This is above the trust average turnover of 16%.

	Substantive staff	**Substantive staff Leavers (in past 12 months)**	**Average % turnover**	**Total % staff sickness**	**Ave % permanent staff sickness (over the past year)**
Acute inpatient WAMHS (Oaklands Ward)	20.8	4.80	23%	6%	6%
Adult Services (AMHS)Acute inpatient (Maple Ward)	23.2	7.80	34%	4%	7%
Adult Services Acute inpatient (AMHS) Rowan Ward	21.4	8.05	38%	12%	11%
Adult Services (AMHS) PICU - Amber Ward	28.5	6.81	24%	5%	9%
Adult Servcices (AMHS) Acute inpatient Coral Ward	17.7	4.81	27%	7%	6%

Adult Services (AMHS) Acute inpatient - Jade Ward	15.8	5.60	35%	11%	10%
Pavilion Ward	27.1	4.40	16%	6%	5%
Caburn Ward	27.9	4.80	17%	7%	4%
Regency Ward	26.8	4.00	15%	2%	3%
Acute inpatient Adult Female (Amberly Ward)	26.8	3.00	11%	4%	4%
Acute inpatient Adult Mental Health (Bodiam Ward)	26.1	0.00	0%	6%	5%
Woodlands Centre for Acute Care	29.1	3.00	10%	2%	8%
Core service total	292	57	19%	6%	6%
Trust total	2420	391	16%	5%	5%

- The below table covers staff fill rates for registered nurses and care staff during April, May and June 2017.
- Bodiam ward had not enough registered nurses for day and night shifts in April and not enough nurses for night shifts in May and June.
- Maple Ward had not enough night shift nurses in June and not enough day time care staff in April, May and June.
- Oaklands Centre had not enough day time care staff in June and not enough day time nurses in June.
- Rowan Ward had not enough day time care staff in April, May and June.
- Woodlands had not enough day time nurses in April, May and June.
- Amberly Ward had not enough night time nurses in May and June, too many day time care staff in April and too many day time care staff in May.
- Coral Ward had not enough night time nurses or care staff in June.
- Jade Ward had not enough night time nurses or care staff in April, not enough night care staff in May and too many day time care staff in April.
- Caburn Ward had not enough day time nurses in April and too many night time care staff in April and May.

- Regency Ward had not enough day time nurses in April, May and June and too many night care staff in May and June.
- Amber Ward had too many day care staff in April.
- Pavilion Ward had too many night care staff in April, May and June and too many night care staff in April.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff
	MONTH				MONTH				MONTH			
Bodiam	87.3%	111.0%	89.8%	100.0 %	91.7%	107.4%	82.3%	104.9 %	100.2%	100.3 %	76.5%	114.1 %
Maple Ward	96.2%	88.9%	103.3%	114.8 %	96.6%	85.9%	106.5%	98.0%	91.4%	86.7%	106.7 %	77.6%
Oaklands Ward	105.8%	118.2%	90.4%	113.8 %	101.7 %	100.4%	92.4%	110.2 %	80.3%	65.6%	99.0%	104.3 %
Rowan Ward	98.6%	87.5%	100.0%	101.9 %	96.7%	81.1%	100.0%	94.4%	94.9%	89.2%	100.0 %	98.7%
Woodlands Centre	72.5%	98.9%	91.7%	115.7 %	74.3%	102.1%	101.6%	103.7 %	72.3%	104.6 %	98.3%	105.2 %
Amberley Ward	108.8%	91.2%	93.6%	136.7 %	104.3 %	158.2%	62.8%	99.9%	108.8%	120.2 %	63.8%	178.4 %
Coral Ward	103.7%	112.3%	95.8%	100.3 %	102.8 %	115.3%	90.0%	101.8 %	97.2%	104.3 %	75.8%	72.9%
Jade Ward	108.4%	126.1%	70.0%	84.8%	97.6%	119.9%	94.8%	89.3%	97.8%	112.3 %	94.8%	106.1 %
Caburn Ward	88.8%	108.6%	102.3%	168.1 %	93.8%	110.2%	98.5%	151.3 %	91.6%	106.2 %	103.0 %	123.5 %
Regency Ward	85.0%	101.4%	99.7%	113.7 %	82.4%	112.5%	101.0%	143.2 %	89.8%	120.4 %	90.8%	128.8 %
Amber Ward	112.4%	145.1%	111.9%	121.8 %	95.6%	124.0%	97.6%	105.2 %	112.9%	114.4 %	101.9 %	114.1 %
Pavillion Ward	90.5%	129.6%	101.7%	155.2 %	93.1%	122.1%	100.0%	134.0 %	98.9%	120.2 %	97.2%	135.4 %

- All wards used the National Institute of Health and Care Excellence guide for acute hospital staffing to estimate the number and grade of nurses required on each shift. The numbers of nurses and health care assistants on all wards matched the required numbers set by the ward rotas to meet the nursing levels of the wards.

- Ward managers were able to adjust the staffing levels daily to meet the required establishment levels on the wards. Additional staff were required to meet additional needs of the patient mix by using bank or agency staff familiar with the wards. Many wards had block booked bank and agency staff to ensure consistency of staff across the service. The service ensured that bank staff had appropriate two week inductions to the wards and received mandatory training.

- Staffing levels on most wards ensured that patients had regular one to one time with their named nurse who was allocated to them at the beginning of each shift. Staff on Rowan ward told us that staffing pressures meant there were no regular one to ones with patients and patients there told us there were not enough staff. Staff on Maple ward told us that staffing pressures were an issue especially when carrying out observations on the ward and ensuring that patients received their Section 132 rights (explanation of the conditions of patients' admission under the Mental Health Act).

- Staff we spoke with told us that escorted leave were rarely cancelled on the wards. If escorted leave was cancelled it was because staff were required to remain on the ward to maintain safety due to patient incidents. When this was the case, staff explained the situation to patients and rescheduled leave as soon as possible. Ward activities were rarely cancelled as a range of skilled staff meant that alternative activities could be arranged to replace a cancelled scheduled activity.

- All wards had enough staff to carry out restraint and to support patients when being nursed in seclusion.

Medical staff

- There was adequate medical cover across all wards day and night which meant that a doctor could attend quickly in the event of a medical emergency.

Mandatory training

- The compliance for mandatory and statutory training courses as of 31 July 2017 is 86%. Of the training courses listed five failed to achieve the trust target of 85% and failed to score above 75%.
- Infection Prevention (Level 1) had the highest training compliance with 100%. Manual Handling - People scored the lowest out of all the training courses with 54%.

Key:

Below CQC 75%	Between 76% & 84%	**Above Trust target 85%**

Training course	This core service	Trust wide mandatory training total %
Adult Basic Life Support	75%	68%
Clinical Risk Assessment	96%	93%
Equality and Diversity	96%	93%
Health and Safety (Slips, Trips and Falls)	91%	84%
Infection Prevention (Level 1)	100%	95%
Infection Prevention (Level 2)	90%	75%
Information Governance	92%	88%
Manual Handling - Object	94%	87%
Manual Handling - People	54%	68%
Mental Capacity Act Level 1	90%	83%
Mental Health Act	90%	80%
Other (Please specify in next column)	85%	78%
Personal Safety - MVA	73%	74%
Personal Safety Breakaway - Level 1	55%	57%
Rapid Tranquilisation	94%	93%
Safeguarding Adults (Level 1)	93%	85%
Safeguarding Adults (Level 2)	93%	87%
Safeguarding Children (Level 1)	94%	93%
Safeguarding Children (Level 2)	86%	82%
Safeguarding Children (Level 3 Additional)	N/A	72%
Grand Total	**87%**	**81%**

- In December 2017 the trust provided a refresh of the training data and this showed that this was at 85%. These rates were higher than those in earlier data received from the trust and meant that wards now met the trust's training compliance target. Many wards now had higher compliance levels, for example Jade ward had 100% compliance in Mental Capacity Act and Mental Health Act training, Coral ward had 100% completion in Immediate Life Support, Fire Safety, Medication Management, Mental Capacity Act and Mental Health Act training. The trust provided us with a plan outlining measures to ensure that training levels would be further increased during 2018. It also provided details to show when staff could take protected time to complete mandatory training or had booked training in advance.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We reviewed 57 care records which included patient risk assessments. The trust used a risk assessment template which was stored on their electronic recording system called Care Notes. Most of the risk assessments were detailed, current and included new risks identified following recent incidents on the wards. However, one out of six risk assessments we reviewed on Maple ward did not include risks from numerous incidents involving one patient in September 2017 nor had their care plan been updated accordingly.
- Staff reviewed patient risk assessments regularly in daily and in weekly multi-disciplinary meetings and whenever incidents occurred involving patients. In Langley Green Hospital staff regularly audited patients' risk plans to ensure they were signed, up to date and that physical health conditions were recorded where relevant. We observed handovers where staff discussed urgent dental treatment required for a patient, patients' medicine needs and mental health status. Staff developed crisis plans with patients where required, for example how to manage a health crisis if a patient had diabetes and how to manage a patient's self-harm crisis.

Management of patient risk

- Staff we spoke with were aware of and dealt with risk issues such as falls or pressure ulcers. For example, staff assessed patients' external physical wellbeing using a body map assessment on admission which helped identify if a patient had any pressure sores so they could be treated immediately.
- On all wards staff responded to changing risks to or posed by patients. Throughout shifts on all wards staff held 'risk huddles' when they met together to quickly review risks and incidents on the wards and agree actions to manage them. For example, during our inspection when one patient became aggressive on Amber ward we observed staff holding a risk huddle and quickly agreed to increase observation levels for the patient at risk of harming others. Staff who were in the office were positioned on the ward to increase ongoing observations on the ward to increase safety.
- On Jade ward, staff held weekly risk huddles together with patients to review risks and ask for their views on events and what could be done differently next time to prevent incidents from reoccurring. For example, if an increase in self-harm incidents was recorded, staff would ask patients if they felt safe and what more could be done to make them feel safer.
- On Amber ward an incident had occurred in the week prior to our inspection, where a patient threw a cup of hot water from the kitchen's water boiler at a nurse. During our visit we identified that the water temperature was still high and continued to pose a risk if thrown at a patient or staff. We brought this to the attention of the ward manager who reported that the water temperature was reduced during our inspection. This kitchen was listed on the ward's risk register to ensure its safety was reviewed annually. A similar incident had taken place on Amberley ward and the ward manager cut the hot water supply off and the trust reviewed a kitchen re-design to improve safety. Hot water for drinks was supplied to patients from water urns which had a capped temperature to prevent risk to patients and others.
- During the inspection period, separate serious incidents occurred on Coral, Bodiam and Maple wards concerning patients at risk. These were being investigated at the time of reporting.

- Staff on Regency ward in Mill View Hospital used the Broset Violence Checklist which assisted staff to predict imminent patient violent behaviour. The shift team met each morning after handover to rate the observed behaviour of each patient on the ward. Staff formulated aggression management plans for patients who scored over a certain threshold for the coming shift. The consultant was involved in discussions if additional medicines were required. These meetings enabled staff to be prepared in the event of a patient becoming violent during the next shift and to identify which patients may need to move to more intensive nursing in the psychiatric intensive care units.

- Staff on all wards followed good observation policies and procedures to manage risk from potential ligature points. They also followed trust procedure for search patients' bedrooms. However, during our visit to Amber ward, we observed that the garden was unsupervised on three occasions during the day while patients were socialising in the garden despite staff being allocated to carry out this observation duty on an hourly rota basis.

- Staff applied restrictions on patient's freedom only when justified. For example, if a client was assessed as being at risk to themselves or others it was explained to them that their leave off the ward was suspended until they were assessed as no longer being a risk to themselves or others. Staff did this to manage risk on the wards and in the community to patients and others.

- Wards did not have any blanket restrictions which meant patients were able to have their mobile phones and belts with them as along as it was risk assessed as being safe for them to do so. A list of prohibited items, such as blades, plastic bags and charger leads, was given to patients on admission to promote safety on the wards.

- All wards followed best practice in implementing a smoke-free policy as the trust grounds were a smoke-free zone. Staff explained the policy to patients on admission and it was outlined in their ward welcome booklets. Staff offered patients smoking cessation support sessions, nicotine replacement therapy and they could purchase e-cigarettes if required. Some patients were smoking in the gardens at Meadowfield Hospital and Oaklands Centre, however staff told us they were working to support patients to smoke off the grounds or to use e-cigarettes where possible.

Use of restrictive interventions

- This core service had 639 incidents of restraint (on 336 different patients) and 166 incidents of seclusion between 1 July 2016 and 30 June 2017
- Over the 12 months, there was an increase in the incidence of restraint. In May and June 2017, a decrease in seclusion in January 2017 and an increase in seclusion in May 2017
- The below table focuses on the last 12 months' worth of data: 1 July 2016 to 30 June 2017

	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Amberley Ward	1	37	21	4	9
Bodiam Ward	8	21	16	6	13
Amber Ward	34	46	29	4	9

Coral Ward	8	48	34	2	16
Jade Ward	4	38	26	1	7
Reception - LGH	0	1	1	0	0
Maple Ward	3	40	23	1	8
Reception - Meadowfield	0	1	1	0	0
Rowan Ward	0	45	26	0	6
Caburn Ward	15	120	49	18	50
Pavillion Ward	74	86	37	3	9
Regency Ward	17	31	26	0	7
Oaklands Ward	1	26	14	3	13
Woodlands In-Patient Services	1	99	33	9	43
Core service total	**166**	**639**	**336**	**51 (8%)**	**190 (30%)**

- Meadowfield Hospital and Oaklands Centre had open ward policies which was least restrictive practice. These wards had completed a literature review which had considered national research and guidance on open ward environments. This published literature review suggested that there was evidence of reduced complete suicides and absconsions without return to the ward for patients who were treated on open wards. The doors on the wards were open and patients requested to be risk assessed prior to leaving the ward. This was carefully managed by staff. For some patients this style of nursing was an important symbol of recovery where they felt trusted to stay on an open ward. All remaining wards displayed signage on the locked ward doors explaining informal patients' rights to leave the ward.

- There were 51 incidents of prone restraint which accounted for 8% of the restraint incidents.
- Compared to the previous year, there was an increase in the use of restraint from 529 to 639.
- The use of prone restraint has decreased from 55 to 51.
- Incidents resulting in rapid tranquilisation for this core service has increased from 143 to 190.
- There have been no instances of mechanical restraint over the reporting period.
- Caburn ward accounted for 17% of restraints yet the ward has 30% and 235 rapid tranquilisations.
- Of the 99 restraints at Woodlands, 43% resulted in rapid tranquilisation.

- All staff we spoke with told us that they used restraint only when de-escalation, such as engaging patients in activities to distract them, had failed. Staff and patients in Langley Green Hospital developed a list of activities they each would do if they became distressed, such as counting backwards from 20, and naming items from a pre-written list. Staff on Caburn ward used a therapeutic key-ring as a distraction and self-soothing technique with patients which was designed by a psychologist. The pocket sized key-ring had 17 strategies for staff and patients to carry for use. The strategies included grounding techniques, positive self-talk, distraction techniques and breathing exercises.

- Staff understood and worked within the Mental Health Act definition of restraint.
- Compared to the previous 12 months there has been an increase in seclusion, from 156 to 166.
- Pavilion Ward accounted for 44% of all seclusions.
- Over the 12 months, a decrease in seclusion in January 2017 and an increase in seclusion in March 2017, where there were a total of 19 instances.
- The number of seclusion incidents reported during this inspection is higher than the 156 reported at the time of the last inspection.
- There had been no instances of long term segregation over the 12 month reporting period or in the previous 12 months.

Safeguarding

- A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or adult at risk from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.
- Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or adult at risk, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.
- All staff we spoke with understood the trust's safeguarding policy and procedures on how to raise a safeguarding referral. All wards had safeguarding leads to ensure that all colleagues understood their responsibilities regarding safeguarding.
- Staff told us how they keep patients safe from harassment and discrimination by observing behaviours on the ward and between patients and visitors. All wards had strong working relationships with the local safeguarding teams and with the trust's safeguarding lead.
- All wards had access to family rooms where patients met family members, children and friends if it was risk assessed as safe to do so. All patients due for visits were risk assessed on the day to assess if the visit could take place safely. Family rooms were located off the wards which ensured that children under the age of 18 were not permitted on the ward for their safety.
- Sussex Partnership NHS Foundation Trust has submitted details of zero external case reviews commenced or published in the last 12 months that relate to this core service.

Staff access to essential information

- Information across this core service was stored on the trust's electronic recording system. Staff uploaded all paperwork to ensure information was easily accessible.

- Electronic information was available to all relevant staff to deliver patient care while on the wards and when they were transferred between teams.

Medicines management

- Pharmacists in Mill View, Meadowfield, and Langley Green hospitals carried out 'mind the gap' audits as part of a pilot initiative. This pilot was conceived to reduce the incidence of blank administration records (and potentially reduce missed doses through raised awareness and focus) within inpatient settings. Audits conducted for 12 months to March 2017 showed missed dose reductions of 20% to 11% in Mill View Hospital, 78% to 10% in Meadowfield Hospital, and 30% to 10% in Langley Green Hospital.

- Medicine records across all the wards were generally well completed. However, on Rowan ward six out of 17 records contained recording errors. For example, one did contain consent to treatment paperwork, one did not list the patient's allergies, one had not been reviewed since 30 August 2017 and one patient was prescribed a high dose of two anti-psychotics but there was no evidence a high dose anti-psychotic form had been completed. This omission was not detected in the daily medicine record audits. A CQC medicines optimisation inspector reviewed these medicine records in December following our inspection and determined that all of these issued had been addressed.

- During our previous inspection in April 2016, Jade and Amber wards did not meet the fundamental standards related to Regulation 12, with regard to safe care and treatment where staff did not always ensure that physical health observations were recorded accurately for patients. During this inspection we reviewed 158 patient medicine records. Staff we spoke with told us they followed National Institute for health and Care Excellence guidance and the trust's rapid tranquilisation policy when monitoring patients' physical health after the administration of rapid tranquilisation and we saw evidence of this across all wards except for Amber and Rowan and Maple wards.

- On Rowan ward, one out of 17 patient medicine records we reviewed noted that staff did not record physical health observations post administration of rapid tranquilisation as the patient was 'volatile'. On Maple ward there was no record that physical health observations were carried out for one patient who received rapid tranquilisation. This meant we did not see evidence that staff were observing patient's health post administration of rapid tranquilisation in line with the trust's own policy on these two occasions. However, the trust implemented a new non-contact physical observation post rapid tranquilisation protocol immediately after our inspection. This provided staff with clear guidelines and recording materials for use during non-contact observations.

- We saw evidence on all wards of good transport, storage, dispensing, recording and disposal of medicines across all wards.

Track record on safety

- Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.
- Between 1 July 2016 and 30 June 2017 there were 20 STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident

was apparent/actual/suspected self-inflicted harm meeting serious incident (SI) criteria with six. Four of the self-harm incidents involved unexpected deaths.

- Three of the four incidents categorised as unauthorised absence meeting SI criteria were patients from Oaklands.
- A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.
- We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS although the trust reporting systems included one incident that was not reported to STEIS.
- The number of serious incidents reported during this inspection is higher than the 39 reported at the last inspection by the trust and 43 reported through STEIS.

Ward	Abuse/alleged abuse of adult patient by third party	Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Disruptive/ aggressive/ violent behaviour meeting SI criteria	Failure to obtain appropriate bed for child who needed it	Pressure ulcer meeting SI criteria	Sub-optimal care of the deteriorating patient meeting SI	Unauthorised absence meeting SI criteria	Pending revieew	Total
Amber Ward	2									2
Amberly Ward			1					1		2
Bodiam Ward									1	1
Coral Ward			2	1						3
Jade Ward	3					1				4
Maple Ward					1					1
Oaklands Ward		1						3		4
Regency Ward		1					1			2
Woodlands Inpatient Service			1	1				1		3
Total	**5**	**2**	**4**	**2**	**1**	**1**	**1**	**5**	**1**	**22**

Reporting incidents and learning from when things go wrong

- The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

- In the last two years (01/04/16-24/07/17) there have been nine prevention of future death reports sent to Sussex Partnership NHS Foundation Trust. The trust submitted action plans relating to these. Three of the reports related to this core service, details of which can be found below:

  1. The Coroner's concerns were:

  - *No record of cardiac problems that were reported to staff by family member*
  - *Delay in obtaining full past medical history*

  The trust gave the following details of improvements made:

  - Staff briefing
  - Documentation audits
  - New system – CRHT administrators request Primary Care Summary record / encounter report from GP surgery within 48 hours.
  - Chief Pharmacist guidance produced and included in Junior doctor induction.

  2. The Coroner's concerns were:

  - *Records, handovers, risk assessments, and care plans often insufficient and at times contradictory.*
  - *Ability of sectioned patients to abscond.*
  - *Staffing levels at times inadequate.*

  The trust gave the following details of improvements made:

  - Frameworks for addressing practice put in place for the nurses.
  - Handover template revised and changed to ensure that current risks and required actions updated and communicated for each shift using the SBAR (situation, background, assessment and recommendation) model.
  - Care Plans and Risk Assessments reviewed at MDTs – revised care plan process.
  - Supervision and reflective practice for staff and induction includes expected standards and compliance with key policies.
  - Training on AWOL policy
  - Audit and investigation of patients failing to return to the ward.
  - Clinical risk training
  - Review of staffing levels – consultation led to additional recruitment to senior nursing posts
  - Paperless staffing roster introduced
  - Bank staff coordinator introduced
  - Recruitment strategy for improved recruitment and selection processes. .

  3. The Coroner's concerns were:

- *Lack of formal assessment.*
- *Lack of CCTV in corridors and communal areas at Woodlands.*
- All staff we spoke with understood how to report incidents and explained they report incidents including restraint, self-harm, pressure sores, and seclusion. We saw evidence of this in the incident forms we reviewed on all wards.
- On Coral ward we identified that the pharmacist noted a medicine spelling error where the consultant had prescribed a medicine which did not exist, however a medicine was administered to the patient. The pharmacist noticed the error and amended the medicine record to reflect the correct spelling of the prescribed medicine, however an incident form was not submitted. We brought this to the attention of the ward manager who raised an incident form immediately.
- A recent incident on Coral Ward led to a series of de-brief sessions with staff led by the psychologist. During the sessions, one member of staff requested that emergency resuscitation drills were introduced on the ward. During our inspection, the service manager announced these drills would take place from the middle of October to ensure that staff were skilled in dealing with such emergencies.
- Staff understood the duty of candour and told us they were open and transparent with patients and their families if something went wrong. For example, a patient was admitted with a pressure sore and this was not detected at admission. When nursing staff identified the sore, they treated the patient appropriately and ensured a pressure sore mattress and water cushions were used to offer comfort to the patient. The ward manager communicated and apologised for this oversight to the patient and included their family members with the patient's consent.
- Learning about incidents across all wards took place in team meetings, discussions in daily ward risk huddles. All staff we spoke with told us they felt supported after incidents and lessons learnt from incidents were displayed on boards in Langley Green Hospital for staff, patients and visitors to read. As a result of the incident involving the pressure sore, the relevant ward manager in Langley Green Hospital developed a training session for all staff across the hospital to skill teams to now incorporate the use of body maps on admission to identify pressure sores on patients and teach them how to treat them if they occurred. The training session took place during the monthly lessons learnt training programme which was developed to share learning of incidents and best practice to improve care and treatment in this hospital.
- The trust had an interactive incident dashboard which detailed incidents for the previous 12 months across all wards which recorded incidents such as absconsions and self-harm. Incidents and learnings were published in the trust's Patient Safety Matters leaflet. Staff in Langley Green Hospital shared incident data from the incident dashboard with patients in weekly community meetings to ask for their view on incidents which occurred on their wards. For example, on Jade ward staff identified that incidents were peaking at 6pm on Fridays. When staff asked patients why they thought this was happening, patients told them they were bored at that time. Staff and patients developed a schedule of film and popcorn Friday evening events and found that incidents then reduced.
- The trust ran an annual Learning from Incidents conference where service leads for inpatient and community mental health teams came together to look at learnings from incidents across the service. Speakers at the conferences included parent carers, patients and Care Quality Commission representatives.
- Staff we spoke with told us they were de-briefed following serious incidents and this was generally provided by a hospital psychologist in group and individual sessions. Staff in

Oaklands and Meadowfield were debriefed by the ward matrons and psychologists from the community-based psychology teams following incidents.

Is the service effective?

Assessment of needs and planning of care

- We reviewed 57 current care records for this core service.
- Staff carried out comprehensive assessments with all patients following their admission. These assessments contained information about the patient's safety risks, physical health, mental health, social needs, communication needs and discharge planning details.
- The duty doctor completed physical health assessments for all patients on admission which included an electro cardiogram, blood test, and a body map assessment to identify any issues such as physical injury or pressure sores,.
- Staff monitored ongoing physical health conditions requiring care, such as diabetes or epilepsy, by completing national early warning system (NEWS) forms. NEWS forms are used as a monitoring system for all patients in hospitals to track their physical health conditions and alerting the clinical team to any medical deterioration so they can respond in a timely manner. NEWS forms were generally completed for all patients daily in accordance with national guidance. On Amberley ward three out of 18 NEWS forms we reviewed had not been updated daily.
- Staff completed a physical health care plan for each physical health condition patients presented with to ensure they received appropriate care. We spoke with patients who confirmed they had been referred to health specialists for individual health conditions and who had had their diet adapted to support their physical health while admitted to the wards. However, on Rowan ward we found that two out of six physical health care plans were incomplete. One patient was assessed as requiring support due a physical disability, however we did not see evidence of ongoing physical health care support in their plan. One other patient who had identified weight management support needs, had not had their weight or height recorded in their physical health assessment. In Woodlands one out of five care plans we reviewed did not include details of a patient's physical health issue requiring treatment.
- Staff completed care plans with patients following their admission. These were 72 hour care plans for the period directly after admission which were followed by completion of a fuller care plan. Care plans were generally personalised, recovery focussed and holistic across all wards. On Rowan ward four out of six care plans we reviewed were not personalised or recovery focussed. Two out of six care plans on Rowan ward were 72 hour admission care plans, however the patients had been admitted for longer than 72 hours (admitted 27 Sept 17 care plan reviewed 3 October 2017)(admitted 24 Sept care plan reviewed 3 October 2017). When we raised this with the trust, they reported that they rectified this immediately. This meant that staff had not completed full care plans with these patients after the 72 hour period had passed. When we fed this back to the trust they informed us they took immediate action to rectify this and will monitor the situation to ensure the standards are maintained. On Caburn ward one patient's care plan was dated 12 days after their admission and there was no 72 hour care plan on their records.
- Staff in Langley Green Hospital used a brief 'getting to know me' care plan for patients who were unable to or declined to engage with care planning at admission. The brief care plan

enabled staff to quickly agree with patients what their early triggers were before they became unwell, how they wished to be engaged with if they became unwell, and what they liked and disliked including hobbies. This plan was used by staff and patients until a fuller care plan was completed with the patient.

- Staff on all wards updated care plans with patients in individual sessions and in weekly multi-disciplinary meetings.

Best practice in treatment and care

- All wards had input from psychologists who were either part of the staff team or from the community-based psychology teams. Patients for this service had access to a range of therapies recommended by National Institute of Health and Care Excellence, for example art therapy, mindfulness, grounding and coping strategy groups, and psychology.

- Each of the wards had good access to physical healthcare. Doctors and physical healthcare lead nurses on the wards provided assistance with physical healthcare and if necessary patients were taken to the local hospital.

- Staff used health of the nation outcome scales to measure the health and social functioning of patients on the wards.

- The trust is a smoke-free environment and staff supported patients with smoking cessation groups and nicotine replacement therapy. Staff also encouraged patients to improve their health by exercising in the gym and eating healthily. We observed patients exercising in the gym and playing sports in the sports hall throughout our inspection and playing table tennis on Amber ward. Patients we spoke with told us they enjoyed walks and exercise sessions as part of their weekly routine.

- Healthy living boards were displayed on the ward walls in Langley Green Hospital offering information on healthy activities and food for patients to read.

- This core service participated in four clinical audits as part of their clinical audit programme 2016 – 2017.

Audit name/Title	Sites included	Date of Audit	Key actions following the audit
Improving the documentation of physical health parameters in a working Aged Mental Health unit Audit by use of specifically designed front sheet	Oaklands ward	01/08/2016	There is seen to be a marked improvement in the recording of the physical parameters, use of tobacco and the discussion of potential interventions with patients after the introduction of the physical health template. • Of the 7 areas we looked into 4 of these (intervention of patients with Qrisk2 >10, advice/NRT given to current smokers, routine bloods performed AND documented and ECG performed) were greater than 90% • It is important to note that 2 of the remaining areas (smoking status recording and health advice being given to all patients were close to the target of 90%

Mental Health Act Audit of Legal Paperwork and Consent to Treatment	Langley Green Hospital	01/09/2016	• Section 2 & 3 papers: 100% (18 out of 18) of the Section 2 & 3 papers uploaded to Carenotes on all wards
Audit of both PICUs	Amber and Pavillion PICU wards	07/07/1905	
7th Re-audit Cycle High Dosage Antipsychotic (HDA) Prescribing	Langley Green Hospital	17/02/2017	In this audit, the percentage of those prescribed with more than one antipsychotics was 16.7% (12 of 72) and reduced further when all patients in acute services are taken into consideration to 13.5% (12 of 89) compared to the National POMH-UK 2010 results which showed combined antipsychotics of 43% of patients in acute adult wards in the UK at baseline and 39% at re-audit 1 year later. The percentage of patients prescribed antipsychotics above BNF limit for individual antipsychotics was 1% for regular and 0% for prn

- Staff carried out weekly and monthly audits to monitor performance and identify improvement in areas ion such as national early warning systems, ward activity events, staff sickness, and care plans.

Skilled staff to deliver care

- Multi-disciplinary teams across this core service comprised of skilled and qualified consultants, junior doctors, nurses, occupational therapists, psychologists, healthcare assistants, and pharmacists.
- Ward managers told us that all staff, including bank staff and volunteers, received an induction and training when joining the trust. We interviewed one nurse on Jade ward who was undergoing induction and told us about the mandatory training programme and ward orientation they were beginning.
- The trust's target rate for appraisal compliance is 90%. As at 31 July 2017, the overall appraisal rates for non- medical staff within this core service was 43%.
- There was only one ward (Coral Ward) which was above the trust target
- The most recent rate of appraisal compliance for non-medical staff is higher than the 11% reported in July 2016 prior to the previous inspection.

	Total number of permanent non-medical staff requiring an appraisal	**Total number of permanent non-medical staff who have had an appraisal**	**% appraisals**
Coral Ward	18	17	94%
Amber Ward	31	27	87%

Regency Ward	28	19	68%
Jade Ward	20	13	65%
Bodiam Ward	28	15	54%
Amberly Ward	27	14	52%
Caburn Ward	27	9	33%
Pavilion Ward	26	8	31%
Rowan Ward	21	3	14%
Woodlands Ward	29	3	10%
Maple Ward	23	1	4%
Oaklands Ward	22	0	0%
Core service total	300	129	47%
Trust total	**2703**	**1330**	**49%**

- During our inspection we were provided with refreshed data which showed the average appraisal compliance level for this core service was 81% which was below the trust's compliance target of 90%. Regency, Caburn, Pavilion, Amberley, Bodiam, and Coral wards had compliance levels of 100%. Maple and Rowan wards had the lowest compliance levels of 40% and 58% respectively.
- The trust's measure of clinical supervision data is sessions delivered.
- Between 1 July 2016 and 30 June 2017 the average non-medical clinical supervision rate across within this core service was 56%. This is below the trust target of 85%
- There was no medical clinical supervision data submitted for this core service.
- There were two wards (Regency and Coral) that met the trust target for clinical supervision. All other wards did not.
- Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.
- In the previous comparable data held by CQC (for the 12 months previous as at 30 June 2016) the core service has a 73% clinical supervision rate for non-medical staff, meaning the core service is performing worse this year compared to last year.

	Clinical supervision target	Clinical supervision delivered	Clinical supervision rate (%)
Regency Ward	85%	132	92%
Adult Services (AMHS) Acute inpatient Coral Ward	85%	41	89%
Pavilion Ward	85%	101	78%
Adult Services (AMHS) Acute inpatient - Jade Ward	85%	26	76%
Bodiam Ward	85%	171	69%

Amberley Ward	85%	180	68%
Caburn Ward	85%	76	58%
Adult Services (AMHS) PICU - Amber Ward	85%	20	42%
Woodlands	85%	40	11%
Core service total	**85%**	**787**	**56%**
Trust overall	**85%**	**13594**	**76%**

- During our inspection we noted that the average supervision levels for the month of October 2017 for this core service were 77% which was lower than the trust target of 85%. However, Coral, Jade, Amber wards, and Woodlands Centre had supervision rates of 100%. In December 2017 the trust provided refreshed data which showed that the rate of supervision was at 91%.
- Ward managers ensured their staff received specialist training for their roles such as diabetes awareness, and working with patients with borderline personality disorder. However, staff we spoke with at Mill View told us there was a lack of specialist training available to them.

Multi-disciplinary and inter-agency team work

- All wards held weekly multi-disciplinary meetings to review all relevant elements of patients' treatment and care.
- Staff handed over information to the incoming staff at the changeover of each shift. During this inspection we observed review meetings on each ward where staff discussed observations they made about patients' physical and mental wellbeing, historical and emerging patient risks, any planned patient leave and observation levels required for each patient for that shift. Staff also reviewed and signed off medicine records from the previous shift to ensure accuracy of the work.
- All staff had effective working relationships with other teams. For example, all wards worked closely with their facilitating early discharge team. This team was part of the crisis team and helped reduce delayed discharges by identifying and managing barriers to patients being discharged from the ward.
- Teams across this core service had strong working links with external teams such as social services and GPs.

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

- As of 31 July 2017, 90% of the workforce had received training in the Mental Health Act. This is a mandatory course and is renewed every two years.
- The training compliance reported during this inspection is higher than the 81% reported at the last inspection.

Ward	Eligible staff	Number trained	% Compliance
Rowan Ward	8	8	100
Jade Ward	10	10	100
Woodlands	10	10	100
Bodiam Ward	13	13	100
Pavilion Ward	14	13	93
Oaklands	12	11	92
Caburn Ward	13	12	92
Maple Ward	8	7	88
Regency Ward	15	13	87
Amberley Ward	13	11	85
Coral Ward	12	9	75
Amber Ward	11	8	73
Total	**139**	**125**	**90**

- During our inspection Mental Health Act (MHA) training levels for some wards was now higher than the figures provided by the trust, for example Jade, Coral and Amber wards all had training compliance rates of 100%.
- All staff we spoke with had a good understanding of the MHA, the Code of Practice and the guiding principles. Staff had access to administrative support, legal advice, policies and procedures on the implementation of the MHA within the trust.
- Patients had information on how to access their independent mental health advocacy on the wards. Two patients we spoke with told us how they used advocacy support with regards to making complaints during their admission.
- Staff told us they explained patients' rights under the MHA to them in a way they could understand. For example, during our inspection staff on Amber and Coral wards used translators throughout the week to explain these rights to patients who had language differences. This activity was recorded and repeated regularly throughout each patient's admission. Most patients we spoke with told us that they had their rights explained to them on admission and regularly throughout their treatment. Three out of six patient records we reviewed on Rowan ward did not contain evidence that patients had received their section 132 rights (explanation of the conditions of patients' admission under the Mental Health Act) and one of these patients told us they had not received their rights.
- Staff ensured that patients were able to take their Section 17 leave (permission for patients to leave hospital) when it was granted. This leave was reviewed daily to ensure leave allowance was accurate and could be facilitated by staff.
- Notices were displayed on all wards explaining to informal patients about their entitlement to leave the ward.
- Staff from this core service requested an opinion from a second opinion doctor when necessary.

- We reviewed MHA paperwork for patients on all wards and found them to be in order and stored so they were accessible to all staff who required them.
- Staff on the wards undertook weekend audits to ensure that MHA paperwork was being applied correctly. Any actions necessary to improve record keeping were delegated to team members by the nurse in charge at the start of each week.

Good practice in applying the Mental Capacity Act

- As of 31 July 2017, 90% of the workforce had received training in the Mental Capacity Act. This is a mandatory course and is to be renewed every two years.
- The training compliance reported during this inspection is higher than the 81% reported at the last inspection.

Ward	Eligible staff	Number trained	% Compliance
Oaklands	21	17	81
Maple Ward	22	15	68
Rowan Ward	20	16	80
Amber Ward	31	26	84
Coral Ward	18	15	83
Jade Ward	19	19	100
Pavilion Ward	21	20	95
Caburn Ward	24	24	100
Regency Ward	25	25	100
Amberley Ward	25	23	92
Bodiam Ward	26	25	96
Woodlands	27	27	100
Meadowfield	1	1	100
Core service total	**283**	**254**	**91**

- During our inspection Mental Capacity Act training levels for some wards was higher than the figures provided by the trust, for example Jade (100%), Coral (100%). Amber (94%), and Rowan (82%).
- The trust told us that 135 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority between April 2016 and March 2017, five of which were pertinent to this core service.
- Three applications were from Maple Ward, one from Rowan Ward and one from Woodlands. The only successful application was from Rowan Ward.
- The greatest number of DoLS applications were made in June with two.
- CQC received zero direct notifications from Trust between 1 April 2016 and 31 March 2017.
- The number of DoLS applications made during this inspection is higher than the three reported at the last inspection, although that was for a six month period rather than a 12 month period so cannot be directly compared.

Number of DoLS applications made by month													
	April 16	**May 16**	**June 16**	**July 16**	**Aug 16**	**Sep 16**	**Oct 16**	**Nov 16**	**Dec 16**	**Jan 17**	**Feb 17**	**Mar 17**	**Total**
Applications made	1	0	2	0	0	0	1	0	1	0	0	0	5
Applications approved	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**

- In Woodlands we saw that staff had applied for an urgent Deprivation of Liberty Safeguards (DoLS) authorisation for a patient in May 2017, however the application was not followed up until October 2017. The trust informed us that they raised a safeguarding alert due to the delay in processing this authorisation with the local authority. They informed us that following our inspection staff completed a new DoLS application and were in regular contact with the local authority and monitoring the status of the application.

- Staff we spoke with were aware of and had access to the trust's Mental Capacity Act (MCA) policy.

- The trust had central support available to staff regarding the MCA.

- Staff on all wards worked together to help make decisions for patients, who lacked capacity, in their best interests. They did this by taking the patient's wishes, feelings and cultural identity into account and included the support of family members and carers where appropriate.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

- We observed a range of interactions between staff and patients on all of the wards we inspected. Staff interacted with patients in a caring and compassionate way. Staff responded appropriately to patients in a calm, polite and respectful manner and were interested in their well-being. We observed instances where staff spoke with patients to discuss their daily activities, discharge and concerns where patients were involved in making decisions at every stage.

- We spoke with 58 patients during our inspection and all said they found staff to be kind, polite and treated them with respect. Patients told us that staff knocked before entering their rooms.

- Staff supported patients to understand and manage their care during their admission. Patients we spoke with told us they felt involved in planning their care and had received copies of their care plans

- Patients were supported to access other services to support their recovery. We observed nurses speaking with a patient on Jade ward to encourage them to attend an appointment. They arranged transport to enable the patient to attend that day.

- Staff understood the individual needs of patients and told us of times when they arranged appointments to enable a patient to observe Ramadan and used a 'getting to know me' care plan to identify the likes and dislikes of patients on admission.

- Staff respected and worked to meet the personal needs of patients from the lesbian, gay, bisexual, transgender community. Across this core service, different wards ran a range of a of parties and events to promote the local gay Pride celebration in August.

- Confidential patient information was protected by staff on all wards by the use of secure electronic recording systems which was only accessible by staff who needed it.

- The 2017 PLACE score for privacy, dignity and wellbeing at three core service location(s) scored better than similar organisations.

- Two location(s) including Oaklands Centre (90.2%) and Woodlands (77.8%) were worse when compared to other similar trusts for privacy, dignity and wellbeing.

- Please note that some of the locations provide more than just this core service.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
MILL VIEW HOSPITAL	MH Wards for Older People with Mental Health Problems MH Acute wards / PICU Crisis / Health based places of safety	96%

OAKLANDS CENTRE	MH Acute wards / PICU	90.2%
DEPARTMENT OF PSYCHIATRY	MH Wards for Older People with Mental Health Problems MH Acute wards / PICU Crisis / Health based places of safety	90.9%
WOODLANDS, ST LEONARDS-ON-SEA	MH Acute wards / PICU Crisis / Health based places of safety MH Long stay / rehabilitation wards	71.8%
LANGLEY GREEN HOSPITAL	MH Wards for Older People with Mental Health Problems MH Acute wards / PICU Crisis / Health based places of safety	92.7%
Trust average		89.3%
England average (mental health and learning disabilities)		90.6%

The involvement of people in the care they receive

Involvement of patients

- Staff informed patients about the ward and oriented them to the service during the admission process. All wards gave welcome booklets to patients which contained information including names of the staff team, restricted items (such as alcohol and plastic bags), ward and hospital facilities, leaving the ward, meal times, medication times, smoking, and activities. Patients we spoke with told us they were given a tour of their ward during their admission.
- Patients were involved in their care planning, risk assessments and attended multi-disciplinary meetings and ward rounds to discuss their care. Patient records we reviewed contained evidence that patients views were included and patients we spoke with told us staff involved them in all aspects of their care.
- Staff communicated with patients in ways which supported them understand their care and treatment. For example, nursing staff in on Coral ward used communication flash cards when working with a patient with learning disabilities to support their understanding and involvement in their treatment. All wards used interpreters and translators where necessary. During our inspection, Amber ward arranged for a translator to attend so we could speak with a patient with language difference to hear their views of their treatment.
- Patients in Amberley and Bodiam wards attended regular patient council meetings where they fed back comments which led to ward improvements. For example, they helped choose garden and ward furniture, and were able to participate in staff recruitment interviews.
- All wards offered a range of groups and settings where patients could meet and share their views on the ward environments and their treatment. For example one to one meetings, daily coffee mornings, weekly community meetings, and feedback Friday meetings. Each ward displayed a ‘you said, we did’ board which highlighted feedback from patients and

changes the wards made as a result, for example increased activity schedules in Langley Green Hospital.

- Patients on all wards had access to advocacy services. There was information available on the wards and in welcome packs about how to access advocacy. Some patients we spoke with told us they met with advocacy team members for support.

- On Jade ward, staff asked patients what they would like to know so they could stay safe in the event of a fire. Patients fed back that they wanted a new leaflet and were supported to design one. The new leaflet was displayed on the ward and in patients' welcome packs.

Involvement of families and carers

- All wards held monthly carers' support groups. Where patients had declined to have family members and carers involved in their care, the wards still supported them without disclosing patient information.

- The trust supported patients' families and carers by signing up to the Triangle of Care model. The Triangle of Care model was launched in July 2010 as a joint piece of work between Carers Trust and the National Mental Health Development Unit, emphasizing the need for better local strategic involvement of carers and families in the care planning and treatment of people with mental ill-health. As a commitment to supporting families and carers, the wards developed a carers' pack which contained information on the ward, how to access a carers' assessment, and carer support group details in each hospital. All ward managers in Langley Green Hospital made phone contact with carers within 72 hours of their family member's admission. Staff took into account of patients' wishes and only shared information which patients had consented to. If patients did not consent to having their carers involved in their care, staff continued to offer support those carers in their caring roles to ensure they were supported by the service and in the community. Carers we spoke with told us they attended patient review meetings to include them in patients' care and treatment and hear their feedback.

- In October 2016, the trust published a thematic, independent review of homicides involving people known to our services. They commissioned this review jointly with NHS England. The trust did this to better understand how to provide patients and families with the very best possible care. As a result of findings in the review, this core service developed four family liaison posts to help support families and carers through the difficult process of a SI investigation. The role includes the day to day management of interactions with families and close liaison with the Investigating Lead to ensure that families are treated appropriately, professionally, with respect and according to their diverse needs.

- We saw evidence of family members' and carers' views in patients' care plans across all wards.

- Ward managers at Langley Green Hospital gave their email details to carers when their family member was admitted. We saw evidence where carers emailed to offer updates and received feedback on their family member's care.

- We spoke with staff in Langley Green Hospital who had recently attended a carers' awareness training day to support them in their roles when working with carers. The hospital held an event to promote carers' week in June 2017 which included local support services to promote their work with carers.

- All wards encouraged carers to provide feedback to help improve services. Following feedback from carers for patients in Langley Green Hospital, the matron introduced a weekly matron's surgery where carers could formally meet with the matron to discuss concerns.
- In the July - Sept 2017 Friends and Family test, 96% of respondents rated this core service positively and 0% rated the core service negatively based on 75 replies.

Is the service responsive?

Access and discharge

Bed management

- The trust provided information regarding average bed occupancies for 12 wards in this core service between 1 April 2016 and 31 March 2017.
- All 12 wards within this core service reported average bed occupancies ranging above the provider benchmark of 85% over this period.
- Coral Ward had the highest bed occupancy range over the period, reporting 177% in April 2016, although this did decrease over the remainder of the period.
- When compared to the previous inspection, over the period 1 December 2015 to 31 May 2016 the range of bed occupancies has increased (from a range of 86% to 144%) although this was over a six month rather than a 12 month period.

Ward name	Average bed occupancy (1 December 2015 to 31 May 2016)	Average bed occupancy range (1 April 2016 to 31 March 2017 (current inspection)
Amber Ward	93.5%	83%-99%
Amberley Ward	103.9%	91%-108%
Bodiam Ward	86.2%	88%107%
Caburn Ward	104.5%	102%-118%
Coral Ward	144.2%	129%-177%
Jade Ward	88.8%	102%-126%
Maple Ward	110.4%	98%-109%
Oaklands Unit	102.1%	96%-101%
Pavilion Ward	99.0%	96%-114%
Regency Ward	97.3%	102%-120%
Rowan Ward	107.8%	96%-115%
Surrey - Coral Ward	97.9%	72%-119%
Woodlands	96.9%	99%-111%
Core service overall		72%-177%

- The trust provided information for average length of stay for the period 1 April 2016 to 31 March 2017.
- The trust submitted data covering the 12 month period between 1 April 2016 and 31 March 2017.
- During this time, the average length of stay per month ranged from 10 days to 74 days across the wards within this core service.
- The wards were not consistent with each other across the reporting period. Most wards showed varying lengths per month across the reporting period.
- The ward with the longest length of stay range was Coral Ward.

- When compared to the information provided at the time of the previous inspection, it appears that the average length of stay for all wards have decreased, although it should be noted that the previous data was over a six month period.

Ward	Average length of stay (1 December 2015 to 31 May 2016)	Average length of stay (days) range (1 April 2016 to 31 March 2017)
Amber Ward	103.3	18-51
Amberley Ward	24.8	12-26
Bodiam Ward	20.2	11-31
Caburn Ward	33.4	17-41
Coral Ward	29.0	10-63
Jade Ward	35.3	18-50
Maple Ward	33.0	18-50
Oaklands Unit	25.5	18-29
Pavilion Ward	27.3	18-44
Regency Ward	85.4	19-52
Rowan Ward	48.5	15-61
Surrey - Coral Ward	26.0	13-74
Woodlands	27.4	14-45
Core service total		10-74

- This core service reported 126 out area placements between 1 May 2016 and 31 July 2017.
- As of 8 August 2017 this core service had nine ongoing out of area placements.
- There was one placement that lasted less than one day, and the placement that lasted the longest amounted to 42 days.

Number of out of area placements	Number due to specialist needs	Number due to capacity	Range of lengths (completed placements)	Number of ongoing placements
126	Not provided	Not provided	0-42	9

- Ward managers told us that wherever possible they ensure beds were available for patients living in the catchment area. They worked with bed management co-ordinators to review if other patients were ready for move on or discharge to make beds available. If patients were admitted out of area due to lack of beds, wards worked to ensure they were admitted to their local ward as soon as a bed was available for them.
- Beds were always available when patients returned from leave.
- Staff we spoke with told us that patients were not moved between wards during an admission episode unless it was for a clinical reason, for example requiring more or less intensive nursing care.
- Ward managers we spoke with told us that patient discharge times were agreed on the morning of their day of discharge. Patients were preferably discharged in the morning or during the day once their discharge was approved and their medicines were ready for collection.

- Beds were regularly available for patients on psychiatric intensive care units if a patient required more intensive nursing care. In the event a bed wasn't available, wards arranged for patients to be more intensively nursed on their ward until a bed became available by increasing observation levels and carrying out a medicine review to consider appropriate adaptations to their treatment.
- This core service reported 338 readmissions within 28 days between 1 April 2016 and 31 March 2017
- 48% of readmissions were readmissions to the same ward as discharge. There were three wards where the percentage of readmissions to the same ward were higher than the core service average. These were Coral Ward Surrey Placements (100%), Regency Ward (59%) and Jade Ward (58%)
- The average number of days between discharge and readmission was 12 days. There were no instances whereby patients were readmitted on the same day as being discharged but there were 29 instances where patients were readmitted the day after being discharged.

	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
Amber Ward	4	1	25%	1-19	8
Amberly Ward	68	20	29%	1-28	13
Bodiam	56	27	48%	1-28	13
Caburn Ward	35	25	71%	1-28	12
Coral Ward	8	1	13%	2-28	13
Jade Ward	12	7	58%	2-28	13
Maple Ward	39	15	38%	1-28	10
Oaklands Ward	23	6	26%	2-23	11
Pavilion Ward	6	1	17%	1-27	9
Regency Ward	22	13	59%	1-26	13
Rowan Ward	16	3	19%	1-25	12
Surrey Coral Placements	5	5	100%	5-14	9
Woodlands	44	16	36%	1-28	8
Core service total	338	163	48%	1-28	12

Discharge and transfers of care

- There were four wards within this core service that reported zero delayed discharges.
- Between 1 April and 31 March there were 2727 discharges within this core service. This amounts to 67% of the total discharges from the trust overall (4064).
- The table below shows the number of delayed discharges across the 12 month period.
- There were four wards within this core service that reported zero delayed discharges.
- The wards with the most delayed discharges were Regency Ward (17), Caburn Ward (16) and Jade Ward (14)
- At the time of the last inspection the core service reported 81 delayed discharges, although this was in a six month period so cannot be directly compared.

Team/ward/unit	Total discharges over the 12 months	Total delayed over the 12 months	% discharges delayed
Amber Ward	41	4	10
Regency Ward	242	17	7
Rowan Ward	184	12	7
Jade Ward	222	14	6
Caburn Ward	291	16	5
Coral Ward	92	5	5
Oaklands Unit	241	4	2
Woodlands	286	6	2
Maple Ward	259	3	1
Amberley Ward	328	0	0
Bodiam Ward	365	0	0
Pavilion Ward	42	0	0
Surrey - Coral Ward	134	0	0
Core service Total	2727	81	3
Trust total	4064	416	10

- Staff planned together with patient's for their discharge following their admission to the wards. This was done by involving the discharge teams who were part of the crisis and home treatment teams. This meant that specialist discharge co-ordinators were able to identify and remove barriers to discharge during patients' admission to prevent or minimise delays to their discharge such as lack of accommodation. All patients received a discharge pack during their admission which provided discharge co-ordinator contact details and useful community support contact details.
- All wards supported patients during transfer to acute hospitals and to more intensive nursing wards. For example, support was offered to patients who were moving from a single gender ward to a mixed gender ward to support them to feel safe in a different ward environment than they had been in.
- During our inspection staff at Mill View Hospital told us they had four delayed discharges due to lack of funding for onward placements and two due to lack of accommodation. Teams were working with internal and external teams to reduce discharges to enable patients to move on and allow for new admissions.
- The trust did not supply referral to assessment data for this core service

Facilities that promote comfort, dignity and privacy

- All wards had occupational therapist input and offered daily schedules of activities for patients including art, cookery, pottery, music appreciation, table tennis, exercise, smoothie making sessions, pamper sessions, games, mindfulness, movie and pizza nights. Patients on Pavilion ward only had activities scheduled from Monday to Friday and decided their own activities for each weekend with the support of weekend staff. Patients in Langley Green Hospital were able to spend time with a therapeutic dog who visited with a volunteer during the week.
- Patients had key card fobs to open and lock their bedrooms, however patients in Woodlands had been waiting for two weeks for new bedroom door key card fobs due to an IT technical issue. This meant they had to wait for staff to unlock their bedrooms each time

they wanted to enter them. Each ward had secure cabinets to store patients' valuables which were listed on inventories. All patients had lockable safes in their rooms where they could lock their valuables.

- Patients we spoke to told us they were able to personalise their own bedrooms or areas where they shared a dormitory.
- Three out of six patients we spoke with who shared dormitories on Bodiam ward said they wanted more privacy and their own bedrooms.
- Staff and patients had access to a range of rooms and facilities to support the treatment and care being provide across the wards, for example clinic rooms, meeting rooms, low-stimulus calm rooms, and activity rooms, communal areas and gardens. The communal area on Pavilion ward was increased in size and the ward manager told us this had decreased incidents of social conflict due to patients having more space to sit. Patients in Woodlands had access to a skills kitchen to develop cooking skills. Staff on Regency ward told us they did not have a calm room or a low stimulus area to help de-escalate distressed patients, however they used therapeutic items in a box to help de-escalate patients on the ward.
- All wards had access to quiet family and visiting rooms to ensure that patients maintained relationships with family, children and friends.
- Patients had access to their mobile phones in accordance with their risk assessments which were reviewed daily. Wards provided private space where patients could make private telephone calls if required.
- The 2017 PLACE score for ward food at two locations scored better than similar trusts. There were three locations that scored worse when compared to other similar trusts for ward food.
- The sites with the highest scores (both scoring 100%) were Oaklands Centre and Langley Green Hospital.
- The site with the lowest score was Mill View Hospital with 81.3%
- Please note that some of the locations provided more than just this core service.

Site name	Core service(s) provided	Ward food
MILLVIEW HOSPITAL	MH Wards for Older People with Mental Health Problems MH Acute wards / PICU Crisis / Health based places of safety	81.3%
OAKLANDS CENTRE	MH Acute wards / PICU	100%
DEPARTMENT OF PSYCHIATRY	MH Wards for Older People with Mental Health Problems MH Acute wards / PICU Crisis / Health based places of safety	84.1%
WOODLANDS, ST LEONARDS-ON-SEA	MH Acute wards / PICU Crisis / Health based places of safety MH Long stay / rehabilitation wards	90.7%
LANGLEY GREEN HOSPITAL	MH Wards for Older People with Mental Health Problems MH Acute wards / PICU Crisis / Health based places of safety	100%

Trust overall	92.1%
England average (mental health and learning disabilities)	91.5%

- Patients generally told us that the food was good and they could make hot drinks and have snacks day and night. While the place score for ward food in the Department of Psychiatry was low, all 12 patients we spoke with told us the food was very good and that they had a daily menu choice. However, patients we spoke with in Mill View Hospital told us they were generally unhappy with the standard of food they were given at mealtimes. The ward manager for Jade ward at Langley Green Hospital told us they regularly quality checked the food quality and worked with the catering department to ensure quality was always improved.

Patients' engagement with the wider community

- All patients were encouraged to engage with training and education opportunities through the trust's recovery college where appropriate and with local voluntary agencies. Leaflets advertising these opportunities were displayed on all wards.
- Staff supported patients to have escorted and unescorted leave from the wards when appropriate to ensure they developed and maintained relationships in the service and with the wider community. One patient on Rowan ward told us that staff supported them to visit their relative in the community who was unwell. The trust did not want patients to stay longer than required on the wards, so therefore fully supported patients retaining and developing links to their communities to prepare for discharge.

Meeting the needs of all people who use the service

- All wards were accessible and had a number of disabled adapted rooms on each ward with adapted accessible bathrooms.
- Information on patients' rights, local services and how to complain where displayed in each ward and were noted patient welcome packs.
- Staff ensured that leaflets were available in languages spoken by patients, for example, during our inspection one patient on Coral ward had leaflets translated to her spoken language.
- Cultural needs of patients were met and supported across all wards. Langley Green Hospital held a black history month event during the week of our inspection.
- The trust provided a choice of food to meet the dietary requirements of religious and ethnic groups such as halal food provided for a patient who was recently discharged.
- Service user involvement groups visited patients weekly to offer advocacy, training, peer support and access to a range of support groups in the community.
- Patients had access to appropriate spiritual support while on the wards. Each ward had visiting chaplains and a sacred space for patients to use.

Listening to and learning from concerns and complaints

- This core service received 108 complaints between 1 July 2016 and 30 June 2017. Nine of these were fully upheld, 16 were partially upheld and 65 were not upheld. The trust did not send details of any complaints referred to the ombudsman
- The number of either partially or fully upheld complaints reported during this is higher than the 30 upheld (out of 84) reported at the last inspection. At that time this represented a proportion of 36% of upheld or partially upheld complaints.

Ward	Total Complaints	Fully upheld	Partially upheld	Not upheld	Under investigation	Withdrawn
Amber Ward	5			5		
Amberly Ward	11		2	8	1	
Bodiam Ward	6	1	1	1	1	2
Caburn Ward	10	1	3	4		2
Coral Ward	9	2		4	3	
Jade Ward	11	2	2	5		2
Maple Ward	10	1	1	7		1
MHA Office	1				1	
Oaklands	8			7		1
Pavilion Ward	2		1	1		
Meadowfield Reception	1			1		
Regency Ward	14	1	1	10		2
Rowan Ward	11	1	3	6		1
Woodlands	8		2	5	1	
Ward unspecified	1			1		
Core service	**108**	**9 (8%)**	**16 (15%)**	**65 (60%)**	**7 (6%)**	**11 (10%)**
Trust total	**772**	**103 (13%)**	**119 (15%)**	**448 (58%)**	**43 (6%)**	**56 (7%)**

- Patients we spoke with were aware of how to complain or raise concerns. They told us they did this in meetings with staff, in writing, using the ward suggestion boxes and sometimes with the support of advocacy services.
- All staff we spoke with knew how to handle complaints in accordance with the trust's complaints policy. Ward managers presented us with written examples where they had responded to complaints and feedback from patients.
- This core service received 58 compliments during the last 12 months from 1 July 2016 to 30 June 2017 which accounted for 9% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

- All ward managers and senior staff had skills, knowledge and experience to perform their roles.
- Leaders had a good understanding of the services they were running and senior staff at Langley Green Hospital spent time talking us through quality improvement work they have been implementing since January 2017 to provide high quality care. For example, the re-introduction of long shifts which led to a reduction in missing information at handovers, increases in supervision and training attendance, and the introduction of lessons learnt and bite sized training schedules to ensure constant review and service improvement.
- Senior staff were visible across all of the wards to nursing staff and patients. In Langley Green Hospital, ward managers worked a shift each week to increase their visibility on the wards. All ward managers in the core service were present on the wards throughout each day.
- The trust offered leadership development opportunities to enable staff to progress within the trust. For example, a member of the nursing staff who we interviewed during inspection last year was appointed ward manager prior to this inspection.

Vision and strategy

- Staff we spoke with understood the trust's visions and values and team objectives and appraisals for all staff were based on them.
- In Langley Green Hospital, each ward developed a local vision and strategy which they read before each business meeting to reinforce their dedication to providing transparent, honest and personalised care.
- All staff we spoke with contributed their ideas towards the development of their wards and the core service. For example, the ward manager for Amber ward developed a policy which removed the blanket restriction on the use of mobile phones and belts for patients on that ward.

Culture

- Staff we spoke with were generally very positive and proud about working for the trust. We spoke with staff in Langley Green Hospital who had undertaken sporting events to fund raise for their wards in their spare time. They did this to raise the profile of their wards and raise extra funds to buy items for patient activities. However, staff morale in Millview Hospital was low. Staff told us that low staffing was an issue, occupational therapy support was low and they lacked recognition. We raised this with the trust during our inspection and they informed us they were aware of this and were meeting with the staff to better understand the situation and identify solutions to the issues.
- All staff told us they felt able to raise concerns without fear of retribution and all were familiar with the whistleblowing process.
- During the reporting period there were two cases where staff were suspended and none where staff were placed under restricted practice.

- Data prior to the previous inspection showed that one staff member was suspended.

Caveat: Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted.

Ward	Restricted practice	Suspended	Total
Amberly Ward	0	1	1
Jade Ward	0	1	1
Core service total	0	2	2

- Ward managers dealt with poor staff performance when required and had support from the human resources team and the service managers throughout the process.
- Staff told us that their appraisals included details about career development and many had lead roles in their area of interest, for example safeguarding and carers, to help build their own and peers' skills and knowledge and to improve practice.
- All staff had access to occupational health to support their physical and emotional health.

Governance

- All teams had clear processes to ensure that important information such as learning from incidents and complaints was shared during ward, team, business and directorate meetings.
- The consultant on Amberley ward did not attend the ward's monthly leadership team meeting. When we interviewed the consultant they were unable to provide us with any governance information such as serious incidents on the ward and vacancy issues. Subsequently this meant there was a lack of medical leadership on this ward. Following the inspection the trust informed us that they were working with the ward to ensure that the consultant attended these meetings.
- Staff we spoke with had a good understand of, and implemented recommendations identified from reviews of deaths, incidents, complaints and safeguarding alerts.

  All wards took part in local clinical audits which were reviewed weekly and monthly to identify areas for improvement. Staff we spoke with explained how they had acted on feedback to carry out improvements, such as reviewing medicine records at each shift handover to ensure paperwork was accurately completed.

Management of risk, issues and performance

- The trust has provided a document detailing their 15 highest profile risks. Each of these have a current risk score of 15 or higher. None relate specifically to this core service.
- All wards had access to the risk register and escalated concerns when required. For example, Langley Green Hospital registered a risk of how to maintain safety with mixed gender wards. The service had a risk logged to remind them to review ligature risk assessments annually and to monitor recruitment to reduce vacancies across the wards.

Information management

- Staff had access to information and technology to support them in their work.
- Information governance systems included maintenance of confidentiality of patient records across all wards.
- Ward managers we spoke with had access to information to support them in their role, for example service performance, staffing and patient care. We reviewed documents which indicated this information was being used across all wards to monitor provision and identify areas for improvement.
- Staff had processes in place to ensure that notifications were made to external bodies as required, for example to the Care Quality Commission.

Engagement

- The core service provided updates about their work to staff, patients, and carers through the intranet, newsletters, social media and bulletins.
- A number of the acute wards, such as those at Langley Green and Meadowfield hospitals maintained a twitter account to updates readers on their good practice, ward events, recruitment, and to encourage patient and carer involvement.
- All wards had systems in place which ensured that patients and carers could feedback in a range of ways to ensure they could respond and make improvements.
- Patients and carers were involved in decision-making about changes to the service.
- The psychiatric intensive care units in Mill View and Langley Green Hospitals were members of National Association of Psychiatric Intensive Care Units and were AIMS registered. This membership enables wards to access information to develop their intensive care wards.
- Directorate leaders engaged with external stakeholders such as clinical commissioners and Health Watch.

Learning, continuous improvement and innovation

- NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.
- The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.
- There are three wards this core service which are currently accredited. The trust stated that, under the same scheme, Rowan and Maple wards each have one outstanding level 1 Standard which is the refurbishment of the en-suite doors.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
Accreditation for Inpatient Mental Health Services (AIMS)	Oaklands Centre Meadowfield Hospital	22-11-2016 11 - 2017

- Staff in Mill View, Langley Green and Meadowfield were involved in the project set up stage of research addressing care for caregivers involving peer support for care givers and monitoring outcomes and re-admission rates for the people they care for.
- In October 2016, the trust published a thematic, independent review of homicides involving people known to our services. They commissioned this review jointly with NHS England to learn about incidents within the trust so they could focus on improvement and innovation with patients and their families.
- The service manager at Langley Green Hospital implemented the 'Leader Leader' model of team management at the end of 2016. This meant that staff and patients were encouraged to be leaders in the roles they had on the ward. For example, patients were referred to as service leaders, not patients. Service leaders had a role in contributing to how their ward was run and their views were welcomed at daily and weekly community and risk management meetings. Staff were referred to as nurse leaders and were supported to find solutions to challenges across the hospital in addition to their nursing duties. For example, reviewing incidents with service leaders to find solutions and reduce incident occurrence. Staff and patients we spoke with across this hospital all felt that they had a valid role to play in the running of the wards and felt positive about suggesting ways of making improvements.
- Regency ward in Mill View Hospital were twinned with Amber Ward in Langley Green Hospital to carry out an intensive peer support project to support patients on the wards.
- The trust held an award ceremony in November 2017 to recognise and award staff members for outstanding contributions in their work. The Langley Green Hospital team won a gold award for the significant and continued improvements being made to patient care across all areas of the hospital. The matron at Langley Green Hospital won a gold award for being an amazing role model to both staff and patients, for being an inspiring nurse and for leading their team from the front with humility, tenacity and commitment. Coral Ward in Langley Green Hospital won a silver award for work undertaken to champion physical health through the national early warning score policy and safety book.

Specialist community mental health services for children and young people

Facts and data about this service[1]

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Aldershot Centre for Health	Aldershot Community Team	No Set Clinics	Not specified
Brambly's	Basingstoke Community Team.	No Set Clinics	Not specified
Osborn Centre	Fareham & Gosport Community Team	No Set Clinics	Not specified
Oak Park Children's Services	Havant Community Team (Clinical base only).	No Set Clinics	Not specified
Fort Southwick	Havant Community Team (Admin base only).	No Set Clinics	Not specified
The Bridge Centre	Eastleigh Community Team.	No Set Clinics	Not specified
Ashurst Child and Family Centre	New Forest Community Team	No Set Clinics	Not specified
Avalon House	Winchester Community Team	No Set Clinics	Not specified
Child and Family Therapy, Gosport War Memorial Hospital	Gosport Community Team	No Set Clinics	Not specified
Chalkhill	Day Service	No Set Clinics	Not specified
Chalkhill	Urgent Help Service	No Set Clinics	Not specified
Chalkhill	Mid Sussex Community Team	No Set Clinics	Not specified
Cavendish House	part of East Sussex Early Intervention in Psychosis Team	No Set Clinics	Not specified
The Bedale Centre	part of West Sussex Early Intervention in Psychosis Team	No Set Clinics	Not specified
Arun House	part of West Sussex Early Intervention in	No Set Clinics	Not specified

[1] \\ims\data\CQC\CQC_Records\INSPECTIONS\Mental Health NHS\Sussex Partnership NHS Foundation Trust RX2\2017 2018 Q3\RPIR Documents\11082017 RX2 RPIR MH VFinal UPDATED October.xlsb

	Psychosis Team		
The Aldrington Centre	Brighton Early Intervention in Psychosis Team.	No Set Clinics	Not specified
Highmore	part of East Sussex Early Intervention in Psychosis Team.	No Set Clinics	Not specified
New Park House	Horsham, West Sussex Early Intervention in Psychosis Team.	No Set Clinics	Not specified
Orchard House	Ouse Valley part of the Eastbourne CAMHS Community Team (inc Primary Mental Health and Wellbeing - PMHW).	No Set Clinics	Not specified
Uckfield Community Hospital	Ouse Valley part of the Eastbourne CAMHS Community Team (inc PMHW)	No Set Clinics	Not specified
Peacehaven Health Centre	Ouse Valley part of the Eastbourne CAMHS Community Team (inc PMHW)	No Set Clinics	Not specified
Highmore	Eastbourne and Hailsham area of the Eastbourne CAMHS Community Team (inc PMHW).	No Set Clinics	Not specified
Highmore	CAMHS LD Fiss	No Set Clinics	Not specified
Highmore	LACMHS	No Set Clinics	Not specified
St Anne's Community Centre	Hastings CAMHS Community Team	No Set Clinics	Not specified
New Park House	Northern West Sussex Community Team.	No Set Clinics	Not specified
New Park House	High Risk Sexual Behaviours (also Known as Assessment and Treatment Service)	No Set Clinics	Not specified
New Park House	Primary Mental Health Work	No Set Clinics	Not specified

	Service (CAMHS)		
Carters Lane House	West Sussex LAAC Team.	No Set Clinics	Not specified
Worthing Hospital	Worthing Community Team	No Set Clinics	Not specified
72 Stockbridge Road	Chichester CommunityTeam	No set clinics	Not specified
The Aldrington Centre	Brighton and Hove Community Team.	No set clinics	Not specified
Chanctonbury Building	A&E Liaison Young People	No set clinics	Not specified
Royal Alexandra Children's Hospital	Paediatric Mental Health Liaison Team	N/A	Not specified

Is the service safe?

Safe and clean environment

- At the last inspection we identified concerns regarding adult community mental health patients accessing a residential flat above the Brighton Specialist community mental health service for children and young people. On this inspection, the trust had changed the residential flat into office space and no longer used the area for their adult community mental health patients.
- The East Sussex teams (Hailsham, Brighton and Hastings) had two locations in which the reception and waiting areas were shared with adults. The Hailsham team shared a reception area with adults up to 25 years of age and the Hastings location shared theirs with an older persons' clinic. However, both locations managed the risk to the young people well by having clear protocols in place which meant that all young children in the area were supervised by a member of staff. Both receptions were staffed by administrative staff who could view the waiting area and had access to alarm buttons if additional assistance was required.
- In Horsham, the specialist community mental health service for children and young people had separate entrances and waiting rooms to the adult services co-located at the site. However, the two services shared toilet facilities and the children and young people had to enter the adult's waiting room to access the therapy rooms. The service recognised this issue and implemented safeguarding procedures that required children to always be supervised when accessing the adult waiting room and toilets. This issue had also been flagged on the risk register.
- All other locations had separate and dedicated reception areas and waiting rooms for children and adolescent mental health patients.
- Locations managed their local alarm systems differently. Most sites had either alarms inside therapy rooms where staff were alone with patients or staff carried personal alarms with them into these rooms. Each system triggered an alarm when initiated and a central panel in each reception area would alert staff to the distress call. There was no set 'response team' but were told that all nearby staff would respond quickly.
- However, there were no alarm systems in place for the Chichester service and in Eastleigh the therapy rooms did not all have alarms. Staff did not carry personal alarms at either of these sites. In Eastleigh, the doors for therapy rooms did not have windows to allow clear sight into the rooms. We saw evidence that both of these issues had previously been raised with the estates team and that there had been a long delay in attending the issues.
- All locations had procedures in place to manage the risk to patients and staff when in therapy rooms alone. These included whiteboards with staff whereabouts in staff reception areas, discussions between staff before commencing sessions, using rooms next to staffed office rooms, buddy systems and having two members of staff in therapy sessions when a high risk patient was seen. These local procedures were in addition to the lone working policy which all staff were aware of. We saw evidence within team meeting minutes that risk of violence and aggression within therapy rooms was regularly discussed.

- All locations had clinic rooms with basic physical health monitoring equipment to measure blood pressure, height and the weight of patients.
- At the last inspection we raised concerns that not all physical health monitoring equipment was calibrated. On this inspection, we found that most locations had physical health monitoring equipment that had been appropriately calibrated, maintained and portable appliance tested, with responsibility to annually book this servicing delegated to staff members. However, at the Chichester location we found equipment that was overdue for re-calibration. The third party company responsible for conducting the re-calibration could not attend the location until the equipment was one month overdue. However, we saw that there was an appointment booked for November 2017, the month following the inspection.
- At the last inspection we highlighted the unsuitability of the clinic room at the Eastleigh location. On this inspection, modifications had been made to the Eastleigh clinic room to ensure the room was a dedicated clinic room and shelves were removed, which allowed for more space in the clinic.
- Cleaning rota's were noted at all locations, in addition to cleaning rota's for toys in the reception areas and therapy rooms. These were in line with the trust policy of toy cleaning and infection control procedures.
- All sites appeared clean and well maintained. Many sites were very child friendly and age appropriate with the Hailsham location demonstrating great initiatives by staff and patients to make the whole building more attractive and inviting to visitors. This site had multiple examples of patient's art and photos on the walls and arranged their music in reception to match that requested by patients.

Safe staffing

- Substantive – how many staff in post currently.
- Establishment – substantive plus vacancies, e.g. how many the trust want or think they need in post.

Substantive staff figures			**Trust Target**
Total number of substantive staff	At 30 June 2017	507.3	N/A
Total number of substantive staff leavers	1 July 2016 – 30 June 2017	88.5	N/A
Average WTE* leavers over 12 months (%)	1 July 2016 – 30 June 2017	17%	N/A
Vacancies and sickness			**Trust Target**
Total vacancies overall (excluding seconded staff)	At 30 June 2017	79.76	N/A
Total vacancies overall (%)	At 30 June 2017	13%	N/A
Total permanent staff sickness overall (%)	At 31 May 2017	3%	3.5%

Establishment and vacancy (nurses and care assistants)			Trust Target
Establishment levels qualified nurses (WTE*)	At 30 June 2017	153.1	N/A
Establishment levels nursing assistants (WTE*)	At 30 June 2017	11.5	N/A
Number of vacancies, qualified nurses (WTE*)	At 30 June 2017	22.89	N/A
Number of WTE vacancies nursing assistants	At 30 June 2017	1.67	N/A
Qualified nurse vacancy rate	At 30 June 2017	16%	N/A
Nursing assistant vacancy rate	At 30 June 2017	13%	N/A
Bank and agency Use			**Trust Target**
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 July 2016 – 30 June 2017	1853	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 July 2016 – 30 June 2017	656	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 July 2016 – 30 June 2017	57	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2016 – 30 June 2017	1813	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 July 2016 – 30 June 2017	0	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 July 2016 – 30 June 2017	75	N/A

- *WholeTime Equivalent

	Registered nurses			Health care assistants			Overall staff figures		
Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Urgent Help Service	4.10	10.32	40	0.00	2.80	0	4.15	13.84	30
Aldershot Community Team	1.70	5.30	32	0.00	0.00	0	3.50	17.23	20
Basingstoke Community Team.	-0.59	6.51	-9	0.00	0.00	0	2.39	24.35	10
Brighton and Hove Community Team.	0.60	1.40	43	0.00	0.00	0	-0.40	9.00	-4

Brighton Early Intervention in Psychosis Team.	1.00	8.75	11	0.62	1.62	38	2.22	15.62	14
CAMHS LD Fiss	0.80	2.40	33	0.18	1.64	11	1.72	11.40	15
Chichester CommunityTeam	-0.50	7.00	-7	0.00	0.00	0	2.48	22.68	11
Children in Care Team	0.00	1.00	0	0.00	0.00	0	1.73	19.77	9
Day Service	0.00	0.00	0	0.00	0.80	0	1.00	1.80	56
Eastbourne and Hailsham area of the Eastbourne CAMHS Community Team (inc PMHW).	0.47	4.38	11	0.00	0.00	0	2.82	16.61	17
Eastleigh Community Team.	0.60	5.30	11	0.00	0.00	0	3.50	15.70	22
Fareham & Gosport Community Team	1.90	10.24	19	0.00	0.00	0	2.40	22.67	11
Gosport Community Team	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0
Hastings CAMHS Community Team	1.40	8.50	16	0.00	0.00	0	2.30	19.31	12
Havant Community Team (Admin base only).	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0
Havant Community Team (Clinical base only).	5.33	14.96	36	0.00	0.00	0	9.73	31.06	31
High Risk Sexual Behaviours (also Known as	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0

Assessment and Treatment Service)									
Horsham, West Sussex Early Intervention in Psychosis Team.	2.00	7.00	29	-0.20	0.60	-33	3.40	11.50	30
LACMHS	-0.20	0.00	0	0.00	0.00	0	-1.35	5.36	-25
Learning Disabilities	0.80	4.56	18	0.00	0.00	0	1.73	17.89	10
Mid Sussex Community Team	0.60	4.70	13	0.00	0.00	0	1.94	23.08	8
New Forest Community Team	2.40	8.71	28	0.00	0.00	0	0.97	24.28	4
Northern West Sussex Community Team.	0.00	2.00	0	0.00	0.00	0	2.69	17.39	15
Paediatric Mental Health Liaison Team	0.06	3.66	2	0.00	0.00	0	0.01	4.26	0
West Sussex LAAC Team.	0.00	1.00	0	0.00	0.00	0	-0.76	8.52	-9
Winchester Community Team	-1.70	0.00	0	0.00	0.00	0	-2.41	0.00	0
Worthing Community Team	1.50	2.50	60	0.00	0.00	0	3.20	12.94	25
part of West Sussex Early Intervention in Psychosis Team (Arun)	-0.09	6.12	-1	0.00	0.00	0	0.31	8.39	4
part of West Sussex Early Intervention in Psychosis Team (Bedale)	0.28	4.85	6	1.07	1.07	100	1.35	8.32	16
Ouse Valley	-0.78	2.90	-27	0.00	0.00	0	1.28	12.04	11

part of the Eastbourne CAMHS Community Team (inc PMHW) (Orchard House)									
Ouse Valley part of the Eastbourne CAMHS Community Team (inc PMHW) (Uckfield)	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0
Ouse Valley part of the Eastbourne CAMHS Community Team (inc PMHW) (Peachhaven)	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0
part of East Sussex Early Intervention in Psychosis Team (Highmore)	-0.12	5.48	-2	0.00	1.00	0	-0.12	9.43	-1
part of East Sussex Early Intervention in Psychosis Team (Cavendish)	-0.40	4.88	-8	0.00	1.00	0	-0.20	9.43	-2
Primary Mental Health Work Service (CAMHS) (New Park House)	0.00	0.00	0	0.00	0.00	0	0.00	0.00	0
Primary Mental Health Work Service (CAMHS) (Stockbridge Road)	0.90	2.70	33	0.00	0.00	0	1.30	12.60	10

Primary Mental Health Work Service (CAMHS) (Worthing)	0.83	6.00	14	0.00	1.00	0	2.67	9.80	27
Core service total	**22.89**	**153.1**	**15%**	**1.67**	**11.53**	**14%**	**55.5**	**436.27**	**13%**
Trust total	**210.27**	**799.8**	**26%**	**264.47**	**1239.89**	**21%**	**598.6**	**3020.04**	**20%**

- NB: All figures displayed are whole-time equivalents

Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
354 880050 CHS ChYPS EIP Horsham	10	0	0
354 880051 CHS ChYPS EIP Worthing	66	0	0
354 880052 CHS ChYPS EIP Bognor	16	0	0
354 880511 CHS ChYPS EIP-Brighton	1	0	4
354 882301 CHS ChYPS LAAC - West Sussex	2	0	0
354 882303 CHS ChYPS West Sx Challenging Behaviour	0	0	0
354 882304 CHS ChYPS PMHCW - West Sussex	20	0	0
354 882305 CHS ChYPS ATS West Sussex	93	0	1
354 882308 CHS ChYPS Worthing	15	2	0
354 882309 CHS ChYPS Youth Offenders Team - West Sussex	3	0	0
354 882312 CHS ChYPS West Sussex AE Liaison	32	0	1

354 882319 CHS ChYPS Chalkhill - UHS	289	0	5
354 882322 CHS CHYPS Acute RACH Liaison	0	0	1
354 882325 CHS ChYPS West Sx North West	517	2	0
354 882328 CHS ChYPS Chichester	18	4	0
354 882345 CHS ChYPS Eating Disorders - West Sussex	0	0	0
354 882352 CHS ChYPS LD - B&H	3	0	0
354 882356 CHS ChYPS - Brighton TAPAs	5	0	0
354 882400 CHS ChYPS ESx - Hastings	18	0	1
354 882405 CHS ChYPS ESx - Eastbourne	0	0	0
354 882414 CHS ChYPS Family Intensive Support Service	0	0	0
354 882415 CHS ChYPS East Sx PMHCW	0	0	0
354 882416 CHS ChYPS LAAC East Sussex	36	0	0
354 882451 CHH ChYPS Basingstoke	0	0	0
354 882452 CHH ChYPS Andover	7	69	0
354 882453 CHH ChYPS Winchester	68	384	30
354 882454 CHH ChYPS Hants	0	1	0

Eastleigh			
354 882455 CHH ChYPS Hants New Forest	3	154	0
354 882456 CHH ChYPS Hants Havant	0	0	0
354 882457 CHH ChYPS Hants Fareham & Gosport	42	0	0
354 882458 CHH ChYPS Aldershot	142	40	1
354 882459 CHH ChYPS Hants i2i Urgent Help	0	0	0
354 882462 CHH ChYPS Hants IAPT	5	0	0
354 882468 CHH ChYPS Hants SPA	48	0	2
354 882472 CHK ChYPS South Kent	6	0	0
354 882473 CAK CAMHS Medway	2	0	0
354 882485 CHK ChYPS Kent UH - Urgent Help	56	0	5
354 882520 CHS ChYPS B&H Brighton	178	0	5
354 883966 CHS ChYPS EIP - East Sx	64	0	0
354 883971 CHS ChYPS EIP Hastings	88	0	1
Core service total	1853	656	57
Trust Total	**22910**	**9192**	**1793**

Team	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
354 880050 CHS ChYPS EIP Horsham	38	0	4
354 880051 CHS ChYPS EIP Worthing	63	0	3
354 880052 CHS ChYPS EIP Bognor	22	0	0
354 880511 CHS ChYPS EIP-Brighton	70	0	0
354 882301 CHS ChYPS LAAC - West Sussex	15	0	0
354 882303 CHS ChYPS West Sx Challenging Behaviour	5	0	0
354 882304 CHS ChYPS PMHCW - West Sussex	5	0	0
354 882305 CHS ChYPS ATS West Sussex	41	0	0
354 882308 CHS ChYPS Worthing	43	0	0
354 882309 CHS ChYPS Youth Offenders Team - West Sussex	74	0	2
354 882312 CHS ChYPS West Sussex AE Liaison	174	0	1
354 882319 CHS ChYPS Chalkhill - UHS	126	0	5
354 882325 CHS ChYPS West Sx North West	358	0	7
354 882328 CHS ChYPS Chichester	15	0	0

354 882345 CHS ChYPS Eating Disorders - West Sussex	33	0	0
354 882352 CHS ChYPS LD - B&H	0	0	0
354 882356 CHS ChYPS - Brighton TAPAs	5	0	0
354 882400 CHS ChYPS ESx - Hastings	263	0	46
354 882405 CHS ChYPS ESx - Eastbourne	362	0	0
354 882414 CHS ChYPS Family Intensive Support Service	66	0	0
354 882415 CHS ChYPS East Sx PMHCW	1	0	0
354 882416 CHS ChYPS LAAC East Sussex	3	0	0
354 882451 CHH ChYPS Basingstoke	0	0	0
354 882452 CHH ChYPS Andover	0	0	0
354 882453 CHH ChYPS Winchester	0	0	0
354 882454 CHH ChYPS Hants Eastleigh	0	0	0
354 882455 CHH ChYPS Hants New Forest	0	0	0
354 882456 CHH ChYPS Hants Havant	0	0	0
354 882457 CHH ChYPS Hants Fareham & Gosport	0	0	0
354 882458 CHH ChYPS	0	0	0

Aldershot			
354 882459 CHH ChYPS Hants i2i Urgent Help	0	0	0
354 882462 CHH ChYPS Hants IAPT	0	0	0
354 882468 CHH ChYPS Hants SPA	0	0	0
354 882472 CHK ChYPS South Kent	0	0	0
354 882473 CAK CAMHS Medway	0	0	0
354 882485 CHK ChYPS Kent UH - Urgent Help	12	0	2
354 882520 CHS ChYPS B&H Brighton	0	0	0
354 883966 CHS ChYPS EIP - East Sx	19	0	0
354 883971 CHS ChYPS EIP Hastings	0	0	0
354 882322 CHS CHYPS Acute RACH Liaison	0	0	5
Core service total	1813	0	75
Trust Total	38264	2811	2419

- Staffing establishment at the service was estimated according to the budget available to teams. We saw close working with finance teams and clinical commissioning groups with regards to safe staffing levels. The service had recently job planned for all staff members to calculate their available time to complete their roles and the demand placed upon the service. This demonstrated in many locations that they were understaffed and we saw evidence that teams presented this to commissioners to gain further funding.
- The trust submitted data that reported a vacancy rate for all staff of 13% as of 30 June 2017. There was a 15% vacancy rate for registered nurses and 14% for unqualified members of staff. These were both higher than the 12% and 11% reported respectively at the last inspection.
- The most recent service recruitment report seen on inspection suggested that vacancy rates had slightly fallen as of 1 August 2017, with an overall vacancy rate of 11%. The Hampshire teams held the highest vacancy rate with 16%.

- The service was actively recruiting to vacant posts and the trust had recently implemented a recruitment drive, meaning there were many new starters in teams. Staff reported that the recent recruitment had come as a great relief.
- Where locations had not received appropriate candidates to vacant posts, we saw them actively looking at additional ways to attract applicants. For example, the service began advertising in forums other than NHS jobs, using social media, attending job fairs, presenting to newly qualified staff and altering establishment levels and finances to create new/different posts to benefit the teams.
- The service introduced a 'golden hello' bonus payment of £2000 for successful candidates into posts where there had previously been difficulty in recruiting (defined as being advertised three times with no success). Additionally, the service announced an 'introduce a friend' scheme whereby the referring member of staff could claim a reward following a years service by the member of staff they introduced.
- Medical cover was noted as being particularly difficult to recruit to in both Sussex and Hampshire. However we saw adequate cover across the service with at least one substantive psychiatrist in post, except at Hailsham. Hailsham employed two speciality doctors due to the difficulty in recruiting a suitable candidate. We saw the location mitigate this by ensuring the speciality doctors were supervised on a monthly basis by the clinical lead for Sussex and they also undertook joint assessments with the clinical lead when requested for complex cases.
- We saw the use of speciality doctor posts in the Hampshire and West Sussex locations due to the difficulty in recruiting consultants. Team leaders told the inspection team this greatly benefitted the patients due to the familiarity of staff, rather than various locum and bank staff being used.
- All team leaders reported that they had sufficient help and support offered to them by the human resources department during all aspect of the recruitment process. There was an electronic recruitment tracking system called 'TRAC' that allowed team leaders to gain sufficient approval to post adverts and also track the progress of recruitment.
- Each month the service produced a human resources performance report regarding monthly vacancy rates, projected new starters, candidates for open posts and general updates on recruitment projects to the CAMHS care delivery service (CDS) board. This information was then cascaded down to local leadership meetings with service leads and team leaders.
- We saw evidence that where agency and bank staff were used, regular staff members were requested to ensure continuity of care for patients.

Team	Substantive staff leavers	Substantive staff	Average % staff leavers
Horsham, West Sussex Early Intervention in Psychosis Team.	2.40	8.10	25%
part of West Sussex Early Intervention in Psychosis Team (Arun)	0.00	8.08	0%
part of West Sussex Early Intervention in Psychosis Team (Bedale)	0.60	6.37	7%
Brighton Early Intervention in Psychosis Team.	1.00	13.40	7%

Chichester Community Team	4.00	19.42	21%
Northern West Sussex Community Team.	2.40	15.50	15%
High Risk Sexual Behaviours (also Known as Assessment and Treatment Service)	-	-	
West Sussex LAAC Team.	0.80	10.28	8%
Primary Mental Health Work Service (CAMHS)	1.73	6.83	21%
Worthing Community Team	1.60	10.14	15%
Day Service	0.00	0.80	0%
Urgent Help Service	4.20	12.69	37%
Paediatric Mental Health Liaison Team	1.00	3.25	26%
Mid Sussex Community Team	3.50	20.54	18%
Brighton and Hove Community Team.	0.00	9.40	0%
Hastings CAMHS Community Team	2.20	17.01	13%
Eastbourne and Hailsham area of the Eastbourne CAMHS Community Team (inc PMHW).	9.14	13.79	49%
Ouse Valley part of the Eastbourne CAMHS Community Team (inc PMHW) (Orchard)	0.00	11.31	0%
Ouse Valley part of the Eastbourne CAMHS Community Team (inc PMHW) (Uckfield)	-	-	
Ouse Valley part of the Eastbourne CAMHS Community Team (inc PMHW) (Peacehaven)	-	-	
CAMHS LD Fiss	0.00	10.25	0%
LACMHS	0.00	6.71	0%
Basingstoke Community Team.	3.70	21.17	20%
Winchester Community Team	5.21	-	60%
Eastleigh Community Team.	8.10	12.90	68%
New Forest Community Team	8.40	24.21	36%
Havant Community Team (Clinical base only).	5.58	22.13	26%
Havant Community Team (Admin base only).	-	-	

Fareham & Gosport Community Team	5.71	22.27	29%
Gosport Community Team	-	-	
Aldershot Community Team	2.60	15.63	17%
Children in Care Team	2.00	18.64	11%
Learning Disabilities	0.50	16.79	3%
part of East Sussex Early Intervention in Psychosis Team (Highmore)	0.80	9.75	8%
part of East Sussex Early Intervention in Psychosis Team (Cavendish)	0.00	9.63	0%
Core service total	**77.17**	**376.99**	**15%**
Trust Total	**390.5**	**2440.1**	**16%**

- The service had 77 (15%) staff leavers between 1 July 2016 and 30 June 2017. This was the same as the 15% reported at the last inspection.
- The trust implemented a staff retention policy and each location had a service development improvement plan in place that included action plans to improve and sustain the workforce. The trust also had a separate medical workforce strategy in place to support the work of recruiting consultants to the service.

- Key:

Below CQC 75%	Between 75% & trust target	**Trust target 85% and above**

Training course	**This core service**	**Trustwide mandatory training total %**
Adult Basic Life Support	**67%**	**68%**
Adult Immediate Life Support	**N/A**	**77%**
Clinical Risk Assessment	**94%**	**93%**
Equality and Diversity	**94%**	**93%**
Fire safety Awareness (1year)	**70%**	**78%**
Fire safety onsite - non inpatient	**81%**	**78%**
Fire safety onsite- Inpatient	**100%**	**86%**
Health and Safety (Slips, Trips and Falls)	**82%**	**84%**
Infection Prevention (Level 1)	**96%**	**95%**
Infection Prevention (Level 2)	**67%**	**75%**
Information Governance	**84%**	**88%**
Manual Handling - Object	**90%**	**87%**
Manual Handling - People	**N/A**	**68%**

Medicines Management	**70%**	**70%**
Mental Capacity Act Level 1	**80%**	**83%**
Mental Health Act	**77%**	**81%**
Personal Safety - MVA	**N/A**	**74%**
Personal Safety Breakaway - Level 1	**64%**	**57%**
Rapid Tranquilisation	**50%**	**93%**
Safeguarding Adults (Level 1)	**81%**	**85%**
Safeguarding Adults (Level 2)	**90%**	**87%**
Safeguarding Children (Level 1)	**97%**	**93%**
Safeguarding Children (Level 2)	**96%**	**83%**
Safeguarding Children (Level 3 Additional)	**71%**	**72%**
Total %	**80%**	**82%**

- Staff received mandatory training in subjects such as infection control, clinical risk assessment and safeguarding children. The compliance rate for mandatory training as of 31 July 2017 was 80%. This figure was 2% lower than the trust-wide average of 82%.
- The safeguarding children level 1 course had the highest training compliance with 97%. There were 149 staff eligible for the training course and 144 were up to date with the course. Rapid tranquilisation scored the lowest out of all the training courses with 50%. However, there were only two staff eligible for the training course and one was up to date.
- The service was below 75% completion for seven mandatory training courses. These were; adult basic life support, fire safety awareness (1 year), infection prevention (Level 2), medicines management, personal safety breakaway - level 1, rapid tranquilisation and safeguarding children (level 3 additional).
- However, the training figures submitted include staff on long-term sick leave and maternity leave that may not have completed mandatory training before commencing leave.
- Updated data submitted by the trust in December 2017 showed improved figures across all mandatory training courses, with 84% training compliance across the core service. Five courses fell below the 75% completion rate. However, we were provided with evidence of multiple courses having been booked in the near future to bring all staff up to date. The inspection team found that this did not impact on staff knowledge or their delivery of care. The service submitted an action plan with final completion dates of March 2018 with how all mandatory training levels that were below trust target were going to be completed by all staff. Actions included obtaining additional trainers, providing high quality online training and setting dates and enrolling staff on future courses.

Team	**Total % staff sickness (at latest month)**	**Ave % permanent staff sickness (over the past year)**
Horsham, West Sussex Early Intervention in Psychosis Team.	1%	4%
part of West Sussex Early Intervention in Psychosis Team (Arun)	0%	1%
part of West Sussex Early Intervention in Psychosis Team (Bedale)	6%	7%

Brighton Early Intervention in Psychosis Team.	1%	4%
Chichester CommunityTeam	5%	2%
Northern West Sussex Community Team.	0%	6%
High Risk Sexual Behaviours (also Known as Assessment and Treatment Service)	Not provided	Not provided
West Sussex LAAC Team.	3%	5%
Primary Mental Health Work Service (CAMHS)	0%	2%
Worthing Community Team	7%	5%
Day Service	0%	1%
Urgent Help Service	7%	6%
Paediatric Mental Health Liaison Team	2%	5%
Mid Sussex Community Team	4%	3%
Brighton and Hove Community Team.	0%	0%
Hastings CAMHS Community Team	5%	4%
Eastbourne and Hailsham area of the Eastbourne CAMHS Community Team (inc PMHW).	10%	3%
Ouse Valley part of the Eastbourne CAMHS Community Team (inc PMHW) (Orchard)	0%	2%
Ouse Valley part of the Eastbourne CAMHS Community Team (inc PMHW) (Uckfield)	Not provided	Not provided
Ouse Valley part of the Eastbourne CAMHS Community Team (inc PMHW) (Peacehaven)	Not provided	Not provided
CAMHS LD Fiss	7%	9%
LACMHS	0%	2%
Basingstoke Community Team.	1%	2%
Winchester Community Team	0%	1%
Eastleigh Community Team.	0%	2%
New Forest Community Team	5%	6%
Havant Community Team (Clinical base only).	2%	3%

Havant Community Team (Admin base only).	Not provided	Not provided
Fareham & Gosport Community Team	2%	5%
Gosport Community Team	Not provided	Not provided
Aldershot Community Team	0%	3%
Children in Care Team	0%	2%
Learning Disabilities	1%	1%
part of East Sussex Early Intervention in Psychosis Team (Highmore)	0%	2%
part of East Sussex Early Intervention in Psychosis Team (Cavendish)	6%	3%
Core service total	**2%**	**3%**
Trust Total	**5%**	**5%**

- The sickness rate for this core service was 3% between 1 June 2016 and 31 May 2017. This was the same as the sickness rate of 3% reported at the last inspection.
- We saw evidence of discussions around mandatory training taking place within supervision records and appraisals. Staff were encouraged to complete their mandatory training by team leaders and their personal dashboard on the trust computerised training system called 'My learning', which flagged when training was incomplete or up for renewal.
- Staff reported that face-to face training such as adult basic life support was not always held locally to them and therefore time constraints and work commitments made it difficult to attend. We also found that the most recent adult basic life support course for East Sussex was cancelled due to instructor illness.

- Caseloads within the service varied between each clinician, with the average reported caseload of around 30. Medical staff and those working within the attention deficit hyperactivity disorder (ADHD) pathway had considerably higher numbers on their caseloads. We were told that this was due to a lower number of contacts with this patient group, with some just contacting the service for their bi-yearly medical 'check-ups'. Additionally, a high proportion of the service's referrals came from patients requiring the ADHD pathway.
- The inspection team found that some clinician's caseloads were higher due to the implementation of therapy groups. However, we found processes in place that ensured clinicians had protected time to complete administration and care records following the conclusion of each of these groups.
- Staff spoke with us of the pressures of managing their caseloads but all reported they received good support from management and colleagues. Caseloads were discussed within supervision regularly and complex cases were taken to weekly multidisciplinary team meetings to support staff members and ensure good patient care.
- Changes in needs of patients on caseloads were managed efficiently and there was a duty system in place, in addition to the i2i/urgent help teams, to respond to patients in a crisis.

Assessing and managing risk to patients and staff

Assessment of patient risk

- All patients were risk assessed from the initial referral to allocate the urgency of a case. Teams then fully implemented a thorough patient risk assessment at the first appointment. The trust had a policy to update risk assessments routinely at least every 6 months and sooner if a change in risk or a risk incident occurred.
- We reviewed 53 care records and found all patients had a risk assessment in place with an accompanying risk management plan. However, we found seven patient risk assessments that were not up to date. Two of these had not been reviewed for over a year and five had not been reviewed within six months, as per trust policy. This represented 13% of the cases we reviewed. The Hailsham service contained the highest number of care records that were not up to date, with four out of eight care records not updated within six months.
- The most recent risk assessment audit conducted by the trust in September 2017 found similar findings with 83% of patients audited having a valid risk assessment that had been reviewed in the last six months and 97% reviewed in the last year.
- We found the quality of the risk assessments at all locations to be thorough with a range of risks considered, identified and planned for.
- All teams held weekly multi-disciplinary team meetings and complex case reviews in which all staff members and grades could discuss complex patient care. When we observed these meetings, risk was routinely discussed at length and considered. Members of staff from the service's i2i/urgent help team and A&E liaison staff members attended these meetings to offer their input.
- All locations held weekly conference calls with senior managers to discuss risks and decide upon the correct course of actions to take. This also allowed team leaders to raise risk issues with senior management for escalation that included operational risks, environmental risks and staffing risks.
- Staff had the opportunity to discuss patient risk amongst their caseloads at regular clinical supervision meetings with their supervisors.
- All patients had crisis plans within their risk management plans. These plans stipulated the actions to take and services to contact when a crisis struck. For urgent patient care, we saw out of hours rotas in place for the i2i/urgent help services, team managers and 24 hour psychiatry input to manage out of hours emergencies. Additionally, there was a Sussex mental health helpline which was staffed out of hours weekdays and 24 hours at weekends to offer help and support.
- Service wide audits and reports were undertaken to ascertain each team's compliance with trust policy regarding risk assessment, in addition to local risk assessment sampling we saw occurring in the services. These audits looked at the quality as well as frequency of assessments and plans and feedback was given to staff members during supervision.

Management of risk

- The service implemented a priority system in which those assigned to 'urgent' were initially assessed within four hours, 'priority' cases within five working days and 'routine' referrals

assessed within four weeks. Following assessment, patients were placed on waiting lists for specific therapeutic treatment pathways identified. Patients with more than one identified issue were placed on waiting lists for each pathway identified. The service had lead practitioners for each pathway that held responsibility for managing waiting lists and patient risk.

- Crisis management plans were in place for all patients and included support, advice and signposting for patients and carers. Staff responded promptly to sudden deterioration in patients' health by holding urgent appointments in the diaries for the duty clinician and psychiatrist.
- The service had a policy that stipulated the processes to manage the risk to patients on the waiting lists that included clear flowcharts and assurance processes in place.
- Waiting lists for therapeutic interventions were regularly discussed at weekly multidisciplinary team meetings and we observed teams considering and managing patient risk well. There was proactive engagement with young people on the waiting lists whereby staff phoned the young people and their carers to see if there had been any change in circumstances or risk. 'Z cards' were given to all carers with the initial contact letter. These cards stipulated when parents and carers should be concerned with their child's mental health presentation and what to do if they find their mental health rapidly deteriorating. It included direct lines to each CAMHS service and out of hours services and helplines.
- The 'Z cards' were introduced following a previous serious incident and learning that came from the investigation. Additionally, the Hampshire teams gave out Suicide Awareness For Everyone (SAFE) cards to patients and those attending SAFE events. These cards gave more information on helpline numbers, websites and apps that young people, parents and carers could access for information, guidance and help during a crisis. Patients and carers we spoke with said they had received one or both of these cards and knew what to do in a crisis.
- Across the service, we observed allocation meetings where patients on the priority waiting list were discussed at length and risks considered and managed. Administration staff attended these meetings to immediately update and change patient record information and prepare letters. Following the meetings, the duty clinicians were given a list of tasks to complete in response to the discussions.
- The trust implemented a suicide prevention strategy within CAMHS that all staff were aware of.
- All locations followed the trust wide lone working policy and staff were aware of the policy and its associated procedures. We were told that staff would only very rarely conduct home visits for the most complex cases and for short periods of time to build trust in the service. The Eastleigh service were using a local youth centre room to fulfil appointments for two mornings a week and we saw good evidence that this was appropriately risk assessed and managed well. The service had recently ordered mobile phones for staff using the centre to aid risk management at the centre.
- In the Basingstoke service, the team had recently piloted a parent and carers monthly meeting for parents of patients on the assessment waiting list. These sessions gave an opportunity for parents to talk to members of staff and update them on any changes in risk and for staff to signpost onto other organisations. This aided the service in managing the

risk to patients whilst on the list and to discharge those whose circumstances had positively changed. The sessions included various psycho-educational presentations by clinicians on a variety of topics to help parents and carers to cope at home. The pilot had proved hugely successful and beneficial to both the service and carers and was in transition to be rolled out across the service.

- The service implemented a missed appointment policy that incorporated an active engagement procedure. Changes to this policy were made following a previous lack of follow-ups when people did not attend appointments. Staff we spoke with demonstrated a clear understanding of the policy and the seriousness of a 'child not brought' to the service. There were clear processes in place to ascertain reason for disengagement, multi-disciplinary reviews of patient disengagement and consideration of the Mental Health Act if active risks were present. We saw excellent documentation of these discussions within case records. All locations demonstrated close working with local safeguarding children boards if there were risks concerning significant harm to children following non-engagement. The service demonstrated good working relationships with primary care, assertive outreach and urgent help services to ensure the risk of patients who were not engaging was managed effectively and appropriately.
- The East Sussex service had implemented a service called 'iROCK' which was a separate walk in clinic service available for all young people aged 14-25 experiencing a mental health difficulty. The service aimed to engage young people who would not normally engage with formal services and to ensure young people were seen directly by the most appropriate service and not have to wait for intermediary appointments. The service was initially a one year pilot project but has since gained commissioning to enter into a two year service due to its success.
- The iROCK service saw all presenting young people, whether known to services or not and aimed to provide advice and support on emotional and mental wellbeing, jobs, education and housing. There was no referral process or criteria thresholds for entry but most young people were signposted to the service by their GP. They also carried out presentations in schools, colleges, universities, GPs, youth groups and heavily engaged on social media to raise their profile.
- Due to the success of the iROCK service, we saw plans to implement a similar youth mental health service within the West Sussex service which incorporated CAMHS workers into tier two settings. Community CAMHS services are delivered in line with a four-tier strategic framework which is nationally accepted as the basis for planning, commissioning and delivering services. Tier 2 settings consist of CAMHS specialists working in both community and primary care settings. Practitioners offer consultations to identify severe or complex needs, which require more specialist interventions and assessments.

Safeguarding

- Staff at all locations were knowledgeable on the safeguarding procedures and what constituted safeguarding issues. All staff were confident to raise an alert for safeguarding, with the whole core service making 412 safeguarding referrals between 1 July 2016 and 30 June 2017. A safeguarding alert is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable

adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

- All locations fed into and had excellent links with their local multi-agency safeguarding hub (MASH) which was primarily run by local authorities.
- All teams had local champions who fed into service wide safeguarding meetings and each locality (Hampshire, East Sussex and West Sussex) had overarching safeguarding leads. We received great feedback from staff regarding the accessibility of safeguarding leads and that they were a great source of knowledge, support and advice when needed. There were also lead safeguarding named doctors available.
- Safeguarding leads attended service and trust wide safeguarding meetings, strategic meetings and Serious Incident panels and fed back to teams in a variety of ways including team meetings and presentations.
- In Hampshire, the safeguarding lead distributed a 'safeguarding digest' to all staff members monthly that was discussed in team meetings. The digest included summaries of recent publications and research, upcoming training sessions, care notes guidance for raising safeguard alerts and clear learning from previous safeguarding issues and serious incidents.
- The core service had above trust average compliance rates for safeguarding children (level 1 and level 2) and above trust average compliance rates for adult safeguarding level two. However, the core service had below average training rates for safeguarding adults level one (see below table).

Training course	This core service	Trustwide mandatory training total %
Safeguarding Adults (Level 1)	**81%**	**85%**
Safeguarding Adults (Level 2)	**90%**	**87%**
Safeguarding Children (Level 1)	**97%**	**93%**
Safeguarding Children (Level 2)	**96%**	**83%**

- There was evidence of good working relationships between staff and other agencies such as social workers, police and schools. Additionally in Hampshire, the safeguarding lead worked with and supervised the 'Children in Care' team and 'Willow' team, who were a service dedicated to missing and/or exploited children, to ensure a safeguarding oversight of these high risk teams.

Staff access to essential information

- The service utilised an electronic patient records system called 'carenotes'. All staff had secure log-ins and access to carenotes, including bank and agency staff. There was a drive for the service to become 'paper-light' and where paper records were used (for consent, routine outcome measures, GP letters etc.) admin staff would scan copies of these or enter data onto the carenotes system under the correct tab and then destroy the original paperwork.

- Some staff explained that many of the electronic forms for assessments and care plans on the carenotes system requested duplications of entries and that this sometimes impacted on the time taken to document information.

Medicines management

- The majority of locations did not hold medicines on site and when prescriptions were made, patients had to access pharmacies to receive their medicines. The Aldershot team were located at the Centre for Health and had a pharmacy on site for patients.
- Medicines were kept on site at the Chichester and Brighton locations and we saw robust and appropriate procedures in place regarding correct storage in locked cupboards alongside good reconciliation and logging practices. The medicine in these sites was mostly used for co-located teams, for example the early intervention team at Brighton.
- Service borders were recently re-aligned to clinical commissioning groups within the counties and a shared care agreement with GPs ensured that patient GP's supplied medication for patients with reviews and assessments carried out by CAMHS teams. Many of the teams employed nurse prescribers who could also manage medicine reviews.
- We were informed that at the Worthing location, the consultant psychiatrist held allotted times in which parents could phone the service and gain information and advice from the consultant regarding medicines prescribed to their child.
- There was a nurse prescribing forum at the trust available for all nurse prescribers that met quarterly to give staff the opportunity for reflective practice and knowledge updates.
- Staff demonstrated good knowledge and understanding of assessing and monitoring patients' physical health in relation to prescribed medicines.

Track record on safety

- Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified. Between 1 July 2016 and 30 June 2017 there were no STEIS incidents reported by this core service.
- We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was not comparable with STEIS. There were two incidents reported by the trust through its own systems and these were not reported through STEIS.
- The number of serious incidents reported during this inspection is lower than the 17 reported at the last inspection (June 2015 to May 2016).
- A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

Reporting incidents and learning from when things go wrong

- The service implemented an electronic incident reporting system that all staff had access to and could use to raise an alert. All alerts raised were sent through to team managers to review and grade and depending on severity of the incident, it was sent to service leads. Previous incidents all had actions and outcomes assigned to them with higher grade

incidents requiring internal investigations. We saw evidence that where incidents were deemed serious enough, a manager from a differing team would independently investigate it.

- At the last inspection, CQC found that staff were not reporting all individual incidents apart from the most severe incidents and were instead reporting themes when they arose. Staff knowledge around how to report incidents was also found to be poor. On this inspection, there was a greater emphasis, knowledge and effort by staff to report all incidents and we saw evidence that incidents were routinely being recorded for individual incidents and ranged from patient self-harm to information governance breaches and acts of violence or aggression. Additional training and support was given to staff members on what to report and how to report it. Staff at all locations were confident in explaining the process for reporting.
- The service had implemented a new 'reporting parameters for self-harm' document which explicitly guided staff on when to report self-harming incidents.
- We were told that during weekly reflective practice sessions, staff could bring any concerns regarding reporting incidents to the meeting and discussions would be had to understand the next steps to take.
- Monthly business meetings across all teams held standing agenda items dedicated to learning from incidents. Additionally, incidents were raised and discussed at monthly leadership meetings. We saw examples of learning from incidents at all locations whereby changes in practice were implemented. For example in Brighton, there was an incident where a patient locked themselves in the toilet and self-harmed. As a result of the investigation and learning, the location installed an override key for the toilet should they need to quickly gain access in an emergency again.
- In Hampshire, the general manager created an incident bulletin that was sent to staff monthly that included recent incidents from across the whole trust and how learning was taken from these.

Is the service effective?

Assessment of needs and planning of care

- The service operated a modified 'care and partnership approach' (CAPA) to treatment. Following their referral, patients were put onto a waiting list to receive their initial choice assessment with a clinician. This appointment aimed to focus on meeting the service criteria, formulating risk assessments and care planning based upon goals, strengths and a therapeutic collaboration. For the Brighton team, the service employed a modernisation project manager and as part of this and restructuring of their service, choice appointments had been replaced with 'the wellbeing service'. This service acted like a single point of access and triaged all referrals to the service and was open to any kind of referral.
- Following these initial assessments, patients were put onto specific treatment pathways based upon their needs. The service ran a variety of treatment pathways for a range of patient mental health issues. Each pathway provided evidence-based interventions and was sufficiently resourced and job-planned for, with each one having an allocated professional lead for each location. Additionally, the service offered multiple group based therapies including family therapy and anxiety groups.
- Therapeutic group sessions aimed to support patients in their treatment alongside clinic reviews, whilst they were awaiting specific treatment pathways. This led to a reduction in waiting times across the service and also greater management of the risk to patients whilst waiting for specific pathways.
- We saw clear evidence that patients' physical health needs were regularly assessed. The location and method of physical health monitoring varied across sites. All sites had the facilities to undertake physical health monitoring of patients on site, but we also saw good links with local services to undertake these elsewhere to free up clinicians time.
- In the Basingstoke team we saw plans to run a regular, dedicated physical health clinic for patients. This was to be run by the professional lead for the ADHD pathway and aimed to give patients a set day and time to come in for their specific physical health monitoring checks.
- We saw that during initial choice assessments, patients were given dedicated alone time with a clinician before parents and carers were invited in. Patients reported that they respected this practice as it gave them time to discuss issues they would not feel comfortable raising with their carers in the room.
- We reviewed 53 care records across the service. We found every case record contained a present care plan that was regularly updated and reviewed. Care plans were mostly detailed with good patient involvement, personalisation and evidence that copies of the plans were given or offered to patients and carers. We observed therapy sessions and case reviews whereby staff considered many aspects of patient care and discussions were very holistic in nature, always involving the patient and gaining their view.
- However, we found 12 care records were not holistic in their documentation and were not strength or goal based. This represented 22% of the care records we examined. Hailsham had the most issues with five care plans that were neither holistic or goal based.

Best practice in treatment and care

- The service provided multiple therapeutic pathways for patients based on national institute for health and care excellence (NICE) guidance. These provided clear treatment pathways for patients following their initial choice assessment. The service provided individual treatment pathways including anxiety, depression, eating disorders, children in care, trauma, psychosis and attention deficit hyperactivity disorder (ADHD).
- Additionally, the service provided group therapy sessions that benefitted the patients and provide support to young people on the waiting lists. The groups included family therapy, anxiety, mindfulness, trauma, dialectical behavioural therapy and resilience.
- We witnessed local teams configuring their therapeutic pathways to deliver care that was most appropriate for their client group. For example, in Basingstoke they were planning the introduction of a 'sleep' pathway as they recognised that this was a need for their patients. Additionally, they were planning for a lesbian, gay, bisexual and transgender (LGBT) gender pathway and support group in response to an increase in referrals from this specific characteristic of patients.
- In Horsham the team recognised that their autism spectrum condition (ASC) pathway tended to be more diagnostic than therapeutic. As a result, they worked very closely with 'Autism Sussex' to offer therapeutic intervention and support.
- The service offered a range of therapeutic interventions for patients including cognitive behavioural therapy (CBT) and dialectal behavioural therapy (DBT). In East Sussex, the team had begun a pilot of a high quality online CBT that they could offer to patients. This aimed to reduce the time patients waited for therapy whilst also enabling patients to access the therapy in their own time and in their own homes.
- The service implemented 'minimum clinical standards' that stipulated at each stage of patient care (e.g triage, choice assessment, lead practitioner, risk and care plan and discharge) what the absolute minimum standards were to be expected and what patients would be receiving as a minimum.
- All clinical staff were aware of patients physical health needs and all sites had clinics that could undertake basic physical health monitoring such as height, weight and blood pressure. We saw excellent links with local services to arrange for blood tests and electrocardiograms. There was evidence that the service followed NICE guidance in offering at least two yearly physical health checks for patients on the attention deficit hyperactivity disorder pathway.
- In the Hampshire service, there was a recent pilot undertaken in which community pharmacists conducted basic physical health checks for patients. The evaluation of this service proved very positive for clinicians, pharmacists and patients/carers and we saw plans to develop this model across the whole core service.
- The service utilised a wide range of routine outcome measures for patients. These outcome measures aimed to record the progress of patients in both the short and long term following therapeutic interventions and to feedback on the service provided. The outcome measures used included questionnaires for parents and carers (strengths and difficulties questionnaire, experience of service questionnaire) in addition to the patients themselves

(revised children anxiety depression scale, outcome rating scale and child session rating scale).

- Each treatment pathway was assigned a specific routine outcome measure to use as approved by NHS England's children and young people's improving access to psychological therapies (CYP IAPT) programme. For example, the depression pathway was assigned to the revised children and anxiety depression scale and the wellbeing pathway was assigned to the short Warwick-Edinburgh mental wellbeing scale.
- The service implemented a feedback loop for outcomes and experience measures to ensure patient needs and care planning was adapted based upon outcome measures from each session. All routine outcome measures used were evidence based and well recognised, allowing clinicians to adapt their sessions individually based upon the feedback received.
- The service audited their routing outcome measures regularly with action plans developed from the findings.
- Patients of the East and West Sussex locations had access to the 'discovery' and/or 'recovery' colleges run by the trust. The discovery college was open to patients aged 12-20 using east Sussex services. The discovery college also ran courses available to parents and carers of patients. This service was one of only two currently open and running in England. The recovery college was open to those engaged with either the East or West Sussex locations.

This core service participated in three clinical audits as part of their clinical audit programme 2016-2017.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
National EIP self assessment audit	Early intervention in Psychosis X 6 teams	Benchmark Clinical audit - NICE standards	30 September 2016	Trained more staff to deliver recommended interventions, and we have also completed work to ensure newly acquired skills lead to increased treatment availability. For instance, in Sussex EIP teams we have been training more Lead Practitioners to deliver Cognitive Behaviour Therapy for Psychosis and also been piloting new split LP / CBTp therapist posts. We have trained more staff to deliver Family Interventions and Behavioural Activation/ Graded Exposure. We have also been working to ensure comprehensive physical health checks and support is available to all our clients. We have also been supporting all

				our teams to offer rolling carer psycho-ed and support groups. Currently putting in place work streams to oversee further service improvements for 2017-8 and these include workstreams focusing on physical health assessment/ support and on delivering the recommended psychological therapies
	Early intervention in Psychosis X 6 teams			Trained more staff to deliver recommended interventions, and we have also completed work to ensure newly acquired skills lead to increased treatment availability. For instance, in Sussex EIP teams we have been training more Lead Practitioners to deliver Cognitive Behaviour Therapy for Psychosis and also been piloting new split LP / CBTp therapist posts. We have trained more staff to deliver Family Interventions and Behavioural Activation/ Graded Exposure. We have also been working to ensure comprehensive physical health checks and support is available to all our clients. We have also been supporting all our teams to offer rolling carer psycho-ed and support groups. Currently putting in place work streams to oversee further service improvements for 2017-8 and these include workstreams focusing on physical health assessment/ support and on delivering the recommended psychological therapies
EIP matrix audit		Benchmark Clinical audit - NICE standards	1 September 2016	

Skilled staff to deliver care

- Teams were well staffed by a variety of experienced and qualified mental health workers including consultant psychiatrists, speciality doctors, nurses, psychologists, occupational therapists, art and drama therapists, social workers, play therapists and students or trainees. All staff members reported that they felt well integrated and utilised within the teams.

- The service had recently undergone a significant recruitment drive and employed many new members of staff. We spoke to multiple newly recruited staff and all stated that they had received a local induction and either completed or were booked on for a trust wide induction. New staff members spent a period of time shadowing current staff before they could work independently and were gradually given a caseload to manage. For newly qualified members of staff, the trust operated a preceptorship programme and feedback from staff regarding this was positive.

Team name	Clinical supervision target	Clinical supervision delivered	Clinical supervision rate (%)
A&E Liaison West Sx	85%	2	8%
Aldershot CAMHS	85%	21	57%
Basingstoke	85%	23	96%
Basingstoke CAMHS	85%	33	97%
CHS ChYPS B&H Brighton	85%	74	100%
CHS ChYPS B&H LD	85%	27	90%
CHS ChYPS B&H R U OK	85%	12	100%
CHS ChYPS B&H YOS	85%	24	100%
CHS ChYPS East Sx Eastbourne & Ouse	85%	84	88%
CHS ChYPS East Sx FISS	85%	24	100%
CHS ChYPS East Sx Hailsham	85%	24.	100%
CHS ChYPS East Sx Hastings	85%	107	100%
CHS ChYPS East Sx LACAMHS	85%	6	100%
CHS ChYPS East Sx Ouse Valley	85%	12	100%
CHS ChYPS West Sx Chichester	85%	38	79%
CHS ChYPS West Sx CMHL	85%	36	75%
CHS ChYPS West Sx North West	85%	50	52%
CHS ChYPS West Sx Worthing	85%	6	50%
CRHT (ChYPS)	85%	156	100%
Eastleigh CAMHS	85%	39	78%
FEDS West Sussex	85%	60	100%
Havant and Petersfield CAMHS	85%	24	100%
Havant and Petersfield CAMHS	85%	47	64%
New Forest CAMHS	85%	59	76%
Winchester and Test valley	85%	11	92%

Winchester and Test Valley CAMHS	85%	67	85%
Core service total	**85%**	**1786**	**84%**
Trust Total	**85%**	**13594**	**76%**

- There was evidence that staff supervision was occurring at regular intervals in accordance with trust policy across all locations. Some grades of staff received more frequent supervision, for example trainees and very new staff members.
- Between 1 July 2016 and 30 June 2017 the average rate of supervision across all teams in the core service was 84% against the trust target of 85%. The rate of clinical supervision reported during this inspection is higher than the 80% reported at the last inspection.
- When on inspection, the inspection teams found supervision rates to be much higher than this. This was due to the data being taken from the staff personal online dashboard 'My Learning' once supervision records were uploaded to the system. However, staff reported that they did not always upload their supervision records or log them due to time constraints and therefore the official rates appeared lower. In December 2017 we were provided with refreshed data form the trust which showed that the rate of supervision was at 90%.
- At the last inspection, CQC found that there was a lack of oversight of supervision which meant that managers could not guarantee that all staff received regular supervision. On this inspection, overarching local management of supervision was appropriate and monitored regularly at all locations. There were audits in place to monitor for regularity and quality of supervision by senior leadership. Team managers completed supervision oversight logs at the end of each month and sent these to general managers to ensure consistent oversight and implementation of supervision across all teams.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
03-CA-DAY-Chalkhill	2	2	100%
05-WA-EIS-Eastbourne	10	10	100%
06-CA-CLIASE-Liaison Royal Alexandra	4	4	100%
06-WA-EIS-Brighton	15	15	100%
10-CA-CMHT-Eastleigh	6	6	100%
10-CA-CMHT-Basingstoke	20	19	95%
10-CA-CMHT-Winchester	19	18	95%
08-CA-CMHT-LD & FISS	14	13	93%
04-WA-EIS-Hastings	10	9	90%
09-CA-CMHL-West Sussex	8	7	88%
10-CA-CMHT-Fareham	26	21	81%

10-CA-CMHT-New Forest	25	20	80%
01-WA-EIS-Bognor Regis	14	11	79%
10-CA-CMHT-Aldershot	17	13	76%
11-CA-SS-Learn Dis & CB	19	14	74%
01-CA-CMHT-Chichester	14	10	71%
02-CA-CMHT-Worthing	13	8	62%
04-CA-CMHT-Hastings	40	23	58%
10-CA-CMHT-Havant	19	11	58%
04-CA-CMHT-LACMHS	14	8	57%
03-CA-OUT-Chalkhill	16	9	56%
11-CA-SS-CIC	20	11	55%
02-WA-EIS-Worthing	9	4	44%
01-CA-OUT-Laac	12	4	33%
CHS ChYPS Other Services	11	2	18%
05-CA-CMHT-Eastbourne	N/A	N/A	N/A
05-CA-CMHT-Ouse	N/A	N/A	N/A
03-WA-EIS-Horsham	N/A	N/A	N/A
Core service total	**377**	**272**	**67%**
Trust wide	**1332**	**2706**	**49%**

- The trust's target rate for appraisal compliance was 90%. As at 31 July 2017, the trust submitted data that overall appraisal rates for staff was 67%. The rate of appraisal compliance for staff reported during this inspection improved on the 60% reported at the last inspection. We received a data refresh from the trust in December 2017 and found that the appraisal rate had improved to 77%. During the inspection, in each service visited, we saw evidence that all teams were at 100% compliance for appraisal rates. The reason given for the lowered submitted data was that staff were not routinely uploading and logging their completed appraisals onto the 'My Learning' platform, from which data was taken from. Additionally, the data included staff members who were either on maternity leave or long term sick leave. The trust acknowledged that locally staff did not always upload onto the central system the appraisals that had been undertaken, and so this was not always accurately captured. There was an improvement plan in place to address this.
- Appraisals followed a set agenda that included staff performance against the values of the trust as well as identifying staff development needs and interests. The service implemented a training need flowchart that stipulated the procedure for requesting and approving staff specialist training. This system ensured suitable staff received specialist training in their areas of interest, but only when the need was identified within the service. This ensured the system and funding was not abused and remained objective.
- All locations we visited participated in regular reflective supervision groups to facilitate clinical discussions and learning.

Multidisciplinary and interagency team work

- The inspection team attended multi-disciplinary team meetings across the service and saw evidence that these were occurring regularly. Multidisciplinary team meetings were well attended by a range of professionals and all staff gave valued input into discussions.
- In addition to these meetings, other multi-disciplinary team meetings were held for specific issues such as 'complex case' reviews and 'allocations' meetings. These meetings aimed to understand and work together to care for some of the most vulnerable and/or complex patients on the caseloads. The meetings enabled staff to gain a clear understanding as to patient needs and regularly review the risk they presented.
- Due to the larger waiting times for the attention deficit hyperactivity disorder pathway, the service was holding weekly or fortnightly multidisciplinary team meetings specific to this pathway to respond sufficiently to the increased demand in this patient group.
- Staff frequently referred to the NICE guidance when discussing cases.
- We saw excellent working relationships with external organisations within health and social care to enable best practice and care for their patients. We saw good links with schools in which staff provided support to pupils and delivered training for school teachers. Each local school had an allocated named nurse for support and advice. In Hampshire, the team delivered three sessions of their coping and resilience education (CARE) programme in conjunction with schools.
- There were very good links to social services and the local authority in all locations. In Hampshire, they held monthly meetings with adult mental health services to discuss patients transitioning to adult services when they reached a certain age.

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

- As of 31 July 2017, the trust submitted data stating that 77% of the workforce had received training in the Mental Health Act. The trust stated that this training was mandatory for all community service staff and was renewed every two years. The training compliance reported during this inspection was higher than the 36% reported at the last inspection.
- The service had members of staff who were Approved Mental Health Professional (AMHPs). Staff told us they were a great source of knowledge and information regarding the Mental Health Act and were easily approachable for guidance.
- Staff demonstrated a basic knowledge of the Mental Health Act and knew that the trust had a central Mental Health Act office if they required further assistance or legal advice on the matter. Staff could access the electronic shared drive to gain access to the trust central Mental Health Act policies and procedures.

Good practice in applying the Mental Capacity Act

- As of 31 July 2017, 80% of the workforce had received training in the Mental Capacity Act. The trust stated that this training was mandatory for all community service staff and renewed every two years. The training compliance reported during this inspection is higher than the 44% reported at the last inspection.

- Staff could access appropriate Mental Capacity Act policies and guidance via the electronic shared drive.
- Staff knowledge of the Mental Capacity Act was found to be sufficient, with staff able to explain the key guiding principles of assessing capacity. Staff were knowledgeable of and understood Gillick competency. Gillick competency means young people are under the legal age of consent but deemed capable of consenting for themselves
- In the Brighton location we were told that they had a local Gillick competence champion who was a source of advice and guidance.
- We saw evidence of discussions and consideration of Gillick competence in multidisciplinary case reviews and care records. However, we found that documentation of capacity was not consistently uploaded onto the care notes system or recorded in the same manner.
- Whilst consent to treatment was not explicitly documented in the patient records system in the West Sussex services, we obtained other evidence to ensure that implied consent was sought and competence considered. Valid consent to treatment means that the clinician has given the child and/or those with parental responsibility appropriate information about the purpose and nature of treatment, including any risks and any alternatives. On inspection, carers and patients told us they received enough information regarding the types of treatment on offer in order to make an informed decision about their care. Additionally, the service routinely obtained session-by session feedback from both the carers and patients to gain their views on their care.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

- We observed many positive and engaging interactions between staff and patients across all locations and staff demonstrated a caring attitude towards patients.
- We witnessed staff speaking sensitively and respectfully when discussing patient care in all meetings and there was a real understanding from clinicians of each patient on their caseload. Staff were knowledgeable of patient risks and treatment plans and they were sensitive towards patients cultural, religious and social needs.
- Staff did not appear to rush appointments and gave clear and honest information when discussing care to patients and family members. The inspection team felt that during all appointments staff were respectful to patient's needs and wishes and gave valuable and practical advice and support.
- We spoke with 32 carers and three patients across the service and feedback from all locations was largely positive. Many carers stated that the service had been excellent at all stages of treatment and patients fed back that they felt safe and listened to by the service. Patients and carers were complimentary about staff attitudes and said they were very polite, caring and took a real interest in their wellbeing. Patients and carers reported that they were given plenty of information about the service and that they felt really involved in their care. Patients felt positive about their future thanks to the input of the service.

- We found good processes across the service for information sharing with external agencies. Carers were asked to sign an opt-in form for information sharing when entering the service. Staff were aware of the requirements to involve patients in this decision making, especially if they were deemed to be competent in understanding and retaining the information to make a decision. There was clear information available to patients and procedures in place for when it was necessary to break confidentiality.

The involvement of people in the care they receive

Involvement of patients

- Most patients and carers we spoke with said they felt involved in their care plan and were offered a copy of the plan. Evidence within care plans demonstrated that patient choice was valued and documented and that patient goals and actions were written in first person.
- We saw evidence that staff found effective ways of communicating with patients when there were communication difficulties. This included the use of interpreters for patients whose first language was not English and using 'signers' for other patients.
- In Hastings, we saw evidence of using child friendly resources to help patients understand attention deficit hyperactivity disorder (ADHD) through the use of cartoon characters.
- Patients were invited to apply to become part of the advice consult experience (ACE) project in which a panel of patients could become involved with decisions regarding the delivery of the service. This included giving feedback on staff recruitment and sitting on the recruitment panel for vacant staff posts. Each location had a nominated ACE champion.
- The trust had set up the 'discovery college' in Sussex where they offered young people and their carers groups and courses to attend. Courses included drama, music, art, woodland workshops and peer mentoring.
- The West Sussex locations employed a participation lead who had set up a young person's forum that met once a month. This forum gave a space for young people within the service to give feedback in a constructive manner that could then be taken to leadership meetings within the service.
- The Hampshire service undertook a variety of activities to involve young people in their care. They conducted a 'Starfish Project' that involved young people across Hampshire accessing a half hour interactive workshop focusing on exploring issues impacting on emotional health, wellbeing and functioning with discussions on how to cope when in a crisis.
- They also delivered 'Hampshire fit fest' annually. This young people's health and wellbeing event encouraged young people in Hampshire to 'get fit, get happy and get healthy'. A range of workshops were delivered by clinicians, artists, and sports people. Young people had the opportunity to learn how to manage their stress, cope in times of crisis, nutritional education, bullying and managing their internet lives safely. The service also provided a bubbleologist and an animal petting zoo to aid enjoyment and attract young people. The workshops had an evidence base in cognitive behavioural therapy (CBT) techniques and outcome measures had been developed in order to assess its effectiveness.

Involvement of families and carers

- There were multiple families and carers groups across the service and information days for parents and carers to attend and meet with and ask staff questions about treatment.

- All carers we spoke with said they felt involved in the patients care and that they were well informed by the service.

- In Basingstoke, a recent pilot of inviting parents and carers of those on the waiting lists had proved successful. This informal monthly meeting ensured carers and patients felt supported whilst on the waiting list and that the service was appropriately managing the risk to patients on the waiting list.

- The Hampshire team held a yearly, one day parent and carer event (PACE) with the aims of engaging families with the service, equipping them with knowledge and management tools to deal with potential issues and concerns and provide useful information on mental health. The event held a multitude of workshops including autism awareness, managing challenging behaviour, supporting a child with substance misuse, supporting a child in crisis and managing anxiety for parents and carers. The event was a jointly run with the primary behaviour service, parent voice, autism Hampshire, school nursing teams and Solent NHS trust. Feedback from attendees of the event was overwhelmingly positive and we saw plans to introduce more regular PACE events in the future.

- The Brighton location had good links with a local carers group called ‘amaze’ that provided help, guidance and support for carers of young people with learning and developmental disabilities.

- In East Sussex we saw the team supporting the running of a kinship carers group in response to the service recognising the increasing number referrals from young people who were looked after by relatives other than their birth parents.

- All locations had feedback boxes and forms in the reception areas for parents and carers to give feedback on the service. The Hailsham service had a ‘bullseye board’ in their reception area that displayed analysed data based upon patient and carer feedback on questions such as ‘did you feel listened to?’. This gave staff, patients and carers a live snapshot of how the service was performing based solely upon feedback.

- Across the service we saw multiple ‘you said, we did’ boards in which improvements and changes to the service, based upon patient and carer feedback was displayed for patients and carers to see. We heard from carers that this made them feel like their feedback was valued and worthwhile.

Is the service responsive?

Access and waiting times

- The service had clear and consistent referral and acceptance criteria across all locations. This criteria included the threshold for acceptance into the community CAMHS service and the priority criteria for patients to be seen, based upon presenting risk. The Hampshire and East Sussex services operated a single point of access team to triage referrals for appropriateness against the criteria and signpost to external support groups and initiatives when appropriate. The single point of access teams held good links with external agencies to ensure smooth and consistent referrals onto other services in a timely manner. The single point of access team in Hampshire recently won a silver award for the 'team award' at the trust's 'positive practice awards' 2017. The West Sussex services operated a similar service called the 'wellbeing service'. The Worthing team also held fortnightly meetings with the local paediatric team at the general hospital to discuss and triage referrals.

Name of hospital site or location	Name of in-patient ward or unit	Service Type	Days from referral to initial assessment		Days from assessment to treatment	
			Local target	Actual (mean)	National target	Actual (mean)
Carters Lane House	01-CA-CMHT-CBST	Child and Adolescent Mental Health Services	28	9	98	0
72 Stockbridge Road	01-CA-CMHT-Chichester	Child and Adolescent Mental Health Services	28	15	98	7
Carters Lane House	01-CA-OUT-Laac	Child and Adolescent Mental Health Services	28	13	98	1
Worthing Hospital	02-CA-CMHT-Worthing	Child and Adolescent Mental Health Services	28	16	98	11
New Park House	03-CA-CMHT-Northern West Sussex	Child and Adolescent Mental Health Services	28	20	98	5
St Anne's Community Centre	04-CA-CMHT-Hastings	Child and Adolescent Mental Health Services	28	3	98	31
Highmore	04-CA-CMHT-LACMHS	Child and Adolescent Mental Health Services	28	5	98	1

Highmore	05-CA-CMHT-Eastbourne	Child and Adolescent Mental Health Services	28	15	98	14
Orchard House	05-CA-CMHT-Ouse	Child and Adolescent Mental Health Services	28	16	98	13
The Aldrington Centre	06-CA-CMHT-Brighton CAMHS	Child and Adolescent Mental Health Services	28	20	98	12
The Aldrington Centre	06-CA-CMHT-LD	Child and Adolescent Mental Health Services	28	19	98	3
The Aldrington Centre	06-CA-CMHT-RU-OK?	Child and Adolescent Mental Health Services	28	15	98	22
The Aldrington Centre	06-CA-CMHT-YOT	Child and Adolescent Mental Health Services	28	7	98	4
Highmore	08-CA-CMHT-LD & FISS	Child and Adolescent Mental Health Services	28	18	98	3
Highmore	08-CA-PMHT-East Sussex	Child and Adolescent Mental Health Services	28	0	98	0
Princess Royal Hospital	09-CA-CMHT-Risk Assessment Team	Child and Adolescent Mental Health Services	28	18	98	76
Chanctonbury, Swandean	09-CA-CMHT-West Sussex	Child and Adolescent Mental Health Services	28	0	98	0
New Park House	09-CA-OUT-HighRisk Sexual Behaviour	Child and Adolescent Mental Health Services	28	0	98	2
Aldershot Centre for Health	10-CA-CMHT-Aldershot	Child and Adolescent Mental Health Services	28	36	28	15
Brambly's	10-CA-CMHT-Basingstoke	Child and Adolescent Mental Health	28	33	28	81

		Services				
The Bridge Centre	10-CA-CMHT-Eastleigh	Child and Adolescent Mental Health Services	28	55	28	37
Osborn Centre	10-CA-CMHT-Fareham	Child and Adolescent Mental Health Services	28	76	28	74
Oak Park Children's Services	10-CA-CMHT-Havant	Child and Adolescent Mental Health Services	28	57	28	90
Brambly's	10-CA-CMHT-i2i	Child and Adolescent Mental Health Services	28	0	28	0
Ashurst Child and Family Centre	10-CA-CMHT-New Forest	Child and Adolescent Mental Health Services	28	81	28	93
Avalon House	10-CA-CMHT-Winchester & Test Valley	Child and Adolescent Mental Health Services	28	61	28	57
New Park House	10-CA-CMHT-YOT	Child and Adolescent Mental Health Services	14	12	14	2
Cherry Tree House	11-CA-SS-CIC	Child and Adolescent Mental Health Services	42	22	28	14

- The trust implemented target times for referral to assessment and assessment to treatment for the service that was aligned with national targets. The trust target for referral to assessment was 4 weeks and assessment to treatment was 14 weeks. These targets were implemented to ensure compliance with the NHS constitution that no patient should wait more than 18 weeks for any treatment.
- The trust submitted data prior to the inspection regarding average waiting times for assessment and treatment. The whole service fell within target times according to the data, except for all three Hampshire teams who had longer average waiting times for assessment. The Hampshire services were within target time for assessment to treatment This data was consistent with evidence found on inspection. The longest wait for assessment was at the Eastleigh service with an average wait time of eight weeks.
- Generally, all locations held between four to six choice assessments per day for clinicians and in Hampshire we saw plans for a choice assessment ‘blitz’ week, in which significantly

higher number of appointments were being made in a single week in an effort to reduce waiting times for those locations.

- All services were on average within the national 18 week referral to treatment targets, despite the increased wait times for assessment in Hampshire.
- In Chichester, the team operated a system in which patients on the waiting list for specific therapies were immediately assigned a date for their appointment. Staff reported that this vastly reduced the anxiety of parents and carers who previously frequently called the service to ask where they were on the waiting list. We were told that the appointment date made could still be brought forward if there was a change in need and/or availability of appointments.
- The inspection team found that all locations were managing the risk of their waitlists well and were constantly engaging with patients, parents and carers to assess any changes in circumstances and risk. Care coordinators were routinely offering support sessions to patients that were on specific treatment pathways waiting lists.
- There was a consistent approach across the service to responding to and dealing with urgent referrals. All locations held a duty rota that included urgent appointment slots for the duty clinician and psychiatrist. All teams implemented an i2i/urgent help team to respond quickly and assess within local hospitals for crisis referrals with the support of A&E liaison nurses. These services also offered out of hours support.
- The i2i/urgent help teams across the service were able to take referrals from the community teams to provide increased appointments and home treatment support. These teams were co-located and supervised by the CAMHS community team in some locations that greatly helped and supported working relationships. These teams were able to provide follow up appointments for young people discharged from hospital. Staff we spoke with were knowledgeable of the responsibilities of these teams and found them to be highly supportive and responsive. There were also A&E liaison teams in place to provide support and access to the service to young people who were admitted to A&E with psychiatric problems.
- In the East Sussex services, the teams conducted a pilot in which the urgent help team completed telephone assessments of patients, with the support of local CAMHS staff and training. The aim of this was to reduce the waiting lists for assessment and get patients directly onto specific treatment pathways. The initial feedback and evaluation of this was very positive and there were discussions within the service regarding implementing a similar scheme across the whole core service.
- We saw good evidence that teams responded promptly, appropriately and sensitively when parents and carers phoned the service and triaged calls with appropriate signposting if the situation was not urgent enough to be seen by the service.
- The service appropriately engaged patients with their services and we found that there was a proactive approach to re-engaging young people and their families following missed appointments. Staff engaged with schools and contacted GP's in attempts to re-engage patients. There were good procedures in place to ensure 'children not brought' to the service were followed-up with new appointments, calls, letters and contact with social services was made if deemed suitable to the risk presented by non-engagement.

- In Eastleigh, Basingstoke, Hailsham and Brighton, the teams offered late night clinics and appointments for patients to aid engagement with the service as patients and carers did not have to take time off work/school. We found good risk assessments and lone working procedures were in place to ensure the safety to staff and patients was maintained.
- The inspection team found that appointments and clinics were rarely cancelled across the service, except where explicitly necessary, for example through staff sickness.
- However, we were told that due to the lack of facilities at the Eastleigh location and the paper room booking system in place, many appointments could not be made, some were double booked and so reduced in time or some were cancelled all together at short notice. This had been raised by the local team and was currently on the risk register.
- Locations within the East Sussex services recognised that waiting times for certain treatment pathways such as cognitive behavioural therapy were high. In response to this, they were trialling high quality online cognitive behavioural therapy (CBT) with their patients and were awaiting feedback and evaluation of the service.
- The service had transition protocols in place to suitably transition patients from community CAMHS to adult services if required. This process generally begun when patients were 17 and a half and we saw documented evidence of this within care plans.
- In Hampshire, teams implemented monthly meetings with adult services to aid transitional arrangements for patients.
- However, we spoke with two carers of older patients in Chichester who expressed concerns regarding transitioning arrangements. They felt they did not know what was going to happen next and were uncertain what arrangements may or may not have been be in place.

The facilities promote comfort, dignity and privacy

- All locations had a variety of rooms available for staff to use and they included dedicated clinic rooms to undertake basic physical health monitoring such as height, weight and blood pressure measurements.
- All locations had appropriately sized therapy rooms and many sites had two way mirrors for family therapy appointments. Therapy rooms had well maintained furniture within them and age appropriate toys available for child use. We noted cleaning rotas and a toy cleaning policies for all locations. All locations also had a dedicated art therapy room with maintained, clean and tidy equipment to aid sessions.
- However, the Eastleigh, Hailsham and Chichester sites did not have enough therapy rooms on site and were renting rooms in other facilities externally. We saw that the lack of rooms was impacting on the delivery of care at Eastleigh with appointments not being made, shortened or cancelled last minute. At all three locations, staff commented on the difficulty and frustration of the room booking systems.
- All waiting rooms had sufficient seats for patients and carers to use with the exception of Eastleigh. Eastleigh's waiting room was extremely small with four waiting chairs. Carers and staff told the inspection team that this sometimes got cramped and a bit chaotic when multiple people were in the waiting room.

- All waiting rooms had a range of leaflets and information to browse that included information on advocacy service, external support groups and treatment information.

Patients' engagement with the wider community

- Patients of the East and West Sussex locations were encouraged and supported to engage with the educational opportunities available at the recovery and discovery colleges provided by the trust. Leaflets and prospectuses advertising these opportunities were readily available and displayed to patients visiting the locations.
- Staff told us that patients were encouraged to develop and maintain relationships with people that mattered to them. This was through engaging patients to include their parents and family members in their treatment planning and care where the young person was deemed competent and also engaging in social activities outside the service.
- The Hampshire teams ran a 'suicide awareness for everyone' (SAFE) campaign from September 2016 to September 2017 that aimed to engage the public and raise awareness to young person's mental health needs and self-harm amongst the general public. It additionally aimed to raise the profile of mental health and reduce stigma on those attending services. The campaign held stalls and workshops throughout the year and helped to equip young people and their carers with the tools needed to self-treat any minor mental health issues in order to integrate and cope better in the community.
- In Brighton, the team frequently held 'pizza meet up' days for patients of the service. This day provided a fun and informal setting for patients to meet other young people, build confidence and self-esteem and take part in activities. This was aimed at strengthening young people's social wellbeing and support network in a relaxed and casual manner.

Meeting the needs of all people who use the service

- Each location had suitable disabled access and adapted bathrooms. Where services were not on the ground floor, there were lifts available to transport disabled parents, carers and patients to their therapy rooms.
- Staff in Basingstoke had noted an increase in lesbian, gay, bisexual and transgender (LGBT) related referrals recently and were developing a pathway to respond to the increasing need within their patient group and local population.
- We were told that staff could access information leaflets in different languages via a central requesting system for patients. We saw examples of this in practice in Aldershot whereby a proportion of the local population and patient groups spoke Napali and required leaflets and interpreters to overcome the language barrier. Additionally, we saw evidence in the Basingstoke service that sign language interpreters had been used previously.
- Some locations held late night clinics to ensure that patients and parents were not having to take time out of school, college or work which aided greater engagement with the service.

Listening to and learning from concerns and complaints

Team name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Under investigation	Withdrawn
A&T CAMHS (Horsham)	2	1	0	1	0	0
ADHD (West Sussex)	3	1	0	2	0	0
CAMHS - LAAC (East Sussex)	5	1	1	3	0	0
CAMHS - UHS (West Sussex)	2	0	0	1	1	0
CAMHS (Aldershot)	5	1	3	1	0	0
CAMHS (Andover)	3		1	2	0	0
CAMHS (Ashurst)	3	1	1	1	0	0
CAMHS (Basingstoke)	10	1	3	5	1	0
CAMHS (Brighton)	13	1	2	9	1	0
CAMHS (Chalkhill)	3	0	0	3	0	0
CAMHS (Eastleigh)	2	0	0	1	0	1
CAMHS (Fareham & Gosport)	7	2	0	4	0	0
CAMHS (Hastings)	4	1	1	1	1	0
CAMHS (Havant - Fort Southwick)	10	4	1	4	1	0
CAMHS (Highmore)	5	1	2	2	0	0
CAMHS (Lewes & Ouse Valley)	5	0	1	3	1	0
CAMHS (NW Sussex) Chalkhill	1	0	0	1	0	0
CAMHS (NW Sussex) New Park House	10	2	3	5	0	0
CAMHS (Uckfield & N Wealden)	2	1	0	1	0	0
CAMHS (West Sussex)	1	0	0	1	0	0
CAMHS (Winchester Specialist)	3	1	2	0	0	0
CAMHS (Worthing)	7	1	1	4	1	0
CAMHS I2i North (Hants)	5	0	0	3	0	1
CAMHS I2i South West (Hants)	2	1	0	1	0	0
CAMHS Specialist	3	0	1	2	0	0

(Havant - Oak Park)						
Early Intervention Service (H & R)	1	0	0	1	0	0
Early Intervention Service (Highmore)	1	1	0	0	0	0
Early Intervention Service (New Park Hou	1	0	0	1	0	0
Early Intervention Service (The Aldringt	2	0	0	0	0	2
Mental Health Liaison Practitioners (Bed	1	0	0	0	0	1
Recovery & Wellbeing (Adur)	1	0	0	1	0	0
SOAMHS (Hastings & Rother)	1	0	0	1	0	0
Core service total	124	22(18%)	23(19%)	65 (52%)	7(6%)	5(4%)

- We found a culture of handling complaints locally at all locations to limit the need for official complaints to be made. This ensured that complaints were managed in a quick and efficient manner and made it easier for patients and carers to raise complaints informally. Carers reported that this generally worked very well and resolutions made were satisfactory for all parties.
- Where complaints were raised in an official format, the trust submitted data that showed the service received 124 complaints between 1 July 2016 and 30 June 2017. 22 (18%) of these complaints were upheld, 23 (19%) were partially upheld and 65 (52%) were not upheld.
- Of the locations visited, Brighton held the highest total number of complaints with 14. The highest number of complaints upheld or partially upheld was at Aldershot and Basingstoke (4).
- We witnessed good duty of candour within all teams in discussing their complaints progress and outcomes with patients and carers. All managers wrote to patients and carers when an investigation into a complaint had concluded and described the action taken as a result.
- Where complaints had been raised and upheld by the parliamentary and health service ombudsman (PHSO) we saw clear action plans that were followed and reviewed by teams to ensure all actions and recommendations were met.
- There was a drive within the service to ensure compliments were routinely being recorded and uploaded onto the electronic system. This core service received 111 compliments during the 12 months from 1 July 2016 to 30 June 2017. This accounted for 16% of all compliments received by the trust as a whole (681).

Is the service well led?

Leadership

- All staff we spoke with in the service commented on good leadership and direction from local team leaders and overall service leads. Staff said they felt supported by management and encouraged to propose new ideas and inflict positive change.
- Leaders within the service all came from different backgrounds, with some being clinicians and holding small caseloads or running groups and clinics. All team leaders were visible within each location and we were told that staff were encouraged to take on additional responsibilities and training where a mutual benefit could be identified.
- Staff members reported that there was appropriate management leadership training available to staff regardless of grade and job role. The trust recently ran an 'emerging leaders' event and we saw staff from all locations attend this. We saw evidence that following this training, some staff members had taken up leadership roles within the service.

Vision and strategy

- The trusts vision and values were displayed around all locations and staff we spoke with were aware of what they were and what they meant.
- Staff appraisals were structured as such to review staff performance and behaviours against the trust values. This meant that staff were explicitly aware of and expressing the values of the trust at all times during their working days.
- Staff were aware of the leadership teams locally and trust wide. Staff stated local leadership teams were highly visible and always approachable. When discussing trust wide senior leadership, all staff were aware of who they were, how to contact them and stated that they had occasionally visited their sites. Staff commented that they had felt a positive change in the purpose and value of their services since the introduction of multiple new members of the trust board and chief executive.
- Staff were acutely aware of the budget and resource restraints on the service. Local leadership teams discussed alternative ways of working and delivering the service to meet these needs. Across the service, we saw job planning work for all clinical staff members to aid in planning. We saw evidence of job planning being presented to local Clinical Commissioning Groups to successfully increase funding. This included additional or temporary funding to aid innovative ideas such as the SAFE campaign, FITFEST and the iROCK service.

Culture

- All staff members we spoke with were immensely proud of the work they and their teams did. Staff felt positive working in their services and felt pride working for the trust. There was a real sense of comradery within the teams and everyone supported each other to deliver good care to patients.

- Whilst there was generally high morale amongst staff members and all staff said they had great support, many stated that they felt under a lot of pressure to meet targets and deliver their service.
- Staff said they felt respected by all colleagues including managers and that their work was valued. In Hailsham there was a staff appreciation board in which staff could write compliments and thanks out on post it notes and post it on the wall.
- The Hampshire service undertook several events during the SAFE campaign anniversary week dedicated to staff wellbeing, including a staff wellbeing day. This included a selection of fun events for staff including arts and crafts, yoga, drama and 'escape rooms' puzzle tasks. The service participated in its inaugural reward ceremony where teams and disciplines were honoured and rewarded for their hard work, dedication and commitment.
- The service had enhanced its staff health and wellbeing agenda to support the recruitment and retention programme. Alongside the Hampshire staff wellbeing day, staff in Sussex were offered head and shoulder massages, health checks during August and September and ad-hoc health and wellbeing workshops for all staff.
- The Basingstoke team recently had three staff members nominated for various awards at the trust wide 'positive practice awards' ceremony.

Governance

- There were systems in place to ensure all staff members received regular supervision and yearly appraisals. There was much more oversight of these from local managers and service leads and we saw regular discussions to cement their importance to staff within team meetings and supervision
- However, whilst supervision and appraisal rates were high across the service and well managed locally, senior leadership were not obtaining correct data relating to them due to staff not uploading their records onto 'My Learning' consistently.
- The service an action plan in place to demonstrate how all mandatory training levels that were below trust target were going to be completed by all staff. Actions included obtaining additional trainers, providing high quality online training and setting dates and enrolling staff on future courses.
- All locations had clear processes and policies in place to address complaints, incidents and safeguarding alerts and ensured that any learning that was taken forward from these was disseminated to staff in a timely and efficient manner.
- There was clear governance and action plans for service improvement, particularly around managing risk to patients. The whole core service demonstrated that they were thinking of innovative and unique ways of working to ensure their service matched the increasing needs of their population and patient groups.

Management of risk, issues and performance

- Team leaders at all locations had access to electronic local risk registers and could add entries onto it. Team leaders reported that they could easily escalate any issues to the service leads if required which could then be put onto the trust wide risk register.

- We noted conversations in team meetings regarding the risk register and discussions around mitigating the entries on the risk register. However, it was not clear if other staff members could access the risk register and complete entries themselves.
- The service had mitigation plans in place for emergencies and contingency plans for staff shortages.
- A number of staff commented on and were concerned about the number of fixed term contracts in place. They reported that this led to de-motivation and insecurity for many staff members. The trust provided data that stated 78% of all staff in Hampshire CAMHS and 38% of all staff in Sussex CAMHS were on fixed term contracts. We were told that the high number of fixed term contracts within Hampshire was due to the service receiving non-recurrent funding to support specific pieces of work.
- There had been many cost improvements within the service and whilst staff reported the pressures of this and the restructuring of services, the teams were working hard to ensure it did not impact on patient care.

Information management

- Staff had access to appropriate equipment and information technology they needed to fulfil their roles. In Hampshire, the service had implemented 'Dragon' software recently that aimed to reduce admin time for staff. This software used headphones to dictate what clinicians would say directly onto the care notes system or letters they were producing.
- There were appropriate and efficient support systems and teams within the trust to quickly deal with any issues regarding equipment or information technology. There was appropriate information technology infrastructure in place to provide staff with help and support to any queries.
- The care records system was shared trust wide and held confidentially on systems that only staff had access to with a secure username and password.
- Team leaders had access to information regarding team performance on an easy to use 'dashboard'. This displayed multiple key performance indicators including incidents, complaints and staff records.

Engagement

- Staff, patients and carers were kept up to date regarding the service and trust wide initiatives via leaflets, newsletters, emails and social media. The service had a strong social media presence and engaged with young people well through this.
- The service continually collected feedback from patients and carers in a variety of way. Feedback was discussed in team meetings and where necessary, changes were made.
- Service leaders engaged regularly with external stakeholders such as commissioners. The service undertook regularly 'Mock CQC' visits in which commissioners were invited to and we saw evidence of their previous attendance.

Learning, continuous improvement and innovation

- The inspection team were told of a culture in which quality improvement changes were encouraged from staff level. There was evidence of multiple pilot ideas and projects in place that were initiated by patient facing staff, with the support of the leadership teams around them. The structuring of the service within the care delivery service (CDS) model supported 'front-line' staff to lead change.
- Staff were afforded opportunities to be involved within research and we saw evidence that this was previously supported. Where funding was provided for staff training needs, study leave was also granted.
- Within the Hastings team, two members of staff were acknowledged for their work towards a research study regarding attention deficit hyperactivity disorder (ADHD) that was published in the British Medical Journal. Additionally, one member of staff also presented their work at a national ADHD conference.
- The service had committed to the 'triangle of care' membership scheme. This scheme, by the carers trust, was a three stage recognition process for services who commit to self-assessing their services and action planning to ensure the triangle of care standards were achieved.
- The Hampshire team employed a full time innovation lead who had implemented a number of innovative ventures including the SAFE campaign, FITFEST, staff wellbeing day, national citizen service programme support and the PACE event. The innovation lead thoroughly evaluated all campaigns that the service supported, utilising a range of qualitative and quantitative data to ensure that the campaigns were efficient and effective in their delivery.
- The trust ran a discovery and recovery college with multiple courses, workshops and classes available for patients and carers to attend. We found these were very well attended and consistently received positive feedback. The discovery college was one of only two currently running in the country.
- The iROCK service in Hastings was an innovative and intuitive way in which the service could offer young people quality mental health advice and support in an informal and non-threatening environment. The service received a 'highly commended' in a recent NHS clinical commissioners healthcare transformation awards ceremony and continued to gain positive feedback from service users. The service was also shortlisted for a Health Service Journal award in November 2017.