Sussex Partnership NHS Foundation Trust

Evidence appendix

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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 the University of Sussex and has a national reputation for research into mental health issues. The trust operates from over 100 sites including the community services and serves a population of 1.6 million people in Sussex and 1.3 million in Hampshire. The trust employs approximately 4617 staff through 430 teams.

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 authority areas of Brighton and Hove, East Sussex and West Sussex and Hampshire.

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

The trust has 27 locations registered with the CQC.

Registered location	Code	Local authority
78 Crawley Road	RX2DX	West Sussex
Amberstone Hospital	RX2F3	East Sussex

Registered location	Code	Local authority
Avenida Lodge	RX2G9	East Sussex
Beechwood Unit	RX2L8	East Sussex
Chalkhill	RX2X4	West Sussex
Connolly House	RX237	West Sussex
Department of Psychiatry	RX2E7	East Sussex
HMP Lewes - Prison Healthcare Department	RX2DC	East Sussex
Healthcare HMP Ford	RX2CY	West Sussex
Horsham Hospital - Iris Ward	RX2C8	West Sussex
Hove Community Learning Disability Team	RX2XD	Brighton and Hove
Langley Green Hospital	RX2PO	West Sussex
Lindridge	RX2Y5	Brighton and Hove
Meadowfield Hospital	RX277	West Sussex
Millview Hospital	RX213	Brighton and Hove
Oaklands Centre for Acute Care	RX26N	West Sussex
Orchard House	RX239	West Sussex
Rutland Gardens Hostel - Community Wards	RX202	Brighton and Hove
Salvington Lodge (The Burrowes)	RX2A3	West Sussex
Selden Centre, Specialist Assessment and Intervention Service	RX2Y6	West Sussex
Shepherd House	RX232	West Sussex
St Anne's Centre & EMI Wards	RX2K3	East Sussex
The Chichester Centre	RX2X5	West Sussex
The Harold Kidd Unit	RX240	West Sussex
The Hellingly Centre	RX2E9	East Sussex
Trust Headquarters	RX219	West Sussex
Woodlands	RX2L6	East Sussex

The trust had 588 inpatient beds across 37 wards, 16 of which were children's mental health beds. The trust had no acute outpatient clinics, community mental health clinics or community physical health clinics per week.

Total number of inpatient beds	588
Total number of inpatient wards	37
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 children's beds (Acute setting)	0
Total number of outpatient clinics per week*	0
Total number of community mental health clinics per week	0
Total number of community physical health clinics per week	0
Total number of dedicated EOLC inpatient beds	0

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

The last Well Led review of the trust took place from the 5 - 7 December 2017. We identified one regulatory breach during the 2017 Well Led inspection. This was in relation to maintaining the equipment and premises in the acute wards for adults of working age and psychiatric intensive care units:

- The trust must ensure that staff in Woodlands carry out and record daily ward environmental risk assessments.
- The trust must ensure that ligature risks in the ward gardens of Langley Green Hospital are scored in parity with similar ligature risks present on the wards.
- The trust must ensure that a mesh guard is fitted to the gap where a window on Amber ward opens out onto the communal walking area.
- The trust must ensure that communication and observation for the seclusion room in Amber ward is improved.
- The trust must ensure that staff conduct weekly checks on resuscitation equipment in Meadowfield Hospital, that clinic room fridges are monitored regularly on Regency and Rowan wards, and that the missing piece of resuscitation equipment is replaced on Regency ward.
- The trust must ensure that safety regarding the hot water temperature in the Amber ward patient kitchen is improved.

We also told the trust that it should take action either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services:

- The trust should ensure all staff understand their responsibilities under the Mental Capacity Act 2005 and implement these in their work with patients.
- The trust should ensure that mandatory training levels for all training subjects meet the trust's compliance target of 85%.
- The trust should ensure all older adult wards comply with the Department of Health eliminating mixed sex accommodation requirements.
- The trust should progress its action plan to ensure that serious incident investigations are completed to the timelines within their policy.
- The trust should ensure that evidence is held of occupational health screening for all executive and non-executive directors.
- The trust should ensure that staff receive regular appraisal.

- The trust should ensure all staff upload their supervision and appraisal onto the centralised system.

We have reviewed evidence in relation to these areas of improvement at this well led review. Whilst we did not inspect the acute wards for adults of working age and psychiatric intensive care units, the trust provided assurance that these areas had been addressed.

We also:

- Interviewed seven executive directors, two non-executive directors, the chair and the chief executive of the trust.
- Held a focus group with four non-executive directors of the trust.
- Interviewed the lead governor and observed one council of governors meeting.
- Undertook an online feedback survey with the trust governors.
- Spoke with trust leads in the Mental Health Act, Mental Capacity Act, serious incidents, pharmacy, complaints, governance, quality improvement and patient experience.
- Interviewed the freedom to speak up guardian.
- Spoke with two Mental Health Act service officers.
- Spoke with the independent mental health advocacy providers, and approved mental health professional leads, for East and West Sussex, and Brighton and Hove.
- Interviewed the junior doctor representatives of the trust.
- Observed two trust board meetings (public and private meetings on both occasions).
- Observed quality committee, audit committee and safety committee meetings.
- Observed a patient and carer engagement steering group workshop.
- Held two focus groups with black and minority ethnic (BAME) staff.
- Held 25 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, support workers, corporate and estates staff and consultants. These were attended by 118 staff.
- We spoke with approximately 135 staff during the core service inspections.
- Reviewed trust policies, procedures and meeting papers.
- Reviewed three serious incident investigation reports.
- Reviewed five complaint records.
- Reviewed three death investigation reports.
- Observed different staff network meetings, including the BAME, LGBTQI meeting, women's network meeting and race reference group meeting.
- Attended the 'not just an admin' conference, suicide prevention conference and a chief executive briefing event.
- Observed clinical strategy transformation board meeting, triangle of care meeting and three care delivery service meetings.
- Received feedback about the trust from the Central Sussex Commissioning Alliance (the seven Sussex clinical commissioning groups).
- Received feedback about the trust from NHS England specialised commissioning and NHS Improvement.
- Received feedback from East and West Sussex and Brighton and Hove councils.
- Received feedback about the trust from Brighton and Hove overview and scrutiny committee and health and well-being board.
- Received feedback from East Sussex and Brighton and Hove Healthwatch.
- Received feedback from the Health and Safety Executive.

- 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

External stakeholders commented that there was an improving organisational culture, openness and drive towards quality improvement across the trust. They found the senior leaders of the trust were very positive about engaging, providing timely information and that the trust provided a really positive model of stakeholder engagement. Comments included that at all levels within the trust, there was demonstration of good practice and compassionate care. From the focus groups we held with trust staff there was positive feedback about the senior leadership team that they had met, where they were approachable and encouraged improvement and innovation in services. Through our observations of meetings across the trust in the months leading up to the well led review we saw that these were well led, with appropriate challenge by non-executive directors and inclusive of all parties present. The board members spoke of the support and respect they had for each other, where they could use each as a sounding board, but where they also felt able to challenge each other on issues to seek a resolution. We observed that all directors and non-executive directors attended board and committee meetings prepared, having read papers and bringing appropriate challenge and questions.

The trust board had 18 members, made up of 10 executive directors, six non-executive directors, an associate non-executive director and the chair. During 2018 the board had undergone a number of changes since the last well-led review. A new chief digital and information officer started in January 2018, followed by a new trust chair in April, new director of human resources and organisation development in July, and more recently a new chief nurse in December. A number of non-executive directors (NEDs) had commenced during the same period, due to the end of tenure for some previous NEDs. The executive board had one (17%) black and minority ethnic (BAME) member and five (83%) women. The non-executive board had two (29%) BAME members and three (43%) women. Since the last well led review, the existing members had grown in confidence, understanding of their roles and how they can be used to drive improvement.

The chief executive was held in high regard by senior leaders and throughout the organisation. She was highly visible, approachable, knowledgeable and used her leadership capability and compassion to raise the profile of mental health with external partners and in her role as strategic mental health lead within the local sustainability and transformation partnership.

The chair demonstrated a considered approach and had a good understanding of where the trust was in relation to quality governance, its risk approach, system risks and the trust skills set.

The non-executive directors had a range of skills and experiences to enhance the senior leadership of the trust. These included board and organisational development, education, quality improvement and financial management. The non-executive directors were supported in the learning and development through the induction process and board development days, with three to four days per year dedicated to this.

There were processes in place to ensure that new directors met the fit and proper person requirement criteria. All necessary checks had been undertaken, though we identified the need for more information to be obtained of evidence of qualification for one non-executive director. The monitoring of the requirements was overseen by the remuneration or nominations committee, depending on the board members' role as an executive of non-executive director.

All board members had lead areas, including non-executive directors who chaired committees, such as the finance and investment committee, quality committee and charity committee, of which different executive directors also attended. However, due to a gap in the recruitment of non-executives in 2018 some committees did not have more than one non-executive present. The non-executive director present was also the chair of the meeting, so it meant that they were limited on the challenge they were able to bring. The gap in recruitment was explained as following a skills audit carried out by the new chair, gaps were identified in the board make up and they wanted to ensure the right calibre and experiences of the new non-executive directors to enhance the leadership of the trust.

There was a programme of board visits to services. Staff told us that they were not aware of all members of the board and had only seen one or two who had visited their service. The timetable of visits showed that 52% of trust sites (inpatient and community) had received a board visit during 2018, with the majority of these carried out by the executive team members, due to the gap in non-executive directors. This could reflect why not all staff were aware of board members. All staff spoke highly of the visibility of the chief executive and her spending time with them when she visited services. Staff appreciated the opportunity to speak with her and other members of the executive team directly.

The chief pharmacist led the medicines department. The trust board received annual updates on medicines optimisation via the trust's medicines workplan. The drugs and therapeutics group (chaired by the medical director) monitored medicines optimisation within the trust and reported to the trust effective care and treatment committee. The chief pharmacist was line managed by the medical director. This meant there was executive awareness of medicines optimisation.

The trust leadership team had a high level of awareness of the challenges they faced and the priorities they wanted to drive forward. This included the difficulties in meetings the demand and capacity of their services and the recruitment and retention of nursing and medical staff. However, all were focussed on ensuring that the needs of the people who used, or who were in need of the services were paramount and at the forefront of their priorities. What also came through from observations of meetings and interviews with the senior leaders was the way that executive directors talked about issues in areas other than their line of responsibility and the way that issues and developments in each impacted on the others.

Trust governors provided feedback that the trust was very well-led and the chief executive was a good role model. They commented on the flat-hierarchy, with all views treated equally to seek improvements in the services. Non-executive directors spoke positively of the governors being a strong voice and visionary, and how pleasing it was to have a number with lived experience of using mental health services. They felt there was a healthy relationship with governors, and they gave good scrutiny and challenge.

We found the lead governor to be outstanding. She had a clear understanding of her role, influence and how to lead the governors to ensure that the voice of the service users and staff were heard. She paid close attention to the well-being and support needs of the governors to ensure they had all they needed to carry out their role and to be able to put forward the views of their constituents. She was actively involved in the work of the trust and encouraged the role of governor as a critical

friend to the non-executive directors and chair. However, emphasised the need to remind governors that they were independent and were there to support the trust but also to challenge. She had developed a clear outward facing role and developed positive links with external regulators. She had set up Sussex lead governors meetings to enable joint working together and to understand what was happening in different organisations and to promote more cross systems-working.

There were a number of leadership training programmes to support staff to progress within the trust. This included the emerging leaders programme, leadership development and access to NHS leadership academy programmes. A review of the programmes took place in 2018 and whilst the findings were positive, work had been identified to develop a clear leadership and management competence framework that was mapped to leadership and management apprenticeship standards. The coverage of participants involved in the training was monitored to ensure that this involved staff from a number of different service types across the trust, as well as staff from black and minority ethnic (BAME) backgrounds. This was overseen by the well led committee and workforce committee.

The trust had a number of leadership programmes to support succession planning, such as the emerging leaders and trust leadership development programmes. Succession planning was in place for the non-executive directors, through the recent recruitment of an associate non-executive director. However, succession planning was not established amongst the executive team and needed to be developed.

Vision and strategy

The trust had a clear vision and planned services to take into account local needs. They continued to implement the goals of the overarching '2020 vision' to provide 'outstanding care and treatment you can be confident in'. The achievement of these were supported by eight care delivery services across the trust, which provided local leadership of a particular care group and/ or geographical area. The aim of the these 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 achievement of the vision was enhanced by the implementation of the trust clinical strategy (2017-2020) which had been developed in partnership with patients, carers, staff, commissioners and other key stakeholders. Trust involvement in the new care models across Kent, Surrey and Sussex for forensic, Wessex CAMHS child and adolescent mental health services (CAMHS), Sussex CAMHS further helped to inform the trust strategy. This involvement ensured that patient, carer, and local population needs were incorporated into the strategy, as well as that of different stakeholders. We observed a clinical strategy transformation board meeting that was attended by patient/ service user leads lead, carer lead and members of the executive team. There were strengthened links to the work of the care delivery services was evident, along with links to the risk register, focus on suicide prevention, the crisis care model, though also identifying the risks to not having secured funding to realise the full strategy and trust goals.

The trust medicines strategy had nine overlapping visions covering the patient experience, safety, clinical and service cost-effectiveness. This was linked to recommendations made within the Carter I and II reports. A key feature was the training of staff to enable an increase in informed service user choice within their care plans.

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. The funding for mental health was low compared to the national average, which created a challenge for the trust. The trust chief executive was the STP senior responsible officer for the mental health strategy of the STP, which enabled the plan for change to be aligned to the trust clinical strategy. The trust had recently been successful in securing funding for 24-hour crisis service in April 2020, which was much needed for the population of Sussex and to alleviate pressure on local acute urgent care services.

Culture

The trust senior leaders outlined that the culture of the organisation was something that they paid close attention to. They recognised that they had come a long way over the past few years, but that they could not rest on this. They paid close attention to the NHS staff survey results and ensured that each team were provided with a breakdown of this to enable the information to be reviewed on team away days.

The new chief nurse spoke of having observed the positivity and patients at the heart of everything prior to working for the trust. She said she had found a positive culture and really supportive executive team to help her settle into her role. From the focus groups we held with staff her appointment had been well received and staff liked that not only was she from a BAME background, but that she brought a fresh and dynamic approach to the trust.

The morale and motivation of the staff was good and they were committed to the delivery of high quality care. They felt well supported by their managers and the teams in which they worked. We held 25 focus groups with different disciplines of staff, across the geographical footprint of the trust. These groups included allied health professionals, qualified nurses, support workers, corporate and estates staff, junior doctors and consultants. In total 118 staff attended the focus groups to tell us what it was like working for the trust. This was in addition to approximately 135 staff we spoke with during the core service inspections. Staff were positive about the changes to the senior leadership team. They were encouraged to try out new ideas and ways of working, and felt valued for the recognition they received. Non-executive directors commented that in their visits to services the staff they met with were open and forthcoming about the work they were doing and ideas for change.

Feedback from governors was that the culture had continued to improve significantly over the past few years, with staff more open and focussed on providing the best care to patients. They commented that the board were encouraging of new ideas and that in their role of governor they never anticipated they would experience such openness to be able to effect changes.

The trust had a continued focus on culture and ensuring a balance between decision making freedom, empowerment, distributed leadership and appropriate assurance.

In the 2017 NHS staff survey the trust had better results than the previous year in three key findings.

Key finding	Trust score - (2017)	Previous trust average - (2016)	Comparison to last year
Key Finding 5. Recognition and value of staff by managers and the organisation	3.63	3.59	
Key Finding 6. % of staff reporting good communication between senior management and staff	40%	36%	

Key finding	Trust score - (2017)	Previous trust average - (2016)	Comparison to last year
Key Finding 15. % of staff satisfied with the opportunities for flexible working patterns	63%	64%	
Key Finding 19 - Org and management interest in and action on health / wellbeing	3.78	3.67	

In the 2017 NHS staff survey the trust had worse results than the previous in 13 key findings:

Key finding	Trust score - (2017)	Previous trust average - (2016)	Comparison to last year
Key Finding 2. Staff satisfaction with the quality of work and care they are able to deliver	3.70	3.71	
Key Finding 3. % of staff agreeing that their role makes a difference to patients / service users	87%	89%	
Key Finding 4. Staff motivation at work	3.85	3.91	
Key Finding 13. Quality of non-mandatory training, learning or development	4.02	4.07	
Key Finding 14. Staff satisfaction with resourcing and support	3.21	3.19	
Key Finding 17. % of staff feeling unwell due to work related stress in the last 12 months	45%	43%	
Key Finding 18. % of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	55%	53%	
Key Finding 20 - % experiencing discrimination at work in last 12 mths	14	12	
Key Finding 22 - % experiencing physical violence from patients, relatives or the public in last 12 mths	18	19	
Key Finding 24 - % reporting most recent experience of violence	90	91	
Key Finding 25. % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	34%	32%	
Key Finding 26. % of staff experiencing harassment, bullying or abuse from staff in last 12 months	24%	23%	

Key finding	Trust score - (2017)	Previous trust average - (2016)	Comparison to last year
Key Finding 28 - % witnessing potentially harmful errors, near misses or incidents in last month	26%	23%	

In the 2017 NHS Staff Survey, 77% of staff said they had worked extra hours, which was worse than the national average of 71%.

The trust's engagement score shows how it compares with other mental health / learning disability trusts on an overall indicator of staff engagement. Possible scores range from one to five, with one indicating that staff were poorly engaged (with their work, their team and their trust) and five indicating that staff are highly engaged. In the 2017 NHS staff survey, the trust's score of 3.76 was the same as trusts of a similar type.

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 generally felt able to raise concerns and knew about the whistle-blowing process, though the trade union representatives we met with said there was still some room for improvement in this area.

A freedom to speak up guardian (FTSUG) and a number of advocates were available across the trust for staff to contact. The FTSUG discussed that their role was a balance of supporting staff who do speak up and wider engagement with staff, however, they had found that the service had become better known across the trust compared with the previous year, with more staff getting in touch. She found that the trust was positive about encouraging staff to speak up, and there was a real focus to speak sooner, rather than let issues build up, with issues tending to be resolved in local teams rather than through more formal routes. However, there was further work to be done in this area and she discussed plans of the trust to implement a more compassionate approach to leadership and training managers in this so that not all issues immediately go down a formal route. Part of the exit interviews of staff leaving the trust had recently involved a discussion with the FTSUG to give them the opportunity to inform of any particular reasons why they had decided to leave. The FTSUG reported to a non-executive director and attended the board meeting quarterly and gave and updates of numbers of contacts made, themes arising and presented anonymised case studies.

Trust senior leaders were committed to making improvements in the workforce race equality standard (WRES) which became compulsory for all NHS trusts in April 2015. Trusts were measured against nine measures of equality in the workforce. The findings below showed a mixed picture, and that there was more work to do. The trust acknowledged there had been little progress at band 8B and above, and had recently launched a black and minority ethnic (BAME) leadership development programme to encourage more BAME leaders in the organisation.

1. The percentages of white and black and minority ethnic (BAME) staff in each of the agenda for change pay bands 1 to 9, and at very senior manager level (including executive board members), compared with the percentage of staff in the overall workforce in 2018.

   NB. The data has been drawn from the electronic staff record (business intelligence) in line with WRES requirements and does not include the Oakleaf or Lindridge centres.

Non-Clinical					
	White	**BAME**	**Total**	**White %**	**BAME%**
Band 2	221	28	249	88.7%	11.3%
Band 3	314	15	329	95.4%	4.6%
Band 4	220	6	226	97.3%	2.7%
Band 5	107	2	109	98.2%	1.8%
Band 6	72	4	76	94.7%	5.3%
Band 7	63	2	65	96.9%	3.1%
Band 8A	54	3	57	94.7%	5.3%
Band 8B	31	1	32	94.0%	6%
Band 8C	21	3	24	87.5%	12.5%
Band 8D	12	0	12	100%	0%
Band 9	6	0	6	100%	0%
VSM	3	1	4	75%	25%
Total	**1,124**	**65**	**1,189**	**94.5%**	**5.5%**

Clinical					
	White	**BAME**	**Total**	**White %**	**BAME%**
Band 2	243	84	327	74.3%	25.7%
Band 3	230	37	267	86.1%	13.9%
Band 4	139	7	146	95.2%	4.8%
Band 5	264	62	326	81%	19%
Band 6	803	82	885	94%	6%
Band 7	486	28	514	94.5	5.5%
Band 8A	213	10	223	95.5	4.5%
Band 8B	85	4	89	95.5	4.5%
Band 8C	36	1	37	97.1	2.9%
Band 8D	20	0	20	100%	0%
Band 9	3	0	3	100%	0%
VSM	1	0	1	100%	0%
Medical Consultants	96	43	139	69.1%	30.9%
Medical Non-consultants	26	32	58	44.8%	55.2%
Medical trainee	32	15	47	68.1%	31.9%
Other	**6**	**1**	**7**	**85.7%**	**14.3%**
Total	**2,683**	**406**	**3089**	**86.9%**	**13.1%**

2. In 2018, white candidates were 1.3 times more likely than BAME candidates to get jobs for which they had been shortlisted. The trust performance against this measure has improved from 1.7 times more likely in 2017.
3. In 2018, BAME staff were 1.9 times more likely to be disciplined when compared with white staff. This has decreased from 2.1 times more likely in 2017.
4. In 2018, white staff were 0.5 times more likely to take part in voluntary training than BAME staff.
5. In the same year 39% of BAME staff experienced harassment, bullying or abuse from patients, relatives and the public in the past year (2017 NHS staff survey). This decreased from 40% in 2016 and was worse than the national average for similar trusts (36%). The figure for white staff increased from 31% in 2016 to 33% in 2017. This was worse than the national average for similar trusts (32%). The difference between white and BAME staff was not statistically significant in

2017 and was statistically significant in 2016.

6. In 2018 28% of BAME staff experienced harassment, bullying or abuse from staff in the past year (2017 NHS staff survey). This increased from 22% in 2016 and was worse than the national average for similar trusts (26%). The figure for white staff was the same at 23% for both 2016 and 2017. This was worse than the national average for similar trusts (21%). The difference between white and BAME Staff was not statistically significant in 2017 and was not statistically significant in 2016.
7. The survey told us that 85% of BAME staff believed that the trust provided equal opportunities for career progression and promotion (2017 NHS staff survey). This increased from 81% in 2016 and was better than the national average for similar trusts (77%). The figure for white staff was the same at 89% for both 2016 and 2017. This was better than the national average for similar trusts (87%). The difference between white and BAME staff was not statistically significant in 2017 and was statistically significant in 2016.
8. In 2018 8% of white staff experienced discrimination from a colleague or manager in the past year (2017 NHS staff survey). This increased from 6% in 2016 and was worse than the national average for similar trusts (6%). Figures for BAME staff increased from 12% in 2016 to 14% in 2017. This was equal to the national average for similar trusts. The difference between white and BAME staff was statistically significant in 2017 and was statistically significant in 2016.
9. The percentage of BAME staff on the board was 0% compared with 11% BAME staff in the overall workforce. The percentage difference between the board voting membership and overall workforce was 11%

Feedback from the staff in the BAME network was that they would like to see more visibility of different BAME leaders in the trust to inspire them to progress. However, they were pleased at the recruitment of the new chief nurse, who they saw as a crucial BAME presence on the senior leadership team.

The trust worked with different trade unions representing the interests of different staff across the trust. We held a focus group with some of the trade union representatives. They gave generally positive feedback about their relationships with senior trust leaders and their willingness to listen. However, they did find that raising issues in some local areas had proved more of an issue for them but that this had started to improve.

This trust has reported a vacancy rate for all staff of 15% as of 30 September 2018.

This trust reported an overall vacancy rate of 19% for registered nurses at 30 September 2018.

This core service reported an overall vacancy rate of 17% for healthcare assistants.

	Registered nurses			Health care assistants			Overall staff figures		
Core service	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
MH - Acute wards for adults of working age and psychiatric intensive care units	63.5	164.0	39%	44.8	196.6	23%	107.3	395.4	27%
MH - Wards for people with learning disabilities or autism	3.3	8.3	39%	5.0	19.8	25%	8.6	32.4	27%
MH - Secure wards/Forensic inpatient	26.4	76.7	34%	19.4	106.4	18%	55.0	232.3	24%
MH - Child and adolescent mental health wards	2.0	14.2	14%	3.1	15.2	20%	6.0	33.3	18%
MH - Long stay/rehabilitation mental health wards for working age adults	8.4	49.0	17%	10.5	49.3	21%	21.0	119.0	18%
MH - Mental health crisis services and health-based places of safety	22.8	100.6	23%	12.6	42.8	29%	37.4	182.5	21%
Other - ASC service	0.0	0.8	0%	10.3	65.2	16%	11.2	71.4	16%
MH - Wards for older people with mental health problems	30.3	124.7	24%	16.9	153.6	11%	42.1	306.8	14%

	Registered nurses			Health care assistants			Overall staff figures		
Core service	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Other	6.9	51.4	13%	0.2	7.6	2%	20.1	158.4	13%
MH - Other Specialist Services	9.1	68.3	13%	3.4	9.0	38%	17.7	141.8	12%
MH - Community-based mental health services for adults of working age	30.4	198.8	15%	-3.7	39.1	-9%	38.1	380.3	10%
MH - Community mental health services for people with a learning disability or autism	1.8	27.6	6%	0.0	0.0	n/a	6.1	81.5	7%
MH - Specialist community mental health services for children and young people	0.2	148.0	0%	-0.5	9.7	-5%	19.9	403.0	5%
MH - Community-based mental health services for older people	5.0	91.7	5%	-1.2	10.6	-11%	5.4	146.8	4%
Trust total	**225.5**	**1211.8**	**19%**	**121.9**	**730.2**	**17%**	**406.2**	**2791.2**	**15%**

NB: All figures displayed are whole-time equivalents

The chief nurse outlined how they were building upon the work already underway when they came into post. This included increased support, engaging nurses in quality improvement approaches and clear career pathways, especially for those not wanting to move into management. A new nursing strategy had been drafted in January 2019 with four other priority areas agreed through the Nursing Board. They were:

Priority 1 – Nursing recruitment and retention

Priority 2 – Nurses wellbeing and engagement

Priority 3 - Career pathways, training and development opportunities

Priority 4 – Research, innovation and quality improvement

The chief nurse outlined that through the development of this work they were building on work to help the trust make a difference to the lives of patients and families and strengthen the nursing voice.

Between 1 October 2017 and 30 September 2018, of the 2369456 total working hours available, 8% were filled by bank staff to cover sickness, absence or vacancy for qualified nurses. The main reason(s) for bank and agency usage for the team was not supplied. In the same period, agency staff covered 4% of available hours for qualified nurses and 19% of available hours were unable to be filled by either bank or agency staff.

Core service	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
MH - Acute wards for adults of working age and psychiatric intensive care units	320744	43824	14%	44130	14%	124227	39%
MH - Child and adolescent mental health wards	27786	2778	10%	3103	11%	3930	14%
MH - Community mental health services for people with a learning disability or autism	53930	0	0%	0	0%	3481	6%
MH - Community-based mental health services for adults of working age	388753	12632	3%	12894	3%	59522	15%
MH - Community-based mental health services for older people	179310	3834	2%	104	0%	9699	5%

Core service	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
MH - Long stay/rehabilitation mental health wards for working age adults	95873	16429	17%	380	0%	16425	17%
MH - Mental health crisis services and health-based places of safety	196635	20600	10%	0	0%	44485	23%
MH - Other Specialist Services	133495	4906	4%	0	0%	17794	13%
MH - Secure wards/Forensic inpatient	150038	16259	11%	9738	6%	51525	34%
MH - Specialist community mental health services for children and young people	289399	13737	5%	6806	2%	411	0%
MH - Wards for older people with mental health problems	243877	37941	16%	10116	4%	59268	24%
MH - Wards for people with learning disabilities or autism	16152	4333	27%	2674	17%	6375	39%
Other	100586	3953	4%	1419	1%	13434	13%
Other - ASC service	1564	0	0%	0	0%	0	0%
Trust Total	**2369456**	**196179**	**8%**	**91456**	**4%**	**440904**	**19%**

Between 1 October 2017 and 30 September 2018, of the 1427911 total working hours available, 29% were filled by bank staff to cover sickness, absence or vacancy for healthcare assistants.

The main reason(s) for bank and agency usage for the teams was not supplied.

In the same period, agency staff covered 2% of available hours and 17% of available hours were unable to be filled by either bank or agency staff.

Core service	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
MH - Acute wards for adults of working age and psychiatric intensive care units	384432	137148	36%	5291	1%	87602	23%
MH - Child and adolescent mental health wards	29644	10644	36%	851	3%	6062	20%
MH - Community mental health services for people with a learning disability or autism	0	0	0%	0	0%	0	0%
MH - Community-based mental health services for adults of working age	76397	2830	4%	701	1%	-7235	-9%
MH - Community-based mental health services for older people	20649	104	1%	0	0%	-2307	-11%
MH - Long stay/rehabilitation mental health wards for working age adults	96303	26124	27%	156	0%	20571	21%
MH - Mental health crisis services and health-based places of safety	83711	8395	10%	33	<1%	24579	29%
MH - Other Specialist Services	17520	111	1%	0	0%	6570	38%
MH - Secure wards/Forensic inpatient	208055	87978	42%	6256	3%	37993	18%
MH - Specialist community mental health services for children and young people	18870	3432	18%	41	0%	-958	-5%
MH - Wards for older people with mental health problems	300389	84630	28%	8977	3%	33124	11%

Core service	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
MH - Wards for people with learning disabilities or autism	38717	21656	56%	1885	5%	9777	25%
Other	14802	6601	45%	26	0%	313	2%
Other - ASC service	127394	18645	15%	266	0%	20160	16%
Trust Total	**1427911**	**411620**	**29%**	**24878**	**2%**	**238422**	**17%**

The trust had 371 (15%) staff leavers between 1 October 2017 and 30 September 2018.

Core service	Substantive staff (at latest month)	Substantive staff leavers over the 12 months'	Average % staff leavers over the 12 months'
Other - ASC service	122	52	45%
MH - Specialist community mental health services for children and young people	331	70	21%
MH - Child and adolescent mental health wards	27	6	21%
MH - Acute wards for adults of working age and psychiatric intensive care units	254	48	19%
MH - Wards for older people with mental health problems	261	44	17%
MH - Secure wards/Forensic inpatient	174	28	16%
MH - Community mental health services for people with a learning disability or autism	78	11	14%

Core service	Substantive staff (at latest month)	Substantive staff leavers over the 12 months'	Average % staff leavers over the 12 months'
MH - Other Specialist Services	123	13	11%
Other	142	14	10%
MH - Mental health crisis services and health-based places of safety	131	16	12%
MH - Community-based mental health services for older people	140	14	10%
MH - Community-based mental health services for adults of working age	403	38	9%
MH - Wards for people with learning disabilities or autism	23	2	9%
MH - Long stay/rehabilitation mental health wards for working age adults	99	9	9%
Trust Total	**2424**	**371**	**15%**

The sickness rate for the trust was 5% between 1 September 2017 and 31 August 2018. The most recent month's data (August 2018) showed a sickness rate of 5%.

Core service	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
MH - Acute wards for adults of working age and psychiatric intensive care units	7.9	6.9
MH - Wards for older people with mental health problems	6.1	6.9
MH - Secure wards/Forensic inpatient	6.0	6.0
Other - ASC service	6.0	5.6

Core service	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
MH - Community-based mental health services for older people	5.2	5.2
MH - Wards for people with learning disabilities or autism	3.8	4.8
MH - Mental health crisis services and health-based places of safety	4.8	4.7
MH - Community-based mental health services for adults of working age	4.1	4.1
MH - Community mental health services for people with a learning disability or autism	1.6	3.9
Other	3.1	3.9
MH - Other Specialist Services	2.1	3.8
MH - Long stay/rehabilitation mental health wards for working age adults	3.4	3.7
MH - Specialist community mental health services for children and young people	3.8	3.3
MH - Child and adolescent mental health wards	1.3	2.1
Trust Total	**4.7**	**4.9**

From the core service inspections we found that team/ ward managers calculated the number of nurses and healthcare assistances required for each shift using the trusts' safer staffing tool. They were able to adjust staffing levels to account for the case mix and acuity on the wards. The staffing was monitored daily by the charge nurses and matrons, and service directors, with any staffing concerns escalated in accordance with the trust safer staffing escalation policy. The trust was in the process of procuring a new electronic rostering system, and were working on reviewing staffing requirements with team/ ward managers and matrons, with the aim of ensuring the trust had the right staff in the right place with the right skills. Safer staffing was reported through the safety committee, to quality committee and onto the board, who received a monthly safer staffing quality dashboard. The board were fully aware of the staffing issues, retention and recruitment issues and had ongoing plans to address these.

The trust had continued to implement new and innovative ways to attract new staff to the trust and retain current staff. These were well publicised, with two recent recruitment campaigns aimed at nurses and doctors shared across different forms of social media. Over the past year the trust had a specific focus on the retention of staff and trying to understand why staff might leave in the first year of employment with them. Part of exit interviews included a discussion with the freedom to speak up guardian to enable staff to raise anything they had not previously. Other steps to retain staff included a radical overhaul of the induction programme to take place over two days and included statutory and mandatory training and included hearing from service users and carers. There was also increased involvement from the executive team periodically throughout the first year to enable staff to have direct communication with them. There was a focus on developing staff into different roles and progression, including the band six development programme for nurses and peer apprentice programme. For healthcare assistants and administrative staff there was the nurse

associate role to skill them up and attract them into a career in nursing. The trust held its first 'not just an admin' conference and nurse associate role for health This complimented the nurse recruitment campaign and aimed to show what living in the area and working for the trust would look like. There were specific incentives for nurses, such as a new preceptorship programme, financial incentives for moving from out of area and financial incentives for nurses returning to practice.

Different staff networks were in place and in varying levels of maturity. During the inspection we observed a number of these, such as the women's network meeting and lesbian, gay, transsexual and questioning network. We also held focus groups with black and minority ethnic staff and the staff disability network. Staff were generally positive about the trust and the promotion of their rights, equality and inclusivity, although some feedback was that more senior leadership buy-in was needed to improve staff's experience. A message that came through was that where staff had asked for or suggested for initiatives/ training to be provided to the wider staff group, they were asked to implement these, as opposed to their being taken up at a more senior level, which made them feel demoralised to be able to effect changes. In some diversity groups they were not able to tell us if they had an executive sponsor who was their voice on the trust board, despite these being in place.

The compliance for mandatory and statutory training courses at 1 April 2018 to 1 October 2018 was 87%. Of the training courses listed 10 failed to achieve the trust target and of those, four failed to score above 75%. The trust set a target of 85% for completion of mandatory and statutory training. The training compliance reported for this core service during this inspection was higher than the 83% reported in the previous year.

Key:

Below CQC 75%	Met trust target	Not met trust target	Better	Same	Worse	Error
						N/A

Training Module	Number of eligible staff	Number of Staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Equality and Diversity	2434	2309	95		
Infection Prevention (Level 1)	255	243	95		
Information Governance	2434	2305	95		
Health and Safety (Slips, Trips and Falls)	2424	2273	94		
Manual Handling - Object	2409	2256	94		
Clinical Risk Assessment	2070	1950	94		
Safeguarding Children (Level 1)	325	306	94		
Rapid Tranquilisation	327	300	92		
Safeguarding Adults (Level 2)	1896	1748	92		
Fire safety onsite - non inpatient	1421	1312	92		
Safeguarding Children (Level 2)	1830	1645	90		

Training Module	Number of eligible staff	Number of Staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Prevent	2434	2147	88		
Safeguarding Adults (Level 1)	489	432	88		
Mental Capacity Act Level 1	2145	1845	86		
Personal Safety Breakaway - Level 1	1392	1196	86		
Mental Health Act	1450	1199	83		
Infection Prevention (Level 2)	2195	1810	82		
Medicines management	810	662	82		
Prevent (WRAP)	2123	1715	81		
Personal Safety - MVA	714	553	77		
Adult Basic Life Support	1769	1348	76		
Fire safety onsite- Inpatient	1020	751	**74**		
Manual Handling - People	938	648	**69**		
Adult Immediate Life Support	301	208	**69**		
Safeguarding Children (Level 3 Additional)	321	216	**67**		
Total	**35926**	**31377**	**87%**		

We inspected three 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. For example, in the wards for older people with mental health problems staff we spoke with told us they were up to date with their mandatory training. Ward managers provided documentation recording mandatory training levels above the trusts' required level of 85%. For example, mandatory training levels were at 93% on Brunswick ward, 92% on St Raphael ward, 96% on Iris ward, and 99% on Heathfield ward. All wards offered staff protected study time to enable them to complete training. On the forensic/ secure inpatient wards we saw a slight improvement in overall mandatory training compliance rates for the whole service with 89%. All seven wards we visited were at or above the trust target of 85%.

The trust's target rate for appraisal compliance was 95%. At the end of last year (1 October 2017 to 30 September 2018), the overall appraisal rate for all staff was 48%. As at 31 July 2018 the overall appraisal rate was 63%. None of the 14 services achieved the trust's appraisal target. The services with the lowest compliance were 'MH CAMHS wards' with 18%, 'Other – ASC Services' with 39% and 'MH - Acute wards for adults of working age and psychiatric intensive care units' with 47%.'

Core Service	Total number of permanent staff requiring an appraisal	Total number of permanent staff who have had an appraisal	% appraisals (as at 31 July 2018)	% appraisals (previous year 1 October 2017 – 30 September 2018)
MH - Community LD / Autism	93	79	85%	77%
MH - Wards for people with learning disabilities or autism	27	22	81%	96%
MH - Other specialist services	55	43	78%	34%
MH - Community-based mental health services for older people	169	130	77%	68%
MH - Forensic inpatient	176	135	77%	42%
MH - Specialist community mental health services for children and young people	387	292	75%	66%
MH - Wards for older people with mental health problems	299	204	68%	46%
MH - Long stay/rehabilitation mental health wards for working age adults	104	68	65%	52%
MH - Mental health crisis services and health-based places of safety	126	82	65%	48%
MH - Community-based mental health services for adults of working age.	413	231	56%	36%
Other	177	93	53%	20%
MH - Acute wards for adults of working age and psychiatric intensive care units	299	142	47%	43%
Other - ASC Service	168	66	39%	28%
MH - Child and adolescent mental health wards	28	5	18%	93%
Trust total	**2541**	**1605**	**63%**	**48%**

However, at the time of the well led review in February 2019, the overall trust figure for appraisals had risen to 77%.

We inspected three 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, we found these to be at 100% for the wards for older people with mental health problems and forensic patient/ secure wards.

The trust had appropriate staff management policies and procedures for managing poor staff performance. Processes were transparent and where staff were not performing at a reasonable

The trust's target of clinical supervision for non-medical staff was not supplied. Between 1 October 2017 and 30 September 2018, the average rate across all 13 core services in this service was 40%.

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

Core service	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
MH - Wards for people with learning disabilities or autism	246	203	83%
MH - Secure wards/Forensic inpatient	1952	1463	75%
MH - Community mental health services for people with a learning disability or autism	993	524	53%
MH - Acute wards for adults of working age and psychiatric intensive care units	2827	1285	45%
MH - Long stay/rehabilitation mental health wards for working age adults	1207	533	44%
MH - Wards for older people with mental health problems	3048	1144	38%
MH - Specialist community mental health services for children and young people	3997	1361	34%
MH - Mental health crisis services and health-based places of safety	1945	833	43%
Other	2085	650	31%
MH - Other Specialist Services	1426	431	30%
MH - Community-based mental health services for adults of working age	5947	2425	41%
MH - Community-based mental health services for older people	1930	282	15%
MH - Child and adolescent mental health wards	317	18	6%
Trust Total	**28506**	**11280**	**40%**

We inspected three 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. For example, in the wards for older people with mental health problems we found the wards ranged from 75-100% for staff receiving supervision. On the forensic inpatient/ secure wards we found that local supervision records held by ward managers indicated much higher rates of supervision completion rates. Not all staff were uploading records onto their online My Learning portal when they had completed supervision and was the reason for lowered central data percentages. Individual clinical supervision was offered to staff every 4-6 weeks. Managers had oversight of supervision and kept a log of up to date records either via the electronic portal or local records. Staff had facilitated reflective practice and group supervision sessions which were not always recorded on the central system as

supervision.

The trust's target of clinical supervision for medical staff was not supplied. Between 1 October 2017 and 30 September 2018, the average rate across all 11 core services in this service was 8%.

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

Core service	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
MH - Wards for people with learning disabilities or autism	12	11	92%
MH - Specialist community mental health services for children and young people	413	96	23%
MH - Community mental health services for people with a learning disability or autism	74	11	15%
MH - Other Specialist Services	120	11	9%
Other	82	3	4%
MH - Acute wards for adults of working age and psychiatric intensive care units	120	0	0%
MH - Wards for older people with mental health problems	38	0	0%
MH - Community-based mental health services for adults of working age	579	0	0%
MH - Community-based mental health services for older people	50	0	0%
MH - Long stay/rehabilitation mental health wards for working age adults	12	0	0%
MH - Mental health crisis services and health-based places of safety	34	0	0%
Trust Total	**1570**	**132**	**8%**

The reason given for the lower submitted data for staff training, supervisions and appraisals was that staff were not routinely uploading and logging their completed appraisals onto the 'My Learning' platform, due to finding this too time-consuming to do. 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. During the inspection we spoke with approximately 230 staff. All staff told us they had regular supervision and an annual appraisal. The trust board were aware of the issues of uploading the data and the use of My Learning to capture the training, supervision and appraisals of staff, and this was being addressed through the new digital strategy. During the well led review the compliance figures were showing an

improvement trajectory recorded at 66%.

Governance

The trust had structures, systems and processes in place to provide assurance and support the delivery of its goals. This included committees that reported directly to the board and care delivery services that reported through these committees to the board. The board was effective and operated well. Board meetings took place bi-monthly and attendees were well prepared, having been provided with papers in advance and having read these prior to the meeting. There were always a number of observers, including some governors and staff or service users who gave a presentation of their recovery, or work they were involved in. The private (confidential) part of the board meeting covered appropriate items and discussion by the board members. Board meetings had tight agendas, with a lot to cover, though the meetings were well chaired and agenda items covered. At the end of each agenda item the chair summarised key points to ensure understanding and key action points for people to take forward.

There were six sub-committees of the board. These were appointment and renumeration, audit, finance and investment, quality, charity and the Mental Health Act committees. Each were chaired by a non-executive director. Executive directors and other non-executive directors attended each meeting. However, during the period from the mid-end of 2018 when there were less non-executive directors for the trust, it meant there was a lack of non-executive directors (other than those chairing the committee) present to be able to provide sufficient challenge and scrutiny. The non-executive directors chairing these said that they managed it, but that it was difficult due to also chairing the meeting at the same time.

Of the committees that reported directly to the board, the quality committee carried a significant portfolio of numerous sub-committees that fed into this, such as safety committee that had 10 reporting committees/ meetings and the well led and workforce committee which had eight reporting groups. This was a large portfolio for a bi-monthly meeting and it unclear how escalation of key issues worked in practice, as this was not clearly evidenced in the committee meeting minutes. It was also was not quite clear how the quality committee interfaced with the audit committee. The trust provided assurance that all sub-committees to the quality committee presented an exception report, highlighting key risks and mitigation. The board also received a key issues report from the quality committee and one of the non-executive directors from the audit committee also attended the quality committee. Despite this, the quality committee had managed to drive through some positive work, such as the improvements in statutory/ mandatory training and gender separation in the wards. As part of the board developmental work, the trust had commissioned a well - led review and had an action plan in place at the time of inspection focused in improving the effectiveness of the quality committee.

The care delivery services accountability framework outlined the board assurance of the eight care delivery services across the trust. These fed directly into the executive management committee and board, where each care delivery service submitted a monthly quality and financial performance report. Each care delivery service operated as a separate business unit through a process of devolved leadership to enable core services/ geographically based service to structure and deliver their services based on local needs. During this review we observed four care delivery service meetings. The meetings were very constructive with a range of issues discussed and addressed, where each attendee had a clear purpose and was actively involved in the meeting. The overarching business plan and long-term plans were threaded throughout the meeting agenda and discussions, with clear evidence that each care delivery service strived to move forward and progress the vision.

The governance framework addressed the need to meet people’s physical health care needs. The

physical health committee reported progress to the quality committee. Since the last well led review in 2017 the trust had strengthened its physical healthcare work. The physical health strategy supported the dedicated team of physical health leads, who were predominantly registered general nurses to get out across the trust and support teams and staff with training, advice and equipment to undertake relevant physical health checks on people using the service to ensure that these were being monitored and any risks escalated appropriately.

The executive lead for the Mental Health Act (MHA) was the director of corporate affairs and temporarily chaired the MHA committee meetings (whilst a new non-executive director was appointed), associate hospital managers forum meetings, quality committee and MHA monitoring group. Membership of the MHA committee included an associate medical director, approved mental health professionals, experts by experience, associate hospital managers and Sussex police representatives. Both the deputy director of social work and director of quality assurance attended on behalf of the chief nurse. Meetings were quarterly and ensured strong and effective governance of the MHA. The quarterly report which identified trends, analysis data and agreed reviews based on such data. The reports also included benchmarking nationally. The MHA team provided regular reporting on MHA statistics and Deprivation of Liberty Safeguards to the committee who again escalated issues to the board as necessary, though reported to the board on a quarterly basis. The MHA committee meeting also considered the trust's response to actions raised following MHA monitoring visits by MHA reviewers and authorised provider action statements to the Care Quality Commission. At the time of reporting the trust were piloting a self-audit tool on the use of the MHA which was to go live across the trust in June 2019.

We met with two chairs of the associate hospital managers. There are 40 associate hospital managers with the trust and recruitment was by word of mouth or by external advertisement. The chairs informed us that they felt the current managers reflected the diversity of the trust population. The chairs attended the quarterly Mental Health Act Committee meeting. They did raise some concerns in regard to the receipt and quality of the reports they received. There were concerns that these had not been discussed with the patient sufficiently in advance of the meetings, not all patients were afforded the opportunity to have legal representation or an advocate during a hearing and that patients' rights were not being fully upheld as patients were not being informed of their right or encouraged to have managers hearing.

Staff recorded medicines incidents using an electronic recording system. A senior member of the pharmacy team was the medicine safety officer, a role created following the NHS England patient safety alert. The medicine safety officer automatically received and reviewed notifications of medicine incidents. A multidisciplinary team at the medication safety group reviewed these incidents and acted on them.

The trust submitted details of external reviews commenced or published in the last 12 months (17 April 2016 to 30 October 2018).

- Niche independent investigation into the care and treatment of a mental health service user Mr W in Sussex. Commenced in April 2016 and published on the 18 October 2018. Report and action plan submitted. Homicide occurred in July 2015 (Mr W).
- Niche independent investigation into the care and treatment of Mr K in Sussex. Draft report received in December 2017 but the publication date has not been set and this responsibility sits with NHS England. Incident occurred in September 2014 (Mr K).
- Caring Solutions – October 2017 - review of evidence of actions taken by Sussex Partnership NHS Foundation Trust following an independent investigation into the care and treatment of Mr RS.

- CQC investigation into HMP Lewes prison death of Mr JO in February 2016 – at the time of reporting the CQC had prosecuted the trust. At a hearing on the 6 March 2019 the trust pleaded guilty for a failure to provide safe care and treatment to the patient.

Management of risk, issues and performance

The trust had systems for the reporting of risks and the monitoring of these. The chief pharmacist managed the pharmacy risk register, which also hosted corporate medicines risks. The medication safety group reviewed national medicines safety alerts. Following the recent alerts for valproate preparations, the trust had reviewed its processes to ensure they reflected best practices and the drugs and therapeutics group had the alert as a standing agenda item. Each service/ ward held a risk register that fed into the care delivery service risk register. There was also the strategic risk register and board assurance framework. The quality committee renewed the risk register, with each sub-committee presenting relevant risks. The top three risks were demand and capacity; patient flow (and there was a strategic goal to increase joined up care between community and inpatients; workforce, in relation to recruitment and retention. The strategic risks were given an initial risk rating, current and target risk rating, though there were gaps in assurance, with internal and external risks not always recorded. It did not seem that the strategic risk register was derived from the local care delivery service risk registers and so themes were not routinely being escalated through to the board. Many of the review dates had expired e.g. 24/7 care and supervision had an expiry date of the 25 May 2018, and demand and capacity the 9 August 2018, and it was also not always clear who held the responsibility for each risk

Monitoring strategy through to the board was not always apparent. It was only reviewed quarterly by the board and not by any assurance committees other than the audit committee. Recent challenges from the audit committee in November 2018 around the need for a more robust approach, mitigation and control of risks demonstrated that further work was required in this area to ensure it drives the agenda of the board and assurance committees.

However, along with this, it was not clear that audit committee viewed its role as assuring itself that the other committees were working as intended. Minutes of meetings needed to be strengthened to ensure they provided assurance of concrete challenge and action.

The director of finance ensured that the trust was on track to meet financial targets despite agenda for change not being fully funded. In observations of the board and committee meetings the director of finance demonstrated a clear commitment to the trust priorities and ensuring that the needs of the patients were at the heart of financial decisions. At the time of inspection there were no clear plans to eliminate dormitories in the older people wards, though there was work being undertaken with commissioners around the older people inpatient provision across Sussex.

	Historical data		**Projections**	
Financial Metrics	Previous financial year (2 years ago) (1 April 2016 to 31 March 2017)	Last financial year (1 April 2017 to 31 March 2018)	This financial year (1 April 2018 to 31 March 2019)	Next financial year (1 April 2019 to 31 March 2020)
Actual costs/ expenditure -full	£254,330,000	£250,943,000	£255,625,000	£262,043,000
Actual income	£252,335,000	£251,022,000	£256,747,000	£263,165,000
Actual surplus (deficit)	-£1,995,000	£79,000	£1,122,000	£1,122,000
Planned budget or (budget deficit)	£720,000	£0	£1,122,000	£1,122,000

In January 2019 the CQC carried out a joint inspection to HMP Lewes with Her Majesty's Prison inspectorate. Three requirement notices were issued for the trust to make improvements. The full report of the findings is here: https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-lewes-2/. The summary of the findings were: *Clinical staff managed admissions to the 10-bed inpatient unit well and the team continued to provide good quality care, but the unit still lacked a therapeutic regime. Health service responsibility for constant watch prisoners stretched resources, as did the wider model of inpatient team care, which included crisis management on the wings, reception screening, segregation assessments and completing prisoner escort records. This wider activity prevented nurse-led therapeutic interventions on the unit. The inpatient environment needed attention and some cells were still in a poor condition, in particular the constant watch cell, which had poorly designed panelling that restricted visibility.*

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.

From 30 November 2016 to 30 November 2018, there have been nine 'prevention of future death' reports sent to Sussex Partnership NHS Foundation Trust. Details of which can be found below;

Prevention of Future Death report

Name: Janet Muller[1]

Date: 16th June 2017

Cause of death: Inhalation of fire fumes

The MATTERS OF CONCERN are as follows:

1. Nursing records, handovers, risk assessments and care plans were often incomplete, insufficient and at times contradictory. Whilst we were told that regular auditing is carried out by the Trust of nursing records it is clear that this is not fit for purpose as it did not identify the fact that there were gaps in Janet's nursing records and other key documents. The lack of proper record keeping increased Janet's risk.
2. The ability of Patients detained under the Mental Health Act 1983 being able to abscond. Whilst it is accepted that the Hospital has now put in place further measures to prevent patients from being able to abscond from the ward, such as increasing the height of the garden wall and put in additional security around the entrance door, patients have still been able to abscond.
3. Staffing levels – The Jury identified that at times the level of staffing was inadequate and this together with the lack of other measures put in place contributed to the risk of Janet's absconding.

Prevention of Future Death report

Name: Derek Lee[2]

Date: 6 February 2017

Cause of death: Natural Causes

[1] Janet Muller PFDR
[2] Derek Lee PFDR

The MATTERS OF CONCERN are as follows:

1 Mr Lee's medication regimen which was to be the core of the admission was barely addressed and no reasons for any changes in medication appear in his notes.

2 Re admission documentation – mental capacity was not properly addressed and when Mr Lee was discharged from the ward after three weeks on the 17th May the paperwork in that respect was still incomplete

3 His 'Falls risk assessment' was flawed in that it failed to take into account information from his wife and son as to how he was mobilising at home. Mobilisation in Mr Lee's case should have been at the core of the 'Care Plan' because he was suffering from Parkinson's disease, where if possible, it is important to maintain mobility. Brunswick ward should know that.

4 No 'Waterlow score' was done until the 4th May. Too late. No appropriate pressure relieving equipment was ordered until 12th May. There was no evidence before me that the equipment was ever received or used for Mr Lee. When Mr Lee was admitted to the Acute hospital he has a Grade 2 pressure sore on his sacrum.

5 The thromboprophylaxis assessment which should have been carried out on either the 27th or 28th April was not done until the 6th May.

6 No bowel chart was kept until the 12th May, why not? Even non-nursing, non-medical professionals know that one of the several dangers of Parkinson's disease is constipation.

7 Medical instructions and recommendations were not handed over. One example relates to instructions to clean Mr Lee's infected eyes with saline every 2 hours to keep them open. This was not done and when he arrived at the Acute hospital his eyes were crusted shut.

8 The MUST score was properly calculated on admission but not reviewed when it was clear he was not eating.

9 There was no evidence of any reaction to Mr Lee's substantial weight loss. There was no referral to dieticians. They just happened to attend a multi-disciplinary meeting on the 9th May (he was admitted on 27th April and by 9th May had lost 10 ¾ pounds – 4.8 kilos. Re-weighing was requested by dieticians, it did not take place.

10 There was no evidence of dates when Mr Lee was referred to the Occupational Therapist, Physiotherapist, dieticians or the Parkinson's specialist nurse. At the Inquest, I heard evidence that these referrals should have taken place as soon as possible after admission and certainly within the first 3 or 4 days. It is clear from the evidence that very little happened so far as Mr Lee was concerned, too late.

11 There was apparently no appreciation of the deterioration in Mr Lee's mobility. He was at high risk of falls and yet the mobilisation of a Parkinson's patient is imperative and also since he was being special led during his entire admission there is absolutely no excuse for not trying to assist him with mobilising.

12 It was not until the 12th May, 2 weeks after Mr Lee's admission to Brunswick ward that he was seen by the Parkinson's nurse specialist. When the specialist nurse saw Mr Lee he made three important recommendations and asked for feedback within seven days, the referral to the speech and therapy team was done the next day. The enema did not take place for two days, too long and possibly dangerous. The change in medication was never even discussed.

13 As time went on there was no regular review of his original assessments. This should have been done by his Primary nurse who carried out none of these functions and therefore her appointment for Mr Lee was irrelevant. There should be a review of the role of a Primary nurse.

14 There was no coherent and carefully considered and reviewed care plan.

15 A care co-ordinator was not appointed, even though at the inquest, it was confirmed that Mr Lee was being looked after on the Care Programme Approach (CPA). The appointment of a

care co-ordinator is at the heart of this framework and it was clear that such an appointment could have been helpful if not crucial in this case.

Brunswick is supposed to be a specialist unit for patients with Mr Lee's problems and yet it is clear that he was failed most miserably. It is equally clear that these specific failings, even in combination and on the balance of probabilities did not change the outcome (i.e. Mr Lee's death) on 5th June 2016, however they were all matters that need addressing in order to raise the standard to an appropriate level for the proper care of these vulnerable patients.

Prevention of Future Death report

Name: Matthew Roberts[3]

Date: 9th February 2017

Cause of death:

1a – major haemorrhage at tracheotomy site

1b – acute arteritis of the innominate artery

2 – coma and hypoglycaemia due to mixed drug and insulin toxicity

The MATTERS OF CONCERN are as follows:

1 That there was no relevant policy, procedure or practice requiring faxes to the Bognor EI team be logged and scrutinised on receipt so that it might be noted if faxed pages were missing and potentially important information not received.

2 That there was no policy, procedure or practice requiring a member the EI team to read written information provided by a referrer before zoning meeting and initial risk assessment. Additionally, it was practice, on occasions, for the information to be left unread until shortly before the first face to face appointment with the patient. Hence the determination of patient's needs, the current level of risk and the urgency with which the first contact should be made with a patient was not informed by all the available information being fully considered.

3 That there was no relevant policy, procedure or practice whereby the Bognor EI team would clearly confirm with the referrer the date on which contact with a newly referred patient would be made.

4 The SPFT did not appear to have undertaken any formal review of the death of someone known to the organisation and, although SPFT were aware a RCA was being conducted by Avon and Wiltshire NHS trust, SPFT had not received nor sought that final RCA report from Wiltshire. An opportunity to learn relevant lessons from the above events had therefore been delayed until the inquest, almost a year after the events.

Prevention of Future Death report

Name: Thomas Wall[4]

Date: 2 August 2017

Cause of death: He took his own life

[3] Matthew Roberts PFDR
[4] Thomas Wall PFDR

The MATTERS OF CONCERN are as follows:

1 That there is no local in-patient detox facility such as used to exist at Millview hospital. It is not acceptable that local people needing in-patient detox have to travel to Islington away from their family and friends. It is also unacceptable that the waiting list is so long especially when often Mental Health will not be fully assessed until detox has taken place. How many dual diagnosis patients are there in the UK?

2 A much more collaborative approach to dual diagnosis patient's treatment is needed. The dual diagnosis is at the heart of this problem. It is not appropriate to try and separate each component and only agree to treat/assess one component when the other is dealt with. The dual diagnosis is the person. When in crisis they are doubly at risk. That period of risk should be reduced as quickly as possible. The delays and refusals serve to exacerbate the patient's distress and increase their despair.

As Thomas Wall said in a text message to his wife, 'I want to get better but I can't do that on my own whereas I can take my life on my own'.

Prevention of Future Death report

Name: Sabrina Walsh[5]

Date: 14 July 2017

Cause of death: Fatal ligature around the neck, although it is unknown whether the patient intended the outcome to be fatal, this was contributed to by neglect.

The MATTERS OF CONCERN are as follows:

1 The lack of CCTV in corridors and communal areas at Woodlands Acute care, St Leonards on Sea, which would enhance location of vulnerable patients where observations do not immediately locate them. Valuable minutes would be saved in locating vulnerable patients if CCTV was installed.

Prevention of Future Death report

Name: Paul Wolferston Vila[6]

Date: 18 April 2017

Cause of death: Suicide

The MATTERS OF CONCERN are as follows:

1 The evidence heard and the experiences suffered by the family in this case has highlighted a lack of coherent and standard practice in the handling of cold calls to the Sussex AMPH and Mental Health helpline.

[5] Sabrina Walsh PFDR
[6] Paul Wolferston Vila PFDR

2 There appears to be a lack of centralised management of the handling and direction of calls when service users needing care do not call a local number. There appears to be a lack of suitable triage or immediately actionable steps available to help and action rather than to listen and refer.

3 The service does not appear to apply a set or common approach across the country with regard to the allocation of calls to an AMPH or mental health practitioner, causing significant distress to families and therefore a clear risk of failing to place persons in acute need of care and assistance, quickly and effectively with the nearest and most appropriate support.

4 There appears to be a difficulty in or failure to access notes entered by an AMPH on the framework I system by the call service operators or the absence of a countrywide system which can record and give access to all enquiries.

5 That a family cannot get through to a mental health line at a point of crisis or be assisted or placed with a suitable practitioner who can offer them clear and structured help within one call is a significant cause for concern.

Prevention of Future Death report

Name: Roger Pavey[7]

Date: 15 September 2016

Cause of death: Respiratory failure due to systematic sepsis as a result of infected leg ulcers

The MATTERS OF CONCERN are as follows:

1 That nursing staff at HM Prison, Lewes did not apparently recognise the significance of Mr Pavey's legs being infected (blood tests on 1 February but not looked at until 6 February but communicated to Nurses on that date that he had a bacterial infection of his legs).

2 He should have been closely monitored and had regular observations taken as to the state of his legs.

3 Treatment in the form of bandaging and the changing of bandages regularly if necessary should have been instituted.

4 If nursing staff were uncertain or unclear on how to treat Mr Pavey's infected legs then they should have sought advice.

5 Since the prison population is apparently increasingly becoming older with chronic disease and disability it seems clear that there should be a more careful approach with these prisoners and their needs and it seems that training is necessary to ensure that the situation never progresses again to the systematic sepsis suffered by Mr Pavey in the early hours of 14th February.

Name: Mr Robin Ellis[8]

Date: 1 September 2016

Cause of death: Multi organ failure

[7] Roger Pavey PFDR
[8] Robin Ellis

The MATTERS OF CONCERN are as follows:

1 The chaotic and cruel attempt to transfer Mr Ellis from Langley Green to Hove on 16th February.
   - Serious consideration must be given to whether a transfer is in the patient's best interest
   - The patient who was deemed to have mental capacity should have been consulted, he was not.

2 The overall quality of Mr Ellis's notes was very poor. For example,
   - There is no mention anywhere of the personal hygiene being given
   - There is no rationale for the two doses of Lorazepam given orally in the morning and the evening of the 20th February. It is surely no coincidence that that is the night when Mr Ellis was found on the floor of his room with no explanation as to how he got there.
   - The intermittent (15 minute) observations are risible. They might just as well not have been carried out. It is of note that the 15-minute observation just prior to him being found on the floor of the 20th are missing, the form is blank.
   - During his time on Meridian ward there is no evidence that staff attempted to co-operate with Robin regarding his feeding regime. There is no evidence that they even discussed it with him seriously. The result was he ended up cutting off the PEG on the 22nd/23rd February and being admitted to the Royal Sussex County Hospital.
   - During his time on Meridian there were delays in ordering equipment for him and no appreciation of his left-sided hemiplegia. It was clear from the evidence that this hospital was unable to cope with this patient's physical needs and had no appreciation of them.

3 The Sussex Partnership rapid tranquilisation policy was implemented overnight on the 25th/26th February in dubious circumstances in that the documentation is poor. Intramuscular Lorazepam was given at 4am on the 26th. None of the required monitoring or observations were carried out. Family concerns were ignored. The documentation is either non-existent or inadequate.

4 As a result of 3 above, Mr Ellis condition deteriorated into a moribund state by 1:30 pm on 27th February was missed by staff so that, by the time he arrived at the Royal Sussex county hospital he was effectively beyond assistance – in spite of all the efforts over the next week in the acute hospital

5 There were missed opportunities to treat Mr Ellis throughout his admission to Sussex Partnership care. None is so grave as the missed opportunities from 4am on the 26th February.

Name: Paul Hanton[9]

Date: 18 January 2018

Cause of death: Head Injuries

The MATTERS OF CONCERN are as follows:

1 Need for clear information to be given by hospital staff when making the 999 call to report a patient has gone AWOL in order to proactively answer the known risk questions and maximise the opportunity for police to take timely action to trace the patient within the golden hour.

2 Langley Green to ensure that hospital CCTV is accessible at all times for police viewing.

[9] Paul Hanton PFDR

3 Langley Green to consider review and amendment of current AWOL policy
4 Police to ensure the initial risk assessment is clearly endorsed in the CAD and timely actions are undertaken both locally and appropriate referrals are made to other forces.
5 Police to consider joint policy with Adult safeguarding board
6 Police to consider equal response to informal as well as sectioned patients if guided by clinical staff of high risk. There is a different response from the police when the missing patient is an informal patient rather than under an MHA order. In the latter case, often a blue light police car is immediately dispatched to the hospital, this is not the case with informal patient's.

The trust assured that all action plans associated with each prevention of future deaths reports were complete. The chief medical officer was the lead for deaths and the trust held an annual 'learning from serious incidents' conference to share the learning from serious incidents with staff across the trust.

Learning from incidents and deaths was shared through 'patient safety matters' newsletter, the trust-wide 'learning from when things go wrong' newsletter or the clinical message of the month, of which recent ones had been focussed on diabetes management and sepsis awareness. These related to concerns from recent Coroner inquests and endeavoured to alert staff to the risks of these and ensuring patients were appropriately supported. During the core service inspections staff demonstrated that they were aware of the shared learning and were taking steps to implement in their local areas.

The trust submitted details of three serious case reviews commenced or published in the last 12 months.

Reference Number	Team/Ward/Unit	Recommendations	Actions Taken	Outstanding Actions
SAR F	New Park House Adult Services (AMHS) ATS Recovery & Wellbeing Team	Recommendations relating to management of ECRs, CPA, Carers, interface with A and E services.	Action plan developed and agreed by Chief Nurse. Action plan agreed by SAB. Feedback to key staff, and CDS Board. Presentations at organisational learning events. Most actions have Trust wide implications.	All actions are ongoing.
Miss A (Bedfordshire SAB)	Hove Polyclinic-West ATS	Recommendations relating to management of specialist placements out of area and to good practice with regards to the MCA.	Action plan developed and agreed by Chief Nurse. Action plan agreed by SAB. Feedback to CDS Board. Presentations at organisational learning events. Most actions have Trust wide implications.	All actions are ongoing.

Reference Number	Team/Ward/Unit	Recommendations	Actions Taken	Outstanding Actions
SAR C	Cavendish House- Assessment & Treatment Service	New SAR recommendations not developed yet	New SAR recommendations not developed yet	Participation in SAR process

We analysed data about safety incidents from three sources: incidents reported by the trust to the national reporting and learning system (NRLS) and to the strategic executive information system (STEIS) and serious incidents reported by staff to the trust's own incident reporting system. These three sources are not directly comparable because they use different definitions of severity and type and not all incidents are reported to all sources. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents.

Between 1 October 2017 and 30 September 2018, the trust reported 147 serious incidents. The most common type of incident was apparent/actual/suspected self-inflicted harm meeting serious incident criteria with 96. Fifty-seven of these incidents occurred in MH - Community-based mental health services for adults of working age. From the trust's serious incident information, there were eight unexpected deaths which related to 'apparent/actual/suspected self-inflicted harm meeting SI criteria' and this occurred in MH - Acute wards for adults of working age and psychiatric intensive care units.

We reviewed the serious incidents reported by the trust to the strategic information executive system (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable to STEIS with 157 reported.

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. The trust reported no never events during this reporting period.

Type of incident reported on SIRI	MH - Acute wards for adults of working age and psychiatric intensive care units	MH - Community-based mental health services for adults of working age	MH - Community-based mental health services for older people	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 - Secure wards/Forensic inpatient	MH - Specialist community mental health services for children and young	MH - Wards for older people with mental health problems	Other	Provider wide	Total
Abuse/alleged abuse of adult patient by staff	0	0	0	0	0	0	0	0	0	1	0	1

Type of incident reported on SIRI	MH - Acute wards for adults of working age and psychiatric intensive care units	MH - Community-based mental health services for adults of working age	MH - Community-based mental health services for older people	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 - Secure wards/Forensic inpatient	MH - Specialist community mental health services for children and young	MH - Wards for older people with mental health problems	Other	Provider wide	Total
Apparent/actual/suspected homicide meeting SI criteria	0	0	0	0	0	1	0	0	0	0	0	1
Apparent/actual/suspected self-inflicted harm meeting SI criteria	11	57	4	1	12	0	0	2	0	9	0	96
Confidential information leak/information governance breach meeting SI criteria	0	1	0	0	0	0	0	1	0	0	1	3
Disruptive/ aggressive/ violent behaviour meeting SI criteria	0	4	0	0	1	1	0	5	0	0	0	11
Failure to obtain appropriate bed for child who needed it	0	0	0	0	1	0	0	0	0	0	0	1
Operation/treatment given without valid consent	0	0	0	1	0	0	0	0	0	0	1	2
Pending review (a category must be selected before incident is closed)	2	0	0	0	0	0	0	0	1	2	0	5
Pressure ulcer meeting SI criteria	0	0	0	0	0	0	0	0	1	1	0	2
Slips/trips/falls meeting SI criteria	5	0	0	0	0	0	0	0	7	1	0	13
Unauthorised absence meeting SI criteria	2	0	0	0	1	0	9	0	0	0	0	12
Total	**20**	**62**	**4**	**2**	**15**	**2**	**9**	**8**	**9**	**14**	**2**	**147**

Providers are encouraged to report patient safety incidents to the national reporting and learning system (NRLS) at least once a month. The average time taken for the trust to report incidents to

NRLS was 27 days which means that it is considered to be a consistent reporter.

The highest reporting categories of incidents reported to the NRLS for this trust for the period August 2017 and July 2018 were self-harming behaviour; Patient accident and disruptive, aggressive behaviour (includes patient-to-patient). These three categories accounted for 3399 of the 4668 incidents reported. 'self-harming behaviour' accounted for 86 of the 89 deaths reported.

Ninety-seven percent of the total incidents reported were categorised as no harm (69%) or low harm (28%).

Incident Type	No Harm	Low Harm	Moderate	Severe	Death	Total
Self-harming behaviour	1095	734	29	7	86	1951
Patient accident	477	359	29			865
Disruptive, aggressive behaviour (includes patient-to-patient)	462	116	4		1	583
Medication	544	4				548
Access, admission, transfer, discharge (including missing patient)	488	22				510
Other	88	10	1		2	101
Treatment, procedure	11	31				42
Patient abuse (by staff / third party)	17	8	1			26
Infrastructure (including staffing, facilities, environment)	15	1				16
Implementation of care and ongoing monitoring / review	4	9	2			15
Clinical assessment (including diagnosis, scans, tests, assessments)	5	2	1			8
Infection Control Incident	2	1				3
Total	**3208**	**1297**	**67**	**7**	**89**	**4668**

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).

Sussex Partnership NHS Foundation Trust reported fewer incidents from August 2017 to July 2018 compared with the previous 12 months.

Level of harm	August 2017 to July 2018
No harm	3208
Low	1297
Moderate	67
Severe	7
Death	89
Total incidents	**4668**

Between September 2017 and August 2018, there were 0.1 patient safety incidents reported to the national reporting and learning system for every mental health patient spell, which was worse than the national average of 0.2.

The feedback we received from NHS England specialised commissioning was that improvements were needed in being informed about complaints and serious incidents, as these appeared to be quite low for the specialised commissioning services. There was a risk that the threshold for a serious incident at Mill View Hospital had been set too high, although this had been done in consultation with other agencies. The incident had been investigated as a higher learning review. The recommendations from the review were monitored through a quality improvement plan including all key service partners. The trust board also commissioned an independent review of all investigations and all recommendations, their implementation and the impact they had on embedding learning and enhancing practice.

We reviewed a sample of three serious incident investigation reports where people using the service had died unexpectedly. These were thorough and clearly set out the steps taken to investigate the incident and identify root causes, with a focus on looking for improvements to prevent recurrence, rather than apportion blame, which links in with the trust drive towards a more 'just culture'. There was evidence of involving families and carers, and a single point of contact for them, though their involvement in setting the terms of reference for each investigation was not always clear.

The medication safety group (which reported to the trust safety committee and informed the drugs and therapeutics group) reviewed medicines incidents. Learning from incidents and near misses was also discussed at the medication safety group. The drugs and therapeutics group included patients and their representatives.

There were appropriate systems and processes for safeguarding in place. The chief nurse was the executive lead, overseeing a team of leads and nurses across the trust. There had been a recent change in the safeguarding strategy which aligned to the national framework and ensured clear governance and reporting structures to the board through the safety and quality committees.

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	48 hours

	In Days	Current Performance
What is your target for completing a complaint?	25 working days or agreed timeframe	85%
If you have a slightly longer target for complex complaints please indicate what that is here?	N/A	N/A

** 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**	362	1 October 2017 - 30 September 2018
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	4	1 October 2017 - 30 September 2018

**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 trust ensured that information on how people could make a complaint was accessible. Information was on display in the wards, services and also on the trust website. We reviewed a sample of five completed complaints. These had all been investigated and responded to within set timeframes. The responses were of a good quality and reflected good communication with the complainant, consideration of the best interest of the patient with evidence of plans to changes and review processes as a result of the complaint findings. It was not always clear where the responsibility for the final oversight of complaint responses lay to ensure that all issues raised had been fully responded to, and that due process had been followed. We were informed that in April 2019, an external audit was being undertaken into complaints to assist in the development of this service.

The executive lead for safeguarding was the chief nurse and the safeguarding committee reported to the board via the safety and quality committees. A new safeguarding policy had been ratified in April 2018 and cross-referenced key policies such as clinical risk assessment and safety planning, prevent and domestic and sexual abuse. The children's safeguarding policy had been developed in conjunction with key stakeholder partners and was available in accessible formats for younger people.

This trust received 660 compliments during the last 12 months from 1 October 2017 to 30 September 2018. MH - Community-based mental health services for adults of working age' had the highest number of compliments with 27%, followed by 'MH - Mental health crisis services and health-based places of safety' with 14% and MH - Specialist community mental health services for children and young people with 11%.

Staff were provided with training in the duty of candour. The investigation reports and complaint records we viewed demonstrated this had been applied appropriately.

Information management

There were a range of systems in use for the operation of the trust, including for patient records, staff recruitment, training and supervision records and to capture performance data. During the core services inspections the team managers showed us their local dashboards and how they used it to monitor the staffing, patient care and performance of the service. Information technology (IT)

systems generally worked well to ensure people received good quality care. Information governance systems enabled the confidentiality of patient records though password protected record systems.

Board papers demonstrated a continued emphasis on quality, sustainability and the patient experience. Committee chairs informed that information provided prior to meetings had improved over the past year to be more timely and succinct.

When a patient is admitted to hospital, the provider is required to submit a record to the mental health services data set each month until their inpatient admission ends. Between October 2016 and September 2017, the trust only provided end dates for 97% of inpatient episodes, which had ended. For the same period, the proportion of provider closed episodes of patients detained under the Mental Health Act out of total closed episodes was 90%. This gives an incomplete picture about discharges from hospital and patients length of stay and indicates there may be problems with recording or sharing data externally.

The trust acknowledged that the digital systems needed to be improved. There was a need to address problems with data quality, multiple systems and the amount of duplication these created. The chief digital and information officer was strong and outlined a clear vision and plans for the digital strategy. The trust had received an award of £3m global digital exemplar funding by NHS Digital to help improve patient care using digital technology, with five priorities:

1. Improve patient experience e.g. self-management apps, video consultations
2. Improve care by developing ways to securely shape information with partner organisations
3. Improve electronic patient information system and introduce electronic prescriptions management
4. Improve decision making by helping clinicians make better use of clinical information
5. Improve technical infrastructure to support digital development.

There was an internal audit programme, which included controlled drug audit checks, clinical pharmacy visits, pharmacist intervention audit, and medicines being obtained within 24 hours. The trust had also taken part in national schemes, such as the prescribing observatory for mental health (POMH-UK). The majority of ward and unit-based audits had been successfully transferred from pharmacy to the wards for completion. Pharmacy retaining an oversight of these audits. There had been a rollout of pharmacy staff access to patients' summary care records to allow accurate and timely medicine reconciliation on admission to hospital.

Engagement

The trust had many ways for engaging with people who use services and carers. There were two established patient leader posts and one carer leader. The trust participation strategy was aligned to the clinical strategy and work to support its implementation was embedded in three priorities to: increase the number of people participating; increase the diversity of people participating; and promoting the co-production in everything they do. Since April 2018 the trust had added 100 experts by experience to its database of 400. Approximately 30% of trust committees included people with lived experience. They received support through quarterly supervision groups and were able to undertake some trust training, including quality improvement training. The Working Together Group programme had matured over the past year and each was chaired or co-chaired by an expert by experience. Befriending volunteers worked in two-thirds of inpatient units. The peer supporter role had developed along with peer apprenticeships.

The trust had been implementing the triangle of care and was working towards accreditation. In the core service inspections there was clear evidence of the implementation of this and closer working with carers.

Engagement with communities was enhanced through the work involved in the trust charity called Heads On. This encouraged people in the community, staff and service users to be involved in different activities to raise funds to enhance the services people received from the trust. Recent grants included a side by side cart for the inpatient learning disability ward and funds towards the decoration and arts projects on different wards.

Team Springwell was the trusts' learning disability experts by experience group who have worked on the Springwell project. This was an area of the trust website for people with learning disabilities to access advice, information and support, and to enable people with learning disabilities to have a voice in their care.

The board team spoke highly of the director of communications and his work on the promotion of the service user voice and showing work of the trust through social media and trust website.

In the 2016 Community Mental Health Survey, the trust scored 8 out of 10 for patients having been involved as much as they wanted to be in agreeing what care this would receive, which was better than the average range of 7 to 8 out of 10. In the 2016 Community Mental Health Survey, the trust scored 4 out of 10 for patients having received help/advice with finding support for physical health needs, which was worse than the average range of 4 to 6 out of 10. The trust had recently developed the Sussex experience survey, which was a downloadable App to enable people using the services to provide gain real-time feedback.

The trust worked in partnership with a number of local authorities and we received positive feedback from these about close working arrangements in relation to various areas such as safeguarding and the work of approved mental health professionals (AMHP). Where AMHPs were not directly employed by the trust Section 75 agreements were in place for the provision of these in community mental health and crisis teams. This aimed to ensure there was a consistent service available across the county. Apart from Brighton and Hove, the AMHP managers informed us there were some issues in ensuring enough AMHPS were available to carry out assessments in a timely manner. Recruitment of AMHPs was taking place. Lack of available beds and Section 12 approved doctors throughout the day also caused some delays in assessments. These issues were escalated through the Mental Health Act Committee to the trust board. There were seven service level agreements in place with acute trusts to support when detained patients were assessed in the emergency department and when they needed physical care. Training on the Mental Health Act was provided under the service level agreement to the acute trust staff.

The trust pharmacy team worked with the pharmacy teams in adjacent trusts and local clinical commissioning groups through networking groups. These included chief pharmacist, and sustainability and transformation groups. Benefits for staff included an increased awareness of other services' challenges and priorities. Patients benefited as staff knew who to contact with queries relating to patients under the care of other organisations. The trust had awarded a local NHS trust the contract to supply medicines and brought in house the clinical pharmacy staff previously employed by other organisations.

Senior leaders understood the importance of engaging with staff and had a number of routes for enabling this. These included visits to services/ wards by members of the board, which staff really appreciated. Many staff commented on the accessibility and visibility of the chief executive to different services, and how she visited each inpatient ward on Christmas day, which they were very impressed by. Staff were able to attend the chief executive briefings, where they could hear directly from the chief executive and other senior leaders and of work taking place across the trust.

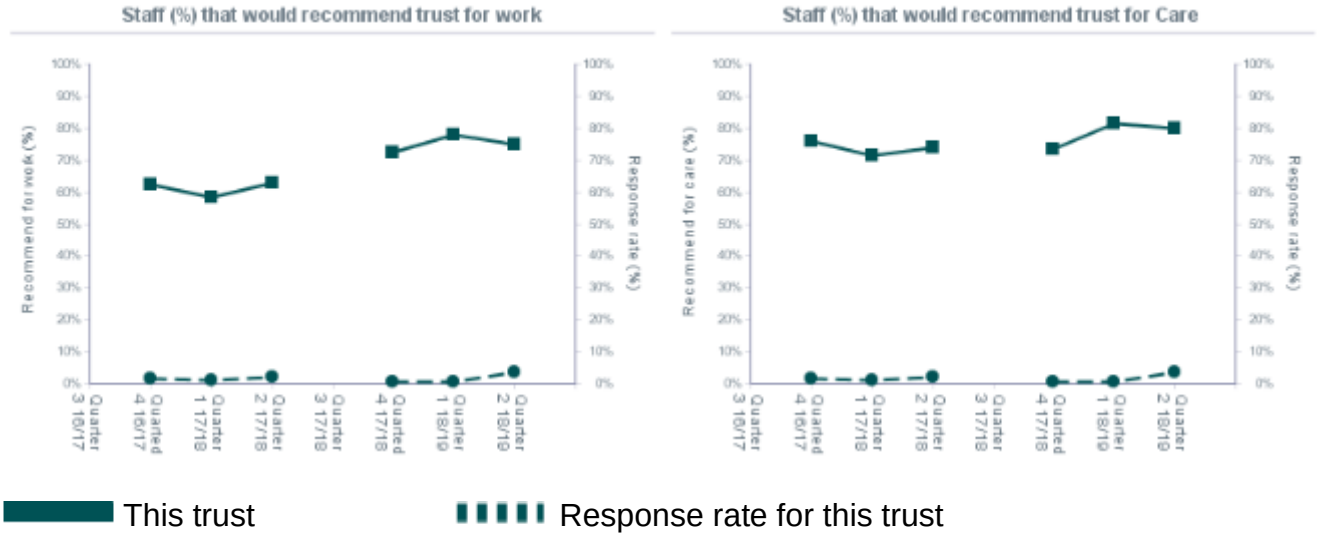
The patient friends and family test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored similar to the England

average for patients recommending it as a place to receive care for one of the five months in the period (April 2018). The trust was lower than the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care in none of the five months.

	Trust wide responses				England averages	
Month	**Total eligible**	**Total responses**	**% that would recommend**	**% that would not recommend**	**England average recommend**	**England average not recommend**
December 2017	16765	135	77.0%	10.4%	88.0%	4.3%
January 2018	18211	137	83.9%	5.8%	88.5%	4.2%
February 2018	17980	148	80.4%	10.1%	88.7%	4.3%
March 2018	18304	153	81.0%	9.8%	89.0%	4.0%
April 2018	17969	135	88.9%	4.4%	88.7%	4.2%

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 percentage of staff that would recommend this trust as a place to work in Q2 18/19 increased when compared to the same time last year. The percentage of staff that would recommend this trust as a place to receive care in Q2 18/19 increased when compared to the same time last year. There is no reliable data to enable comparison with other individual trusts or all trusts in England.



Please note: Data is not collected during quarter three each year because the staff survey is conducted during this time.

Learning, continuous improvement and innovation

The trust had continued its quality improvement journey using the institute for healthcare improvement model for improvement. This linked to the clinical strategy workstreams. Over 400 staff had completed bronze training with a further 200 having completed the silver training. This training was also open to peer support workers and carers. Staff across the trust had an understanding of quality improvement and were enthusiastic about how they could use it to improve their work. They said they were supported to be innovative and come up with new ideas to improve their services and the experiences of people using them. Stakeholders acknowledged the quality improvement work taking place across the trust and they promoted this work and achievements through social media. There was a quality improvement team, based in a newly established quality house, who worked with staff across the trust to support quality improvements projects. At the time of reporting there were approximately 40 registered projects, with more coming on board. Two wards within the trust were part of the national quality improvement collaborative to reduce the use of restrictive interventions. The trust was also part of the South of England mental health patient safety collaborative. The focus of the collaborative for 2018-19 was sharing the learning from deaths in mental health, where the trust hosted an event focussing on the use of ligatures from a non-anchor point where different trusts from across the country came together to share innovative practice in this area. Leading up to this the trust carried out a detailed audit of suicides across the trust, of how and when they occurred and the patient pathway. This identified key themes that has enabled the trust to tighten its work on suicide prevention, and there has been a reduction on inpatient suicides for 2018/19 from three to one from the previous year.

The trust provided healthcare services into HMP Lewes and HMP Ford. The physical care and treatment of one patient in September 2016 was subject to a prevention of future deaths report (above) from the Coroner. Physical and mental healthcare in the prison setting was a challenge for the trust due to the environment and lack of clarity with the prison over processes. They were acutely aware of the need for improvements to continue in this area and had an action plan in place that was being closely monitored.

The trust continued to implement the national quality board guidance (2017) on learning from deaths. The chief medical officer was the trust lead for learning from deaths. Each death was reported via appropriate incident reporting systems and also reviewed by the monthly mortality scrutiny group, which reported to the quality committee via the safety committee. These were signed off by the associate director of nursing standards and safety or the clinical professional, depending on whether a preliminary or comprehensive review had been undertaken. The trust was compliant with the learning disabilities mortality review (LeDeR) programme, where all expected and unexpected deaths of people with a learning disability receive a comprehensive mortality review.

External organisations had recognised the trust's improvement work. Some wards and services within the trust had won some good practice awards in the year since the previous inspection of the trust. These included:

- In July 2018 the trust became one of only six trusts to become Cyber Essentials PLUS accredited. This is a scheme designed to help UK organisations with limited experience of cyber security improve their defences and demonstrate publicly their commitment to cyber security.
- Parts of the trust were actively promoting the inclusion and awareness of the needs of lesbian, gay, bisexual, transsexual, questioning (LGBTQ) people. In October 2018 Langley Green Hospital became the first mental health hospital to receive the gold LGBTQ inclusion award for the improvements they had made for the service to be more inclusive of the LGBTQ community. This included all ward staff being trained in LGBTQ awareness to silver standard and ward toilets

were gender neutral. This followed with Mill View Hospital being awarded the same award for inclusion. The award recognises the work taken to address historical inequalities in healthcare outcomes for LGBTQ people and is a partnership between Switchboard and Trans Alliance Brighton. The award encourages facilities to strive to achieve a bronze, silver or gold award by meeting a range of criteria for LGBTQ inclusion.

- In October 2018 the team at Langley Green Hospital won the positive practice in mental health collaborative national clinical team of the year award in in recognition of the outstanding mental health care they provide. The collaborative is a user-led multi-agency collaborative of 75 organisations, including NHS trusts, commissioners, police forces and third sector organisations. It was established to recognise and share excellence in mental health and mental health services.
- In October 2018 the trust's child and adolescent mental health (CAMHS) community teams were highly commended by the mental health collaborative judges after being shortlisted in two awards. Hampshire CAMHs specialist eating disorder team was commended in the community mental health services for eating disorders for adults or children and young people (supported by NHS England) category and the Hampshire CAMHS New Forest team was commended in the innovation in children and young people's mental health services category.
- In November 2018 the trust became one of the first 13 trusts to join the NHS Improvement Leadership for Improvement programme.

- In February 2019 some of the staff from Langley Green Hospital went to Parliament to mark the publication of 'A Happy, Healthy Workplace', a report co-produced by The Positive Practice in Mental Health Collaborative and The National Collaborating Centre for Mental Health. The report shared a number of examples of practice from Langley Green Hospital and staff presented some of these.
- The trust participated in the POMH-UK– quality improvement programme and the NHS benchmarking network, pharmacy and medicines optimisation provider project. These provided benchmarking data and analysis of aspects of mental health prescribing practice and the safe and effective use of medicines.

The trust annual positive practice awards recognised and celebrated achievements and innovation across the trust. This was launched in 2015 with 130 nominations. Since this time staff had wanted to get more involved and share good practice, with the number of nominations having increased to 570 nominations in 2018.

The trust had a dedicated research department and was a teaching trust of Brighton and Sussex medical schools. It had a national reputation for research into mental health issues and a research income that exceeded £1.5 million. The national institute of health research league table for 2017/18 the trust had continued to improve on its recruitment to high quality research studies. This has been maintained for a number of years.

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	Comments
AIMS - OP (Wards for older people)	MH - Wards for older people with mental health problems	Orchard Ward and Larch Ward 2017	
AIMS - WA (Working Age Units)	MH - Acute wards for adults of working age and psychiatric intensive care units	Oaklands Ward 2016, Maple and Rowan Ward 2017	
CCQI Forensic Services	MH - Secure wards/Forensic inpatient	Chichester Centre; Pine, Fir and Hazel Wards - 15/02/18. Hellingley Centre; Oak, Willow, Ash and Elm 20/03/18	
Memory Services National Accreditation Programme (MSNAP)	MH - Community-based mental health services for older people	All three MAS Services in West Sussex are accredited by MSNAP. The South Team was reviewed in 2018 with further reviews planned for the remaining services.	
Psychiatric Liaison Accreditation Network (PLAN)	MH - Mental health crisis services and health-based places of safety	Mental Helath Liaison Team at Royal Sussex County Hospital-Brighton are accredited by PLAN 2018	
Quality Network for Community CAMHS (QNCC)	MH - Specialist community mental health services for children and young people	Hampshire CAMHS is a member of QNCC and QNCC-ED	
Quality Network for Inpatient CAMHS (QNIC)	MH - Child and adolescent mental health wards		Not current accredited but working towards re-accreditation for the Chalkhill Unit.
Quality Network for Inpatient Learning Disability Services (QNLD)	MH - Wards for people with learning disabilities or autism	Selden Centre September 2018	
RCP Enabling Environments Award	MH - Secure wards/Forensic inpatient	Elm Ward - 26-02-2017	

Accreditation scheme	Core service	Service accredited	Comments
RSQM Forensic Service	MH - Secure wards/Forensic inpatient	Forensic Services are a member of the Sussex Restorative Justice Partnership (SRJP) which hold accreditation for restorative justice services delivered in Sussex	

Mental health services

Mental health crisis services and health-based places of safety

Facts and data about this service

Sussex Partnership NHS Foundation Trust provided mental health crisis services and health-based places of safety as part of the trust's mental health services. The service offered emergency assessment and intensive home treatment as an alternative to hospital admission. The service provided support for people in mental health crisis aged 18 and over with a functional mental health problem or those requiring assessment under Section 136 or 135(1) of the Mental Health Act 1983. There was no upper age limit for people who needed to access the service.

A Section 136 is an emergency power which allows for the removal of a person who is in a place to which the public have access, to a place of safety, if the person appears to a police officer to be suffering from mental disorder and to be in immediate need of care or control.

A section 135(1) warrant is issued to approved mental health professionals by the courts. It allows them, with the police, to enter private premises to remove a person to a place of safety if there are concerns for their, or others, safety resulting from their mental state. A mental health assessment can then be arranged to assess their needs. A section 135(2) warrant is to provide police officers with a power to enter private premises for the purpose of removing a patient to be taken or returned to hospital.

Sussex Partnership NHS Foundation Trust has six crisis resolution home treatment teams based at:

- Oaklands Centre, Chichester
- Meadowfield Hospital, Worthing
- Mill View Hospital, Hove

- Langley Green, Crawley
- Department of Psychiatry, Eastbourne
- Woodlands Hospital, Hastings
- The trust has six health-based places of safety (HBPOS) at:
- Meadowfield Hospital, Worthing
- Mill View Hospital, Hove
- Langley Green, Crawley
- Department of Psychiatry, Eastbourne
- Woodlands Hospital, Hastings
- Chalkhill, Haywards Heath

A health-based place of safety is a place for people detained under section 136 of the Mental Health Act. They are taken to the place of safety by the police from an area where the public have access, if they believe that the person is suffering from mental health issues following concerns that they are at risk due to their mental state. Once in the suite, the individual is assessed by mental health professionals to establish if treatment is needed.

The HBPOS at Chichester, Eastbourne, Hastings, Haywards Heath and Hove are used for adults and young people detained under section 136 or section 135(1) of the Mental Health Act in order for a Mental Health Act assessment to be undertaken. The HBPOS at Chalkhill young person's unit is used for minors aged under 18.

The trust also provided a street triage service. Street triage is an initiative where mental health professionals work alongside police officers to provide support to people experiencing mental health issues and avoid them being taken into a place of safety or police custody.

Location site name	**Ward name**	**Number of beds**	**Patient group (male, female, mixed)**
Department of Psychiatry	Acute inpatient Adult Mental Health (Section 136) (Department of Psychiatry)	N/A	Mixed
Mill View Hospital	Acute inpatient Adult Mental Health (Section 136) (Mill View Hospital) Street Triage	N/A	Mixed
Langley Green Hospital	Adult Services (AMHS) Crisis Home Treatment Team (Crisis Team North)	N/A	N/A
Langley Green Hospital	Adult Services (AMHS) Acute inpatient - (Section 136) (Langley Green)	N/A	Mixed
Langley Green Hospital	Adult Services Ambulance Street Triage Pilot	N/A	N/A

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Mill View Hospital	Mental Health Rapid Response Service (MHRRS)	N/A	N/A
Meadow field Hospital	Section 136 Assessment Street Triage	N/A	N/A
Woodlands	Section 136 Facility	N/A	Mixed
Meadow field Hospital	Sussex Mental Helpline	N/A	N/A
Chalkhill	Urgent Help Service Section 136	N/A	N/A
Mill View Hospital	Approved Mental Health Practitioners (AMHP's)	N/A	N/A
Pepperville House	ATS Satellite Site Adult Services (AMHS) AAW Mental Health Liaison Practitioners (MHLPs)	N/A	N/A
Woodlands	CRHT	N/A	N/A
Department of Psychiatry	CRHT & Liaison	N/A	N/A
Meadow field Hospital	Crisis Home Treatment Team (AMHS) - Crisis Team AAW	N/A	N/A
Oaklands Centre for Acute Care	Crisis Resolution Home Treatment Team WAMHS Crisis Team Chichester	N/A	N/A
Mill View Hospital	Crisis Response and Home Treatment (CRHT)	N/A	N/A
Eastbourne Police Station	East Sussex Street Triage (Eastbourne Police Station)	N/A	N/A
Hastings Police Station	East Sussex Street Triage (Hastings Police Station)	N/A	N/A
Langley Green Hospital	Functional AMHS Groups	N/A	N/A

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

We inspected this core service as part of our next phase mental health inspection programme. The inspection of this core services was prompted in part by notification of an incident at Mill View

Hospital health-based place of safety. This incident is subject to an ongoing separate investigation and as a result this inspection did not examine the circumstances of the incident.

The Care Quality Commission last inspected the mental health crisis teams and health-based place of safety in September 2016 as part of a comprehensive inspection of Sussex Partnership NHS Foundation Trust.

Our inspection took place between 29 and 31 January 2019. The inspection was unannounced, which means that staff did not know we were coming, to enable us to observe routine activity. We carried out a further short notice inspection on the 26 February 2019 to check concerns we had identified with medicines management on the first inspection.

Before the inspection, we reviewed information that we held and asked other organisations to share what they knew about the trust. These included NHS Improvement, local Healthwatch organisations, local clinical commissioning groups and local authorities.

During the inspection visit, the team:

- visited four of the crisis resolution home treatment teams and all six health-based places of safety
- interviewed three team leaders, three nurses, a bank nurse, a social worker, an occupational therapist, a street triage nurse lead, an acute care lead, a clinical nurse lead, a helpline operator and helpline manager
- interviewed two accident and emergency consultants, a matron, a ward manager, six nurses, a social care practitioner and approved mental health professional (AMHP) lead, a senior practitioner and AMHP lead, an AMHP practice manager, a police lead and the head of the local ambulance service.
- spoke with the health-based place of safety clinical lead nurse, the deputy director of capital projects, assurance and environmental services, a clinical lead nurse manager and a support worker
- spoke with three service managers for the crisis teams
- interviewed two administrators
- spoke with 10 patients and one carer from the crisis teams and four current and one former patient of the health-based places of safety
- observed three handovers
- observed three home visits
- reviewed the medicines management at each crisis team inspected at this time
- reviewed two medicine records in the health-based places of safety
- reviewed 29 care records, including risk assessments for the crisis teams and 30 care records for the health-based places of safety
- pathway tracked five incidents
- reviewed supervision and training records.

Is the service safe?

Safe and clean environment

- The crisis teams saw most of their patients in their own homes. Availability of interview rooms varied across the sites. There were interview rooms at the crisis team based at Mill View Hospital. Staff from the crisis team at Meadowfield hospital could book rooms at the adjoining hospital. Staff at Chichester arranged to see patients at local centres if they preferred not to be seen at home. Staff did not leave patients alone in rooms to ensure they remained safe.
- There were alarms in the interview rooms at Mill View hospital to summon support if required. Staff from Meadowfield and Langley Green risk assessed patients' suitability to be seen in the hospital interview rooms. Staff could request a personal alarm from the hospital reception if required. Interview rooms were generally clean although one of the interview rooms at Mill View Hospital contained dirty furniture and had a damp smell.
- All four teams inspected had large offices with access to computers. A duty rota was in place for the shift coordinator, with access to a range of information and resources. The shift coordinator was responsible for triaging calls, prioritising assessments and home treatment activities, and monitoring whereabouts of staff.
- Staff from Mill View hospital had access to an automated external defibrillator (AED) located on the downstairs corridor. Staff from Meadowfield, Chichester and Langley Green had access to an AED on the adjoining hospital site. The temperature in the clinic room and fridge at Mill View hospital was checked regularly and was within safe range.

Health Based Place of Safety

- All places of safety were clean, tidy and appropriately furnished. The furniture at Chalkhill was being replaced to be more child friendly, with the involvement of young people in choosing furniture. Staff had made efforts to make the environment in all places of safety as welcoming as possible for patients. Ligature assessments were appropriate up to date, and tear free clothing and bedding was available. Staff completed environmental checklists which included action plans and outcome information.
- There were clear procedures in place for observation and engagement and mitigation of risk from harm. Patients remained on eyesight observation throughout their detention within the place of safety.
- Staff had access to alarms to alert colleagues where required. Staff from wards adjoining the place of safety responded if the alarm was activated. We observed staff quickly responding to an alarm during our inspection.
- Staff were always present to observe patients. The door to the place of safety was left open, where appropriate. Alternatively, staff used the viewing panel and CCTV to monitor patients. Apart from Langley Green Hospital, all places of safety had CCTV cameras to support observations and ensure patients were safe. The trust was reviewing the current CCTV with alternative cameras to ensure full coverage of the suites, ensuring that patients' privacy and dignity was maintained at all times.
- All places of safety had access to emergency equipment located on the closest ward. Staff from the place of safety at Eastbourne also had access to the hospital 24-hour crash team. The trust confirmed that they were able to meet the Royal College of Psychiatry guidelines to meet the three-minute response time at all places of safety in the event of an emergency.
- Although the places of safety met minimum privacy and dignity standards, the trust had significant refurbishment plans to standardise all places of safety and improve the service for

patients. The trust aimed to ensure that no more than one place of safety was closed at any one time during the refurbishment process. The operational management board monitored planned works.

- During the inspection, we identified issues including lack of hot water in bathroom at Mill View, staff unable to isolate water and blind spots in the places of safety. Findings were raised with the trust who provided written confirmation that immediate action had been taken to address any concerns identified during the inspection.

Maintenance, cleanliness and infection control

For the most recent patient-led assessments of the care environment (PLACE) (2018), Mill View Hospital scored higher than similar trusts for both aspects overall.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance
Mill View Hospital	MH - Mental health crisis services and health-based places of safety	99.4%	99.0%
Meadow field Hospital	MH - Mental health crisis services and health-based places of safety	97.2%	93.5%
Woodlands	MH - Mental health crisis services and health-based places of safety	98.8%	93.4%
Langley Green	MH - Mental health crisis services and health-based places of safety	97.81%	92.21%
Department of Psychiatry	MH - Mental health crisis services and health-based places of safety	97.48%	93.02%
Chalkhill	MH - Mental health crisis services and health-based places of safety	97.7%	95.1%
Trust overall		**98.0%**	**94.8%**

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance
England average (Mental health and learning disabilities)		**98.5%**	**94.5%**

Clinic room and equipment

Clinic rooms were equipped with the necessary equipment to carry out physical examinations. Staff at all teams had access to physical health monitoring equipment including thermometers, manual sphygmometers and blood pressure machines. However, we were not assured that these were calibrated regularly. This meant that the readings may become inaccurate over time. Inspectors raised this with the trust who provided assurance that equipment was calibrated regularly through a third-party provider.

Safe staffing

Nursing staff

This core service has reported a vacancy rate for all staff of 21% as of 30 September 2018.

This core service reported an overall vacancy rate of 23% for registered nurses at 30 September 2018.

This core service reported an overall vacancy rate of 29% for healthcare assistants at 30 September 2018.

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Mill View Hospital	Acute inpatient Adult Mental Health (Section 136) (Mill View Hospital)	3.8	5.8	66%	9.8	9.8	100%	13.6	15.7	87%
Hastings Police Station	East Sussex Street Triage (Hastings Police Station)	1.5	1.9	79%	0.0	0.0	0%	1.7	2.4	71%
Chalkhill	Urgent Help Service	4.0	10.3	38%	0.0	2.8	0%	3.4	13.8	25%

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Woodlands	CRHT	4.2	14.9	28%	0.0	2.8	0%	6.1	25.9	24%
Oaklands Centre for Acute Care	Crisis Resolution Home Treatment Team WAMHS Crisis Team Chichester	2.0	10.1	19%	0.0	0.0	0%	2.2	13.3	16%
Department of Psychiatry	CRHT & Liaison	4.3	19.1	22%	0.6	11.6	5%	6.2	39.8	16%
Eastbourne Police Station	East Sussex Street Triage (Eastbourne Police Station)	0.9	1.9	47%	0.0	0.0	0%	0.4	2.4	16%
Meadow field Hospital	Crisis Home Treatment Team (AMHS) - Crisis Team AAW	1.8	8.5	22%	1.0	2.0	50%	2.3	15.7	15%
Langley Green Hospital	Functional AMHS Groups	1.0	1.0	100%	0.0	0.0	0%	0.6	4.3	14%
Mill View Hospital	Crisis Response and Home Treatment (CRHT)	-1.3	19.2	-7%	0.8	0.8	100%	1.3	27.6	5%
Mill View Hospital	Mental Health Rapid Response Service (MHRRS)	0.5	7.1	7%	0.1	2.9	3%	0.3	11.0	2%

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Meadow field Hospital	Sussex Mental Helpline	0.0	0.7	0%	0.2	10.0	2%	-0.6	10.7	-6%
Core service total		**22.8**	**100.6**	**23%**	**12.6**	**42.8**	**29%**	**37.4**	**182.5**	**21%**
Trust total		**225.5**	**1211.8**	**19%**	**121.9**	**730.2**	**17%**	**406.2**	**2791.2**	**15%**

NB: All figures displayed are whole-time equivalents

Between 1 October 2017 and 30 September 2018, of the 196635 total working hours available, 10% were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

The main reason for bank and agency usage for the team was not provided.

In the same period, agency staff covered 0% of available hours for qualified nurses and 23% of available hours were unable to be filled by either bank or agency staff.

Wards	**Total hours available**	**Bank Usage**		**Agency Usage**		**NOT filled by bank or agency**	
		Hrs	**%**	**Hrs**	**%**	**Hrs**	**%**
Acute inpatient Adult Mental Health (Section 136)	11420	1323	12%	0	0%	7509	66%
CRHT	29077	2058	7%	0	0%	8252	28%
CRHT & Liaison	37329	3956	11%	0	0%	8389	22%
Crisis Home Treatment Team (AMHS) - Crisis Team AAW	16621	1369	8%	0	0%	3578	22%
Crisis Resolution Home Treatment Team WAMHS Crisis Team Chichester	19808	3086	16%	0	0%	3852	19%
Crisis Response and Home Treatment (CRHT)	37622	2640	7%	0	0%	-2464	-7%
East Sussex Street Triage	3657	1970	54%	0	0%	1701	47%

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
East Sussex Street Triage add to SOP	3715	1608	43%	0	0%	2933	79%
Functional AMHS Groups	1955	0	0%	0	0%	1955	100%
Mental Health Rapid Response Service (MHRRS)	13942	1582	11%	0	0%	1036	7%
Sussex Mental Helpline	1310	0	0%	0	0%	0	0%
Urgent Help Service	20180	1007	5%	0	0%	7743	38%
Core service total	**196635**	**20600**	**10%**	**0**	**0%**	**44485**	**23%**
Trust Total	**2369456**	**196179**	**8%**	**91456**	**4%**	**440904**	**19%**

Between 1 October 2017 and 30 September 2018, of the 83711 total working hours available, 10% were filled by bank staff to cover sickness, absence or vacancy for healthcare assistants.

The main reason for bank and agency usage for the team was not provided.

In the same period, agency staff covered 0% of available hours and 29% of available hours were unable to be filled by either bank or agency staff.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Acute inpatient Adult Mental Health (Section 136)	19241	3191	17%	33	0%	19241	100%
CRHT	5553	114	2%	0	0%	0	0%
CRHT & Liaison	22761	520	2%	0	0%	1251	5%
Crisis Home Treatment Team (AMHS) - Crisis Team AAW	3911	13	0.3%	0	0%	1955	50%
Crisis Response and Home Treatment (CRHT)	1564	47	3%	0	0%	1564	100%
Functional AMHS Groups	0	68	0%	0	0%	0	0%
Mental Health Rapid Response Service (MHRRS)	5651	603	11%	0	0%	176	3%

Sussex Mental Helpline	19554	1308	7%	0	0%	391	2%
Urgent Help Service	5475	2531	46%	0	0%	0	0%
Core service total	**83711**	**8395**	**10%**	**33**	**<1%**	**24579**	**29%**
Trust Total	**1427911**	**411620**	**29%**	**24878**	**2%**	**238422**	**17%**

Mental health crisis services

- The trust used the department of health model to calculate number and skill mix of staff. Staffing numbers were based on caseload and patient needs. Caseloads ranged between 12 at Chichester to 35 at Mill View Hospital. Staffing levels for Mill View crisis team consisted of seven staff in the morning and six in the afternoon. The staff skill mix consisted of nurses, an early discharge nurse, the clinical team lead, doctors, two social workers and the team leader. The average caseload for the service was 35. Staff sickness could be problematic. There were three sickness absences on the day of our inspection.
- Caseloads were managed by a 'team approach' to support continuity of care because of shift patterns. Managers could increase staffing numbers by using regular bank staff who knew the patients and the service well. None of the teams used agency staff.
- Each team had access to a dedicated consultant psychiatrist, supported by other doctors including specialist registrars, and senior house officers (SHO). Psychiatrists were able to see patients at home. The amount of medical cover varied across services because most of the consultants worked part time. This meant that SHOs provided cover when a consultant was not available. Staff from Worthing told us that it was sometimes difficult to access medical cover. A senior house officer provided cover when a psychiatrist was unavailable. However, staff told us that they were sometimes reluctant to prescribe because they didn't know the patients.
- Crisis teams' operational hours were 8.30am to 9pm Monday to Friday and 8.30am to 8.30pm Saturday and Sunday. In Brighton the crisis team operated from 8:30am to 10pm. Staff worked before and after these times to attend handovers. The senior nurse practitioner from the local hospital provided out of hours cover for Worthing, Chichester and Langley Green crisis teams. The mental health rapid response team from Mill View provided out of hours cover.
- Street triage provided cover at different times/ days across the county, based on the needs of the local demographic. These included: in Brighton the street triage service ran from 4:00pm to 2:00am from Thursday to Sunday; in Hastings this was provided from 9:00am to 9:00pm Wednesday to Sunday; and in Chichester this was provided each day of the week, ranging from such times as Tuesday-Wednesday 3:00pm to11:00pm and weekends from 7:00am to 11:00pm.
- A mental health helpline was available for patients. However, commissioning arrangements meant that the availability varied across East and West Sussex. In West Sussex, 24-hour support was available. However, in East Sussex, the helpline was only available out of hours. Staff gave patients the details for the mental health helpline to contact if required. We received mixed feedback regarding patient's success in getting through to the helpline.
- Staff were expected to complete mandatory training. Training data provided from the trust showed that training compliance was generally good. The trust used an electronic record to monitor training and staff were sent emails when training was due or overdue. Team leaders could look at and monitor staff training records to discuss during supervision.

Health-based place of safety

- A clinical lead nurse for places of safety had been appointed specifically to standardise and improve the places of safety across the trust. This had enhanced clinical oversight of the services and had been positively received by staff. Their aim was to provide support to operational teams with consistency of high provision of care in places of safety, sharing good practice, improvements and standardisation across the trust. There was a clinical standards forum which had developed a protocol for each of the places of safety. During this meeting incidents and subsequent learning were discussed.
- Commissioning arrangements for Chalkhill did not fund the staffing of the place of safety. Staff told us that only one qualified member of staff from the ward was available and that once the person had been admitted to the place of safety, staffing reduced to a support worker with telephone / radio support from the ward next to the place of safety. Inspectors raised this with the trust who confirmed that young people were only admitted to the place of safety once suitable staffing has been identified. The trust held regular discussions with the commissioners in an attempt to resolve staffing issues.
- There was no dedicated staffing for the places of safety although there was an allocated nurse and support worker from the adjoining ward, who were supernumerary to ward staffing numbers. However, at Meadowfield Hospital there was a band 6 nurse specifically for the place of safety. The nurse accepted the patients attending the place of safety to ensure fitness to detain and receive paperwork from the police. The support worker was responsible for completing observations. Staff were only left alone if the patient was considered low risk.
- Mill View Hospital had recently recruited five band two staff for the place of safety. Two were in post and three were on induction at the time of our inspection.
- All staff were expected to complete mandatory training. Staff told us about a new training course which was based on ‘no force first’ and encouraged staff to use de-escalation strategies.
- The trust had developed a place of safety competency checklist for staff which was due to be implemented the week following our inspection. Staff shadowed staff from the place of safety and spent time with the Mental Health Act (MHA) practitioners, approved mental health professionals and the MHA administrator. Staff from the urgent care team had delivered training and developed a training pack to support staff from the accident and emergency departments.
- The trust confirmed that at a clinical operational managers and clinical lead nurses meeting for places of safety on 25 January 2019, the trust was securing temporary staffing, pending recruitment, for the places of safety that did not have dedicated staffing.

This core service had 16 (12%) staff leavers between 1 October 2017 and 30 September 2018.

Location	Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Oaklands Centre for Acute Care	Crisis Resolution Home Treatment Team WAMHS Crisis Team Chichester	10	3	29%
Eastbourne Police Station	East Sussex Street Triage	2	1	22%
Meadow field Hospital	Sussex Mental Helpline	10	2	20%
Langley Green Hospital	Adult Services (AMHS) Acute inpatient - Langley Green S136	29	5	18%
Woodlands	CRHT	20	4	17%
Chalkhill	Urgent Help Service	10	1	10%
Mill View Hospital	Crisis Response and Home Treatment (CRHT)	27	1	4%
Langley Green Hospital	Adult Services Ambulance Street Triage Pilot	1	0	0%
Meadow field Hospital	Crisis Home Treatment Team (AMHS) - Crisis Team AAW	10	0	0%
Mill View Hospital	Mental Health Rapid Response Service (MHRRS)	10	0	0%
Mill View Hospital	Acute inpatient Adult Mental Health (Section 136)	2	0	0%
Core service total		**131**	**16**	**12%**
Trust Total		**2424**	**371**	**15%**

The sickness rate for this core service was 4.7% between 1 September 2017 and 31 August 2018. The most recent month's data (August 2018) showed a sickness rate of 4.8%.

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff Sickness (over the past year)
Mill View Hospital	Acute inpatient Adult Mental Health (Section 136)	3.2	14.5

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff Sickness (over the past year)
Mill View Hospital	Mental Health Rapid Response Service (MHRRS)	9.9	7.1
Meadow field Hospital	Crisis Home Treatment Team (AMHS) - Crisis Team AAW	1.3	6.8
Langley Green Hospital	Adult Services (AMHS) Acute inpatient - Langley Green S136	10.5	6.2
Woodlands	CRHT	0.1	5.2
Chalkhill	Urgent Help Service	7.7	4.3
Mill View Hospital	Crisis Response and Home Treatment (CRHT)	2.4	2.9
Meadow field Hospital	Sussex Mental Helpline	1.7	1.8
Oaklands Centre for Acute Care	Crisis Resolution Home Treatment Team WAMHS Crisis Team Chichester	3.9	1.8
Eastbourne Police Station	East Sussex Street Triage	0	0.5
Langley Green Hospital	Adult Services Ambulance Street Triage Pilot	0.0	0.0
Core service total		**4.8**	**4.7**
Trust Total		**4.7**	**4.9**

Medical staff

Between 1 October 2017 and 30 September 2018, of the 10950 total working hours available, 0% were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same period, agency staff covered 0% of available hours and 0% of available hours were unable to be filled by either bank or agency staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
CRHT	2933	0	0%	0	0%	-978	-33%
CRHT & Liaison	3129	0	0%	0	0%	196	6%
Crisis Home Treatment Team (AMHS) - Crisis Team AAW	391	0	0%	0	0%	0	0%
Crisis Resolution Home Treatment Team WAMHS Crisis Team Chichester	782	0	0%	0	0%	782	100%

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Crisis Response and Home Treatment (CRHT)	3715	0	0%	0	0%	0	0%
Core service total	**10950**	**0**	**0%**	**0**	**0%**	**0**	**0%**
Trust Total	**336290**	**8648**	**3%**	**41155**	**12%**	**21392**	**6%**

Mandatory training

The compliance for mandatory and statutory training courses at 1 October 2018 was 92%. Of the training courses listed three failed to achieve the trust target and of those, two failed to score above 75%.

The trust set a target of 85% for completion of mandatory and statutory training.

The training compliance reported for this core service during this inspection was higher than the 86% reported in the previous year.

Key:

Below CQC 75%	Met trust target	Not met trust target

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Rapid Tranquilisation	3	3	100	
Fire safety onsite-Inpatient	1	1	100	
Personal Safety - MVA	2	2	100	
Infection Prevention (Level 1)	21	21	100	
Safeguarding Children (Level 1)	19	19	100	

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Information Governance	143	141	99	
Clinical Risk Assessment	124	120	97	
Health and Safety (Slips, Trips and Falls)	143	138	97	
Safeguarding Adults (Level 1)	19	18	95	
Equality and Diversity	116	109	94	
Fire safety onsite - non-inpatient	141	133	94	
Personal Safety Breakaway - Level 1	111	104	94	
Safeguarding Children (Level 2)	144	135	94	
Manual Handling - Object	143	134	94	
Safeguarding Adults (Level 2)	124	113	91	
Prevent	143	130	91	
Prevent (WRAP)	122	111	91	

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Mental Capacity Act Level 1	124	106	86	
Infection Prevention (Level 2)	121	104	86	
Mental Health Act	110	94	85	
Medicines management	87	74	85	
Adult Basic Life Support	122	103	84	
Adult Immediate Life Support	2	1	50	
Manual Handling - People	2	0	0	
TOTAL	**2087**	**1914**	**92%**	

Assessing and managing risk to patients and staff

Assessment of patient risk

- The 29 risk assessments that we reviewed across the four crisis teams varied with respect to their quality and level of detail. Staff completed an initial risk assessment as part of patients 72-hour care. Twenty-four of the risk assessments were thorough, up to date and reviewed as required. We found a risk assessment was missing from one of the records reviewed at the Mill View team and the remaining five contained limited information and did not accurately reflect the current clinical presentation for the patient. Findings were raised with the service manager who confirmed that concerns would be addressed.
- Teams used the red, amber, green (RAG) risk assessment tool to identify level of risk. Chichester also numbered patients between one and seven to further identify risk level. RAG status was reviewed and updated on the whiteboard in team offices during handover and clinical review meetings.
- Staff saw all patients daily for the first three days and then reviewed frequency of visits. We saw evidence that staff saw patients twice a day where risk was considered high. Staff made home visits in pairs if required.
- Street triage teams worked with the police across the trust. The teams consisted of mental health professionals who provided support to people in distress. Workers had access to the trusts electronic records, local authority and police systems. Workers had iPads so that they could upload notes in real time.

Health-based place of safety

- We reviewed 30 care records of patients who had used a place of safety. All contained detailed risk assessments and included any risks reported from the police when the patient was bought to the place of safety. Staff who had carried out the assessment had considered risks when making recommendations about the patients' ongoing care and treatment.

Management of patient risk

- Staff responded to sudden deterioration of patient's health. Any deterioration was recognised during patients' presentation, home visits and communication from patients, carers or professionals. We saw examples of staff responding to risk which included increasing the number of visits. All staff we spoke with had a good understanding of patients' risk.
- We observed comprehensive and focussed discussions during the twice daily handovers. Discussions included risk, level of support and consideration of other agency involvement. Staff in all handovers observed demonstrated a good knowledge of their patients. Meetings were attended by a range of disciplines and demonstrated good multi-disciplinary working.
- Staff from Mill View hospital told us that information noted during the handover meeting would be added to the patient's care notes. However, we found no evidence of this during our review of care records. The team leader told us that this was a relatively new process so was taking time to embed.
- Staff followed the trust lone working policy. Staff recorded visits on the office whiteboard. The shift co-ordinator was responsible for monitoring staff whereabouts. Staff telephoned the shift co-ordinator before and after home visits. All staff had access to Guardian 24, a tracking and tracing app on their work phone so that they can easily access support and track whereabouts.

Health-based place of safety

- Staff completed a place of safety risk plan at the point of admission with the police or ambulance service. The police and ambulance service completed specific documentation as part of the handover process. Police searched patients before leaving which staff recorded on the patient's electronic care record.
- Staffing numbers were determined during the initial assessment. Staff reviewed and monitored risk through observation, talking to the patient and the presentation of the patient. Patients remained on eyesight observations while they were in the place of safety.
- Staff completed prevention and management of violence and aggression training. Staff from Chalkhill received extra training for restraint, especially if the young person was underweight. Staff used de-escalation techniques to avoid using restraint where possible. Staff initiated the trusts seclusion policy if the door to the place of safety was closed. Staff told us this was used only in exceptional circumstances.

Use of restrictive interventions

This service had 38 incidences of restraint (36 unique individual service users) and 33 incidences of seclusion between 1 October 2017 and 30 September 2018.

The below table focuses on the last 12 months' worth of data: 1 October 2017 to 30 September 2018.**Location**	**Ward name**	**Seclusions**	**Restraints**	**Individual service users that restraint was used on**	**Of restraint, incidents of prone restraint**	**Rapid tranquilisations**
Woodlands Unit	CRHT (Woodlands)	0	1	1	0	0
Mill View Hospital	MHRRS	0	1	1	0	0
Chalkhill Inpatient Unit	S136 (Chalkhill)	1	0	0	0	0
Dept. of Psychiatry	Acute inpatient Adult Mental Health (Section 136) - Department of Psychiatry	2	3	3	2	4
Langley Green Hospital	S136 (LGH)	2	2	2	1	0
Meadow field	S136 (Meadow field)	16	8	7	3	3
Mill View Hospital	Acute inpatient Adult Mental Health (Section 136) – Mill View Hospital	11	16	16	4	4
Woodlands Unit	S136 (Woodlands)	1	7	6	2	3
Core service total		**33**	**38**	**36**	**12 (32%)**	**14 (37%)**

There were 12 incidents of prone restraint, which accounted for 32% of the restraint incidents. Over the 12 months, incidences of restraint ranged from one to seven. The number of incidences (38) was higher than the previous 12-month period (26).

There were 14 instances of rapid tranquilisation over the reporting period. Incidents resulting in rapid tranquilisation for this service ranged from none to four over the 12 months. The number of incidences (14) was higher than the previous 12-month period (7).

There were no instances of mechanical restraint over the reporting period.

There were 33 instances of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from none to five. The number of incidences (33) increased when compared to

the previous 12-month period (11).

There were no patients placed in long-term segregation over the 12-month reporting period.

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 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.

This core service made 221 safeguarding referrals between 1 October 2017 to 30 September 2018, of which zero concerned adults and 221 children.

Number of referrals			
Core service	**Adults**	**Children**	**Total referrals**
MH - Mental health crisis services and health-based places of safety	0	221	221

The number of child safeguarding referrals ranged from 12 to 32 (as shown below).

No serious case reviews related to this service, were commenced or published during the past 12 months.

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff completed mandatory safeguarding training. Staff we spoke with were able to give examples of when a safeguarding alert should be raised. Team leaders were confident in staff knowledge of safeguarding and when to raise concerns. Staff could complete an online safeguarding referral of via the local authority website.
- Safeguarding concerns were discussed during handovers and clinical team meetings. Staff at Mill View placed a teddy on the whiteboard in the staff office where children's

safeguarding concerns had been identified.

- Managers could request the number of safeguarding alerts raised from the trust safeguarding team.
- Social workers were integrated into all home treatment teams. We observed a social worker at Mill View clarifying safeguarding information for staff during the handover meeting. We saw evidence in the progress notes of social workers at Mill View following safeguarding processes and evidence that this had also been through a panel for consideration.
- One of the social worker's at Mill View attended weekly multi agency risk assessment conference (MARAC) meetings. MARAC meetings are attended by professionals including the police, probation services, housing and health services to discuss and share information about high risk domestic abuse cases.
- We saw evidence of staff following the trust's safeguarding procedure when reviewing care records at Meadowfields. Initiation of a safeguarding referral was discussed during the handover meeting at Chichester home treatment team.

Health Based Places of safety

- Staff knew how to identify abuse and when a safeguarding referral would be appropriate. Staff contacted the senior nurse practitioner or approved mental health professional with safeguarding concerns.

Staff access to essential information

- Staff used a combination of electronic and paper records, although the level of paper records varied across the teams. In Chichester, staff held a full paper copy of records as well as the electronic record. The team leader explained staff were keen to maintain a full paper record so that they can access records in the event of the electronic system failing.

Health Based Place of Safety

- Staff had access to the patient electronic records. Staff completed paperwork specific to the place of safety during the initial assessment which they subsequently uploaded to the patient's electronic care record.

Medicines management

- Staff at Chichester did not always complete a record of receipt and storage information didn't always reflect actual stock. Medicines taken away from patients to be dispensed by staff were kept in a locked cupboard. We saw that stock included medicines waiting for disposal for patients who had been discharged from the service. There was no robust policy in place for tracking medicines.
- Some teams used patient group directions to enable nurses to administer a small selection of pre-agreed medicines appropriate to the clinical needs of the team. There were no patient group directions in place at Mill View as the clinical nurse lead was a nurse prescriber. The clinical nurse lead was responsible to oversee the medicines management for the team They completed a monthly check of controlled drugs. All medicines stock for the Mill View home treatment team was stored in a locked cupboard. Stock included physical health medicines for patients that may be coming in and out of hospital, 'in case' required. Staff did not record the medicines held on behalf of the patient. Staff checked when pharmacy delivered medicines and when staff dispensed to patients. However, there was no auditable check for what medicine was in the cupboard.

- We reviewed 18 medicine administration records for Mill View home treatment team. Staff did not follow policy for recording when medicines were given to patients. Five of the 18 medicine charts did not have allergies recorded or indicated that there were no known allergies. Where care plans were missing, there was no way to evidence how many days of medicines should be given to the patient.
- We saw that medical devices had been checked and calibrated the week before our inspection at Worthing home treatment team. However, we found no evidence of medical equipment including blood pressure machines, manual sphygmoters, and thermometers being calibrated at Chichester or Mill View home treatment teams.
- Registered nurses completed medicines management training. We observed staff adhering to the trust policy for preparing dispensed medicines for non-nursing staff to give to patients during home visits.
- The room temperature and fridge temperature in the clinic room at Mill View was checked regularly and was all within a safe range.

Following the inspection, we received assurance from the trust that concerns have been acted on and appropriate provision put in place to support teams. On the 26 February 2019 we carried out a short-notice inspection to follow up the concerns we had identified regarding medicines management. We found the trust had addressed the high risk concerns we identified around the variation in practice. It was clear that:

- The Mill View service care model was different to the other two sites (more risk averse, more removal of and packing down of medicines into smaller supplies, more use of a medicines chart and prescribing – in part due to greater access to doctors)
- Pharmacy staff had concerns and our inspection raised the profile of those concerns to the board and a reactive action plan was developed and implemented
- The issue that still needed to be resolved was in relation to the FP10. Sites records would have identified if some were missing, apart from at Mill View Hospital.

Health-based place of safety

- Staff followed the trust medicines policy and spoke with the pharmacist where appropriate.
- Staff checked medicines and that a patient was medically fit during their initial presentation to the place of safety.
- There was a separate medicine chart for patients in the places of safety. Medicines were administered under a patient group direction. Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription.

Track record on safety

Between 1 April 2018 to 1 October 2018 there were 15 serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was ‘apparent/actual/suspected self-inflicted harm meeting SI criteria’ with 12. There were no unexpected deaths reported by this service.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents

recorded by the trust incident reporting system was comparable with STEIS with 15 reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

Type of incident reported	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	Unauthorised absence meeting SI criteria	Total
CRHT WA (E) (Woodlands)	1	0	0	0	1
CRHT WA (LGH)	1	0	0	0	1
CRHT WA (Meadow field)	3	0	0	0	3
CRHT WA (Mill View)	2	0	0	0	2
CRHT WA (Mill view)	1	0	0	0	1
Liaison and Urgent Care Lounge (DoP)	2	0	0	0	2
MHRRS (MVH)	1	0	0	0	1
S136 (Chalkhill) Place of Safety	0	0	1	0	1
S136 (MVH) Place of Safety	0	1	0	1	2
Urgent Care Lounge (Woodlands)	1	0	0	0	1
Total	**12**	**1**	**1**	**1**	**15**

- All staff had access to an electronic incident reporting tool. Staff were able to give examples of what incidents should be reported. Details of each incident was sent to the health and safety team and team manager for review and action. Incidents were not always investigated by investigating officers' external to the team to ensure objectivity.
- Incidents were discussed during team meetings. Staff we spoke with were able to give examples of local incidents and the learning from these. The trust sent a bulletin to all staff with information about recent incidents and any learning identified. Staff had access to debrief sessions after serious incidents that were facilitated by senior managers and psychologists.
- Inspectors case tracked two recent serious incidents for the Chichester team and saw that appropriate investigations, support for family and duty of candour had taken place into each incident. Of the three incidents reviewed at Mill View, we saw an action that personalised care plans should be in place by March 2019.
- The trust had a duty of candour policy and staff were aware of their responsibilities. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers

of health and social care services to notify people (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. We saw examples of senior managers having spoken directly to families when an incident had taken place.

Health-based place of safety

- Staff used the online incident reporting tool to record incidents. All incidents were received by the trust's risk and safety team and the place of safety clinical lead nurse. Staff were able to give examples of incidents that should be reported.
- Staff discussed incidents and documented outcomes for circulation to staff. Staff received a debrief following an incident. Incidents were discussed during the monthly places of safety clinical standards forum.
- Staff were aware of their responsibilities under the trusts duty of candour policy.

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 12 'prevention of future death' reports sent to Sussex Partnership NHS Foundation Trust. One of these related to this service, details of which can be found below.

Paul Wolferston Villa – Date of report: 18 April 2017

Reg 28

Suicide

The Coroner's concerns were:

1. The evidence heard, and the experience suffered by the family in this case has highlighted a lack of a coherent and standard practice in the handling of cold calls to the Sussex AMHP and mental Healthline.
2. There appears to be a lack of centralised management of the handling and direction of calls when service users needing care and assistance do not call a 'local' number. There appears to be a lack of suitable triage or immediately actionable steps available to 'help and action', rather than to 'listen and refer'.
3. The service does not appear to apply a set or common approach across the country with regard to the allocation of calls to an AMHP or mental health practitioner, causing significant distress to families and therefore a clear risk of failing to place persons in acute need of care and assistance, quickly and effectively with the nearest and most appropriate support (taking to account that the quickest route to an AMHP or MHP may not always be to the AHMP or MHP in the area where the user either lives or their GP is located.)
4. There appears to be a difficulty in or failure to access notes entered by an AHMP on the framework I system by the call service operators or by the absence of a countrywide system which can record and give access to all enquires (perhaps by caller/user name or unique reference) should a family have cause to call the helpline or a different mental health team in the county.
5. That a family cannot get through to a mental Healthline at a point of crisis or be assisted or placed with a suitable practitioner who can offer then clear and structured help, within one call,

is a significant cause for concern.

The trust did respond to the coroner concerns – Trust Response

Is the service effective?

Assessment of needs and planning of care

- The trust was in the process of developing a care plan template for use across all services. We reviewed 29 care records across the four home treatment teams inspected. We found inconsistencies in the care plans completed by staff. At Chichester, Worthing and Langley Green home treatment teams, staff completed an initial 72-hour assessment form. However, staff at Mill View home treatment team told us that had been instructed not to use this document.
- Of the 29 care records reviewed, 23 were high quality, personalised, holistic and recovery orientated. They demonstrated robust initial assessments with evidence of multiagency working and joint working with care co-ordinators where appropriate. These 23 records, all recorded informed consent from the patient. We saw that staff completed physical health monitoring at the initial assessment and liaised with doctors as appropriate. We case tracked two records for patients involved in recent incidents. We saw evidence of staff reviewing risk, duty of candour and post incident support for the patient's family.
- Four of the six care records reviewed for Mill View home treatment team did not contain care plans. Two of the patients without a care plan were of concern due to the complexity and level of risk. There was no evidence in another care record of staff liaising with the local substance misuse service who were also involved in the patient's care. The inspecting team raised these concerns with the service manager for their immediate attention. The remaining two records contained care plans although these were not holistic and did not reflect the full range of needs of the patients. The care plans lacked description of recovery orientated strengths and goals. None of the records reviewed contained evidence of informed consent from the patient.
- Staff from Mill View recorded the date of review for care plans on the whiteboard in the team office. Staff wrote in red where care plans were overdue, so that it was easily identified. However, we saw that several care plans were noted as overdue on the board, that had not been actioned. Moreover, we reviewed one of the patient records which noted that a care plan was overdue by 10 days and could not find any care plan in the patient record.
- Staff told us Mill View was piloting uploading a photograph of signed care plans onto the electronic records system, to support staff workload. However, there was no evidence of this in the records reviewed.
- Inspectors escalated concerns and we have received reassurance since the inspection that action has been taken to address the issues raised.

Health-based place of safety

- All staff had access to the trusts electronic care record system. Staff said that assessments

may be delayed if the patient was asleep or refused to engage.

- Staff completed an initial screening which included physical observations. Assessments included information about a patient's previous history. Staff completed physical health checks and raised any concerns with a doctor. Staff completed a 'Getting to know me' informal care plan with the patient, which was then uploaded onto the electronic care records.
- We reviewed 30 care records of patients that had used the place of safety. We saw that 12 out of 30 records were not fully completed. Staff had not recorded the time that the approved mental health professional and section 12 doctor had been requested. This meant that the nurse could not accurately calculate the time from request to completion of assessment. The Mental Health Act Code of Practice 16.47 says that a doctor and approved mental health professional should attend within three hours where there are no clinical grounds to delay an assessment. We saw that staff had not recorded the reason that nine people had not been seen within the recommended three hours.

- Data provided by the approved mental health professionals for Brighton and Hove showed they had completed 94 assessments for the 106 referrals received between September and December 2018. Reasons why assessments had not taken place included patients transferred to another place of safety and doctors who had seen the patient had decided that there was no mental health disorder.

Best practice in treatment and care

- Staff followed the National institute for health and care excellence (NICE) guidelines such as involvement of patients in care planning, crisis care planning and assessment, involvement and support of carers and family, supporting clients to identify triggers to violent and aggressive behaviours and working with patients with sensory impairment. We saw examples where NICE guidelines quality statements 14, 34, 136 and 154 had been followed.
- We saw evidence of staff considering a range of care and treatment interventions for patients during handovers and team meetings. Staff considered least restrictive practice when discussing patient needs. Staff from Chichester had access to an education, training and employment advisor based in the community mental health team. We observed staff from Mill View consider resources available in the community including the recovery college and general treatment services during a handover meeting. However, staff did not appear to have close links or consider potential support available for patients who attended the local university.
- Patients at Langley Green could access the day service for daily group therapy in a range of psycho-social interventions Monday to Friday. Groups offered included mindfulness, managing anxiety and art therapy.
- Psychological interventions varied across the sites we visited. The clinical psychologist at Worthing completed an initial formulation assessment with patients to determine if psychology or cognitive behavioural therapy (CBT) would be helpful for patients. One to one psychology sessions were only offered for selected patients, although the team acknowledged that patients referred to the community teams may then have to wait for psychology support. Three of the team at Worthing were trained in CBT and could offer appointments for patients. The psychology team at Chichester offered assessment

formulation and recommendations for the long-term care of patients.

- Plans were in place at Mill View to cover one and a half psychology sessions during the long-term absence of the psychologist who was due to return in August 2019.
- One of the doctors from Mill View was a lead for 'open dialogue' treatment. Open dialogue teams work with patients, families and extended social networks to gain a greater understanding of the impact of the mental health crisis for all involved.
- The clinical lead nurse at Mill View was a nurse prescriber. This meant that they could prescribe medicines to patients to streamline a patient's treatment journey.
- The support time and recovery worker based at Mill View crisis team was funded by the local authority. They provided practical support to patients including how to identify early signs of relapse, housing, benefits, money advice lighting, electricity and shopping to promote independent living. None of the other teams visited had support workers in post.
- Staff discussed patients' physical health during handover meetings. We saw evidence of staff completing a physical health screening tool and observations during the initial assessment. There was a physical health care lead in the Chichester team who liaised with GPs when appropriate. Staff sent a physical health monitoring letter to patients which included results of tests and recommendations for health and wellbeing including diet, exercise, smoking, losing weight, alcohol and sexual health. The physical health monitoring equipment at Mill View included a palm pad electrocardiogram (ECG) machine used as a preliminary indication during lithium and clozapine titration.
- The crisis teams used the Health of the Nation Outcome Scales (HONOS), Generalised Anxiety Disorder assessment (GAD9) and Beck Depression Inventory scales. HONOS is used to measure the health and social functioning of people with severe mental illness. GAD9 is an anxiety and depression score and the Beck Depression Inventory is used to measure the severity of depression.

Health-based place of safety.

- The clinical lead nurse for places of safety was standardising processes to improve the service for patients. They were developing a new protocol for each place of safety. Initiatives included developing staff competency for place of safety staff and standardising seclusion across the trust. They were developing a step by step guide for staff detailing the patient pathway for places of safety.
- Staff from Mill View and Langley Green Hospitals were involved in a reducing restrictive intervention programme to minimise the number of restrictive practices used. The number of seclusions had reduced significantly since starting the project. Staff were due to give a presentation about their success at the Royal College of Psychiatry.
- Staff completed local audits which included ethnicity, incidents and use of seclusion. Staff told us that there was no formal trust wide audit for section 136.

Through the Mental Health Act monitoring group audits were carried out to monitor the patients' pathway and outcomes.

Skilled staff to deliver care

Mental health crisis services

- There was a range of disciplines in the crisis teams which included doctors, nurses,

psychologists, occupational therapists and social workers. All staff we spoke with were appropriately experienced and qualified to meet the needs of patients.

- New staff received an induction to the trust and within their local team. New staff were supernumerary to staffing numbers during the two-week induction period and spent time shadowing staff, orientation to the service and receiving log in details to allow them to complete their role. There was an induction checklist for all new staff.
- We saw evidence of discussions regarding training in two of the four supervision records reviewed. Staff could access specialist training including venepuncture, cognitive behavioural therapy, graded exposure, mindfulness and schema. Leadership training was available for team leaders and managers.

Health Based Place of Safety

- There were sufficient numbers of suitably skilled staff to ensure people were kept safe. Additional staff could be requested from wards if required. Staff had access to a range of other professionals if needed, including consultants, mental health professionals and the police.
- Staff completed training relevant to their role and included: 136 policy, risk assessment and management, observational skills, use of the Mental Health Act and prevention and management of violence and aggression.
- The pharmacy team had developed a medicines management competency checklist for staff.

The trust's target rate for appraisal compliance is 95%. At the end of last year (1 January 2017 to 31 July 2017), the overall appraisal rate for all staff within this service was 48%. This year so far, the overall appraisal rate was 65% (as at 30 September 2018).

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 48% reported in the previous year.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 30 September 2018)	% appraisals (previous year 1 January 2017 to 31 July 2017)
CRHT-Chichester	12	4	33%	17%
CRHT-Worthing	12	7	58%	8%
CRHT-Northern West Sussex	20	18	90%	40%
CMHT-Street Triage	0	0	N/A	100%
CRHT-Hastings	25	19	76%	93%
CMHT-Street Triage (Eastbourne)	2	2	100%	100%
CRHT-Eastbourne	28	26	93%	75%
136-Millview	2	0	0%	100%
CRHT-Brighton	25	6	24%	17%

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 30 September 2018)	% appraisals (previous year 1 January 2017 to 31 July 2017)
Core service total	**126**	**82**	**65%**	**48%**
Trust wide	**2541**	**1605**	**63%**	**48%**

There was no information provided for medical staff.

Between 1 October 2017 and 30 September 2018, the average rate across all 10 teams in this service was 43%.

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

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
East Sussex Street Triage	30	29	97%
Adult Services (AMHS) Crisis Home Treatment Team (Crisis Team North)	138	120	87%
CRHT & Liaison	500	396	79%
CRHT	380	256	67%
Crisis Response and Home Treatment (CRHT)	288	17	6%
Mental Health Rapid Response Service (MHRRS)	132	5	4%
Urgent Help Service	131	4	3%
Crisis Home Treatment Team (AMHS) - Crisis Team AAW	202	5	2%
Crisis Resolution Home Treatment Team WAMHS Crisis Team Chichester	120	1	1%
Acute inpatient Adult Mental Health (Section 136)	24	0	0%
Core service total	**1945**	**833**	**43%**
Trust Total	**28506**	**11280**	**40%**

Between 1 October 2017 and 30 September 2018, the average rate across all three teams in this service was 0%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different

ways, so it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Adult Services (AMHS) Crisis Home Treatment Team (Crisis Team North)	8	0	0%
Crisis Resolution Home Treatment Team WAMHS Crisis Team Chichester	2	0	0%
Crisis Response and Home Treatment (CRHT)	24	0	0%
Core service total	**34**	**0**	**0%**
Trust Total	**1570**	**132**	**8%**

- Supervision every four to six weeks was one of the targets set by the trust. Staff across all four teams told us they received regular supervision. We reviewed the supervision records of four members of staff at Chichester and saw that since being in post, efforts had been made by the team leader to improve the quality and regularity of supervision for staff. We saw that prior to their appointment in October 2018, staff supervision had been sporadic. The team leader had developed their own spreadsheet to monitor supervision. Staff were supported to source their own clinical supervision every 4-6 weeks. Staff were asked to record supervision on their 'my learning' dashboard. The team leader had regular peer supervision with her counterpart in Worthing.
- Staff from Chichester Mill View and Langley Green received regular reflective practice with the psychologist.
- The social workers at Mill View received supervision with the local authority. The team leader provided supervision as and when required.

Multidisciplinary and interagency team work

- A range of disciplines including doctors, nurses, psychologists, occupational therapists and managers attended the twice daily handovers where possible. We observed staff sharing appropriate information and risks during the meeting. Discussions were patient centred and demonstrated knowledge of patients' needs. All staff were engaged with the meetings, all views were valued and there was clear evidence of strong teamwork. However, there were inconsistencies in how meetings were recorded.
- Staff attended team meetings and clinical review meetings where patients were discussed in greater detail. Staff from Langley Green completed a template during their weekly multidisciplinary meeting which covered HoNOS, clustering, risks, plan and safeguarding concerns. Staff recorded the meeting on care notes and sent to the community mental health team to keep care co-ordinators updated. The team manager at Mill View was in the process of embedding staff recording information discussed directly onto the electronic care record during these meetings.
- Staff from Mill View worked closely with the rapid response team who were also based at the hospital. The rapid response service operated between 8am and 10pm on weekdays and

10am to 10pm at weekends. They supported adults who were experiencing a crisis in their mental health who were not already receiving mental health care who were at risk of harming themselves or others. The rapid response team could refer patients to the crisis team.

- Street triage workers attended their local crisis team and attended meetings where possible.
- A nurse from Mill View attended regular meetings with the local personality disorder service. During the meetings, staff reviewed patients, presented case study's, developed crisis plans and shared learning.
- The early discharge nurses attended ward rounds and ward meetings as requested, to facilitate supported early discharge and ensure early discharge was appropriately planned.
- The team leader at Chichester attended a meeting with the community mental health team, street triage, police, helpline and ambulance service each week to support joint working and streamline patients' treatment journey.
- Social workers from Mill View attended weekly multi agency risk assessment conferences to discuss high risk cases of domestic abuse and meetings with the local authority safeguarding team.
- Staff from the mental health helpline attended regular meetings and received regular reflective practice. Staff received debriefs after receiving difficult calls.

Health-based place of safety

- Staff discussed patients during handover meetings. Staff attended monthly team meetings and received regular updates from their matron.
- The clinical lead nurse for places of safety had introduced a multi-disciplinary place of safety forum. During the meeting, staff shared knowledge and good practice across all places of safety.
- The places of safety had a clear and comprehensive standard joint operational policy with other agencies including the police and the local authority. There were local and trust operational protocols for joint working involving the police, the trust and community teams. Regular multi agency meetings ensured effective information sharing and good working relationships.
- There was a monthly manager's meeting with the police, consultants from accident and emergency, ambulance and AMHPs to review all section 136 admissions, length of time in place of safety, outcome and issues. Staff said they found the meetings effective and a good way of bringing operational procedures and differences together.
- Staff worked closely with the police, approved mental health professionals, street triage and ambulance services. There was a named person responsible for analysing and ensuring the dissemination of learning from meetings.
- There was a street triage service whereby an experienced mental health worker accompanied a police officer, at times during the day/night when the police were more likely to apply Section 136. The mental health worker would look for alternatives to Section 136 being applied, such as referral to a local mental health service, or deescalating the patients' crisis, whilst at the same time releasing the police officer to resume their usual policing duties. Staff told us the street triage service had improved working relationships with other agencies.

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

As of 1 October 2018, 85% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every two years.

The training compliance reported during this inspection was lower than the 88% reported in the previous year.

- As of 1 October 2018, 85% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every two years.
- The training compliance reported during this inspection was lower than the 88% reported in the previous year.
- There was a Mental Health Act administration team based in Worthing. Staff could refer to the Mental Health Act policy on the intranet.
- Social workers were integrated in each of the crisis teams inspected. The senior social worker based with the Mill View crisis team was also a trained approved mental health professional (AMHP). When staff felt that a Mental Health Act assessment may be required, the AMHP attended visits with the doctor who was section 12 approved. A section 12 doctor is a doctor who is trained and qualified in the use of the Mental Health Act 1983.
- Social workers provided patients with information about advocacy services. Patients from Mill View had access to ward advocacy.

Health Based Place of Safety

- All health-based places of safety kept clear and concise records of all people brought into the place of safety in accordance with the Mental Health Act Code of Practice.
- Case notes included an initial report from the approved mental health practitioner (AMHP) and a set of section 136 documentation. Care records showed that patients had their rights under the Mental Health Act explained to them. Information about rights was contained in the introduction pack given to patients. Contact with the nearest relative was recorded in the patients care record.
- Staff completed face to face training with the ward manager and annual mandatory e-learning training.

Good practice in applying the Mental Capacity Act

As of 1 October 2018, 86% of the workforce had received training in the Mental Capacity Act Level 1. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every two years. The training compliance reported during this inspection was higher than the 84% reported in the previous year.

Staff completed annual mandatory e-learning training. Staff could refer to the trust's Mental Capacity Act policy on the intranet.

We saw evidence of staff assessing patient's capacity in the electronic care records.

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 October 2017 and 30 September 2018.

CQC received 27 direct notifications from Sussex Partnership NHS Foundation Trust between 1 October 2017 and 30 September 2018. However, none pertained to this core service.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

- Staff were caring, compassionate and respectful during the three home visits observed. One of the visits included an assessment where staff managed expectations in an informative, diplomatic and caring way. Staff took care not to repeat what had previously been discussed during initial referral. We observed staff involving patients in care planning and managing risk during all visits.
- Staff demonstrated a good knowledge and understanding of individual patient needs and risks during handover meetings. Staff held meaningful discussions and spoke about patients in a respectful and caring manner.
- Staff supported patients with social issues. There was a dedicated support and recovery worker at Mill View who supported patients with housing, benefits, shopping, attending appointments and any other identified social need.
- Staff had access to interpreters. We heard an example of staff arranging a signer to support a patient who was deaf.
- We spoke with 10 patients from Chichester, Mill View and Meadowfield crisis teams. All patients spoke positively about the support received. Comments included that staff were invaluable; that staff listen and are easy to talk to; staff are responsive and proactive; staff help with a lot of issues and are very good at communication because they do not have to repeat their story at each visit.
- We observed staff from the mental health telephone service who were supportive and kind in their conversations with callers.

Health-based place of safety

- We spoke with four current and one former patient of the places of safety. All current patients said that staff had treated them with kindness, respect and did their best to make them feel comfortable. Staff offered patient's food and drink and a range of diets to accommodate need. Staff monitored patients' physical observations. Toiletries, spare clothing, activity boxes and welcome packs were also provided.
- Patients had access to a spiritual box and prayer mats. Chaplains were available on site. Activities were available which included games and books. The trust planned to include electronic activities to all places of safety as part of their refurbishment programme. Staff told us that interpreters and sign language were easily accessible
- Outside windows were covered with a film to ensure privacy. Blinds into the place of safety could be closed if patients wanted more privacy.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), the location scored higher than similar trusts.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Mill View Hospital	MH - Mental health crisis services and health-based places of safety	94.4%
Langley Green Hospital	MH - Mental health crisis services and health-based places of safety	81.94%
Department of Psychiatry	MH - Mental health crisis services and health-based places of safety	93.75%
Meadow field Hospital	MH - Mental health crisis services and health-based places of safety	90.3%
Woodlands	MH - Mental health crisis services and health-based places of safety	84.0%
Chalkhill	MH - Mental health crisis services and health-based places of safety	95.3%
Trust overall		**89.1%**
England average (mental health and learning disabilities)		**88.9%**

Involvement in care

Involvement of patients

- Staff provided patients with information about the service during assessments. Patients were given information leaflets which included key information and how to raise concerns.
- We observed staff working collaboratively with patients in their care during home visits. We observed staff sensitively discussing care and treatment and ensuring patient understanding.
- Care plans at Chichester, Meadowfield and Langley Green demonstrated involvement in their care. Although not demonstrated in care plans reviewed at Mill View, patient involvement was observed during home visits.
- Patients were able to provide feedback using the friends and family survey.
- Staff provided patients with advocacy information leaflets. The level and type of advocacy varied across teams. Advocacy from the wards was available at Mill View hospital.

Health Based Places of Safety

- Staff provided patients with information about helplines and additional support available, including advocacy and solicitors. Staff from Chalkhill were developing a pictorial leaflet for young people using the place of safety.
- Patients said that staff had spent time talking with them and explained what would happen next. Staff asked patients if they could contact their nearest relative when they were in the

place of safety.

All patients said they were given information how to complain and were offered the opportunity to provide feedback about the service.

Involvement of families and carers

- We saw evidence of consideration of carers during handovers, care records and home visits. Staff sought the carer perspective during home visits and involved carers with difficult to engage clients where consent had been provided. Staff gave carers an information pack at initial assessment.
- There was a carers support group at Langley Green and Meadowfield. Carers from Mill View could access to a carer's hub in Brighton. Although there was no carer group at Chichester, the team had two carers leads and could refer carers to groups via the community mental health team. A group of 'carer heroes' at Langley Green had recently won trust team of the month.
- Social workers in the Mill View team competed a local authority carer assessment form and could provide one to one support for carers. Staff from Langley Green had developed a carer's check in form to assess carer wellbeing at each contact. Staff completed a carer's care plan but didn't complete a formal carer's assessment.
- Carers could provide feedback using the friends and family survey. The survey could be completed electronically, or paper copies of the survey were available.

Health Based Places of Safety

- Relatives could access the carers support groups available.
- Staff contacted families or carers for patients if they preferred. Staff invited families and carers to assessments where appropriate. Staff encouraged visits from family and carers.
- The approved mental health professional provided nearest relatives with information about rights and then confirmed this in writing.

Is the service responsive?

Access and waiting times

Bed management

- Crisis teams were available from 8.30am until 9.00pm Monday to Friday and 8.30am to 8.30pm at weekends. Outside of these hours, support was available from the mental health helpline, the rapid response service or by going to the local accident and emergency department. The senior nurse practitioner at the local hospital provided cover for the crisis teams, psychiatric liaison and the in-patient wards outside of operational hours.
- Referrals to the service were from professionals including approved mental health professionals, accident and emergency departments, primary care services and older persons mental health services. Referrals from GPs and self/carer referrals were not accepted but were processed by the rapid response team.
- Staff told us they met the service targets to respond to urgent referrals within four hours and non-urgent referrals within 24 hours. Assessment to treatment times were captured within this contact.

- A pilot was being run in Chichester working closely with the accident and emergency liaison team. If staff from the liaison team identified urgent support for a patient, they completed a screening tool and initial risk assessment for the crisis team to follow up, and thereby avoiding the need for a further assessment. A safety plan was also completed with the patient. If an appropriate referral, staff used the screening tool to follow up the patient, rather than reassess, to reduce the number of assessments and improve the patient experience. The team leader met weekly with the liaison team to review the number of admissions from referrals and monitor the effectiveness of the service. They reported a noticeable improvement in the referral and screening process.
- Staff followed the crisis team guidelines for discharging patients. Staff arranged a face to face meeting with the care coordinator when a patient was discharged to the community mental health team. If a face to face meeting wasn't possible, staff arranged a comprehensive telephone handover. Staff sent a patient discharge summary to GPs within 48 hours of discharge.
- There was an early discharge nurse available for all teams inspected. In Chichester, Worthing and Langley Green, the role was part of a pilot. Previously early discharge was a team responsibility which meant it did not get sufficiently prioritised. The nurse bridged the gap between the wards and the crisis team and ensured early discharge was appropriately planned. They attended ward rounds and meetings to discuss patient specific cases as requested, identified patients with barriers to discharge and try to overcome them. However, we saw that patients sometimes remained on team caseloads due to the restricted capacity of the onward referral.
- Crisis teams had a monthly target for assessing 95% of people potentially requiring hospital admission. The senior nurse practitioner was responsible for gatekeeping outside of crisis team operational hours. The trust defined gatekeeping as 'discussing face to face (wherever possible) with patients and referrers the need for hospital admission and full consideration and assessment of the other options available from the service to provide an alternative to inpatient care'. At Langley Green, staff attended a daily meeting on the ward with representatives from the ward, approved mental health professionals and the patient flow team to ensure movement.
- A mental health helpline was available for anybody needing help, whether or not they were already receiving mental health care. However, because of commissioning arrangements, availability was dependent on where the person lived. Helpline staff had access to the trusts electronic record system to update records where callers chose not to remain anonymous. Staff completed a specific record for those who wished to remain anonymous. We observed staff taking a call to the helpline and saw that staff were compassionate and kind. They used mindfulness techniques and explored the callers support network and agreed a safety plan during the call.
- The trust planned to introduce a 24-hour single point of access service by April 2020. Staff had some knowledge of how this would be introduced, although some spoke of experiencing anxiety due to lack of feedback about this.
- Staff discussed hard to engage patients during handovers and actively tried to engage patients who did not attend appointments or found it difficult to engage with the service. Engagement strategies used included telephone contact, carer involvement, making a home visit and placing a note through the door if unanswered, requesting a police welfare check and linking in with street triage.

- Staff were flexible with appointments, including medical reviews, to accommodate patient needs. Appointments were sometimes cancelled due to the volume of appointments, although we were told this was rare.
- Staff followed the trust policy for patients commencing clozapine treatment in the community. Clozapine is an antipsychotic medicine which requires strict monitoring of people's physical health. The referring doctor completed pre-screening checks prior to treatment starting. Staff at Mill View used a palm pad electro cardio gram (ECG) machine as a preliminary indication for clozapine titration.
- Patients could use the 'staying alive' app on mobile devices. The app is a pocket suicide prevention resource containing useful information and tools to help people stay safe in crisis. Teams could respond to a text message from a patient although were not able to initiate them. Emails were also used to communicate with patients.
- Staff supported patients transferring to another service, for example the community mental health team, by arranging joint appointments where possible.

Health-based place of safety.

- All places of safety were open 24 hours a day, seven days a week, unless the place of safety was already occupied by a patient who had been brought in under Section 136 and for whom there was no bed on the ward. Patients who were intoxicated or lacked capacity were not excluded. In these circumstances staff would delay assessments until the patient was able to engage with the process. A doctor could prescribe detox medicines for patients where appropriate.
- There were protocols in place when all places of safety were occupied although staff told us that there were sometimes delays in accident and emergency due to a place of safety not being available. Data reviewed showed that accident and emergency had been used 71 out of 121 times between October and December 2018.
- Approved mental health professionals and police said there were sometimes delays in identifying an available place of safety because of the referral process involved a pager, which then delayed a response to initial contact.
- Staff said that ambulances did not always meet the trust policy's agreed response time. When there was a delay, an alternative health ambulance company was used to transport patients to the place of safety. In an effort to improve response times for conveyance, the police had a category list from the ambulance service.
- Staff arranged Mental Health Act assessments where appropriate. Staff said that there was sometimes a delay in accessing approved mental health practitioner assessments (AMHPs) or Section 12 approved doctors, especially during the day. These issues were monitored and discussed during the monthly multi agency meetings.
- Staff reported improvements in patient treatment journeys because of the street triage service.

Facilities that promote comfort, dignity and privacy

- Staff saw a majority of patients in their own home. The crisis teams were based in offices on hospital sites, so access to rooms to see patients were limited, except at Mill View. We observed that the room was wheelchair accessible. Staff from Chichester arranged to see patients at local centres if patients preferred to be seen away from home.

- A crisis care lounge had recently been opened at Langley Green Hospital for patients who had already been assessed and were either waiting for admission to an identified bed or need a period of safety and containment that provided therapeutic activity to prevent an escalation in risk. A psychiatric decision unit was due to be opened at Mill View Hospital in April 2019 which would cover the whole of the county. The unit will be a five-bedded ward to offer an alternative to accident and emergency.

Health-based place of safety

- Patients told us that staff regularly offered them food and drink. Staff told us that there was a range of food available to meet all dietary needs.
- Patients entered the places of safety using a discreet entrance so that they did not have to walk through a ward. Outside windows were obscured by a film covering the window. Internal windows were obscured by blinds to ensure privacy and dignity.

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the locations scored higher than similar trusts, with the exception of Woodlands were they only scored 79.6%.

Site name	Core service(s) provided	Ward food
Mill View Hospital	MH - Mental health crisis services and health-based places of safety	93.3%
Mill View Hospital	MH - Mental health crisis services and health-based places of safety	93.3%
Meadow field Hospital	MH - Mental health crisis services and health-based places of safety	100.0%
Woodlands	MH - Mental health crisis services and health-based places of safety	79.6%
Chalkhill	MH - Mental health crisis services and health-based places of safety	96.5%
Trust overall		**92.7%**
England average (mental health and learning disabilities)		**93.0%**

Patients' engagement with the wider community

- Staff discussed patients' education and employment needs during handover meetings. The support recovery worker at Mill View supported patients access education and work opportunities. Staff from other teams supported patients where possible and referred on to other services for additional support including the recovery college, where appropriate.
- Staff supported patients to maintain positive relationships with their families through care planning.

Meeting the needs of all people who use the service

- We saw that the interview rooms at Mill View hospital were accessible by wheelchair users.
- Staff, including consultants, saw a majority of patients at home. Staff made arrangements to see patients at other venues if preferred.

- Staff discussed patient needs during handovers. Staff gave information leaflets to all patients during their initial assessment. The leaflet contained information about the service and useful contact numbers.
- Staff had access to interpreters where required. We also heard an example of staff arranging a signer for a patient who was deaf.

Health Based Places of Safety

- Staff had access to interpreters and information leaflets in a range of languages was available on the intranet.
- Staff told us that there were sometimes difficulties in getting somebody home when they were not admitted to the place of safety because it was not considered an emergency. Non-emergency vehicles could be used to convey patients, but the number of vehicles was limited.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), most of the locations scored higher than similar trusts for both aspects overall. The exceptions were Woodlands, scoring 77% for Disability and Dementia friendly was not assessed.

Site name	Core service(s) provided	Dementia friendly	Disability
Mill View Hospital	MH - Mental health crisis services and health-based places of safety	95.8%	96.5%
Mill View Hospital	MH - Mental health crisis services and health-based places of safety	95.8%	96.5%
Meadow field Hospital	MH - Mental health crisis services and health-based places of safety	89.4%	91.0%
Woodlands	MH - Mental health crisis services and health-based places of safety	N/A	77.0%
Chalkhill	MH - Mental health crisis services and health-based places of safety	N/A	94.0%
Trust overall		**91.3%**	**86.4%**
England average (Mental health and learning disabilities)		**84.7%**	**87.8%**

Listening to and learning from concerns and complaints

This service received 41 complaints between 1 October 2017 and 30 September 2018. One of these was upheld, 13 were partially upheld, 17 were not upheld and none were referred to the Ombudsman.

Team name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
CRHT WA (Chichester)	1	0	1	0	0	0	0	0
CRHT WA (E) (Woodlands)	3	0	1	2	0	0	0	0
CRHT WA (LGH)	6	0	2	3	0	0	1	0
CRHT WA (Meadow field)	4	0	0	3	0	0	1	0
CRHT WA (Mill view)	1	0	0	1	0	0	0	0
CRHT WA (W) (Dept. of Psychiatry)	6	0	2	3	0	0	1	0
Dementia Crisis Service (Southern)	1	0	1	0	0	0	0	0
Liaison and Urgent Care Lounge (DoP)	1	0	0	0	0	0	1	0
MHRRS (Brighton CMHC)	5	0	2	2	0	0	1	0
MHRRS (MVH)	1	0	1	0	0	0	0	0
S136 (DOP) Place of Safety	1	0	0	1	0	0	0	0
S136 (LGH) Place of Safety	2	0	2	0	0	0	0	0
S136 (Meadowfield) Place of Safety	1	0	1	0	0	0	0	0
S136 (MVH) Place of Safety	4	0	0	1	0	2	1	0
S136 (Woodlands) Place of Safety	4	1	0	1	0	1	1	0

- Staff gave patients information about how to complain. Teams were able to input into feedback received from patients from the friends and family survey. Staff from Worthing sent a stamped addressed envelope with the discharge pack to encourage patients to return the survey.
- The inspecting team raised concerns regarding the detention of a former patient with the trust who were supporting them to make a complaint against the appropriate agency.
- Staff received feedback from the outcomes of investigations into complaints during team meetings.

Health Based Places of Safety

- Staff followed the trust policy concerning complaints. Information about how to complain was included in the place of safety welcome pack.
- Patients we spoke with confirmed they were given information about how to complain or provide feedback when they were admitted.

This service received 93 compliments during the last 12 months from 1 October 2017 to 30 September 2018 which accounted for 14% of all compliments received by the trust as a whole (660).

Is the service well-led?

Leadership

- The managers and team leaders demonstrated the skills, knowledge and experience to perform their roles. All leaders showed a good understanding of the service and could clearly explain how to provide high quality care.
- Leaders were visible, accessible and approachable in all the teams inspected. We saw that leaders were supportive of the team and competent and professional within their role. All leaders we spoke with were able to clearly communicate how teams were working to provide high quality care.
- The team leader from Mill View had visited other teams to share learning and good practice.
- Staff told us that the chief executive had visited Chichester and Worthing crisis teams and had a good understanding of the service. The chair of the board had visited Chichester team.
- Leadership training was available for managers, although not all team leaders we spoke with had completed this training.

Health Based Places of Safety

- The clinical lead nurse for place of safety had been in post since October 2018. They were responsible for standardising processes and improving services to patients in the places of safety. Staff reported an improvement in clinical practice and cascading information since they had been in post.
- Staff reported feeling valued, listened to and supported by managers. Leaders were approachable and responsive to concerns or ideas to improve the service.

Vision and strategy

- The trusts vision and values were available on the staff intranet. Staff were aware of the trusts vision and values and how they linked in with their work. Staff objectives were based on the trust vision and values.
- Staff were aware of the trusts 20/20 vision to improve patient care. They knew about plans to introduce a 24 hour, more accessible service, in line with the trust clinical strategy and NHS five year forward view plan. The project lead for the planned single point of access and urgent care service recently attended an away day to share information with teams. However, some staff told us that they had received limited information regarding level of

detail of changes and the impact on staff which was anxiety provoking.

Culture

- We observed a person-centred culture within the teams. Staff worked together to ensure the best patient outcomes.
- Staff from Chichester, Meadowfield and Langley Green spoke positively about feeling respected and valued. However, staff from Mill View crisis services said that although they felt supported and able to raise concerns, morale was low because of tension between staff and managers. Staff spoke of strong personalities in the team and resistance to change of some staff which affected team dynamics. We spoke with managers who were aware of these issues who told us of efforts to implement changes in a supportive way, including team building events and discussions in supervision. Managers said that smarter working would reduce pressures on staff. The inspecting team were concerned about the implications of risk to patients because of the lack of care plans and detailed risk assessments at Mill View. We reviewed a serious incident from December 2017 which identified a contributing factor regarding lack of a crisis team personalised care plan. The investigation into the incident recommended that all patients should have a care plan in place by March 2019. We would expect all patients to have a care plan in place in line with national guidance. During this inspection we saw that four of the six care records reviewed did not contain a care plan, and the two that did, were not holistic and did not reflect the full range of needs of the patients. Furthermore, we heard of how morale was affected by the strong personalities and team dynamics. We saw a copy of what was considered a care plan audit that had no methodology and did not speak to the quality of the information in the care plans or risk assessments.
- The team leader at Mill View spoke of initiatives implemented to support staff to work smarter to reduce pressure. These included an escalation protocol devised by managers and the unions. The protocol was implemented when caseloads reached certain trigger points. The protocol identified issues regarding capacity and demand and identified steps that staff should take in response to these. There were colour coded escalation alert levels with trigger criteria for each level. Criteria included prioritising high-risk patients and reducing contact or closing patients whose discharged was delayed because of the capacity of onward referrals. The team leader acknowledged the implications of having patients on caseloads who could be discharged. The team leader at Mill View had recently made changes to streamline the handover process and further support staff. This included making an electronic record of patients discussed during the handover. However, we did not see this taking place during the handover observed.
- Staff had opportunities to take the lead in areas such as carer engagement and physical health. Additional training including venepuncture, cognitive behavioural therapy, schema and mindfulness was available for staff.

Health Based Place of Safety

- Staff told us they felt respected and valued. Staff from Mill View told us that a culture change had improved morale and allowed staff to challenge practice.
- Staff were aware of the whistleblowing process and felt able to raise concerns without fear of victimisation.

Governance

- There were regular team meetings in each of the four teams visited. There were weekly multidisciplinary clinical review meetings to discuss all patients on the caseload. Team leaders met regularly with service managers.
- There was a learning lessons monthly forum and trust wide learning days. Learning was cascaded to the teams via monthly governance meetings.
- The team leader from Chichester attended regular meetings with the community mental health team, the psychiatric liaison team and street triage team.
- There was an urgent care network meeting which reviewed number of assessments and appointments completed to get a better understanding of impact on travel and staffing.
- There was a clear framework of what must be discussed at a team or directorate level to ensure that essential information, such as learning from incidents, was shared and discussed.
- We saw evidence of regular auditing, and meaningful use of the outcomes to improve practice. However, the type of audit varied across the teams visited. Data included assessments versus home treatment, activity and contact analysis. The team leader in Mill View had developed an audit to capture information about a patient's length of time in treatment. The audit included number of days the patient was on the team caseload and reason for discharge.
- Administrators in teams created spreadsheets to capture performance and monitor gatekeeping. Team leaders had devised a range of spreadsheets to monitor performance including supervision and time in treatment.
- Training and supervision data was captured on the 'My learning' dashboard. This allowed gaps to be identified and addressed in a timely manner.
- We saw evidence of staff working closely with other teams and providers to ensure that the needs of the patients were met.
- We spoke with administrators during our inspection who were extremely competent and knowledgeable and able to locate all information and data requested during the inspection.

Health Based Places of Safety

- The clinical lead nurse for places of safety was responsible to standardise processes and improve the service for patients. Since being in post, they had introduced monthly meetings with place of safety leads to discuss concerns and share good practice.
- There was a trust wide strategy meeting that reviewed input from local areas. Staff were invited to give feedback and share issues and good practice during the meetings.
- The policy for places of safety was under review during our inspection. The policy included changes to legislation so that staff were able to support a smooth transition when helping people in crisis.
- There was a place of safety competency checklist for staff which was due to be implemented the week following our inspection.

Management of risk, issues and performance

- Staff discussed risk during team meetings and showed a good understanding of risk. Staff were aware of how to escalate risk to managers.
- The trust had a severe weather policy. There was a local protocol for managing client contact in an emergency. Crisis services referred to the severe weather policy in the first

instance for emergencies. The policy outlined how home treatment teams would continue to support patients if they were unable to physically visit them at home.

- Team leaders reviewed performance using data provided by the trust. The trust provided clear procedures for managers to support staff if there were concerns about their performance. Managers were aware of the policy and felt supported by the trusts human resources department.
- The team leader at Mill View had developed a spreadsheet to capture patients' length of time in treatment and discharge information.

Information management

- The electronic care notes system allowed staff to access and record data as required. Staff were trained in using the electronic care notes during their induction. Staff from the mental health helpline and street triage team had access to the system so could update records if contacted by patients in service.
- Staff had individual log in details to access electronic records. This ensured that information remained confidential. Information governance was part of the mandatory training for the trust. Staff recorded patient consent to share information. However, we did not see patient consent in any of the records reviewed at Mill View. The clinical nurse lead said that they considered there was implied consent at initial engagement meetings. Inspectors raised this with the service manager.
- Staff accessed their training through an electronic system called 'My learning'. This meant managers could monitor training and performance.
- The service followed policy regarding notifiable incidents to external agencies such as the local authority, NHS bodies and the Care Quality Commission.

Health Based Places of Safety

- All staff had access to the electronic care notes system. This meant that they could access information entered by other services that the patient may have come into contact with, for example the crisis team or rapid response service.

Engagement

- The trust had an informative website which clearly detailed the services they provided and how people could access them. Staff could access information such as policies and bulletins via the trusts intranet.
- Patients and carers were invited to provide feedback about the service by completing the friends and family survey. The team in Worthing tried to encourage patients and carers to return the survey by sending a stamped addressed envelope as part of the discharge pack. Feedback was discussed during team meetings and used to improve the service where possible.
- Staff from Langley Green had recently invited the local public to attend the hospital to try and reduce stigma attached with local mental health unit. Feedback from those who attended the event was positive.

Learning, continuous improvement and innovation

- There were several pilot projects across this core service, which demonstrated a commitment

to innovation and continuous improvement.

- The teams at Chichester and Worthing had identified that early discharge had not always been sufficiently prioritised so were piloting a dedicated early discharge nurse post. The nurse bridged the gap between the wards and the crisis team and ensured that discharged patients could access the crisis team if appropriate. They attended ward rounds and meetings to discuss patient specific cases as requested, identify patients with barriers to discharge and try to overcome them.
- The street triage team worked closely with police to provide support to people experiencing mental health distress and reduce those taken into a place of safety or police custody.
- The team leader at Chichester was involved in a pilot to improve joint working to reduce the number of assessments to streamline patients' treatment journey. They met regularly with the liaison team to review referrals, outcomes, implementing change and themes to discuss with the community mental health team to improve the patient journey.
- The Worthing team were planning to implement a pilot with the accident and emergency department from the middle of February to improve the referral system for patients.
- Staff from Worthing and Chichester attended regular multiagency meetings with the police, street triage and ambulance service to streamline the service for patients.
- The team leader at Mill View had introduced an escalation protocol and digital handover. The protocol identified issues regarding capacity and demand and identified steps that should be taken in response to identified triggers.
- In December 2018 the trust developed a new initiative to strengthen collaborative working between AMHPs, crisis and home treatment teams to help reduce informal admissions to in-patient services. As part of this they were promoting the practice of carrying out joint assessments between AMHP and crisis colleagues to understand the benefits or challenges may be in terms of working in this way. As of December 2018 they were asking AMHPs to routinely refer to crisis colleagues at the point of receiving a referral for a Mental Health Act assessment, where it was felt that crisis/ home treatment team support may be a possible outcome of the assessment.
- A five-bedded psychiatric decision unit was due to open in April 2019. The unit would serve the whole of the county. The unit would act as an alternative to patients using the accident and emergency department.

Health Based Places of Safety

- The clinical lead nurse was standardising processes to improve the service for patients. They encouraged staff feedback and involvement to develop and improve the service.
- Staff had delivered training and created flow charts for staff in accident and emergency departments to increase understanding.
- In Woodlands there was a good protocol in place and specific training schedule for the nurses who worked in the place of safety.

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 teams within this service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Core service	Service accredited	Comments
Psychiatric Liaison Accreditation Network (PLAN)	MH - Mental health crisis services and health-based places of safety	Mental Health Liaison Team at Royal Sussex County Hospital-Brighton are accredited by PLAN 2018	

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)
Horsham Hospital - Iris Ward	Adult Services (AMHS) Inpatient Organic Older Adults (Iris Ward)	12	Female
Langley Green Hospital	Adult Services (AMHS) Inpatient Functional Older Adults (Opal Ward)	19	Mixed
Meadowfield Hospital	Adult Services (AMHS) Inpatient Functional Older Adults Larch Ward	18	Mixed
Salvington Lodge (The Burrowes) Patients have been temporarily moved to Brunswick see row 11)	Adult Services (AMHS) Inpatient Organic Older Adults - The Burrowes	10	Mixed
Beechwood Unit	Beechwood Specialist Dementia Treatment Unit	15	Mixed
MillView Hospital	Brunswick Ward (Dementia)	15	Mixed
The Harold Kidd Unit	Inpatient Functional (AMHS) Older Adults (Orchard Ward)	12	Mixed
Department of Psychiatry	Inpatient Integrated Functional Adult (Heathfield Ward)	18	Mixed
St Anne's Centre & EMI Wards	Inpatient Integrated Functional Adult (Raphael Ward - St Anne's)	17	Mixed
The Harold Kidd Unit	Inpatient Organic (AMHS) Older Adults (Grove Ward)	10	Male
Mill View Hospital	Meridian Ward (Functional)	19	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean environment

Safety of the ward layout

On Iris ward 18 electric radiators were installed in October 2018. At the time of our inspection the radiators were exposed without protective covers. The matron informed us that covers were being manufactured and were due to be fitted on the 5 February 2019. The matron had entered this risk onto the trust's risk register on 21 January 2019. To manage patient safety while the radiators were uncovered patient observation levels had been increased for those who were at risk of falling. We brought the risk of the uncovered radiators to the attention of the trust and they assured us that the radiator thermostats had been reduced. Following the inspection we re-visited the ward on 26 February 2019 and all radiators had been covered with bespoke protective covers.

All seven wards we inspected 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 they could view the bedroom areas and regular checks of patients. Wards had sufficient numbers of staff available to increase the observation of patients at a high risk of self-harming or falling over, for example.

Staff carried out daily environmental risk assessments which were up to date and reviewed regularly.

There were ligature risks on 11 wards within this service. All wards had a ligature risk assessment in the last 12 months.

There were ligature risk assessments for all seven wards we inspected within this core service. Induction packs for new staff included clear guidance on how ligature risks were managed and how to report new risks. Staff had identified 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. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Millview - Meridian Ward	All anchor points assessed in accordance with trust policy on patient profile, room designation, height and compensatory factors such as observation and ingenuity. There remain a few anchor points where removal or reduction is limited.	Yes	Current identified risks managed clinically in line with various clinical risk policies. Scope of works out to tender to remove ligature anchor points associated with ensuite bathrooms. This incorporates communal bathrooms.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
St. Annes - St Raphael Ward	All anchor points assessed in accordance with trust policy on patient profile, room designation, height and compensatory factors such as observation and ingenuity. There remain a few anchor points where removal or reduction is limited.	Yes	Ward has undergone a partial refurbishment incorporating some ligature reduction works. This is due to be re-assessed following these works in October 2018.
The Burrowes (ward closed 31/08/2018)	All ligature anchor points were assessed in accordance with Trust policy. However, these are managed for dementia patients as per policy as aids for daily living i.e. taps. Ward closed in August 2018 and therefore not re-assessed in 2018 due to this planned closure.	Yes	Ward now empty and undergoing extensive works for dementia patient care group to incorporate reduced ligature which does not impact on aids for daily living.
Department of Psychiatry - Heathfield Ward	All anchor points assessed in accordance with trust policy on patient profile, room designation, height and compensatory factors such as observation and ingenuity. There remain a few anchor points where removal or reduction is limited.	Yes	Anchor point reduction work undertaken in last 24 months to reduce ligate anchor points. Any remaining risks where removal or reduction is limited is managed through clinical risk policies.
Harold Kidd Unit - Grove Ward	All ligature anchor points are assessed in accordance with Trust policy. The age and construction of the property does not lend itself to a reduced ligature environment and some anchor points remain a risk. However, these are managed for dementia patients as per policy as aids for daily living i.e. taps.	Yes	Current identified risks managed clinically in line with various clinical risk policies. No planned E&F works due to ward re-location in 2019.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Harold Kidd Unit - Orchard Ward	All anchor points assessed in accordance with trust policy on patient profile, room designation, height and compensatory factors such as observation and ingenuity. There remain a few anchor points where removal or reduction is limited. The age and construction of the property does not lend itself to a reduced ligature environment and some anchor points remain a risk. However, these risks managed via clinical risk policies	Yes	No planned priority works with regards to estates. Current identified risks managed clinically in line with various clinical risk policies.
Iris Ward - Horsham Hospital	All ligature anchor points are assessed in accordance with Trust policy. The age and construction of the property does not lend itself to a reduced ligature environment and some anchor points remain a risk. However, these are managed for dementia patients as per policy as aids for daily living i.e. taps.	Yes	No planned priority works with regards to estates. Current identified risks managed clinically in line with various clinical risk policies.
Langley Green Hospital - Opal Ward	All anchor points assessed in accordance with trust policy on patient profile, room designation, height and compensatory factors such as observation and ingenuity. There remain a few anchor points where removal or reduction is limited. Some opportunistic risks remain such as en-suite doors. However, planned works in place to mitigate this.	Yes	Current identified risks managed clinically in line with various clinical risk policies. Various works have been undertaken to reduce opportunistic risk in en-suite bathrooms and bedrooms. This has included replacement of spouts in sinks in en-suite basins and application of anti-pick mastic to gaps in various locations. Anti-ligature en-suite doors replacement contract due to begin November 2018.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Meadowfield - Larch Ward	All anchor points assessed in accordance with trust policy on patient profile, room designation, height and compensatory factors such as observation and ingenuity. There remain a few anchor points where removal or reduction is limited.	Yes	Bedrooms and ensuites have been refurbished in the last 12 months to reduce anchor points. Current identified risks clinically managed in line with various clinical risk policies
Millview - Brunswick Ward	All ligature anchor points are assessed in accordance with Trust policy. Some anchor points remain a risk however, these are managed for dementia patients as per policy as aids for daily living i.e. taps.	Yes	Complete refurbishment undertaken and opened at the end of January 2018. Ward for designed for dementia patients so some obvious anchor points are in -situ but managed as an aid to daily living. However, some replacement to anti-ligature fixings in place which do not impact cognitive function of patients i.e. en-suite doors and mirrors.
Uckfield Hospital - Beechwood Unit	All ligature anchor points are assessed in accordance with Trust policy. Some anchor points remain a risk however, these are managed for dementia patients as per policy as aids for daily living i.e. taps.	Yes	Ward for designed for dementia patients so some obvious anchor points in -situ but managed as an aid to daily living. However, some replacement to anti-ligature fixings in place which do not impact cognitive function of patients i.e. anti-pick mastic in areas completed this year.

Over the 12-month period from 1 October 2017 to 30 September 2018 there were 73 mixed sex accommodation breaches within this service. All the mixed sex wards had female-only lounges. At the time of our inspection there was one mixed sex breach on Opal ward at Langley Green Hospital. Staff mitigated risks of mixed sex breaches by increasing patient observation. However, the care plan of one patient on Opal ward who was being nursed in a room on a corridor for the opposite gender did not accurately record their agreed level of observation to manage their safety. This patient was being nursed on the corridor of the opposite gender as there were no rooms available in the corridor of their gender. We brought this to the attention of the ward manager.

Alarms were available throughout the wards in bedrooms, bathrooms and toilets. Staff carried individual alarms. We saw evidence of staff responding quickly to alarms during our inspection of the wards.

Maintenance, cleanliness and infection control

All wards were clean and had a good range of furnishings.

For the most recent patient-led assessments of the care environment (PLACE) (2018), Mill View Hospital and Beechwood Unit scored higher than similar trusts for both aspects overall.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance
MillView Hospital	MH - Wards for older people with mental health problems	99.4%	99.0%
The Harold Kidd Unit	MH - Wards for older people with mental health problems	94.1%	93.9%
Salvington Lodge (The Burrowes) Patients moved to Brunswick	MH - Wards for older people with mental health problems	95.5%	87.6%
Horsham Hospital - Iris Ward	MH - Wards for older people with mental health problems	97.9%	90.0%
St Anne's Centre & EMI Wards	MH - Wards for older people with mental health problems	100.0%	95.7%
Beechwood Unit	MH - Wards for older people with mental health problems	100.0%	98.9%
Trust overall		**98.0%**	**94.8%**
England average (Mental health and learning disabilities)		**98.5%**	**94.5%**

During this inspection all the wards were clean and we observed domestic staff cleaning carrying out cleaning duties. Additionally, there were infection control and prevention audits and staff hand hygiene to ensure that patients and staff were protected against the risk of infection.

Clinic room and equipment

Each ward we inspected had a clean and tidy clinic room which contained emergency equipment and medicines. Equipment such as weighing scales and blood pressure machines were regularly calibrated and the equipment was checked on a regular basis. Staff maintained records which detailed that regular checks took place to monitor the fridge temperatures for the safe storage of medicines.

Safe staffing

Nursing staff

This core service has reported a vacancy rate for all staff of 14% as of 30 September 2018.

This core service reported an overall vacancy rate of 24% for registered nurses at 30 September 2018.

This core service reported an overall vacancy rate of 11% for healthcare assistants at 30 September 2018.

		Registered nurses			Health care assistants			Overall staff figures		
Location	Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Mill View Hospital	Meridian Ward (Functional)	3.1	12.7	24%	4.2	13.4	32%	7.3	27.1	27%
Beechwood Unit	Beechwood Specialist Dementia Treatment Unit	-0.1	12.7	-1%	10.2	26.8	38%	9.9	44.6	22%
Langley Green Hospital	Adult Services (AMHS) Inpatient Functional Older Adults (Opal Ward)	2.7	12.3	22%	5.0	15.6	32%	5.7	29.4	19%
St Anne's Centre & EMI Wards	Inpatient Integrated Functional Adult (Raphael Ward - St Anne's)	3.5	12.7	27%	1.5	13.4	11%	5.0	27.7	18%

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
The Harold Kidd Unit	Inpatient Functional (AMHS) Older Adults (Orchard Ward)	3.7	10.3	36%	1.9	14.3	14%	5.1	28.1	18%
Horsham Hospital - Iris Ward	Adult Services (AMHS) Inpatient Organic Older Adults (Iris Ward)	3.3	12.5	26%	3.0	15.4	19%	5.5	31.7	17%
Department of Psychiatry	Inpatient Integrated Functional Adult (Heathfield Ward)	4.1	12.7	32%	-1.1	9.3	-11%	4.3	26.2	16%
The Harold Kidd Unit	Inpatient Organic (AMHS) Older Adults (Grove Ward)	3.5	13.5	26%	0.4	15.4	3%	3.2	32.3	10%
Meadowfield Hospital	Adult Services (AMHS) Inpatient Functional Older Adults Larch Ward	5.4	12.9	42%	-4.6	13.0	-35%	-1.0	29.2	-3%
MillView Hospital	Brunswick Ward (Dementia)	1.3	12.7	10%	-3.7	16.9	-22%	-2.9	30.4	-10%
Core service total		**30.3**	**124.7**	**24%**	**16.9**	**153.6**	**11%**	**42.1**	**306.8**	**14%**
Trust total		**225.5**	**1211.8**	**19%**	**121.9**	**730.2**	**17%**	**406.2**	**2791.2**	**15%**

NB: All figures displayed are whole-time equivalents

Between 1 October 2017 and 30 September 2018, of the 243877 total working hours available,

16% were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 4% of available hours for qualified nurses and 24% of available hours were unable to be filled by either bank or agency staff.

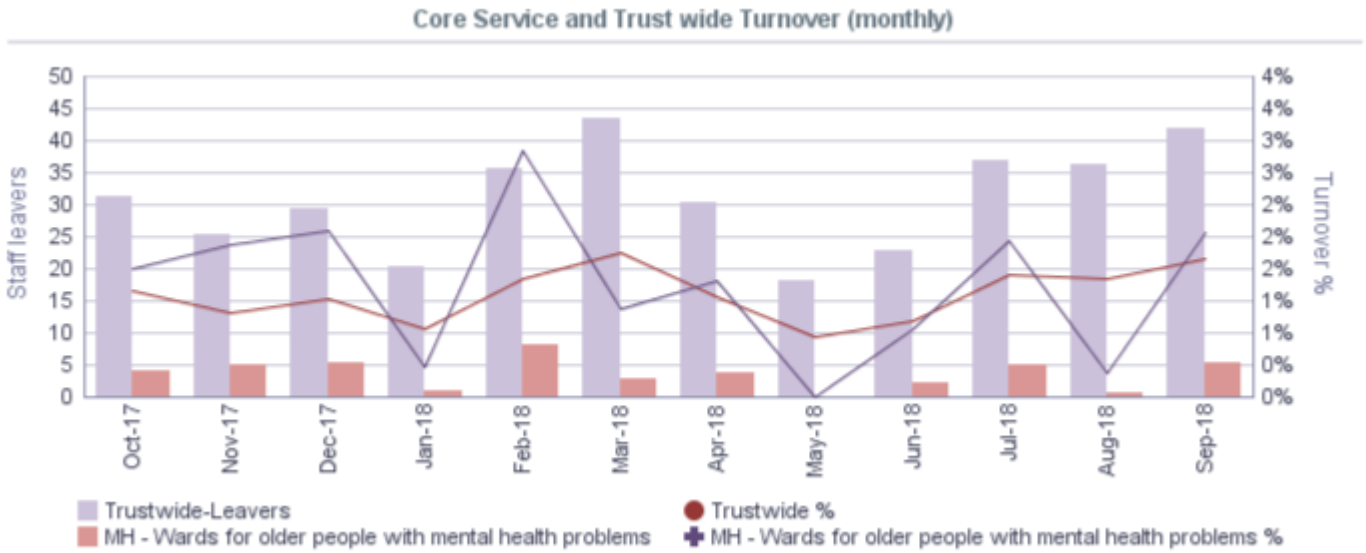
Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Adult Services (AMHS) Inpatient Functional Older Adults (Opal Ward)	23973	5557	23%	1685	7%	5201	22%
Adult Services (AMHS) Inpatient Functional Older Adults Larch Ward	25225	4862	19%	1700	7%	10500	42%
Adult Services (AMHS) Inpatient Organic Older Adults (Iris Ward)	24443	5734	23%	963	4%	6453	26%
Beechwood Specialist Dementia Treatment Unit	24755	3269	13%	233	1%	-137	-1%
Brunswick Ward (Dementia)	24755	2516	10%	957	4%	2464	10%
Inpatient Functional (AMHS) Older Adults (Orchard Ward)	20062	2063	10%	2110	11%	7157	36%
Inpatient Integrated Functional Adult (Heathfield Ward)	24755	2772	11%	0	0%	7939	32%
Inpatient Integrated Functional Adult (Raphael Ward - St Anne's)	24755	4004	16%	517	2%	6785	27%
Inpatient Organic (AMHS) Older Adults (Grove Ward)	26398	3251	12%	644	2%	6922	26%
Meridian Ward (Functional)	24755	3914	16%	1308	5%	5984	24%
Core service total	**243877**	**37941**	**16%**	**10116**	**4%**	**59268**	**24%**
Trust Total	**2369456**	**196179**	**8%**	**91456**	**4%**	**440904**	**19%**

Between 1 October 2017 and 30 September 2018, of the 300389 total working hours available, 28% were filled by bank staff to cover sickness, absence or vacancy for healthcare assistants.

In the same period, agency staff covered 3% of available hours and 11% of available hours were unable to be filled by either bank or agency staff.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Adult Services (AMHS) Inpatient Functional Older Adults (Opal Ward)	30582	6849	22%	111	0%	9797	32%
Adult Services (AMHS) Inpatient Functional Older Adults Larch Ward	25322	8879	35%	161	1%	-8956	-35%
Adult Services (AMHS) Inpatient Organic Older Adults - The Burrowes	0	0	0%	0	0%	0	0%
Adult Services (AMHS) Inpatient Organic Older Adults (Iris Ward)	30094	1540	5%	851	3%	5847	19%
Beechwood Specialist Dementia Treatment Unit	52483	19588	37%	4773	9%	19886	38%
Brunswick Ward (Dementia)	33066	9353	28%	645	2%	-7215	-22%
Inpatient Functional (AMHS) Older Adults (Orchard Ward)	28040	4476	16%	2	0%	3793	14%
Inpatient Integrated Functional Adult (Heathfield Ward)	18263	6665	36%	0	0%	-2073	-11%
Inpatient Integrated Functional Adult (Raphael Ward - St Anne's)	26222	8359	32%	1507	6%	2992	11%
Inpatient Organic (AMHS) Older Adults (Grove Ward)	30113	6899	23%	385	1%	763	3%
Meridian Ward (Functional)	26202	12021	46%	543	2%	8291	32%
Core service total	**300389**	**84630**	**28%**	**8977**	**3%**	**33124**	**11%**
Trust Total	**1427911**	**411620**	**29%**	**24878**	**2%**	**238422**	**17%**

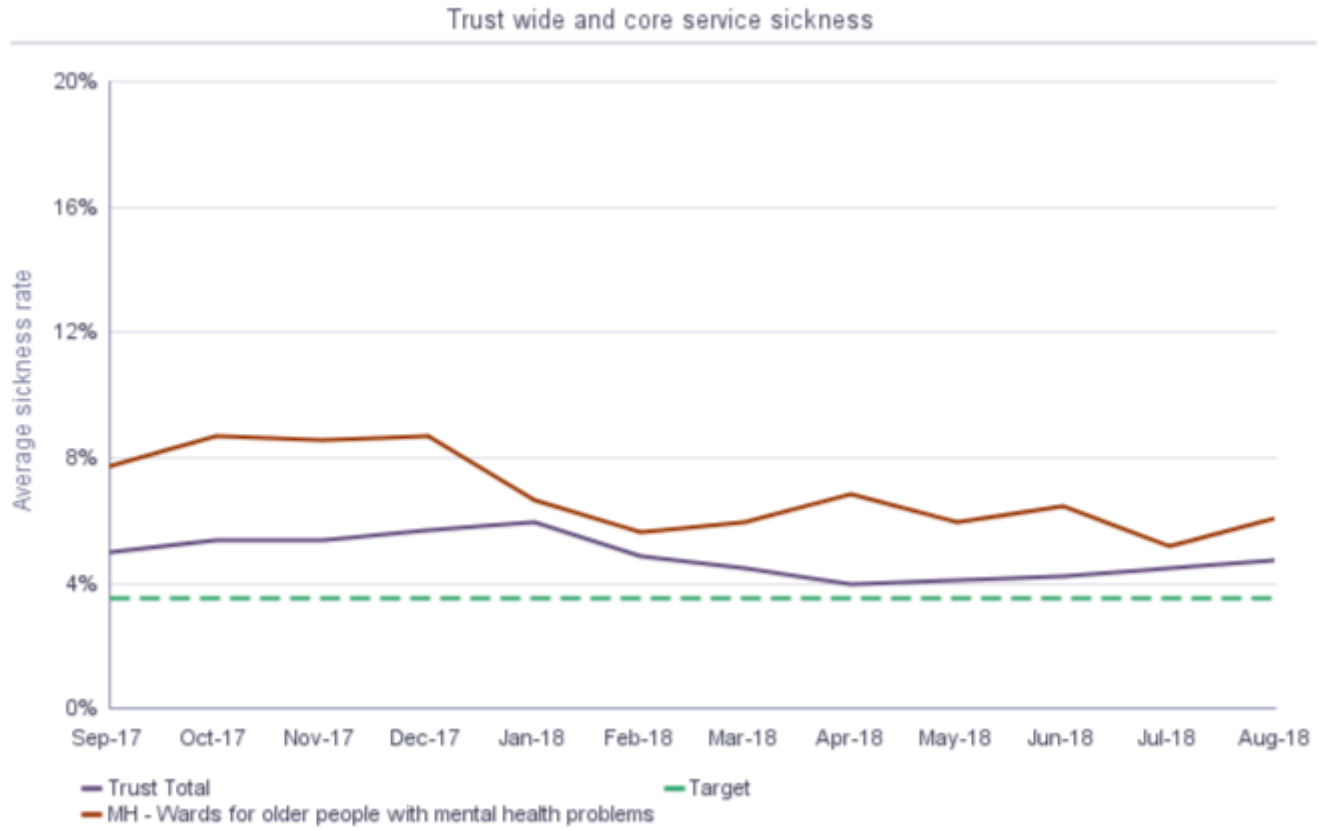
This core service had 44 (17%) staff leavers between 1 October 2017 and 30 September 2018.



Location	Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Langley Green Hospital	Adult Services (AMHS) Inpatient Functional Older Adults (Opal Ward)	18	6	31%
Meadowfield Hospital	Adult Services (AMHS) Inpatient Functional Older Adults Larch Ward	19	6	30%
Horsham Hospital Iris Ward	Adult Services (AMHS) Inpatient Organic Older Adults (Iris Ward)	22	6	29%
The Harold Kidd Unit	Inpatient Organic (AMHS) Older Adults (Grove Ward)	26	8	29%
Mill View Hospital	Meridian Ward (Functional)	20	5	24%

Location	Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
The Harold Kidd Unit	Inpatient Functional (AMHS) Older Adults (Orchard Ward)	22	3	14%
MillView Hospital	Brunswick Ward (Dementia)	26	3	11%
Department of Psychiatry	Inpatient Integrated Functional Adult (Heathfield Ward)	21	2	9%
St Anne's Centre & EMI Wards	Inpatient Integrated Functional Adult (Raphael Ward - St Anne's)	24	2	9%
Salvington Lodge (The Burrowes) Patients temporarily moved to Brunswick)	Adult Services (AMHS) Inpatient Organic Older Adults - The Burrowes	26	1	5%
Beechwood Unit	Beechwood Specialist Dementia Treatment Unit	36	2	4%
Core service total		**261**	**44**	**17%**
Trust Total		**2424**	**371**	**15%**

The sickness rate for this core service was 7% between 1 September 2017 and 31 August 2018. The most recent month's data (August 2018) showed a sickness rate of 6%.



Location	Ward/Team	Total % staff sickness (August 2018)	Ave % permanent staff Sickness (September 2017 – August 2018)
Langley Green Hospital	Adult Services (AMHS) Inpatient Functional Older Adults (Opal Ward)	4.7	12.0
Meadowfield Hospital	Adult Services (AMHS) Inpatient Functional Older Adults Larch Ward	3.3	10.8
St Anne's Centre & EMI Wards	Inpatient Integrated Functional Adult (Raphael Ward - St Anne's)	6.9	10.7
The Harold Kidd Unit	Inpatient Organic (AMHS) Older Adults (Grove Ward)	8.9	9.5
Beechwood Unit	Beechwood Specialist Dementia Treatment Unit	7.3	6.6
Salvington Lodge (The Burrowes) Patients have been temporarily moved to Brunswick see row 11)	Adult Services (AMHS) Inpatient Organic Older Adults - The Burrowes	4.0	6.6

Location	Ward/Team	Total % staff sickness (August 2018)	Ave % permanent staff Sickness (September 2017 – August 2018)
Mill View Hospital	Meridian Ward (Functional)	10.4	6.0
MillView Hospital	Brunswick Ward (Dementia)	13.9	5.7
Horsham Hospital - Iris Ward	Adult Services (AMHS) Inpatient Organic Older Adults (Iris Ward)	2.3	3.0
Department of Psychiatry	Inpatient Integrated Functional Adult (Heathfield Ward)	0.6	2.5
The Harold Kidd Unit	Inpatient Functional (AMHS) Older Adults (Orchard Ward)	0.9	2.2
Core service total		**6.1**	**6.9**
Trust Total		**4.7**	**4.9**

The below table covers staff fill rates for registered nurses and care staff during July, August and September 2018.

Seven of the 11 wards had below 90% of the planned registered nurses for day shifts in August. This situation improved in September with four wards being under 90%.

Key:

> 125%	< 90%

	September 2017				**August 2017**				**July 2017**			
	Day		**Night**		**Day**		**Night**		**Day**		**Night**	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurse (%)	Care staff (%)
Beechwood	96.6%	92.8%	86.7%	110.4%	112.6%	89.4%	85.5%	109.7%	114.0%	85.6%	92.1%	105.6%
Burrowes Ward	Closed		Closed		73.9%	108.1%	57.8%	90.2%	76.0%	113.3%	94.4%	98.3%
Grove Ward	89.6%	134.2%	73.3%	177.1%	61.1%	119.7%	53.9%	149.8%	78.1%	115.4%	85.4%	122.3%
Brunswick Ward	87.9%	154.1%	90.2%	194.8%	79.7%	111.4%	90.8%	144.7%	89.3%	112.7%	93.5%	151.7%
Iris Ward	96.8%	110.6%	98.3%	121.2%	84.9%	113.7%	99.3%	116.2%	79.1%	115.4%	95.2%	121.1%

Heathfield Ward	94.8%	113.7 %	99.7%	100.0 %	81.6%	113.3 %	104.9 %	98.5%	91.3%	106.7 %	102.3 %	98.4%
Larch Ward	90.9%	109.7 %	136.7 %	90.0%	87.9%	101.9 %	100.0 %	94.6%	92.5%	101.2 %	100.0 %	97.8%
Meridian Ward	96.3%	138.6 %	95.0%	111.7 %	93.3%	152.4 %	93.6%	108.4 %	97.3%	118.6 %	88.9%	121.8 %
Opal Ward	89.3%	94.3%	96.5%	90.0%	91.7%	89.0%	95.2%	99.0%	85.9%	90.1%	93.9%	100.4 %
Orchard Ward	85.1%	109.4 %	52.6%	206.5 %	84.2%	104.6 %	53.2%	196.8 %	79.0%	112.1 %	53.2%	209.6 %
St Raphael Ward	102.8 %	97.9%	88.3%	107.9 %	97.5%	103.4 %	88.9%	110.5 %	95.0%	112.9 %	93.3%	120.9 %

Ward managers had calculated the number of nurses and healthcare assistances required for each shift using the trusts' safer staffing tool. We reviewed staffing rotas on Opal, St Raphael and Brunswick wards and they all recorded full staff compliment for each shift for the previous month.

Ward managers told us they adjusted staffing levels daily to take account of case mix. We observed a 'huddle' meeting in Langley Green Hospital where all ward managers reported whether they required additional staff to manage patient risk on their wards including Opal ward.

Bank staff known to wards were used when required. They joined substantive staff on shift to fill for staff on annual leave, for sickness and to provide increased observation levels for patients who required this.

A qualified nurse was always present in communal areas of the wards.

Staffing levels enabled patients to have regular one to one time with their named nurse and we observed patients requesting this and it was recorded in the patient records we reviewed.

Staff told us that escorted leave and activities were very rarely cancelled. All measures were taken to ensure that these activities were supported.

There were enough staff on the wards to carry out physical interventions including observations which we observed throughout our inspection.

Medical staff

Between 1 October 2017 and 30 September 2018, of the 17012 total working hours available, 1% were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same period, agency staff covered 24% of available hours and -27% of available hours were unable to be filled by either bank or agency staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Adult Services (AMHS) Inpatient Functional Older Adults (Opal Ward)	2933	0	0%	2542	87%	-2933	-100%
Adult Services (AMHS) Inpatient Functional Older Adults Larch Ward	978	0	0%	0	0%	0	0%
Adult Services (AMHS) Inpatient Organic Older Adults - The Burrowes	0	0	0%	0	0%	0	0%
Inpatient Organic (AMHS) Older Adults (Grove Ward)	0	0	0%	163	-	0	0%
Inpatient Functional (AMHS) Older Adults (Orchard Ward)	978	0	0%	326	33%	-978	-100%
Adult Services (AMHS) Inpatient Organic Older Adults (Iris Ward)	0	0	0%	766	-	-1955	0%
Brunswick Ward (Dementia)	1662	0	0%	86	5%	0	0%
Meridian Ward (Functional)	2053	0	0%	0	0%	196	10%
Inpatient Integrated Functional Adult (Heathfield Ward)	2346	196	8%	0	0%	391	17%
Beechwood Specialist Dementia Treatment Unit	2933	0	0%	0	0%	782	27%
Inpatient Integrated Functional Adult (Raphael Ward - St Anne's)	3129	36	1%	261	8%	-39	-1%
Core Service Total	**17012**	**231**	**1%**	**4144**	**24%**	**-4537**	**-27%**
Trust Total	**336290**	**8648**	**3%**	**41155**	**12%**	**21392**	**6%**

There was adequate medical cover over a 24-hour period, seven days a week across all the wards. During out of office hours and at weekends on-call doctors were available to respond to and attend the hospitals in an emergency.

Mandatory training

The compliance for mandatory and statutory training courses at 1 October 2018 was 91%. Of the

training courses listed six failed to achieve the trust target and of those, one failed to score above 75%.

The trust set a target of 85% for completion of mandatory and statutory training.

The training compliance reported for this core service during this inspection was higher than the 86% reported in the previous year.

Key:

Below CQC 75%	Met trust target	Not met trust target	Higher	No change	Lower	Error
						N/A

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Manual Handling - Object	273	268	98		
Clinical Risk Assessment	256	249	97		
Health and Safety (Slips, Trips and Falls)	273	264	97		
Equality and Diversity	293	285	97		
Safeguarding Adults (Level 2)	256	249	97		

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Safeguarding Children (Level 2)	254	242	95		
Information Governance	273	260	95		
Infection Prevention (Level 1)	21	20	95		
Rapid Tranquilisation	97	91	94		
Mental Health Act	113	105	93		
Prevent	273	255	93		
Mental Capacity Act Level 1	258	235	91		
Medicines management	89	81	91		

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Manual Handling - People	246	218	89		
Infection Prevention (Level 2)	257	226	88		
Safeguarding Children (Level 1)	17	15	88		
Adult Basic Life Support	150	128	85		
Prevent (WRAP)	252	211	84		
Safeguarding Adults (Level 1)	17	14	82		
Personal Safety Breakaway - Level 1	31	25	81		
Personal Safety - MVA	235	188	80		

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Adult Immediate Life Support	96	72	75		
Fire safety onsite-Inpatient	275	204	**74**		
TOTAL	**4305**	**3905**	**91%**		

Staff we spoke with told us they were up to date with their mandatory training. Ward managers provided documentation recording mandatory training levels above the trusts' required level of 85%. For example, mandatory training levels were at 93% on Brunswick ward, 92% on St Raphael ward, 96% on Iris ward, and 99% on Heathfield ward. All wards offered staff protected study time to enable them to complete training.

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 30 patient risk assessments across the wards we inspected. Each assessment contained comprehensive description of patients' identified risks.

Management of patient risk

Staff told us they safely managed identified risks by implementing relevant mitigation measures. For example, the level and frequency of observations of patients by staff were increased in response to increased risks. Staff also carried out body mapping where they suspected a patient was at risk of developing a pressure ulcer so they could monitor their skin health to mitigate this risk. The Waterlow score was also used to give a patient's estimated risk for the development of a pressure sore.

Risk assessments were detailed, complete and comprehensive. Assessments covered patients' mental state, skin condition, oral hygiene, continence, moving and handling and nutritional needs.

Staff carried out a range of audits to assess for and manage patient risk including falls, food and fluid intake charts, and Waterlow audits. Waterlow audits undertaken on Brunswick ward prior to December 2018 indicated low completion levels. To improve this practice, Brunswick ward had a registered general nurse in their staff team to support delivery of physical health care on the ward. The manager also brought in a community physical health nurse for weekly visits to upskill staff in the use and importance of these audits to improve prevention and management of patient pressure ulcers. Two physical health nurses attended Opal ward weekly to support the team around physical health issues such as wound care.

The ward manager on Brunswick ward told us about work their team were doing to manage patient falls risks. They installed infra-red motion sensors in patient bedrooms which activated an alarm if a patient fell, worked with senior medical staff to improve training and awareness around falls prevention. Staff used this technology in conjunction with appropriate observation levels to manage falls risks. The ward worked with a local primary school in October 2018 to deliver a project called 'pimp my zimmer'. Children decorated patients' zimmer frames to encourage patients to use their zimmer frames to reduce falls, help patients identify which zimmer was theirs, and to increase awareness around dementia amongst the young student group. These falls management initiatives collectively led to a significant decrease in patient falls. Grove ward had received delivery of falls reduction sensors and were awaiting installation at the time of our inspection.

Staff discussed and shared risks in the daily verbal handover meetings and in a written handover to all staff.

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 the wards. 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.

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 with said that if patients were informal they could 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.

St Raphael ward operated an open-door policy which was carefully managed by staff and displayed in a policy on a page format in the nursing office. The ward door status was decided daily, but the default was that it was assumed to be unlocked. If the ward team decided the door should be locked it was logged as an incident. Each day a sign on the door displayed the hours the door was open or closed for anyone wanting to leave the ward. The reception area was directly outside the ward entrance to ensure patients could not leave the ward unnoticed. This policy was in place to meet best practice guidelines and ensure practice was least restrictive. Patients who requested to leave were risk assessed prior to leaving the ward.

Use of restrictive interventions

This service had 135 incidences of restraint (86 unique individual service users) and ten incidences of seclusion between 1 October 2017 and 30 September 2018.

The below table focuses on the last 12 months' worth of data: 1 October 2017 to 30 September 2018.

Ward name	Seclusions	Restraints	Individual service users that restraint was used on	Of restraint, incidents of prone restraint	Rapid tranquilisations
Beechwood Unit	0	11	8	9%	9%
Brunswick Ward	0	33	19	6%	6%
Grove Ward	0	18	10	11%	22%
Heathfield Ward	0	1	1	0%	0%
Iris Ward	0	1	1	0%	100%
Larch Ward	0	10	10	10%	60%
Meridian Ward	7	18	12	6%	61%
Opal Ward	1	16	9	25%	63%
Orchard Ward	0	5	3	60%	100%
St Raphael Ward	0	16	9	25%	31%
The Burrowes Unit	2	6	4	17%	83%
Core Service Total	**10**	**135**	**86**	**14%**	**37%**
Trust Total	**313**	**956**	**459**	**23%**	**34%**

There were 19 incidences of prone restraint, which accounted for 14% of the restraint incidents. Over the 12 months, incidences of prone restraint ranged from zero to two per month. The number of incidences (19) is higher than the previous 12-month period (12).

There were 50 incidences of rapid tranquilisation over the reporting period. Incidents resulting in rapid tranquilisation for this service ranged from 0 to five per month over the 12 months. The number of incidences (50) was higher than the previous 12-month period (35).

There were no incidences of mechanical restraint over the reporting period, this was the same as the previous 12 months.

Ward managers and staff we spoke with told us that there were no incidents of prone restraints in the month prior to our inspection.

All staff received training which included the management of actual and potential aggression.

Staff told us that there were minimal levels of rapid tranquilisation in the months prior to our inspection. Ward managers told us there were three episodes of rapid tranquilisation on Brunswick ward, two on St Raphael ward, two on Opal ward.

Staff followed national institute for health and care excellence guidance when using rapid tranquilisation. They monitored patients' physical health in line with guidance using patient national early warning score charts which we reviewed during our inspection and found to be in order.

There were ten incidences of seclusion over the reporting period. Over the 12 months, incidences

of seclusion ranged from 0 to seven per month. The number of incidences (10) was higher than the previous 12-month period (three).

Ward managers told us there were no incidents of seclusion in the month prior to our inspection. There were no seclusion facilities on the wards we inspected.

There were no instances of patients being placed in long-term segregation over the 12-month reporting period, this was the same in the previous year.

Staff we spoke with understood and worked within the Mental Capacity Act definition of restraint.

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 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.

This core service made seven safeguarding referrals between 1 October 2017 to 30 September 2018, all of which concerned adults.

Number of referrals			
Core service	**Adults**	**Children**	**Total referrals**
MH - Wards for older people with mental health problems	7	0	7

The number of adult safeguarding referrals ranged from zero to four per month.

All 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.

Staff told us that they remained vigilant to observe changes in patient behaviour and when receiving visitors to watch out for signs so staff could protect patients from harassment and discrimination including physical, emotional and financial abuse.

All wards had access to family rooms where patients could meet 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.

No serious case reviews related to this service, were commenced or published during the past 12 months.

Staff access to essential information

Staff used the trust's 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.

The ward manager on Iris ward had (when managing Burrowes ward), over several years, developed an electronic dashboard which contained links to shift planners, all essential nursing forms, useful contact details, policies and guidance. Step by step guides to completing all Mental Health Act (MHA) documentation had been developed and stored on the dashboard to ensure all staff could complete this paperwork properly. Each document a member of staff needed to view or print could be found following links contained on the dashboard. The dashboard was also interactive as it contained links to enable staff to email or telephone other teams including the MHA administrator and external teams via their websites. This database system also contained training videos for staff to access to aid their development.

Medicines management

We reviewed 32 patient medicine records and found all recordings to be in order.

In December 2018 an audit on Iris ward identified 13 missed doses in patients' medicine records. The manager put an action plan in place including checking every record at handover and this has led to significant improvements in recording.

There were appropriate arrangements across all seven wards we inspected for the management of medicines. Staff gave patients information about their medicines and staff and the ward pharmacists met with patients to answer their questions in relation to this. If patients had allergies, these were listed on the front of the medicine charts. 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 for a GP summary. This is to confirm what medicines and dosages the patient was taking so that these medicines could continue while the patient was on the ward. A pharmacist and pharmacy technician visited each of the wards regularly (twice weekly to daily dependent on the ward) and carried out routine audits to ensure that staff were managing medicines safely. Patient medicine records were audited by nurses before the handover of each shift. Patients at risk of side effects from taking high dose antipsychotic medicines were monitored. 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.

A pharmacist and pharmacy technicians visited the wards regularly (twice weekly to daily dependent on the ward) to provide a clinical pharmacy service. Pharmacy staff were contactable outside of scheduled visits for advice.

Ward managers told us that they and the pharmacists audited errors and omissions in the recording of medicines dispensed. Where omissions were identified wards worked to reduce these by raising the issue with staff and delivering training and support where required. The ward manager on Brunswick ward told us that omissions had reduced from 19% in October 2018 to 12% in December 2018.

Staff we spoke with told us that consultants strived to reduce levels of medicine prescribed to patients in the first instance following admission to prevent over-prescribing. This was reviewed weekly in care review meetings.

Track record on safety

Between 1 April 2018 to 1 October 2018 there were nine serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'slips/trips/falls meeting serious incident criteria' with seven. One of the unexpected deaths were

instances of pending review (a category must be selected before incident is closed).

We reviewed the serious incidents reported by the trust to the strategic executive information system (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with 11 reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported no never events during this reporting period.

Type of incident reported	Pending review (a category must be selected before incident is closed)	Pressure ulcer meeting SI criteria	Slips/trips/falls meeting SI criteria	Total
The Burrowes Unit	0	0	3	3
Beechwood Unit	0	1	1	2
Brunswick	0	0	1	1
Grove Ward	0	0	1	1
Meridian Ward	0	0	1	1
St Raphael Ward	1	0	0	1
Total	**1**	**1**	**7**	**9**

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 service, details of which can be found below.

Prevention of Future Death report dated 1 September 2016

The MATTERS OF CONCERN are as follows:

6 The chaotic and cruel attempt to transfer the patient from Langley Green to hove on 16th February.
- Serious consideration must be given to whether a transfer is in the patient's best interest
- The patient who was deemed to have mental capacity should have been consulted, he was not.

7 The overall quality of the patient's notes was very poor. For example,
- There is no mention anywhere of the personal hygiene being given.
- There is no rationale for the two doses of Lorazepam given orally in the morning and the evening of the 20th February. It is surely no coincidence that that is the night when the patient was found on the floor of his room with no explanation as to how he got there.
- The intermittent (15 minute) observations are risible. They might just as well not have

been carried out. It is of note that the 15-minute observation just prior to him being found on the floor of the 20th are missing, the form is blank.

- During his time on Meridian ward there is no evidence that staff attempted to co-operate with the patient regarding his feeding regime. There is no evidence that they even discussed it with him seriously. The result was he ended up cutting off the PEG on the 22nd/23rd February and being admitted to the Royal Sussex County Hospital.
- During his time on Meridian there were delays in ordering equipment for him and no appreciation of his left-sided hemiplegia. It was clear from the evidence that this hospital was unable to cope with this patient's physical needs and had no appreciation of them.

8 The Sussex Partnership rapid tranquilisation policy was implemented overnight on the 25th/26th February in dubious circumstances in that the documentation is poor. Intramuscular Lorazepam was given at 4am on the 26th. None of the required monitoring or observations were carried out. Family concerns were ignored. The documentation is either non-existent or inadequate.

9 As a result of 3 above, the patient's condition deteriorated into a moribund state by 1:30 pm on 27th February was missed by staff so that, by the time he arrived at the Royal Sussex county hospital he was effectively beyond assistance – in spite of all the efforts over the next week in the acute hospital

10 There were missed opportunities to treat the patient throughout his admission to Sussex Partnership care. None is so grave as the missed opportunities from 4am on the 26th February.

Prevention of Future Death report dated 6 February 2017

Cause of death: Natural Causes

The MATTERS OF CONCERN are as follows:

16 The patient's medication regimen which was to be the core of the admission was barely addressed and no reasons for any changes in medication appear in his notes.

17 Re admission documentation – mental capacity was not properly addressed and when the patient was discharged from the ward after three weeks on the 17th May the paperwork in that respect was still incomplete

18 His 'Falls risk assessment' was flawed in that it failed to take into account information from his wife and son as to how he was mobilising at home. Mobilisation in the patient's case should have been at the core of the 'Care Plan' because he was suffering from Parkinson's disease, where if possible, it is important to maintain mobility. Brunswick ward should know that.

19 No 'Waterlow score' was done until the 4th May. Too late. No appropriate pressure relieving equipment was ordered until 12th May. There was no evidence before me that the equipment was ever received or used for the patient. When the patient was admitted to the Acute hospital he has a Grade 2 pressure sore on his sacrum.

20 The thromboprophylaxis assessment which should have been carried out on either the 27th or 28th April was not done until the 6th May.

21 No bowel chart was kept until the 12th May, why not? Even non-nursing, non-medical professionals know that one of the several dangers of Parkinson's disease is constipation.

22 Medical instructions and recommendations were not handed over. One example relates to instructions to clean the patient's infected eyes with saline every 2 hours to keep them open. This was not done and when he arrived at the Acute hospital his eyes were crusted shut.

23 The MUST score was properly calculated on admission but not reviewed when it was clear he was not eating.

24 There was no evidence of any reaction to the patient's substantial weight loss. There was no referral to dieticians. They just happened to attend a multi-disciplinary meeting on the 9th May (he was admitted on 27th April and by 9th May had lost 10 ¾ pounds – 4.8 kilos. Re-weighing was requested by dieticians, it did not take place.

25 There was no evidence of dates when the patient was referred to the Occupational Therapist, Physiotherapist, dieticians or the Parkinson's specialist nurse. At the Inquest, I heard evidence that these referrals should have taken place as soon as possible after admission and certainly within the first 3 or 4 days. It is clear from the evidence that very little happened so far as Mr Lee was concerned, too late.

26 There was apparently no appreciation of the deterioration in the patient's mobility. He was at high risk of falls and yet the mobilisation of a Parkinson's patient is imperative and also since he was being special led during his entire admission there is absolutely no excuse for not trying to assist him with mobilising.

27 It was not until the 12th May, 2 weeks after the patient's admission to Brunswick ward that he was seen by the Parkinson's nurse specialist. When the specialist nurse saw the patient he made three important recommendations and asked for feedback within seven days, the referral to the speech and therapy team was done the next day. The enema did not take place for two days, too long and possibly dangerous. The change in medication was never even discussed.

28 As time went on there was no regular review of his original assessments. This should have been done by his Primary nurse who carried out none of these functions and therefore her appointment for the patient was irrelevant. There should be a review of the role of a Primary nurse.

29 There was no coherent and carefully considered and reviewed care plan.

30 A care co-ordinator was not appointed, even though at the inquest, it was confirmed that the patient was being looked after on the Care Programme Approach (CPA). The appointment of a care co-ordinator is at the heart of this framework and it was clear that such an appointment could have been helpful if not crucial in this case.

Brunswick is supposed to be a specialist unit for patients with this patient's problems and yet it is clear that he was failed most miserably. It is equally clear that these specific failings, even in combination and on the balance of probabilities did not change the outcome (i.e. this patient's death) on 5th June 2016, however they were all matters that need addressing in order to raise the standard to an appropriate level for the proper care of these vulnerable patients.

The trust had taken action in response to both prevention of future death reports, such as with the Brunswick outreach project. This was developed to ensure a smoother transition for people being admitted to the ward.

All staff we spoke with knew what constituted an incident and how to report them. Each member of the ward teams had responsibility to record incidents using the trust's electronic incident reporting system. We reviewed examples of incident report across all wards and found these to be comprehensive. Incident reporting forms included detail of the incident, whether the incident was serious or not, action taken, cause of the incident, and how to prevent re-occurrence. Staff gave us examples of incidents they recorded which included slips, trips and falls, safeguarding, medicine errors, assault, and choking risks.

The trust had a duty of candour policy and staff told us they were open and transparent with patients and their families when 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.

Staff shared information about incidents and incident learnings at shift handover and in daily 'safety huddles'. This ensured that learning was ongoing and timely.

Managers received an 'alert' system email which fed back learning about incidents across the wards. This information was then shared among all ward staff.

All wards had de-briefing sessions for staff and patients following. The trust distributed a monthly 'patient safety matters' bulletin to all wards to share incident and learning information widely.

There was evidence across all wards that changes had been made following incident feedback. For example, strong guidelines and practice was evident on St Raphael's ward in relation to dietary and feeding requirements following a death of a patient when they were given food which was not listed on their dietary plan. Brunswick ward were continuing to develop falls reduction initiatives including falls reduction technology in patient rooms. This change took place following a serious injury sustained by a patient when they fell on the ward. Brunswick ward had also developed a series of teaching videos and bite-sized training following an incident where staff were unclear about oxygen levels in cannisters on the ward.

Is the service effective?

Assessment of needs and planning of care

We reviewed 30 care records and all patients had detailed and timely assessments covering issues such as their current mental state, hobbies, discharge considerations, previous history and physical healthcare needs. All care plans were recovery focused. 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 an initial assessment and care plan completed following admission. A physical examination was carried out for all patients on admission which included a routine blood test and electrocardiogram to check cardiac health. Care plans were updated at least weekly in clinical review meetings.

Staff on all wards carried out weekly malnutrition universal screening tool (MUST) assessments for all patients which were reviewed in weekly clinical reviews. MUST assessments are a five point five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese.

Care plans were not available in easy read or easily accessible format for patients requiring support to read and understand paperwork.

Most care plans were fully patient focussed. Patient care plans on St Raphael ward did not contain patients' preferences around their care. However, all staff we spoke with knew patients' preferences this often was not recorded in care plans. Care plans we reviewed on Iris, Grove and Orchard wards were particularly patient focussed and described patients' likes and dislikes, so staff had a clear understanding of what to include when designing activity timetables. Staff on Brunswick ward had developed 'social profiles', stored in a file for easy access and weekly review, for each patient which listed their likes and dislikes. On Grove ward patients' social profiles were also shared with their carers and included in their discharge notes to ensure their preferences were highlighted. We observed patient focussed care when a patient on Grove ward became distressed and the nurse guided the patient to the activity room, played the patient's favourite

music and gave them a hand massage which was described as a preferred intervention in the patient's profile.

The occupational therapist teams carried out assessments of patients' abilities, including washing and dressing, cognitive abilities, kitchen use, across all wards which enabled development of personalised activity plans. The occupational therapist on Brunswick ward carried out these assessments using the model of human occupation screening tool (MoHOST) which was an example of good practice.

Care plans we reviewed on Iris ward contained discharge planning using the 'let's get you home' model. This model was in place across all wards and involved a multi-disciplinary approach to supporting a patient to return home with support. This was done using occupational assessments, frequent visits home, and early activation of community support services and social services. Care planning for patients on Iris ward also included the use of a therapy doll, a robotic seal and a therapy dog to soothe patients. Studies have shown that use of these robotic toys on wards for older people or those with dementia stimulates social interaction between patients and carers when the toys respond to interaction with movement and sound. These innovations are useful in environments where live animals or infants cannot be present due to treatment or logistical difficulties.

Patients on Grove ward had activity plans on the walls in their bedrooms which were rated red, amber or green to indicate if the patient needed full assistance, prompting or was independent.

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 guidance in the delivery of the therapeutic programme that included nationally recognised treatments for patients. 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.

Staff told us they worked with patients to meet their needs without offering medicine as needed in the first instance. We observed a nurse on Opal ward reminding a patient about their preferred distraction technique. The nurse encouraged the patient to talk about how they felt to explore if this calmed them before administering as needed medicine. The nurse explained they did this to avoid the risk of over-medicating the patient.

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 offered training and advice across all the wards. Training included topics such as falls, dysphasia, diabetes, pressure sores, 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 assessment tool. All wards had access to external physical health professionals including tissue viability nurse specialists, speech and language therapists, dieticians and physiotherapists.

Staff assessed patients' nutrition and hydration needs and developed care plans if needed. Ward staff told us that they recorded patients' food and fluid intake throughout the day. On St Raphael's

ward nursing staff wrote clearly on the top of these care plans exactly why the plan was in place, for example for weight management or for as part of catheter care. This practice was one of many improvements which had taken place on the ward. Health care assistants 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 enough 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, 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. We observed patients on St Raphael’s ward playing carpet bowls. 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, the Crawley wellbeing group attended weekly to offer educational sessions on healthy living and offering patients and staff additional health check-ups.

Staff used ‘health of the nation outcome scale’ to assess and record outcomes. This assessment tool covers 12 health and social domains and enables clinicians to build up a picture over time of their patients’ responses to interventions.

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, medicine management and effective handovers. Staff audited risk assessments and care plans to ensure quality and completion. The service also participated in other audits including falls prevention and family carer audits.

Skilled staff to deliver care

The teams across the wards we inspected came from a range of professional backgrounds, including medical, nursing, social work, occupational therapy and psychology. Staff were experienced and qualified to undertake their roles to a high standard. Where wards required specialist professional input, for example speech and language therapists, they could make referrals to access this support. A geriatrician visited Brunswick ward weekly to review the physical health needs of patients. This is a doctor who specialises in care of the elderly and the diseases that affect them.

Heathfield and Opal wards did not have strong access to junior doctors which put pressure on the consultants’ workloads.

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.

The trust's target rate for appraisal compliance was 95%. At the end of last year (1 October 2017 to 30 September 2018), the overall appraisal rate for all staff within this service was 46%. This year so far, the overall appraisal rate was 68% (at 31 July 2018). The wards which failed to achieve above 75% at 31 July 2018 were Brunswick Ward with an appraisal rate of 24%, Larch Ward with an appraisal rate of 37%, Opal Ward with an appraisal rate of 50%, Grove Ward at 66% and Raphael Ward at 69%.

Ward name	Total number of all permanent staff requiring an appraisal	Total number of all permanent who have had an appraisal	% appraisals (as at 31 July 2018)	% appraisals (previous year 1 October 2017 to 30 September 2018)
The Burrowes	29	26	90%	14%
Heathfield	24	21	88%	71%
Meridian Ward	24	21	88%	81%
Beechwood Unit	40	32	80%	85%
Iris Ward	28	22	79%	24%
Orchard Ward	23	18	78%	5%
Raphael	26	18	69%	14%
Grove Ward	29	19	66%	62%
Opal Ward	20	10	50%	52%
Larch Ward	27	10	37%	7%
Brunswick Ward	29	7	24%	72%
Core service total	**299**	**204**	**68%**	**46%**
Trust wide	**2541**	**1605**	**63%**	**48%**

All staff we spoke with told us they had received an annual appraisal within the last 12 months.

The trust's target of clinical supervision for non-medical staff was not supplied.

Between 1 October 2017 and 30 September 2018, the average rate across all 11 teams in this service was 38%.

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

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Adult Services (AMHS) Inpatient Functional Older Adults (Opal Ward)	142	141	99%
Inpatient Integrated Functional Adult (Heathfield Ward)	231	202	87%
Meridian Ward (Functional)	256	143	56%
Beechwood Specialist Dementia Treatment Unit	470	253	54%
Brunswick Ward (Dementia)	355	179	50%
Inpatient Organic (AMHS) Older Adults (Grove Ward)	276	91	33%
Adult Services (AMHS) Inpatient Organic Older Adults (Iris Ward)	227	57	25%
Inpatient Integrated Functional Adult (Raphael Ward - St Anne's)	271	65	24%
Adult Services (AMHS) Inpatient Organic Older Adults - The Burrowes	322	9	3%
Inpatient Functional (AMHS) Older Adults (Orchard Ward)	235	4	2%
Adult Services (AMHS) Inpatient Functional Older Adults Larch Ward	263	0	0%
Core service total	**3048**	**1144**	**38%**
Trust Total	**28506**	**11280**	**40%**

The trust's target of clinical supervision for medical staff was not supplied.

Between 1 October 2017 and 30 September 2018, the average rate across the four teams for which data was supplied was 0%.

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

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Adult Services (AMHS) Inpatient Functional Older Adults (Opal Ward)	12	0	0%

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Adult Services (AMHS) Inpatient Organic Older Adults (Iris Ward)	2	0	0%
Brunswick Ward (Dementia)	12	0	0%
Meridian Ward (Functional)	12	0	0%
Core service total	**38**	**0**	**0%**
Trust Total	**1570**	**132**	**8%**

All staff we spoke with told us they had regular monthly supervision to review and learn from their practice, address their wellbeing and professional development. Additionally, staff on all wards had access to ad hoc support throughout each shift to support them to undertake their roles. The records for supervision held locally in the service showed that supervision completion levels varied across the core service. For example, Brunswick ward had a supervision level of 85%, St Raphael ward 75%, Iris ward 100%, and Heathfield ward 90% at the time of our inspection. The ward manager on Heathfield ward told us that supervision was the subject of a quality improvement project from January 2018 which had resulted in high levels of uptake.

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 a number of healthcare staff on the wards had received training on phlebotomy and carrying out electrocardiogram testing. All ward teams attended at least twice-yearly development days. However, the trust did not offer dementia e-learning training as part of the mandatory training programme. Although all staff had access to dementia e-learning training. The psychologist who visited Grove ward had developed a form of management of violence and aggression training specifically for patients with dementia. The training was presented at the national psychology conference.

Some healthcare assistants we spoke with were undergoing nursing associate training. This role was designed to bridge the skill gap between the healthcare support worker and more senior regulated professionals.

Ward managers had access to the ‘Leader-Leader’ model of leadership training. This model develops leadership skills in individuals so they can enable their teams to develop leadership at every level to increase team proactivity and ownership. One ward manager told us they were about to start a mentorship at university which was supported by the trust.

Ward managers told us that they had good support from their human resources team which enabled them to deal with any staff performance issues promptly and effectively.

Multidisciplinary and interagency team work

Staff across all wards held weekly multi-disciplinary meetings to review patient care and treatment. Attendees included consultants, nurses, dieticians, pharmacists, psychologists, doctors and occupational therapists.

All shifts began with effective handover from the previous shift to ensure smooth sharing of

information to help manage ward risk and meet patient need.

Ward staff liaised with other agencies including 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.

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

As of 1 October 2018, 93% of the workforce had received training in the Mental Health Act (MHA). The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every two years.

Staff had access to and knew their local MHA administrator for legal advice concerning the implementation of the Act. The MHA administrators also carried monitored requirements and compliance with the Act and Code of Practice monthly.

All wards had access to local MHA policies and procedures and to the Code of Practice.

There was active involvement of the independent mental health advocacy service across all wards we inspected. Information about the service was displayed on information boards in communal areas.

We looked at patients' care record files who were detained under the MHA. The MHA documentation was present and available.

Copies of up-to-date section 17 leave forms were kept electronically and in files accessible in the nurses' offices. Section 17 leave is a section of the MHA which allows the responsible clinician to grant a detained patient leave of absence from hospital. 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.

Patients were encouraged to contact the Care Quality Commission if they chose to about concerns relating to the implementation of the MHA. This was contained in the welcome folders given to all new patients.

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 appropriate consent to treatment in place.

Good practice in applying the Mental Capacity Act

As of 1 October 2018, 91% of the workforce had received training in the Mental Capacity Act (MCA) Level 1. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every 2 years.

Staff we spoke with had a good understanding of the MCA and the five statutory principles.

The trust told us that 172 (all applications were recorded as standard and urgent) Deprivation of Liberty Safeguard (DoLS) applications were made to the local authority for this service between 1 October 2017 and 30 September 2018.

The greatest number of DoLS applications were made in October 2017 with 22.

CQC received no direct notifications from Sussex Partnership NHS Foundation Trust between 1 October 2017 and 30 September 2018.

The trust has stated that;

'The data in the 'Number of Urgent DoLS applications made' section refers to initial urgent applications only and not to applications for extensions to urgent authorisations.'

'The number of standard DoLS applications approved (or not approved) remains small, compared with the total number of applications made. In order to address ongoing delays in Local Authorities carrying out DoLS assessments, the MHA Services team is taking the following actions: The MHA Services team now has a part-time DoLS Administrator who deals with all DoLS referrals for the Trust. The role of the DoLS Administrator is to check that referral forms are complete and signed, forward the referrals to the relevant DoLS team and maintain a manual spreadsheet to support data activity recording and DoLS expiry date monitoring. The DoLS Administrator will also respond to updates from wards regarding discharges and transfers and keep the spreadsheet up to date accordingly.

The team's two MHA Services Officers will check the spreadsheets on a weekly basis, to identify delayed DoLS assessments, make sure any patient discharges are identified and actioned and work with the DoLS Administrator to ensure the records are up to date.

On a monthly basis, the team's Practice Development Officer for Mental Health Law will check the DoLS spreadsheet record against Carenotes records, and for each Local Authority, will compile a list of patients awaiting an assessment by their local authority – this information is forwarded to members of the Trust's Executive Team. Queries raised by the Local Authority are resolved with input from the relevant Ward Matron/Manager. Any issues raised will help to inform and identify training needs and provision for wards.'

	Number of 'Urgent' DoLS applications made by month												
	Oct-17	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Total**
Urgent applications made	22	18	16	21	11	12	8	9	15	17	13	10	172
Urgent applications approved	0	0	0	0	0	0	0	0	0	0	0	0	0

	Number of 'Standard' DoLS applications made by month												
	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Total
Standard applications made	22	18	16	21	11	12	8	9	15	17	13	10	172
Standard applications approved	0	1	0	2	1	0	1	0	0	0	0	1	6

Staff knew where to get advice from within the trust regarding the MCA, including DoLS.

Formal capacity assessments in relation to consent to treatment took place. Nurses on the wards reviewed patients' capacity daily and the consultant reviewed patients' capacity in weekly care review meetings.

Where patients were not detained under the Mental Health Act their capacity to consent to medicine and to stay in the hospital as an informal patient had been assessed.

Patients completed advance directives when they were admitted. An advance directive is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity. There was evidence that patients were assessed for capacity when advance directives were completed with them.

When patients lacked capacity, best interest meetings were held involving a patient's family members, social worker, consultant, nurse known to the patient, to agree a plan of action which was in the best interest of the patient.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We observed staff treating patients with compassion and care by taking time to listen to them and answering their questions. Patients we spoke with told us staff were always 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 observed consistent positive interactions between staff and patients. Patients and staff were heard laughing with fun during some craft activities on St Raphael ward. Staff spoke with patients in a calm, friendly, professional and respectful manner and responded promptly to any requests made for assistance or time. We saw some instances where staff tended to patients' requests who required personal care with kindness, respect and dignity.

We undertook a short observation framework for inspection (SOFI) assessment of a group of four patients for a short duration on St Raphael ward. SOFI is a tool developed with the University of Bradford's School of Dementia Studies and used by our inspectors to capture the experiences of people who use services who may not be able to express this for themselves. During the assessment we observed good interactions from staff with the patient group when the staff member initiated working on a crossword as an activity.

During our inspection we observed staff tending to a patient on St Raphael ward who was unwell. Nursing staff swiftly erected screens around the patient so they could assess and treat them with privacy which protected his dignity.

Staff supported patients to understand and manage their care, treatments and conditions. We spoke with patients who told us about physiotherapy and dietary treatment they were having and the improvements they had noticed. Patients also told us that staff explained their blood pressure readings and ensured that patients understood why certain medicines were changed to treat their conditions.

Staff assisted patients to access other services to help meet their needs such as referring patients to a variety of primary care healthcare professionals and housing.

All patients we spoke with on the wards were complimentary about the staff providing their care. Patients told us they got the help they needed. Patients told us they were treated with respect and dignity and staff were polite, friendly, and always willing to help. Patients told us staff were pleasant and were interested in their wellbeing.

Patients told us that if another patient on the ward was distressed at night, nursing staff immediately tended to the distressed patient and calmed them.

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 anxious, 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 a thorough knowledge of their patients' likes and dislikes. Staff understood the individual needs of their patients, including their personal, cultural, social and religious needs. This was evident in how staff supported activities for patients including weekends with family and craft sessions patients particularly liked.

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.

Patient-Led Assessments of the Care Environment (PLACE) - data in relation to privacy, dignity and wellbeing (remove heading before publication) NonPIR

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), Mill View

Hospital and St Anne's Centre & EMI scored higher than similar trusts.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
MillView Hospital	MH - Wards for older people with mental health problems	94.4%
The Harold Kidd Unit	MH - Wards for older people with mental health problems	87.9%
Salvington Lodge (The Burrowes) Patients have been temporarily moved to Brunswick see row 11)	MH - Wards for older people with mental health problems	87.5%
Horsham Hospital - Iris Ward	MH - Wards for older people with mental health problems	84.5%
St Anne's Centre & EMI Wards	MH - Wards for older people with mental health problems	95.6%
Beechwood Unit	MH - Wards for older people with mental health problems	85.6%
Trust overall		**89.1%**
England average (mental health and learning disabilities)		**88.9%**

Involvement in care

Involvement of patients

Patients received a comprehensive welcome pack on admission to the wards. The packs contained information about the multidisciplinary team, care and treatment options, medicines, physical and mental 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 all 30 of the patient care records we reviewed. All patients had either signed a copy of their care plan or there was a record that they did not want to sign them. The staff care planning approach was person centred, individualised and recovery orientated. Patients reviewed their care plan at least weekly with the multidisciplinary team. Patients told us they were involved with their treatment and care planning and were able to give their opinions on new treatments suggested for them.

Staff communicated well with patients so that they understood their care and treatment. However, there were no accessible or easy read care planning tools available for patients who might need them on most wards including St Raphael, Opal and Brunswick wards. Accessible information about medicine was available for patients on Opal ward.

Staff told us how patients were involved in service development. For example, patients on Opal ward were preparing to attend a 'dragons' den' style panel to propose project ideas to enhance services available on the ward which they would develop and be involved in.

Staff gathered patient feedback through a range of forums and activities. Each ward held daily morning meetings where plans for the day were discussed and issues were raised. Wards also held 'feedback Friday' sessions to gather views from patients. We saw 'you said, we did' feedback boards across the service to indicate which actions had been taken in response to patient feedback. Patients on Brunswick ward fed back to staff that more seating was needed in the carers'/family room. The ward manager provided additional seating in response to this request. 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.
On Opal Ward the team held afternoon tea parties and coffee mornings which were popular with the patients. Patients on this ward also participated in the ENRICH programme; a peer support randomised control trial where patients were screened and paid to participate in the trial. Patients in the trial were allocated peer support workers in the community once discharged. Opal ward also developed letters of care in collaboration with the patients. The letters of care invited patients to write a letter to explain how they would like to be cared for on Opal Ward. These have been instrumental in developing a holistic and collaborative care plan. Several patients from the ward also participated and sang in a concert in January at Langley Green Hospital run by 'music in detention', which works with immigration detainees, bringing them together with musicians and local communities to create and enjoy music.

Involvement of families and carers

Patients told us that their families were included in their care planning. Staff explained it was important to involve families and carers to ensure that a holistic picture was developed of a patient to ensure their needs were met. 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 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.

Where carers or family members were unable to attend care review meetings, they were invited to dial into meetings to stay involved.

Carers' forums were held across all wards. The ward manager on Brunswick ward offered face to face appointments with family and carers on Fridays to answer questions they had. We saw evidence on Brunswick ward how the ward manager had engaged with two families to manage specific concerns regarding the care of their family members. Grove ward hosted monthly carers' meetings. All wards offered ad hoc telephone support to families and carers to answer their queries and listen to feedback if they were unable to attend in person or preferred to phone.

We spoke with seven carers and they 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 complete 'family and friends' tests online. Carer visiting times were unrestricted to enable visiting at times which suited families and friends. On Iris ward the 'Improving carers experience project' produced a carer' information booklet which contained information covering common mental health conditions, managing day to day living, staying well and accessing local support across Sussex. All wards had carers' leads. An area of good practice

was on Opal ward where they had recruited full time carers' support lead. We observed them throughout the day welcoming carers onto the ward and arranging for them to get the information and advice they required.

Staff encouraged the use of comment cards so that carers and family members could submit feedback. The carers' champion on Grove ward developed a satisfaction survey for carers. One outcome was that carers requested more updates from the ward. As a result, a new checklist was developed to support a new standard approach to contact family with updates more frequently.

All staff we spoke with knew how to support carers to access a carer's assessment. A number of carers we spoke with said they had been offered a carer's assessment.

The Grove ward team had signed up for the nationally recognised 'John's Campaign' which was an application of evidence of how you support carers of people with dementia.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for 11 wards in this service between 1 October 2017 and 30 September 2018.

Ten of the wards within this service reported average bed occupancies ranging above the minimum benchmark of 85% over this period.

Ward name	Average bed occupancy (1 October 2017 - 30 September 2018) (current inspection)
Meridian Ward (Functional)	104%
Adult Services (AMHS) Inpatient Functional Older Adults Larch Ward	102%
Inpatient Integrated Functional Adult (Raphael Ward - St Anne's)	102%
Adult Services (AMHS) Inpatient Functional Older Adults (Opal Ward)	100%
Inpatient Integrated Functional Adult (Heathfield Ward)	98%
Inpatient Functional (AMHS) Older Adults (Orchard Ward)	97%
Brunswick Ward (Dementia)	95%
Inpatient Organic (AMHS) Older Adults (Grove Ward)	94%
Beechwood Specialist Dementia Treatment Unit	92%
Adult Services (AMHS) Inpatient Organic Older Adults (Iris Ward)	87%
Adult Services (AMHS) Inpatient Organic Older Adults - The Burrowes	84%

The trust provided information for average length of stay for the period 1 October 2017 to 30 September 2018.

Ward name	Average length of stay (1 October 2017 - 30 September 2018) (current inspection)
Adult Services (AMHS) Inpatient Functional Older Adults (Opal Ward)	34
Adult Services (AMHS) Inpatient Functional Older Adults Larch Ward	41
Adult Services (AMHS) Inpatient Organic Older Adults - The Burrowes	62
Adult Services (AMHS) Inpatient Organic Older Adults (Iris Ward)	58
Beechwood Specialist Dementia Treatment Unit	62
Brunswick Ward (Dementia)	56
Inpatient Functional (AMHS) Older Adults (Orchard Ward)	37
Inpatient Integrated Functional Adult (Heathfield Ward)	45
Inpatient Integrated Functional Adult (Raphael Ward - St Anne's)	52
Inpatient Organic (AMHS) Older Adults (Grove Ward)	83
Meridian Ward (Functional)	42

Out of Area Placements

This service reported eight out of area placements between 1 October 2017 and 30 September 2018. As of 18 October 2018, this service had no ongoing out of area placements. There were no placements that lasted less than one day, and the placement that lasted the longest amounted to 41 days.

Eight out of area placements were due to capacity issues.

Number of out of area placements	Number due to specialist needs	Number due to capacity	Range of lengths (completed and ongoing placements)	Number of ongoing placements
8	0	8	5 - 41	0

Readmissions

This service reported 57 readmissions within 28 days between 1 October 2017 and 30 September 2018. Twenty of the readmissions (35%) were readmissions to the same ward as discharge. The average number of days between discharge and readmission was 13 days. There were no instances whereby patients were readmitted on the same day as being discharged but there were four patients admitted the day after being discharged.

Ward name	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
Adult Services (AMHS) Inpatient Functional Older Adults (Opal Ward)	25	7	28%	2 - 26	13
Adult Services (AMHS) Inpatient Functional Older Adults Larch Ward	5	0	0%	1 - 19	10
Adult Services (AMHS) Inpatient Organic Older Adults (Iris Ward)	2	1	50%	1 - 24	13
Beechwood Specialist Dementia Treatment Unit	3	3	100%	2 - 17	11
Brunswick Ward (Dementia)	1	1	100%	2 - 2	2
Inpatient Functional (AMHS) Older Adults (Orchard Ward)	5	0	0%	6 - 23	16

Ward name	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
Inpatient Integrated Functional Adult (Heathfield Ward)	5	2	40%	1 - 26	12
Inpatient Integrated Functional Adult (Raphael Ward - St Anne's)	3	2	67%	4 - 23	12
Meridian Ward (Functional)	8	4	50%	1 - 24	13

Beds were mostly available when patients returned from leave. However, the ward manager on Heathfield ward said that due to high demand for admissions, beds were not always available to patients when returning from leave.

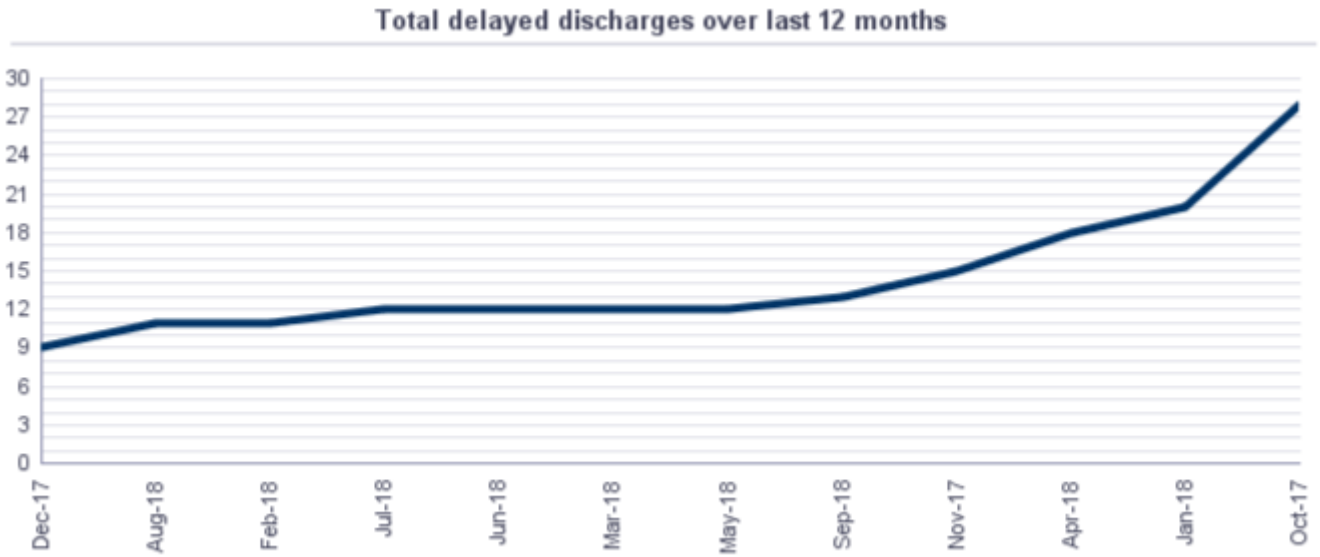
Staff we spoke with reported that patients were not moved between wards during an admission episode unless it was for a clinical reason, for example when they required more or less intensive nursing care.

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, staff arranged for them to be more intensively nursed on their ward until a bed became available. Staff increased nursing care by raising observation levels and carrying out a medicine review to consider appropriate adaptations to the patient’s treatment.

Discharge and transfers of care

Between 1 October 2017 and 30 September 2018 there were 1,074 discharges within this service. This amounts to 29% of the total discharges from the trust overall (3,675). Of these, 194 were delayed discharges (5%).

The graph below shows that delayed discharges across the 12-month period ranged from nine to 28 per month. An upward trend can be seen from May 2018, with an increase in the number of delayed discharges for five consecutive data points.



Staff told us discharge plans were developed and discussed right from the admission date so that factors such as housing and community care could be considered and reviewed. Patients were preferably discharged in the morning or during the day once their discharge was approved and their medicines were ready for collection. We observed a daily 'huddle' meeting at Langley Green Hospital which was also attended by a member of the crisis team in the role of discharge co-ordinator to review all patients who were ready for discharge off the ward.

Patients told us how staff helped them to achieve the goals to aid their recovery which were detailed in their discharge plans. Examples included ensuring that a patient's weight and nutritional intake was stable. One other patient told us that they were going to undergo intensive physiotherapy to build strength in their leg before they could be discharged.

Ward managers told us that delayed discharges were usually due to difficulty in accessing appropriate placements (for example supported living, residential care or nursing home placements) and care packages in the community. In one case, a ward manager told us that a patient was unable to move due to the high cost of the onward placement identified for them to meet their needs. Additional nursing staff were employed to ensure the patients' needs were safely met while they remained on the ward. The cost of the proposed care package was being negotiated between funding managers to facilitate discharge for the patient.

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

Meal times on all wards were protected from telephone calls and doctors' visits to ensure that patients were not distracted.

Boards in all ward kitchens displayed patients' dietary requirements. These were reviewed and updated daily as appropriate.

All wards had equipment and resources for patients including profiling beds, pressure relieving mattresses and cushions. Infra-red falls detection technology was installed in all bedrooms on Brunswick and Iris wards to support in the management of incidents. This technology had been delivered to Grove ward and was ready for installation.

Out of the seven wards we inspected, St Raphael, Orchard and Heathfield wards had dormitory bedrooms and these areas were, in the main, not personalised. The four dormitories (three

dormitories with beds, and one dormitory with three beds) on Heathfield ward had only one sink each. This meant if a patient was using the dormitory sink another patient wishing to also use the sink might have to go out to use the ward bathroom or use a bowl in their bed space. Grove ward had one shared bedroom for two patients, and Iris ward two shared bedrooms in addition to dormitory arrangements. St Raphael ward had a dormitory each for men and women, and a selection of single and shared bedrooms. We spoke with female patients who shared a room and they were happy with the arrangement. Patients told us that sometimes other patients were noisy at night time if they became distressed, however nurses quickly calmed those patients and ensured that everyone else was settled. The trust had listed dormitory sleeping arrangements on their risk register to monitor risk management and working towards eliminating mix sex accommodation.

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 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.

On Brunswick ward, a framed ‘memory' box outside each patient’s room, along with the patient name, contained photographs and pictures of things they liked and were interested in and topics to start conversations. Patient bedroom doors had a list of their interests, hobbies and previous jobs along with their name on Grove ward.

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. The quiet lounge on Brunswick ward included a screen displaying a virtual aquarium to help soothe and relax patients. Research has shown that placing an aquarium in environments with patients with dementia has links to aiding in reducing disruptive behaviour and even improving the eating habits of those suffering with the disease. The dining area on Brunswick ward was café style with vintage advertising signs which patients would remember.

All the wards had kitchen areas where patients could make hot drinks and snacks. We observed that patients had drinks within easy reach across all wards and were encouraged to drink by staff.

All the units had garden areas.

Patients 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 the mobile phone camera. A communal phone was available for patients on all wards to use if they wanted to use this instead of a mobile phone.

The 2018 patient-led assessments of the care environment (PLACE) score for ward food at the Harold Kidd Unit and St Anne’s Centre & EMI wards scored lower than similar trusts overall.

Site name	Core service(s) provided	Ward food
Millview Hospital	MH - Wards for older people with mental health problems	93.3%

Site name	Core service(s) provided	Ward food
The Harold Kidd Unit	MH - Wards for older people with mental health problems	91.7%
Salvington Lodge (The Burrowes) Patients have been temporarily moved to Brunswick see row 11)	MH - Wards for older people with mental health problems	99.6%
Horsham Hospital - Iris Ward	MH - Wards for older people with mental health problems	100.0%
St Anne's Centre & EMI Wards	MH - Wards for older people with mental health problems	91.4%
Beechwood Unit	MH - Wards for older people with mental health problems	98.1%
Trust overall		**92.7%**
England average (mental health and learning disabilities)		**93.0%**

All patients we spoke with told us they liked the food on the ward. One patient we spoke with who was on a special diet was happy that staff were introducing new and more interesting foods into their meal menu as part of their recovery.

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 following 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. Trained therapy 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.

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. We met carers and family members who were visiting patients on wards throughout our inspection and one patient were supported to visit family at weekends if this was appropriately risk assessed. Restrictions on visiting times had been removed on all wards.

Meeting the needs of all people who use the service

For the most recent patient-led assessments of the care environment (PLACE) (2018), Mill View Hospital, Salvington Lodge, St Anne’s Centre and EMI wards and Beechwood Unit scored higher for both ‘Dementia Friendly’ and ‘Disability’ than similar trusts overall.

Site name	Core service(s) provided	Dementia friendly	Disability
Millview Hospital	MH - Wards for older people with mental health problems	95.8%	96.5%
The Harold Kidd Unit	MH - Wards for older people with mental health problems	84.4%	92.1%
Salvington Lodge (The Burrowes) Patients moved to Brunswick	MH - Wards for older people with mental health problems	92.0%	89.6%
Horsham Hospital - Iris Ward	MH - Wards for older people with mental health problems	76.6%	84.7%
St Anne's Centre & EMI Wards	MH - Wards for older people with mental health problems	93.0%	91.4%
Beechwood Unit	MH - Wards for older people with mental health problems	90.3%	90.2%
Trust overall		**91.3%**	**86.4%**
England average (Mental health and learning disabilities)		**84.7%**	**87.8%**

Accessible bath, toilet, and shower facilities were provided on all wards.

All wards were decorated in dementia friendly colour schemes, for example high contract coloured hand rails, and red toilet seats. Using specific colours on the ward helped create an environment that was safe and familiar to patients. All staff wore their names in dementia friendly format of large black print on yellow name badges. However, the dining room on Grove ward was very enclosed and was not decorated in dementia friendly colours.

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.

Information on treatments, local services, patients' rights, and how to complain were displayed on the information boards on each ward. All wards had photographs of the staff to show patients and visitors who they were and what their roles were.

Access to accessible and easy read information was variable across the wards. However, staff told us that they could print off accessible information for patients if they required this. An example of this was easy read for patients with a learning disability. Welcome packs of all 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.

Langley Green Hospital was awarded a gold inclusion award for their lesbian, gay, bisexual, transsexual, queer or questioning (LGBTQ) work. The LGBTQ Inclusion Award helps healthcare facilities to address historical inequalities in healthcare outcomes for LGBTQ people and is a partnership between Switchboard and Trans Alliance Brighton. The Award encourages facilities to strive to achieve a Bronze, Silver or Gold Award by meeting a range of criteria for LGBTQ Inclusion. Opal ward had a strong awareness of the needs of lesbian, gay, bisexual, transsexual patient group. All ward staff were trained in LGBTQ awareness to silver standard and ward toilets were gender neutral.

A choice of food was provided to meet patients' religious and ethnic requirements. There was also a choice of food on all wards to meet dietary requirements such as gluten free.

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. All wards had access to multi-faith rooms for patients to visit for prayer.

Listening to and learning from concerns and complaints

This service received 39 complaints between 1 October 2017 and 30 September 2018. One of these were upheld, seven were partially upheld, 20 were not upheld and one was referred to the Ombudsman.

Team name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Opal Ward	13	0	3	6	0	0	4	0
Larch Ward	6	0	0	2	1	1	2	0
Meridian Ward	5	0	1	3	0	0	1	1
St Raphael Ward	4	0	1	2	0	0	1	0
Beechwood Unit	3	1	1	0	0	0	1	0
Heathfield Ward	3	0	0	3	0	0	0	0
Orchard Ward	2	0	0	2	0	0	0	0

Brunswick	1	0	0	1	0	0	0	0
Iris Ward	1	0	1	0	0	0	0	0
The Burrowes Unit	1	0	0	1	0	0	0	0

This service received 58 compliments during the last 12 months from 1 October 2017 to 30 September 2018 which accounted for 9% of all compliments received by the trust.

Patients we spoke with told us they knew how to make a complaint or raise concerns and described how they could this verbally in private or in groups, and complete complaint forms available on the wards.

When patients complained or raised concern they received feedback. For example, each ward had 'you said, we did boards' to display how wards acted on feedback received. Staff also gave patients feedback individually and in morning coffee group.

Staff knew how to handle complaints appropriately. On Brunswick ward the ward manager talked us through a complaint the ward had received, and we were satisfied that the matter was handled appropriately which resulted in family members feeling better involved in their family member's care. Complaints we reviewed also indicated that complaints had been dealt with quickly and often with direct contact from the ward managers to engage with patients, carers and their family members.

Staff we spoke with told us they received outcomes following investigations of complaints. They told us that this helped them improve further the care they provided.

Is the service well-led?

Leadership

Matrons and ward managers had the skills, knowledge and experience to perform their roles to a high standard. Over the past few years 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.

The wards' senior management team had regular contact with all staff and patients. Staff gave a particular mention to the Chief Executive Officer who often visited the wards and recently had visited some wards on Christmas Day to speak with patients and staff. 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.

Vision and strategy

Staff we spoke with clearly understood the vision and strategic objectives of the organisation. The trust's vision, values and strategies for the service were displayed on information boards on each ward. 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. The ward manager

of Brunswick told us about their recent development away day which helped bond two groups of staff following a move of staff from another location onto the ward.

Culture

All staff told us they felt respected, supported and valued in their work. They praised the support they received from their ward managers. Staff were proud about 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. We heard that the trust's human resources department were supportive in dealing with any staff performance issues to support ward managers through the processes.

Teams worked well together for the well-being of patients, we saw this happening across the wards, in care review meetings, 'huddle' meetings, and discharge planning meetings.

Annual staff appraisals included discussions on personal and professional development needs. All staff commented on how their professional development needs were continually supported by ward managers and matrons.

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 which included varying shift lengths to help them manage other life priorities.

The ward managers encouraged staff to recognise and celebrate their success.

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 dashboard report format which all staff could see. The dashboard displayed numbers of risks, incidents, training, etc. in visual graphs which were easy to understand at a glance. 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 effectively.

We reviewed records which detailed that staff received mandatory training, monthly supervision and annual appraisals. There were sufficient suitably trained staff available on every shift on each ward to deliver good care to patients.

Staff were confident that they continually learnt from incidents, complaints and patient suggestions and feedback. Learning and improvements were evidence across this service during our inspection.

The trust provided the West Sussex, East Sussex and Brighton and Hove risk registers dated October 2018 detailing their 28 highest profile risks. Each of these had a risk score of 15 or higher. Two of these related to this core service and concerned meeting patients' physical health needs on St Raphael ward and a broken lock on the Iris ward spirituality room.

Management of risk, issues and performance

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.

Information management

Staff had access to information and technology to support them in their work.

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. This information included clinical quality audits, human resource management data and complaints and incident data. We reviewed practice and documents which indicated this information was being used across all wards to monitor provision and identify areas for improvement.

Processes were 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'. Patients and carers were encouraged to, 'tell their story' on a national website which captured patient and carer experience.

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.

Ward managers had access to feedback from patients, carers and staff and used this to make improvements.

Patients and carers were involved in decision making about changes to the service.

Learning, continuous improvement and innovation

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.

Falls technology and multi-disciplinary work on Brunswick and Iris wards helped to significantly reduce the falls incidents on the ward. Work between Brunswick ward and a local primary school through the 'pimp my zimmer' project raised awareness of dementia among young school children, increased patients' ability to recognise their own decorated zimmer frame and encouraged use which in turn reduce falls incidents.

Lesbian, gay, bisexual, transsexual, queer or questioning (LGBTQ) awareness work on Opal ward led to care plans being amended to ask patients which pronoun they wished to be referred to as. Staff also wore name badges with their chosen pronoun, for example 'he, him, his', to promote this awareness. Ward staff had been trained to silver level in LGBTQ Inclusion Award.

Langley Green Hospital worked on the principles of the leader-leader model to promote a flattened hierarchy and empowerment to all patients, staff and carers. They jointly created a vision giving everyone ownership of it. This passed the control and leadership to the patients (or service leaders), carers and staff and embraced them to take a lead. The unit gave the staff the skills and development opportunities needed in order to achieve the vision, including development programmes for each band of staff delivered by specialists from all areas (including service leaders and carers). The hospital provided a bespoke local induction programme and learning lessons forums. They had implemented a range of platforms for people to be heard including focus groups, carers strategies, away days, feedback Fridays.

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 teams within this service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Core service	Service accredited	Comments
AIMS - OP (Wards for older people)	MH - Wards for older people with mental health problems	Orchard Ward and Larch Ward 2017	

Forensic inpatient/secure wards

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Hellingly Centre	Ash Ward	15	Male
Hellingly Centre	Elm Ward	15	Male
Chichester Centre	Fir Ward	17	Male
Chichester Centre	Hazel Ward	15	Female
Hellingly Centre	Oak Ward	15	Male
Chichester Centre	Pine Ward	17	Male
Hellingly Centre	Willow Ward	15	Female

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean environment

Safety of the ward layout

Each ward completed daily environmental risk assessments and took appropriate actions where new risks were identified. The allocated security lead completed the checks using a standard template.

All ligature audits were completed annually by members of staff from the estates team and ward team. Ligature audits were comprehensive and highlighted risk based on a scoring system and documented appropriate mitigating actions.

All the wards visited had good lines of site and allowed staff to observe all parts of the ward. There was a staff presence on all wards and regular observations completed to ensure ward safety.

There were ligature risks on seven wards within this service. All wards had a ligature risk assessment in the last 12 months.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
The Chichester Centre - Fir Ward	All anchor points assessed in accordance with trust policy on patient profile, room designation, height and compensatory factors such as observation and ingenuity. There remain a few anchor points where removal or reduction is limited. Some opportunistic risks identified and currently managed clinically.	Yes	Identified risks are clinically managed in line with various clinical risk policies. Quotes for some identified obvious risks currently with PFI providers.
The Chichester Centre - Hazel Ward	All anchor points assessed in accordance with trust policy on patient profile, room designation, height and compensatory factors such as observation and ingenuity. There remain a few anchor points where removal or reduction is limited. Some opportunistic risks identified and currently managed clinically.	Yes	Identified risks are clinically managed in line with various clinical risk policies. Quotes for some identified obvious risks currently with PFI providers.
The Chichester Centre - Pine Ward	All anchor points assessed in accordance with trust policy on patient profile, room designation, height and compensatory factors such as observation and ingenuity. There remain a few anchor points where removal or reduction is limited. Some opportunistic risks identified and currently managed clinically.	Yes	Identified risks are clinically managed in line with various clinical risk policies. Quotes for some identified obvious risks currently with PFI providers.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Hellingly Centre - Willow Ward	This re-audit is scheduled for October 2018. All anchor points assessed in accordance with trust policy on patient profile, room designation, height and compensatory factors such as observation and ingenuity. There remain a few anchor points where removal or reduction is limited.	Yes	No planned priority works with regards to estates. Current identified risks managed clinically in line with various clinical risk policies. Anti-ligature noticeboards for patients developed in the last 12 months and ready after approval.
Hellingly Centre - Ash Ward	All anchor points assessed in accordance with trust policy on patient profile, room designation, height and compensatory factors such as observation and ingenuity. There remain a few anchor points where removal or reduction is limited.	Yes	No planned priority works with regards to estates. Current identified risks managed clinically in line with various clinical risk policies.
Hellingly Centre - Elm Ward	All anchor points assessed in accordance with trust policy on patient profile, room designation, height and compensatory factors such as observation and ingenuity. There remain a few anchor points where removal or reduction is limited.	Yes	No planned priority works with regards to estates. Current identified risks managed clinically in line with various clinical risk policies.
Hellingly Centre - Oak Ward	All anchor points assessed in accordance with trust policy on patient profile, room designation, height and compensatory factors such as observation and ingenuity. There remain a few anchor points where removal or reduction is limited.	Yes	No planned priority works with regards to estates. Current identified risks managed clinically in line with various clinical risk policies. Anti-ligature noticeboards for patients developed in last 12 months and ready after approval.

All wards were single sex wards. Over the 12-month period from 1 October 2017 to 30 September 2018 there were no mixed sex accommodation breaches within this service.

All staff received a personal alarm and set of keys from reception when signing in to work. All staff received an appropriate induction and training on security to ensure proper use of alarms and the key system. All rooms had alarms that patients or staff could use to alert staff to any incident

Maintenance, cleanliness and infection control

All ward areas were clean and tidy with a good standard of furnishings that were well maintained. There was an internal domestic team that were separately managed, and we saw cleaning rotas to demonstrate regular cleaning occurred.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) (2018), the location scored higher than similar trusts for cleanliness.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance
Hellingly Centre	MH - Secure wards/Forensic inpatient	99.5%	93.4%
Trust overall		**98.0%**	**94.8%**
England average (Mental health and learning disabilities)		**98.5%**	**94.5%**

However, due to security issues with the security room on Fir ward, patient wallets, bank cards and money was being temporarily stored in the medicines cupboard in the clinic room. This posed a potential infection control risk. The service immediately rectified the issue when highlighted to them on inspection and moved the items to a new temporary place until the security issues were resolved.

Seclusion room

All seclusion rooms allowed clear observations, two-way communication, contained visible clock and toilet facilities. The seclusion facilities at The Chichester Centre were in the process of being refurbished to enhance the environment. All seclusion rooms had access to secure outside space for use in the event of long-term segregation.

Clinic room and equipment

All clinic rooms were fully equipped with accessible emergency equipment and medicine. All equipment was appropriately calibrated, maintained and portable appliance tested. However, we found some expired items on Ash ward and Hazel ward including oral syringes, urinalysis test strips and disposable tourniquets. When highlighted to the service these were immediately removed and replacements ordered.

All clinic rooms except Willow ward contained fridges for storing medicine when required and this was checked daily by staff. The fridge on Willow ward was not working and a new one was on order. The service mitigated this by storing medicines in another ward's fridge. Patients and staff commented that this delayed dispensing and administration of medicines.

On Fir ward the fridge temperature had been recorded as consistently above eight degrees celsius with no mitigating action documented on the check sheets and patient medicine was being stored there. This was immediately rectified when highlighted to the service who moved the medicine into another ward's fridge. Post inspection, the trust highlighted that this was a recording error by staff reading the thermometer temperatures and had since reminded staff of the correct procedure.

All clinic room ambient temperatures were checked daily to maintain the integrity of stored medicines.

However, on Hazel ward the room temperature was consistently recorded as above the maximum temperature stated in trust policy. An air conditioning unit was on order for the ward and the pharmacy team reduced the medicine expiry date in accordance with trust policy in response to the raised temperatures.

Safe staffing

Nursing staff

The service reported a vacancy rate for all staff of 24% as of 30 September 2018.

The service reported an overall vacancy rate of 34% for registered nurses at 30 September 2018.

This core service reported an overall vacancy rate of 18% for healthcare assistants at 30 September 2018.

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Hellingly Centre	Willow Ward	4.7	10.7	44%	6.9	21.5	32%	13.1	41.1	32%
Chichester Centre	Hazel Ward	3.2	11.2	29%	7.7	15.6	49%	9.5	30.4	31%
Hellingly Centre	Oak Ward	4.7	10.7	44%	2.1	21.0	10%	10.7	40.7	26%
Chichester Centre	Pine Ward	2.2	11.2	20%	1.2	10.2	11%	5.0	26.3	19%
Hellingly Centre	Ash Ward	3.7	10.7	35%	0.9	12.9	7%	6.3	32.8	19%
Hellingly Centre	Elm Ward	4.5	10.8	41%	-0.2	12.4	-2%	6.2	32.4	19%
Chichester Centre	Fir Ward	3.2	11.2	29%	0.9	12.9	7%	4.4	28.7	15%
Core service total		**26.4**	**76.7**	**34%**	**19.4**	**106.4**	**18%**	**55.0**	**232.3**	**24%**
Trust total		**225.5**	**1211.8**	**19%**	**121.9**	**730.2**	**17%**	**406.2**	**2791.2**	**15%**

NB: All figures displayed are whole-time equivalents

Between 1 October 2017 and 30 September 2018, of the 150038 total working hours available, 11% were filled by bank staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 6% of available hours for qualified nurses and 34% of available hours were unable to be filled by either bank or agency staff.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Ash Ward	21001	712	3%	469	2%	7313	35%
Elm Ward	21197	3767	18%	209	1%	8721	41%
Fir Ward	21979	3013	14%	88	0%	6335	29%
Hazel Ward	21979	3564	16%	433	2%	6335	29%
Oak Ward	21001	1731	8%	913	4%	9269	44%
Pine Ward	21881	2620	12%	0	0%	4282	20%
Willow Ward	21001	852	4%	7626	36%	9269	44%
Core service total	**150038**	**16259**	**11%**	**9738**	**6%**	**51525**	**34%**
Trust Total	**2369456**	**196179**	**8%**	**91456**	**4%**	**440904**	**19%**

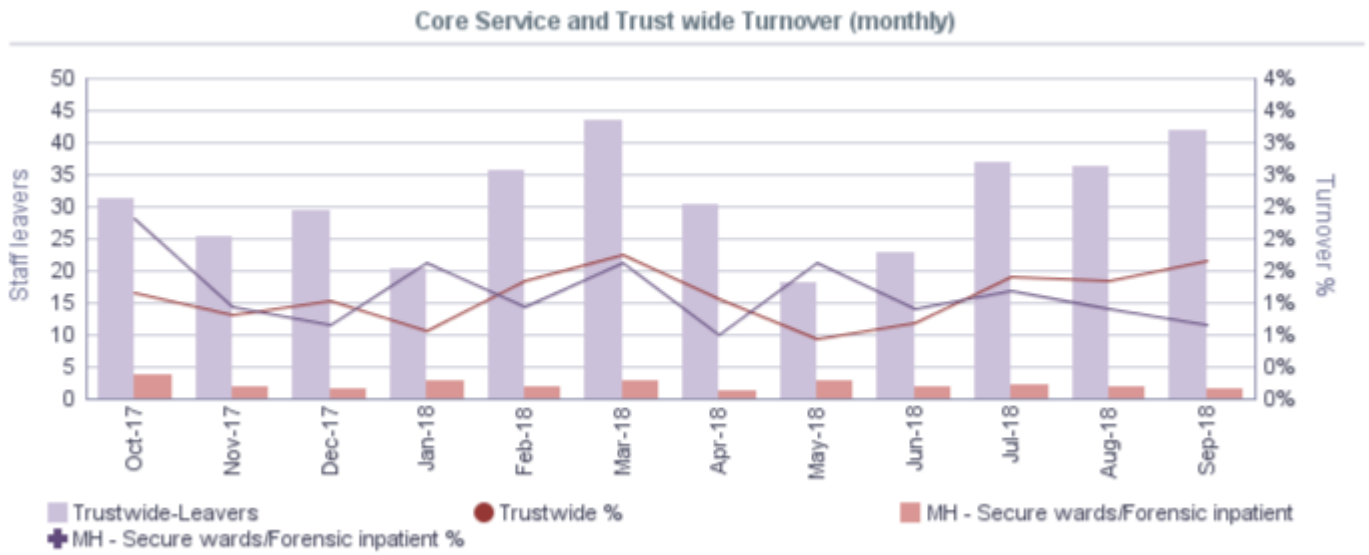
Between 1 October 2017 and 30 September 2018, of the 208055 total working hours available, 42% were filled by bank staff to cover sickness, absence or vacancy for healthcare assistants.

In the same period, agency staff covered 3% of available hours and 18% of available hours were unable to be filled by either bank or agency staff.

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Ash Ward	25244	10266	41%	287	1%	1779	7%
Elm Ward	24267	9228	38%	186	1%	-372	-2%
Fir Ward	25244	10888	43%	0	0%	1779	7%
Hazel Ward	30504	18697	61%	411	1%	15017	49%
Oak Ward	40985	15360	37%	939	2%	4145	10%
Pine Ward	19847	7818	39%	0	0%	2249	11%
Willow Ward	41963	15721	37%	4434	11%	13394	32%
Core service total	**208055**	**87978**	**42%**	**6256**	**3%**	**37993**	**18%**
Trust Total	**1427911**	**411620**	**29%**	**24878**	**2%**	**238422**	**17%**

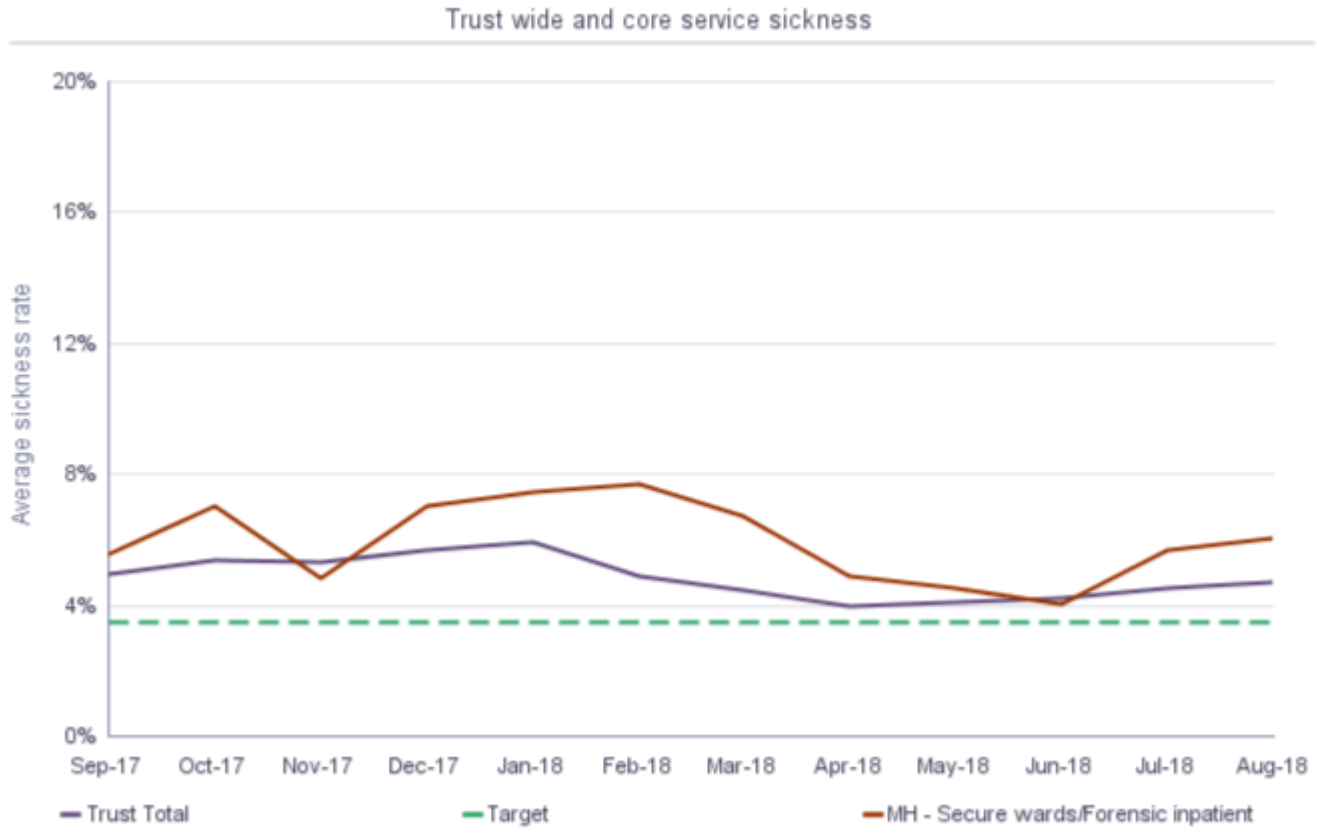
** *Minus figures mean that they are over established.*

This core service had 28 (16%) staff leavers between 1 October 2017 and 30 September 2018.



Location	Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Chichester Centre	Fir Ward	26	1	4%
Chichester Centre	Hazel Ward	19	1	3%
Chichester Centre	Pine Ward	21	2	9%
Hellingly Centre	Ash Ward	26	2	8%
Hellingly Centre	Elm Ward	24	7	29%
Hellingly Centre	Oak Ward	30	3	9%
Hellingly Centre	Willow Ward	28	13	47%
Core service total		**174**	**28**	**16%**
Trust Total		**2424**	**371**	**15%**

The sickness rate for this core service was 6% between 1 September 2017 and 31 August 2018. The most recent month's data (August 2018) showed a sickness rate of 6%.



Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff Sickness (over the past year)
Chichester Centre	Fir Ward	0.7	2.2
Chichester Centre	Hazel Ward	10.4	5.8
Chichester Centre	Pine Ward	2.2	5.2
Hellingly Centre	Ash Ward	7.9	6.4
Hellingly Centre	Elm Ward	11.1	9.8
Hellingly Centre	Oak Ward	3.2	3.1
Hellingly Centre	Willow Ward	7.7	9.5
Core service total		**6.0**	**6.0**
Trust Total		**4.7**	**4.9**

Following the inspection, the trust provided data for the month of December 2018, which showed a sickness rate of 3.5% for the core service and 4.6% for the trust.

The below table covers staff fill rates for registered nurses and care staff during July, August and September 2018.

Elm and Ash wards had below 90% of the planned registered nurses for all day shifts, whereas Willow ward had below 90% of the planned care staff for all day shifts. Hazel ward had above 125% of the planned care staff for night shifts for all months reported.

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 (%)
	July 2018				August 2018				September 2018			
Fir Ward	91.4	91.7	93.5	162.8	90.0	95.2	97.1	97.8	82.8	116.6	103.3	97.8
Hazel Ward	99.1	103.0	108.5	156.3	105.0	161.8	101.3	154.7	103.7	157.1	101.5	170.2
Pine Ward	94.6	74.8	50.0	100.0	71.9	91.3	50.0	100.0	90.8	79.7	50.0	200.0
Elm	76.2	100.1	92.8	134.4	66.1	98.2	101.4	96.0	87.4	100.1	101.2	99.8
Ash	87.2	96.4	107.6	92.4	63.9	104.0	106.0	83.0	58.3	102.0	107.1	83.2
Oak Ward	95.1	85.7	59.3	112.3	80.1	90.2	66.6	115.1	71.4	96.8	120.4	92.1
Willow Ward	90.5	84.2	99.7	84.7	96.0	80.7	107.3	97.8	87.9	80.3	105.1	107.7

Staff worked shifts of 7am to 7:30pm and 7pm to 7:30am. This enabled a crossover of shifts to ensure a substantial handover could be completed between shifts. All wards operated with two qualified staff and three unqualified staff for each shift.

There was always at least one nurse on each shift and the other qualified staff member could be an occupational therapist. They were included within the care staff numbers at least 50% of their working time. Occupational therapist technicians were also included within the unqualified care staff numbers. There was a review of the staffing arrangement taking place shortly after the inspection to discuss reducing the time occupational therapists spent working as part of the ward staffing numbers.

Ward managers could adjust staffing levels to account for the case mix and acuity on the wards. Where this could safely be done by moving staff from other wards we saw this facilitated. Additionally, the service had a pool of bank staff that were inducted to the service that were used when necessary. These staff were familiar with the ward and offered better continuity of care to patients than ad hoc agency staff.

Ward managers had access to an electronic staffing portal 'STAR' to request staff from the wider trust bank staff and agency staff as last resort.

All patients were allocated a named nurse and given one-to-one time with them. Staff shortages very rarely impacted on patient one-to-ones, activities or leave. However, we observed that activities could be delayed as occupational therapists and occupational therapist technicians who facilitated certain groups were busy completing other ward-based tasks, such as observations, due to being counted within the staffing care numbers for the ward.

There were enough numbers of suitably trained staff on each shift to carry out physical interventions when required. However, the wards facilitated a calm and inclusive environment which meant that physical interventions were last resort and rarely used.

Medical staff

Between 1 October 2017 and 30 September 2018, of the 19945 total working hours available, 1% were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same period, agency staff covered 0.5% of available hours and 24% of available hours were unable to be filled by either bank or agency staff.

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Ash Ward	293	0	0%	0	0%	1955	56%
Elm Ward	163	0	0%	0	0%	0	0%
Fir Ward	244	0	0%	0	0%	0	0%
Hazel Ward	261	0	0%	104	3%	-78	-3%
Oak Ward	293	137	4%	0	0%	0	0%

Ward/Team	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Pine Ward	163	0	0%	0	0%	978	50%
Willow Ward	244	0	0%	0	0%	1955	67%
Core service total	**19945**	**137**	**1%**	**104**	**0.5%**	**4810**	**24%**
Trust Total	**336290**	**8648**	**3%**	**41142**	**12%**	**21392**	**6%**

There was adequate medical cover across the service with dedicated ward consultants, speciality doctors and junior doctors available. The Chichester Centre additionally had a visiting GP once a week.

There were appropriate out of hours duty systems in place for on-call consultants and managers.

Mandatory training

The compliance for mandatory and statutory training courses at 1 October 2018 was 87%. This was above a set trust target of 85%.

Of the training courses listed eight failed to achieve the trust target and of those, three failed to score above 75%.

The training compliance reported for this core service during this inspection was higher than the 82% reported in the previous year.

Key:

Below CQC 75%	Met trust target	Not met trust target	Higher	No change	Lower	Error
						N/A

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Manual Handling - Object	166	169	100%		
Infection Prevention (Level 1)	11	11	100%		
Safeguarding Children (Level 1)	6	6	100%		
Equality and Diversity	176	172	98%		
Information Governance	176	171	97%		
Health and Safety (Slips, Trips and Falls)	176	169	96%		
Clinical Risk Assessment	170	161	95%		
Personal Safety Breakaway - Level 1	22	21	95%		
Safeguarding Adults (Level 2)	170	161	95%		

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Rapid Tranquilisation	55	51	93%		
Prevent	176	161	91%		
Medicines management	48	43	90%		
Safeguarding Children (Level 2)	169	152	90%		
Infection Prevention (Level 2)	166	147	89%		
Mental Capacity Act Level 1	170	148	87%		
Safeguarding Adults (Level 1)	6	5	83%		
Mental Health Act	80	65	81%		
Personal Safety - MVA	153	124	81%		
Adult Basic Life Support	105	80	76%		
Fire safety onsite- Inpatient	176	134	76%		
Prevent (WRAP)	166	120	72%		
Adult Immediate Life Support	55	39	71%		
Manual Handling - People	155	98	63%		
TOTAL	**2753**	**2408**	**87%**		

Whilst on inspection, we saw a slight improvement in overall mandatory training compliance rates for the whole service with 89%. All seven wards were at or above the trust target of 85%.

Staff had access to an online electronic portal which displayed their mandatory training compliance on a dashboard. Staff could also book on to any upcoming courses via the portal. Ward managers accessed the portal and obtained an overview of all staff on their ward and prompted staff when they were due refresher training.

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 35 patient care records and found every patient had an up to date and comprehensive risk assessment that was regularly reviewed. Risk assessments were routinely reviewed every seven days and after any events of incidents. Risk assessments explored an array of risks including risk to self and others, neglect and substance misuse.

Staff completed standard risk assessments forms on the electronic care records system that was based upon the five P's; presenting, predisposing, precipitating, perpetuating and protective. This was to ensure all risks were identified as well as triggers, behaviours and actions to take.

Staff also used the historical clinical risk -20 tool, a recognised risk assessment tool as part of risk assessments.

Risk assessments formed part of a weekly care records audit that was completed and highlighted which patients were due or nearly due a review of their risk assessment.

Management of patient risk

Staff knew their patients well and were aware of and responsive to any changes in risk or presentation.

The service had an observation policy in place that staff were aware of and adhered to. We saw good discussions around risk, including discussions around the required observation levels for each patient. All staff completed a competency assessment before undertaking patient observations.

All newly admitted patients were placed on enhanced observations for the first 24 hours after admission. The service actively aimed to reduce observation levels as soon as safety possible on all wards to improve patient-staff relationships and enhance the overall therapeutic environment.

There was a search policy in place that staff adhered to and each patient had a search care plan that detailed behaviours and triggers that could indicate when a search was required. The service undertook regular random room searches and more frequent searches based upon intelligence or incidents and events.

Staff applied blanket restrictions on patients only when justified. Staff discussed and gave clear information to patients when these restrictions were in place and where possible had agreements between the ward and patients. For example, smartphones were not allowed on the wards however basic phones were provided to patients with an agreement signed that stated they could not text other patients on the ward.

All hospital sites were smoke-free at the time of the inspection. Patients were informed of this either before or during admission. The ward encouraged and supported smoking cessation and offered nicotine replacement therapy and/or disposable electronic cigarettes to all patients requiring it.

Some staff within the service were trained in restorative justice and we saw plans to implement restorative culture onto the ward when required to better manage patient interactions and risk on the wards.

Use of restrictive interventions

This service had 46 incidences of restraint (22 unique individual service users) and 71 incidences of seclusion between 1 October 2016 and 30 September 2017.

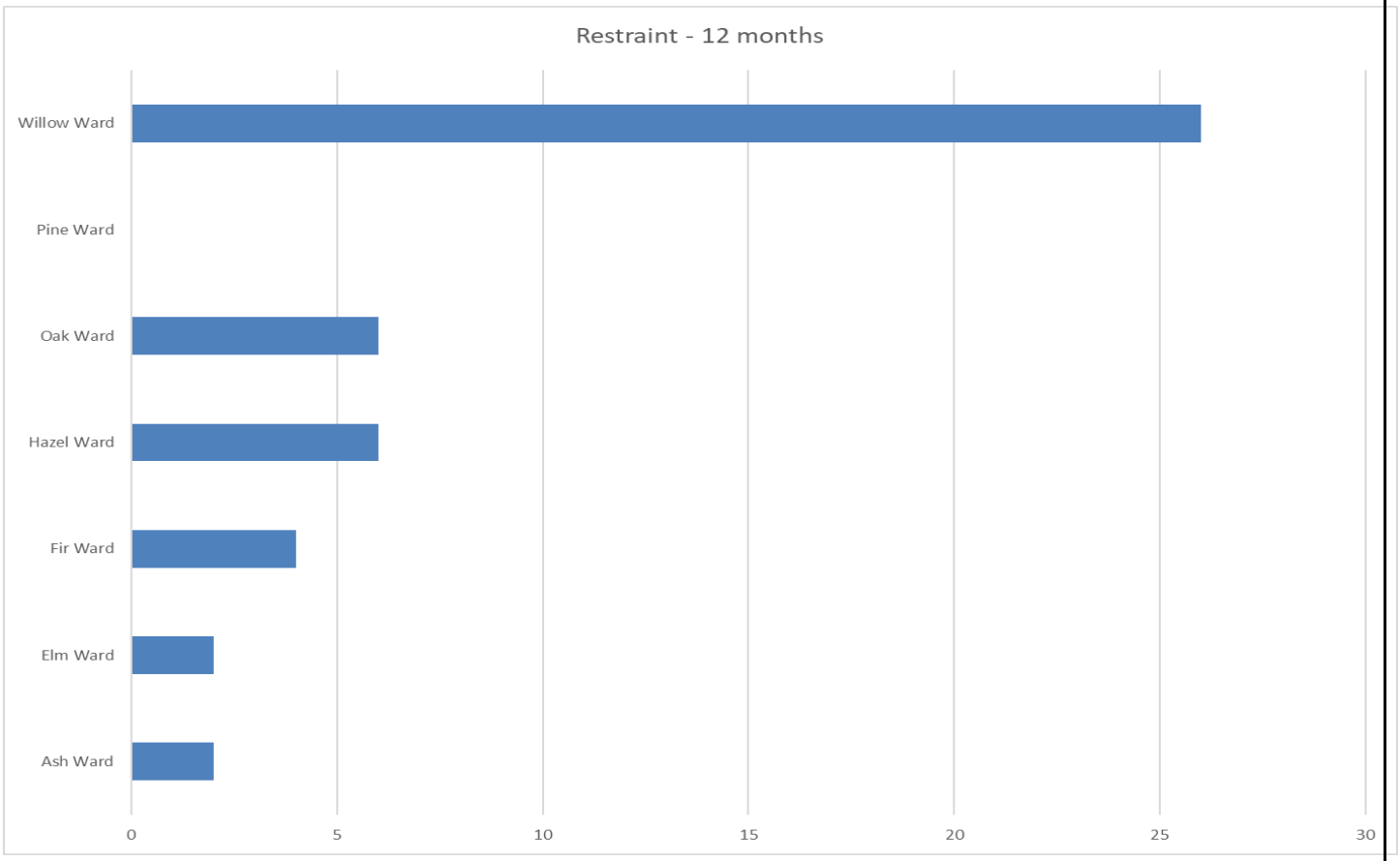
The below table focuses on the last 12 months' worth of data: 1 October 2016 to 30 September 2017.

Location	Ward name	Seclusions	Restraints	Individual service users that restraint was used on	Of restraint, incidents of prone restraint	Rapid tranquilisations
Hellingly Centre	Ash Ward	4	2	1	1 (50%)	0
Hellingly Centre	Elm Ward	2	2	1	0	0
Chichester Centre	Fir Ward	9	4	4	1 (25%)	1(25%)
Chichester Centre	Hazel Ward	4	6	4	0	1(17%)
Hellingly Centre	Oak Ward	9	6	6	1 (17%)	1 (17%)
Chichester Centre	Pine Ward	0	0	0	0	0
Hellingly Centre	Willow Ward	43	26	6	0	6 (23%)
Core service total		**71**	**46**	**22**	**3(6%)**	**9 (20%)**

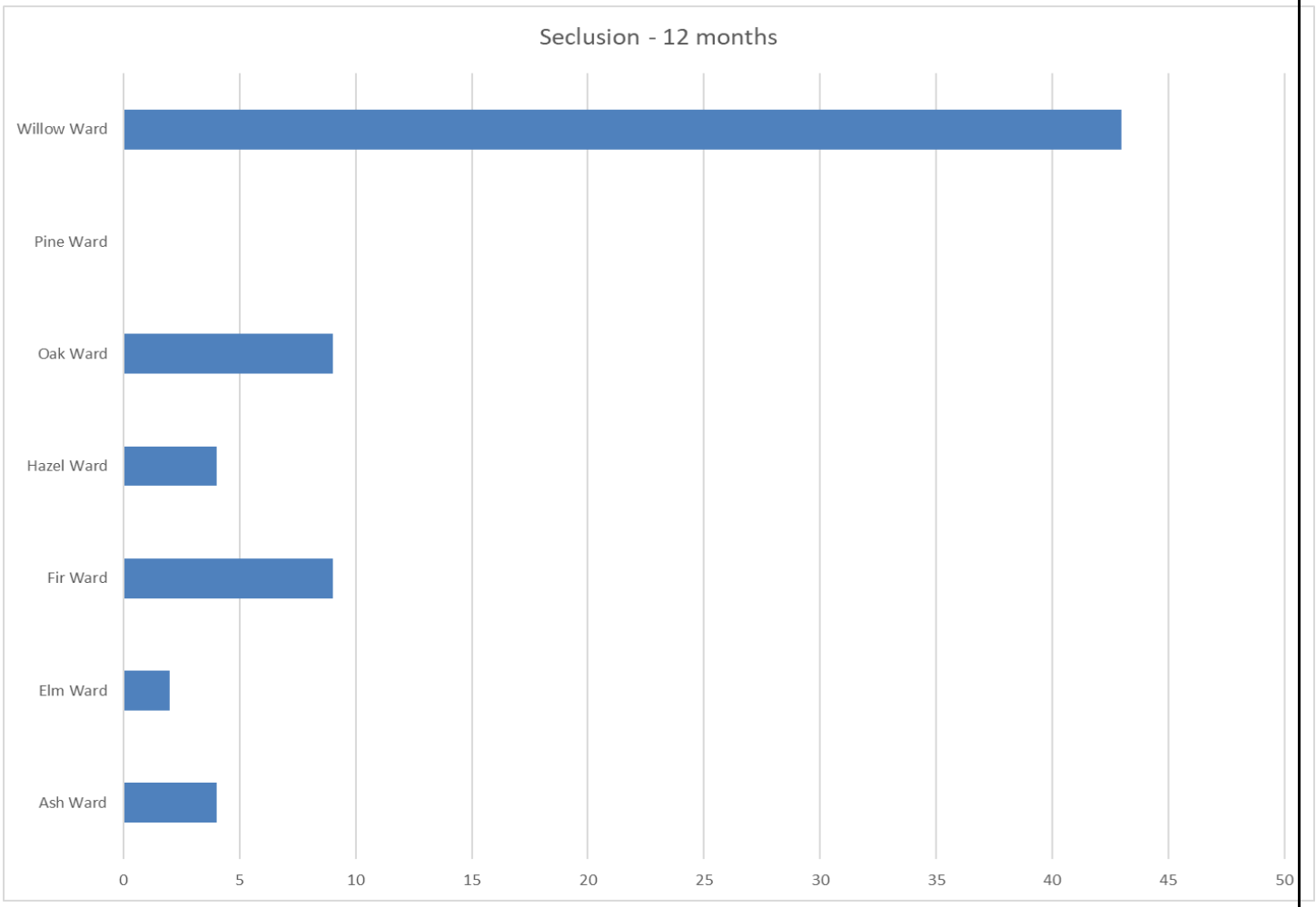
There were three instances of prone restraint, which accounted for 6% of the restraint incidents. Over the 12 months, incidences of restraint ranged from two to 26. The number of incidences fell (46) when compared to the previous 12-month period (49).

There were nine instances of rapid tranquilisation over the reporting period. Incidents resulting in rapid tranquilisation for this service ranged from one to six over the 12 months. The number of incidences (nine) increased when compared to the previous 12-month period (three).

There were no instances of mechanical restraint over the reporting period.

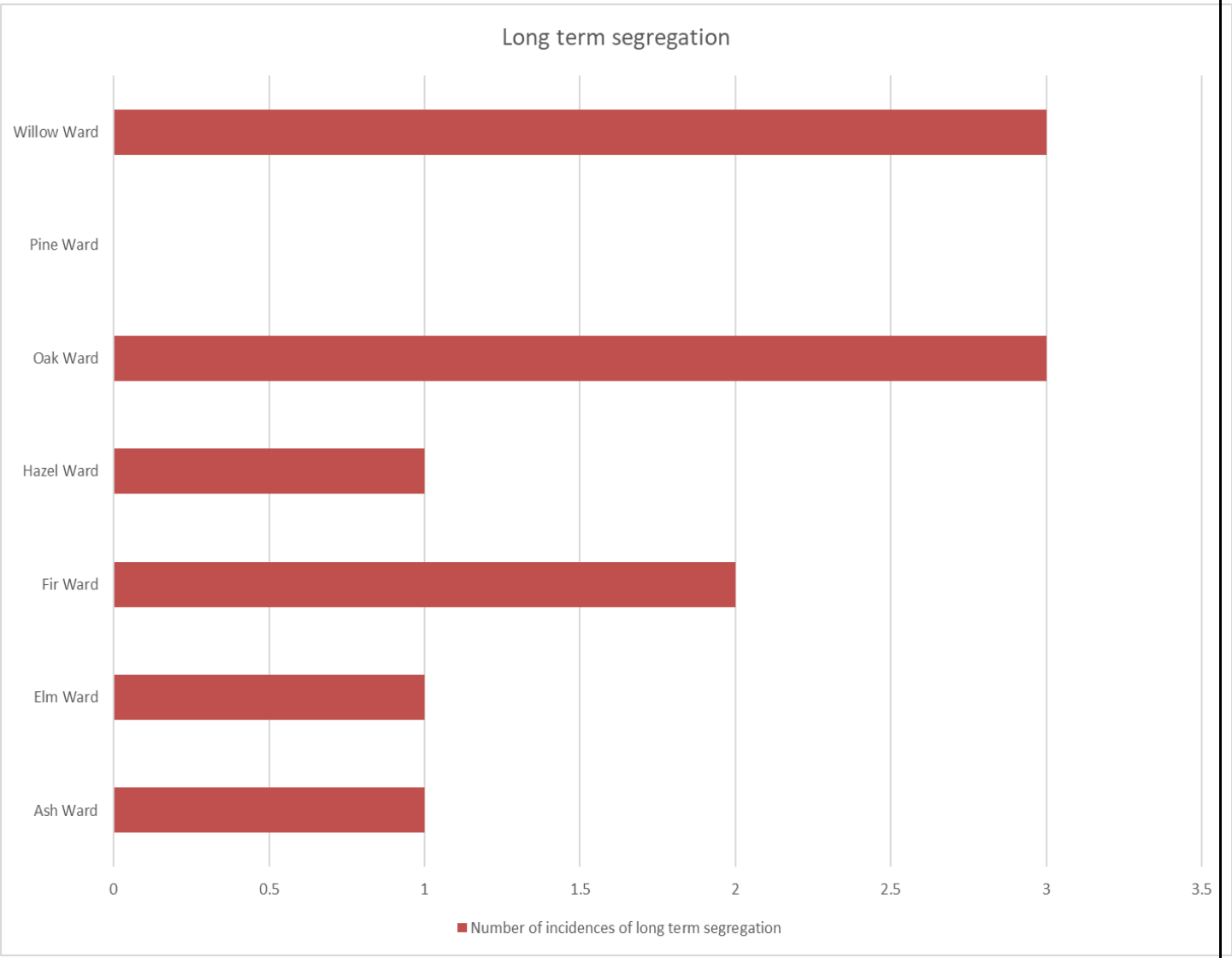


There were 71 instances of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from two to 43. The number of incidences (71) is higher than the previous 12-month period (48).



There were 11 patients placed in long-term segregation over the 12-month reporting period. The number of individual patients placed in long-term segregation (11) is slightly lower than the previous 12-month period (12).

The total number of times patients were placed into long-term segregation is given in the table below:



The service had a restrictive intervention monitoring programme in place that met monthly to review restrictive practices with the aim of reducing their use. This was led by a nurse consultant with learning and changes of practice introduced across all wards. Whilst on inspection we saw a reduction in the use of restrictive interventions for all wards over the last six months.

Additionally, there was a specific reducing restrictive interventions quality improvement project in place on Willow ward.

There was a culture amongst the wards of using the least restrictive option when dealing with challenging behaviour. De-escalation was always the preferred choice and staff maintained positive engaging relationships with patients which led to a calm and therapeutic environment, reducing the chance of requiring restrictive interventions. Staff additionally made use of de-escalation rooms and offering of oral medicine when required.

We saw evidence that staff understood and worked within The Mental Capacity Act definition of restraint. Additionally, staff followed national institute for health and care excellence guidance when using and monitoring patients following rapid tranquilisation.

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 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.

This core service made three safeguarding referrals between 31 May 2017 to 31 May 2018, of which three concerned adults and no children.

Number of referrals			
Core service	**Adults**	**Children**	**Total referrals**
MH - Secure wards/Forensic inpatient	3	0	3

- The number of adult safeguarding referrals ranged from zero to three (as shown below).

No serious case reviews related to this service, were commenced or published during the past 12 months.

Staff demonstrated a sound knowledge of safeguarding and how to raise a safeguarding alert. There was a clear safeguarding process in place to aid staff, with safeguarding leads for each ward available for advice. Staff were aware that they could raise a safeguarding concern directly with the local authority.

Safeguarding concerns were logged and tracked regularly by the social worker for each ward which fed into monthly governance meetings.

Staff could give examples of how to protect patients from discrimination, including those with protected characteristics. There was an appropriate equality policy in place for staff to adhere to

and we saw evidence of the service constantly learning and updating this to align with modern issues and practices.

There were family rooms and safeguarding procedures in place for when children visited patients. The rooms were off the ward environment and prevented children from having to enter the wards.

Staff access to essential information

The service utilised an electronic care records system. All staff, including regular bank staff, had secure log ins in which to access the system. Ad hoc agency staff did not have a secure log in to the system, however would type their notes onto a handover form which a substantive member of staff could then input into the electronic care records system.

Patient information on the system was accessible across the trust to streamline information sharing between services, wards and teams.

Medicines management

The service demonstrated good practice in medicine management including storage, dispensing, administration and reconciliation. A pharmacist visited the wards once a week and a pharmacy technician visited twice a week. The pharmacist was a non-medical prescriber. Regular medicine audits were undertaken by the pharmacy team and actioned by the service.

Patients could request one-to-ones with the pharmacist/ pharmacy team to discuss their medicines.

The Hellingly Centre had one nurse prescriber in post and one staff member undertaking current training to become a nurse prescriber.

We reviewed 65 medicine charts and found that patient medicine was regularly reviewed and the effect on patient's physical health was mostly monitored. The service utilised a range of recognised tools such as the national early warning score and the Glasgow antipsychotic side effect scale.

However, we found three patients prescribed high dose antipsychotic medicine in which their physical health was not appropriately monitored. High dose antipsychotic medicine were medicines prescribed in excess of the upper limits within the British National Formulary. Trust policy stated that patients on high dose antipsychotic medicine should have their physical health monitored at least every three months using the appropriate monitoring form. We found two patients had not had a review for over a year, despite this being flagged by the pharmacist on the front cover of their medicines chart and another patient had not been monitored after the initial three months. The service immediately rectified these and completed a thorough review when highlighted on inspection.

Track record on safety

Between 1 April 2018 to 1 October 2018 there were nine serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'unauthorised absence meeting serious incident criteria' with nine. There were no unexpected deaths reported by this service.

We reviewed the serious incidents reported by the trust to the strategic executive information

system (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with seven reported.

A ‘never event’ is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

Type of incident reported	Unauthorised absence meeting SI criteria	Total
Ash Ward	2	2
Fir Ward	6	6
Willow Ward	1	1
Total	**9**	**9**

Reporting incidents and learning from when things go wrong

Feedback we received from NHS England specialised commissioning was that at the Hellingly Centre they had identified delays in the incident occurrence and the time taken to report, and occasions where this had not been reported wider than at local level. This meant that relevant escalation had not taken place to enable timely investigation and learning to prevent recurrence.

The service implemented an electronic incident reporting system, Ulysses, that all staff had access to and could use to report an incident. All incidents raised were sent through to ward managers to review, confirm severity grading and level of review required. Once complete, the matron for each site offered further review and closure.

We reviewed previous incidents on the ward and found sufficient investigation and learning taken from each incident. Where a further investigation report was required based on the severity of incident, this was well documented and attached to the incident on the system

Ward managers had access to an electronic dashboard that analysed submitted incident report forms to demonstrate the types of incidents, days of incidents and times of incidents to support their forward planning and review of incidents on the wards.

Staff were aware of the types of incidents requiring reporting and previous incidents demonstrated that a range of incidents were correctly reported. This included security incidents, violent incidents and medicine errors.

Staff understood their duty of candour responsibilities. Where things went wrong, the service was open, honest and transparent to patients and family members and attempted to reconcile where possible.

Weekly team meetings were used to ensure any updates, change of practice or learning from incidents was disseminated to all ward staff following previous incidents and staff were informed of service wide learning via monthly newsletters.

During weekly monthly reflective practice sessions staff could bring any concerns regarding reporting incidents or the process to the meeting and discussions would be had to understand the next steps to take and to extract any previous learning.

There was evidence of changes of practice following incidents and learning from them. For example, there were incidents whereby issues were noted with a secure patient transport company that were being used. The service had since changed transport provider and updated their policy to further ensure the safety of staff and patients in transit.

Staff were debriefed following serious incidents both formally and informally as soon as possible after an event.

Is the service effective?

Assessment of needs and planning of care

We reviewed 35 care records and found all patients to have a detailed and comprehensive initial assessment that was completed either before or during admission.

A full range of assessments were undertaken by the service including mental health and physical health examinations. Admissions were mostly pre-planned for and the assessment process started before the patient was admitted to the ward.

The service utilised a physical health screening tool called the national early warning score (NEWS). The tool is nationally recognised to support the detection and response to clinical deterioration in physical health of patients. The service regularly audited their NEWS charts to ensure consistency of care and recording. We saw clear actions taken when items were flagged within the audits.

All patients reviewed had up to date care plans in place. Care plans were holistic in nature, personalised and recovery orientated. Care plans were developed to meet the needs of the patients as identified on assessment and utilised separate care plans dependent upon the patient needs. For example, we saw separate physical health care plans for diabetes and heart conditions.

Care plans included a ‘my safety and risks’ care plan in which patients gave their views and goals with clear action plans and ways in which the service or support networks could facilitate help.

Best practice in treatment and care

The service provided a range of care and treatment interventions suitable for the patient group. Activities were either psychology led, occupational therapy led, or nurse led and could take place on the ward or in the community. Treatment interventions were delivered in line with national institute for health and care excellence guidance.

Each ward had a dedicated psychologist and interventions were delivered either individually or group based. Interventions included anger management, cognitive behavioural therapy, unusual beliefs (formally ‘hearing voices’) and recovery groups.

Additional one-to-one or group therapy sessions were facilitated when the risk was identified. For example, with the provision of fire setting groups, sex offending groups or addictions groups when the patient mix needed it.

The Chichester centre had a ‘pets as therapy’ dog who visited the wards weekly. Patients could look after the dog and take the pet for walks to help normalise socialisation and reduce stigma outside of the ward. Patient feedback was extremely positive regarding this and gave some patients a sense of purpose and pride. The Chichester centre also had a drama therapist who

visited each ward to deliver sessions. The theatrical skills group had previously written plays and performed at local theatres.

Therapeutic sessions and activities were offered to patients across the service over the whole week, including weekends and some evenings.

Patients were offered a 'menu of care' which included the main treatments they would routinely be offered whilst at the service. These treatments were categorised under headings for greater clarity and understanding for patients. Groups of treatments included personal involvement, friends and family, risk reduction and safety planning, social and occupational interventions and improving physical health and wellbeing.

The Chichester Centre had a GP who worked one day a week to continue physical health screening and monitoring for patients and to refer elsewhere when necessary. The trust was in the process of appointing a GP practice to register patients with to ensure the patients received a consistent standard of primary care services. The Hellingly Centre employed a registered general nurse who led on physical healthcare. We saw appropriate referrals from the service for a range of patient physical health needs including podiatry, dental care and diabetes specialists.

There was a service level agreement in principle between a local GP and The Hellingly Centre to provide GP services, however this had not been fully agreed or implemented at the time of our inspection.

At the Chichester Centre, the visiting GP held informal teaching sessions to all ward-based staff regarding physical health and physical health monitoring.

Some staff members within the service were additionally trained in phlebotomy to assist with blood taking and physical health monitoring.

Staff made appropriate referrals to the trust's speech and language team and dieticians when specialist nutrition and hydration needs were identified.

Staff supported patients to lead healthier lives. Each hospital site was smoke free, and the wards offered smoking cessation advice, support and nicotine replacement therapy or disposable electronic cigarettes on admission. There was regular health screening offered to patients and a referral system for substance misuse issues.

On Pine ward they ran a healthy eating group that was relatively well attended by patients and explored healthy eating habits. We saw plans to roll this out to the other wards at The Chichester Centre.

Patients from the service attended local 'aqua fit' and badminton sessions at the leisure centre, utilising local facilities and classes.

The Chichester Centre held a 'physical health week' recently whereby a programme of activities focussing on sports, fitness, health and nutrition was put on including talks on Stoptober, dance sessions, laughing yoga, ground walks and sports games. They also introduced fresh vegetables and steamers to improve food provisions which was very well received. We saw plans to implement steamers and more fresh vegetables into the kitchen to offer greater quality of food for patients in the future. This initiative was not service wide, however learning from the event was shared across all teams.

Staff used recognised rating scales such as health of the nation outcome scores (HoNOS) to assess and monitor patient's progress in the service.

Skilled staff to deliver care

Teams were well staffed by a variety of experienced and qualified mental health workers including consultant psychiatrists, speciality doctors, junior doctors, nurses, psychologists, occupational therapists, social workers, health care assistants, peer support workers and students or trainees. All staff members reported that they felt well integrated and utilised within the teams. Multidisciplinary team meetings were well attended by a range of health professionals.

Each hospital site had a nurse consultant in post that was on-site for part of the week.

All staff were appropriately inducted to the service including bank and agency staff. The service had introduced a 'new to forensics' induction which was run for new starters and included some mandatory training modules. This ensured all staff were up to speed with the service and could feel confident on working on the wards.

The trust's target rate for appraisal compliance was 95%. At the end of the year (1 October 2017 to 30 September 2018), the overall appraisal rate for all staff within this service was 77%. Four of the wards scored below 75%.

The rate of appraisal compliance for all staff reported during this inspection was higher than the 42% reported at the last inspection.

Ward name	**Total number of all permanent staff requiring an appraisal**	**Total number of permanent all staff who have had an appraisal**	**% appraisals (as at 30 September 2018)**	**% appraisals (previous year 1 January 2017 to 31 July 2017)**
Pine Ward	20	20	100%	90%
Willow Ward	29	27	93%	26%
Ash Ward	26	24	92%	60%
Hazel Ward	19	13	68%	48%
Oak Ward	30	19	63%	36%
Elm Ward	26	16	62%	26%
Fir Ward	26	16	62%	10%
Core service total	**176**	**135**	**77%**	**42%**
Trust wide	**2541**	**1605**	**63%**	**48%**

However, on inspection the rates of completed appraisals were 100% for all wards. We were told that the data pulled centrally (above) was lower due to staff not uploading their appraisal records on their online portal at the time of the requests, however ward managers held local records indicating higher rates.

Between 1 October 2017 and 30 September 2018, the average rate across all seven teams in this service was 75%.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Ash Ward	302	273	90%
Oak Ward	324	275	85%
Elm Ward	277	215	78%
Pine Ward	252	191	76%
Willow Ward	276	178	64%
Fir Ward	270	174	64%
Hazel Ward	251	157	63%
Core service total	**1952**	**1463**	**75%**
Trust Total	**28506**	**11280**	**40%**

Local supervision records held by ward managers indicated much higher rates of supervision completion rates. Not all staff were uploading records onto their online portal when they had completed supervision and was the reason for lowered central data percentages.

Individual clinical supervision was offered to staff every 4-6 weeks. Supervision was recorded on a standard trust template and uploaded onto an electronic portal by staff. Topics for discussion regarded personal support, professional development and space to discuss, reflect and learn from practice.

Each ward had a supervision tree in place which also acted as a development opportunity for staff supervisors. The service held monthly reflective practice sessions for staff to act as further group clinical supervision. Managers had oversight of supervision and kept a log of up to date records either via the electronic portal or local records.

We saw evidence that newer and junior staff members held supervision on a more regular basis than trust policy to support them to settle onto the wards and progress professionally.

Development opportunities and training was encouraged for staff and discussed during supervision. Staff were encouraged to take on lead, champion or quality improvement roles and we saw a clear funding process for staff to apply for external courses. The Chichester Centre had two staff members funded for an open university nursing degree, who also worked shifts at the centre.

Leadership training was available to staff and ward managers had nominated members of their nursing team to complete the ‘emerging leaders’ trust wide programme.

Peer support workers had recently been introduced into the service and we saw relevant inductions, training and support offered to them by ward teams and managers.

Ward managers dealt with poor performance effectively and fairly. Support plans and increased supervision was put in place for staff requiring it and ward managers said the human resources team were very supportive during the process.

Multidisciplinary and interagency team work

The wards held weekly multidisciplinary meetings. We saw that these were well attended by an array of healthcare professionals. All team members reported feeling fully integrated in their teams.

Appropriate discussions and plans were made at multidisciplinary team meetings and patients and/or family members were also invited to attend, with the appropriate consent.

Each ward held effective handovers between shifts. Patient risk and status, physical health issues and management of current patient levels of observation alongside recent events and behaviours of the previous shift were discussed.

There was a project on Fir ward aimed at streamlining the handover process through the introduction of patient zoning that was adapted from adult acute inpatients unit tools. Zoning would include risk rating each patient using a traffic light system to enable staff to focus on handing over detailed information on patients who were highest risk. There was a methodology in place for the project and if successful was looking to be rolled out across the service.

We witnessed a new admission handover whilst on inspection that was concise and effective, ensuring all important patient information was obtained by the accepting ward.

The service held face-to-face service wide monthly leadership meetings to discuss ongoing risk, good practice and developments across all wards to ensure there was a shared understanding of the whole service across teams.

Teams had good working relationships with external teams including the forensic community mental health teams and local authorities. Dedicated ward social workers, some of whom were seconded by their local authority into the service, further enhanced this working relationship.

The service recently introduced an ‘Assertive Transitions Team’ to work with patients, ward staff and external agencies to improve transitions and discharges. The team comprised of a variety of healthcare professionals as well as support staff for housing, benefits and employment opportunities. The team aimed to provide support to staff and patients from six months pre-discharge and six months post discharge and improve transitioning of patients through the forensic service line. The trust was successful in their bid for this service and became one of only three trusts chosen nationwide to implement this team as part of the new care models set out by NHS England.

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

As of 30 September 2018, 81% of the workforce had received training in the Mental Health Act (MHA). The trust stated that this training was mandatory for all services for inpatient and all community staff and renewed every two years. The training compliance reported during this inspection was lower than the 91% reported at the last inspection.

Most staff demonstrated a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

All wards had access to MHA administrators who monitored requirements and compliance with the Act and Code of Practice. Monthly audits and reports were pulled by the Mental Health Act office and sent to ward managers to action. The reports included section dates that were due to lapse and due dates for section 132 rights to be read with supporting documents and advice to guide managers.

All patients were subject to the Mental Health Act. All paperwork relating to the MHA was appropriately completed and available in the correct places. The MHA office kept original paperwork and uploaded copies onto patients care records electronically. The trust had relevant policies and procedures in place to ensure practice reflected the most recent guidance.

Consent to treatment documentation was in place for patients on all medicine records we reviewed. We found that both T2 and T3 certificates were reviewed in line with hospital policy. These certificates demonstrated that patients detained under the MHA had the proper consent to treatment in place.

Patients had easy access to information about independent mental health advocacy. Each ward displayed posters on the wards in addition to information being verbally given and written in ward welcome packs. An independent advocate visited the wards once a week.

Patients were explained their rights on admission in a way that they could best understand. Staff repeated the reading of their rights regularly in line with trust policy. We saw evidence within care records when rights were last read and when they were next due, and this was also displayed on the ward office board. The office board also contained information on the patients' current MHA status.

Section 17 leave was supported when this had been agreed and records contained clear information on conditions of leave and level of escort. Risk assessments were also reviewed by staff before commencement of leave. Patients went on leave to enable them to interact and integrate with the local communities at clubs, cafes, gym and shops. Staff followed trust policy and procedures regarding patient searches on return from leave.

Good practice in applying the Mental Capacity Act

As of 30 September 2018, 87% of the workforce had received training in the Mental Capacity Act Level 1. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every two years. The training compliance reported during this inspection was the same as the 87% reported at the last inspection.

The trust told us that no deprivation of liberty safeguard (DoLS) applications were made to the local authority for this core service between 1 October 2017 and 30 September 2018.

Staff demonstrated a sufficient understanding of the MCA and it's five statutory principles.

Staff could access appropriate MCA policies and guidance via the electronic shared drive and request support from the MHA office if required.

We saw evidence of discussions and consideration of capacity in multidisciplinary case reviews and care records. There was a considered and appropriate approach to patient's capacity and the service demonstrated good practice with regards to patients who wished to make advance decisions and in particular around 'do not attempt cardiopulmonary resuscitation'.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

For the most recent patient-led assessments of the care environment (PLACE) (2018), the location scored higher than similar trusts.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Hellingly Centre	MH - Secure wards/Forensic inpatient	89.0%
Trust overall		**89.1%**
England average (mental health and learning disabilities)		**88.9%**

We observed many positive and respectful interactions between staff and patients. Staff spoke with patients in a kind and caring manner, demonstrating respect and compassion and were always available to support patients with their needs. There was a genuine attempt by staff to be visible on the ward and engage in meaningful interactions with patients. During reviews and meetings, staff spoke of patients in a dignified manner.

Staff supported patients to understand and manage their care and treatment. Staff held one-to-ones with patients, supplied patients with information leaflets and responded to queries promptly.

Staff supported and encouraged patients to access other services to enhance their treatment, recovery and vocations.

Patients reported that staff treated them with respect and took a genuine interest in their care and wishes. Staff fostered an inclusive environment and built positive relationships with patients which led to calm and therapeutic wards.

Staff knew their patient groups well and understood their needs. This included patients personal, cultural, social and religious needs and wishes.

Staff ensured patient information was kept strictly confidential at all times.

Involvement in care

Involvement of patients

Patients were orientated to the ward environment by a staff member who showed them the ward facilities and their bedroom and discussed the running and timings on the wards. Patients also received a welcome pack for each ward detailing vital information about the ward, their care and treatment.

Patients were heavily involved in their care planning and risk assessment. Care plans were holistic and considered a range of aspects in a patient's life. Patients reported being involved with devising their care plan and most had received a copy of their care plan. Where patients had refused a copy, this was clearly indicated in the care records.

Patients were invited and encouraged to give their views and wishes during review meetings and care programme approach (CPA) meetings. 'risk clinics' were held two weeks prior to CPA meetings which enabled a space for patients to better understand the discussions taking place in upcoming CPA meetings and to prepare any questions they may wish to bring.

Patients were given appropriate platforms on which to voice their concerns and views. Community meetings were held on a ward level every morning to discuss issues with staff, give compliments, feedback and have a choice of the structured activities offered on the wards. We saw staff encouraging patient involvement with an array of activities based upon patient needs.

Patient representatives from each ward held weekly 'working together group' hospital wide community meetings which fed patient representatives into monthly service leadership meetings.

We saw many examples of change being enacted as a result of patient representation across the service.

All wards had 'you said, we did' posters on the wards detailing the changes made as a result of patient and carer feedback.

Staff enabled patients to make advanced decisions and followed appropriate guidance and legislation when doing so.

Involvement of families and carers

Family members and carers were updated and involved in patients care when consent had been given by the patient. Family members and carers were invited to attend ward rounds or phone into the meetings where this was not possible.

There was an active weekly carers forum for the service and the ward supported with carers assessments. The Chichester Centre held regular family, friends and carers support groups which offered a relaxed and informal opportunity to meet with staff and other carers.

The Hellingly Centre recently held a 'collaborative safety planning' session, led by the consultant, in which carers and family members were invited to the centre to discuss risk assessment, risk planning and care planning and encourage the carer and family members to be part of their patient's recovery journey.

The service encouraged family members and carers to give feedback on the service and completed an annual family and friends test questionnaire.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for seven wards in this service between 1 October 2017 and 30 September 2018.

Six of the wards within this service reported average bed occupancies ranging above the minimum recommended national benchmark of 85% over this period.

Ward name	Average bed occupancy (1 October 2017 - 30 September 2018) (current inspection)
Ash Ward	99.8%
Elm Ward	99.5%
Fir Ward	97.1%
Hazel Ward	93.8%
Oak Ward	98.3%
Pine Ward	99.0%
Willow Ward	70.6%

The trust provided information for average length of stay for the period 1 October 2017 to 30 September 2018.

Ward name	Average length of stay (1 October 2017 - 30 September 2018) (current inspection)
Ash Ward	641
Elm Ward	220
Fir Ward	521
Hazel Ward	478
Oak Ward	229
Pine Ward	473
Willow Ward	594

This service reported no out of area placements between 1 October 2017 and 30 September 2018.

Ward managers and staff worked to make sure they did not discharge patients before they were ready.

This service reported one readmission within 28 days between 1 October 2017 and 30 September 2018. One of readmissions (100%) were readmissions to the same ward as discharge. The average number of days between discharge and readmission was five days. There were no instances whereby patients were readmitted on the same day as being discharged and no patients admitted the day after being discharged.

Ward name	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
Oak Ward	1	1	100%	5 - 5	5

Patient beds were always available to return to after periods of leave due to the majority of admissions being pre-planned for which supported bed management.

The service had a clear referrals process in place that was agreed with neighbouring trusts in response to the new care model's implementation. The service had two routes of referrals for screening via urgent or routine referral processes.

The service recently introduced the 'DUNDRUM' toolkit, a process of measures that aid the triaging of potential patients, as well as the assessment of treatment completion and readiness for discharge. There was a roll out of training on the toolkit for staff and it aimed to improve efficiency of the patient pathway at all points of the journey.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. Staff members from the admitting ward would meet with the patient prior to moving wards and there was a thorough handover between ward teams.

Patient discharges were planned for with target dates. When patients were discharged, this was during the day when their care could be passed on appropriately and medicines were ready to be collected.

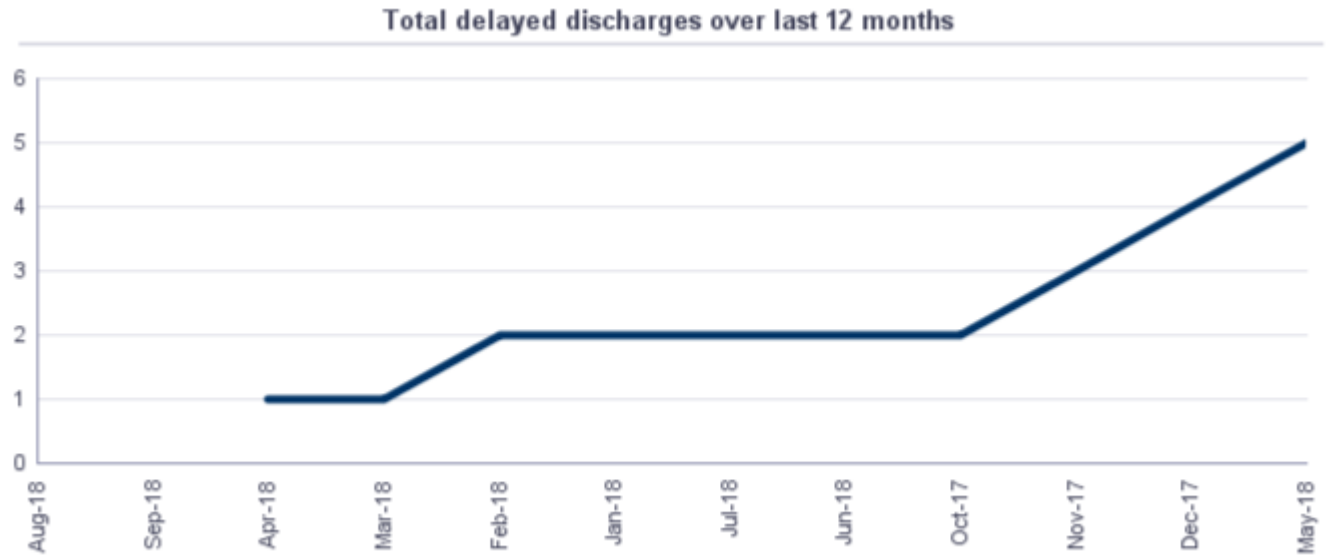
The service held weekly referral and discharge meetings involving ward managers, senior staff, community health teams and external agencies to share knowledge and aid bed management and planning.

The occupational therapy team undertook activities of daily living assessments and programmes of support to ensure patients were better prepared for reintegrating into community life.

Discharge and transfers of care

Between 1 October 2017 and 30 September 2018 there were 71 discharges within this service. This amounts to 2% of the total discharges from the trust overall (3675). Of these, 15 were delayed discharges (21%).

The graph below shows that delayed discharges across the 12-month period ranged from one to five.



The service planned for patient discharge with good liaison between the ward teams, community teams and the Assertive Transitions Team. This ensured all healthcare professionals were suitably informed on the discharge decision and the correct support for the patient could be put into place.

Delayed discharges were mostly due to next step placements, funding and accommodation issues. However, with the recent introduction of the Assertive Transitions Team, the service was anticipating a vast reduction in delayed discharges.

Facilities that promote comfort, dignity and privacy

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for ward food at the location scored lower than similar trusts.

Site name	Core service(s) provided	Ward food
Hellingly Centre	MH - Secure wards/Forensic inpatient	77.6%

Site name	Core service(s) provided	Ward food
Chichester Centre	MH - Secure wards/Forensic inpatient	77.6%
Trust overall		**92.7%**
England average (mental health and learning disabilities)		**93.0%**

Following the inspection, the trust informed us that shortly following the PLACE process in 2018 a catering manager had been employed and had been reviewing food standards and menu choice along with the working together group and multi-disciplinary team with new menus due to be trialled.

All patients had their own bedrooms. Apart from Hazel ward, all bedrooms were ensuite with toilet facilities and there was a mixture amongst the wards with some rooms containing additional showers and some without. For the rooms without, there was an appropriate number of communal showers and bathing facilities available on the wards.

All patients were individually risk assessed to receive their bedroom key or key fob. Those who were not given a key to their room could request for their bedroom door to be left open or closed by staff.

Patients were encouraged to personalise their bedrooms, given the average length of stay on the wards.

The Chichester Centre and The Hellingly Centre recently had art work commissioned and chosen by patients. The Hellingly Centre were awarded their art work as part of one of six units across the country working in collaboration with ‘hospital rooms’

All bedrooms had a secure coded safe that patents could secure their belongings in. For contraband items, all wards had security rooms with lockers that were clearly labelled. Additionally, patients had their own money lockers within the security cupboard. This was to store money, bank cards and wallets and could only be accessed by patients with their unique keycode. All storage and possessions had appropriate signing in and out procedures in place. However, on Fir ward there was a potential security breach with access to the security office and therefore patients’ items were being stored elsewhere.

Each ward had access to a range of rooms and equipment appropriate to support the care and treatment of the patient group. This included activity rooms, therapy rooms, clinical rooms, de-escalation rooms, family rooms and gymnasiums. The Hellingly Centre additionally had a pottery room that was frequently used for activities.

All patients could make phone calls in private. All patients were offered a basic phone in which to have on the wards and signed an agreement for their use. The Chichester Centre wards had dedicated pay phone rooms for patients to make calls if they didn’t have their own mobile or want a basic ward one.

All wards had access to computers, the internet and gaming consoles for patient use. Each one was risk assessed individually and supervised when appropriate. Additionally, some wards contained pool tables for use and ran regular pool tournaments on the wards.

All wards had access to a secure garden for patients use. Patients could always request access to the garden. At the Hellingly Centre, there was an allotment which was used and maintained by patients with the support of staff. Additionally, there was a log cabin which was used by patients for furniture restoration projects under the supervision of staff. Proceeds from the sale of furniture went back into the projects for supplies.

The Chichester Centre recently secured funding for four bicycles and safety equipment for patients to use both on site and in the community, as well as the local authority delivering a 'bike ability' programme for patients.

Patients could make hot and cold drinks 24/7 and could keep their own snacks in their rooms. Biscuits were available on the wards on requesting from staff members.

Patients' engagement with the wider community

Patients had access to a wide range of education, work and volunteering opportunities in the service. Staff supported patients to access vocational courses at local colleges, partake in sessions at the recovery college in addition to volunteering opportunities with the local theatre, radio station, Chichester canal conservation group and local dog kennels. Friends of The Chichester Centre also funded an animal petting zoo to visit the centre and there was a visiting PAT dog that patients were able to walk when granted leave.

Additionally, The Hellingly Centre had a patient run corner shop and café on site that could be assessed by all visitors, staff and patients to the site. Patients gained qualifications in food hygiene and were given the appropriate support and supervision by staff.

The local theatre in Chichester visited the wards to co-facilitate groups with the occupational therapists as well as volunteering opportunities at the theatre and weekly script writing workshops.

The Chichester Centre employed one full time education and vocation staff member to support patients accessing appropriate work and volunteering opportunities in the community based upon their interests.

Staff supported patients to maintain relationships with people that mattered to them, both in the services and in the wider community. We saw evidence that the service allowed close patients to attend a previous patient's funeral and supported an appropriate and consensual relationship amongst patients on one ward that was sufficiently monitored and safeguarded against.

Meeting the needs of all people who use the service

For the most recent patient-led assessments of the care environment (PLACE) (2018), the location scored lower than similar trusts for both aspects overall.

Site name	Core service(s) provided	Dementia friendly	Disability
Hellingly Centre	MH - Secure wards/Forensic inpatient	N/A	71.3%

Site name	Core service(s) provided	Dementia friendly	Disability
Chichester Centre	MH - Secure wards/Forensic inpatient	N/A	71.3%
Trust overall		**91.3%**	**86.4%**
England average (Mental health and learning disabilities)		**84.7%**	**87.8%**

Following the inspection, the trust informed us that they had shared their concerns with these results with the assessors, as Hellingly Centre was a new building and one which considered the needs of people with disabilities.

We found there was appropriate disabled access for patients across the service. We saw adapted disabled rooms that were placed closer to the nursing office in case of the need for more intensive support

Each ward displayed information pertaining to patients' rights, treatments, local services, activities and timings and complaints procedures. Patients also received a detailed welcome pack with further information.

The service had medicine leaflets available for patients to better understand their medicine.

Information leaflets could be ordered in a different language if required.

Managers had access to interpreters and interpreting services when required to help patients communicate and better understand and be involved in their care. Staff made use of translating software for day to day communication with patients who could not speak English and we saw consideration of funding for English courses for patients to support their growth and recovery on the wards.

Patients had a choice of food at all sittings and the service met any dietary requirements or choices.

Each hospital site had a spirituality room available for patients. There were also religious texts available to patients on the wards. Each site had a chaplain visit the wards who could connect patients to all faith communities.

Listening to and learning from concerns and complaints

This service received 35 complaints between 1 October 2017 and 30 September 2018. Three of these were upheld, six were partially upheld, 23 were not upheld and zero were referred to the Ombudsman.

Managers investigated complaints and identified themes.

Team name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Other	Under Investigation	Withdrawn	Referred to Ombudsman
Ash Ward	2	1	0	1	0	0	0	0
Elm Ward	11	0	2	8	0	0	1	0

Fir Ward	6	0	2	4	0	0	0	0
Hazel Ward	5	0	1	2	0	1	1	0
Oak Ward	3	0	0	2	0	0	1	0
Pine Ward	2	2	0	0	0	0	0	0
SFS Management Team	1	0	0	1	0	0	0	0
Willow Ward	5	0	1	4	0	0	0	0

This service received eight compliments during the last 12 months from 1 October 2017 to 30 September 2018, which accounted for 1% of all compliments received by the trust.

Patients reported knowing how to raise a complaint both formally and informally.

Most complaints were dealt with immediately and locally on the wards to offer an immediate resolution to patients. Each morning meeting gave an opportunity for patients to raise concerns in a safe environment.

Staff knew how to handle complaints appropriately and escalate when necessary. Managers investigated formal complaints and identified any themes.

Is the service well-led?

Leadership

Leaders within the service had a variety of experience, skills and knowledge required to ensure an efficient running of the service.

Leaders could clearly explain their roles and demonstrated a high understanding of the services they managed. They clearly explained how the teams worked to provide high quality care. There was a monthly leadership meeting between all ward managers and senior leaders to keep up to date about proceedings and discuss quality improvement projects for shared learning.

Staff told us leaders were visible within the service and approachable for any issues or queries. Staff said they were happy to approach the matrons and senior leaders for support and advice.

There were leadership opportunities available to staff at all levels. Ward managers nominated staff for the trusts ‘emerging leaders’ programme in addition to creating local lead and champion roles on the wards.

The trust had an overall recruitment and retention programme and workforce strategy which heavily focussed on development of staff by offering an array of development and leadership opportunities in addition to evidence-based interventions and self-referral systems for talking therapies.

Vision and strategy

Staff knew and understood the trusts visions and values, and these were embedded into local ward level objectives.

Staff were aware of the leadership teams locally and trust wide. Staff reported that local leadership teams were highly visible and always approachable. When discussing trust wide senior leadership, all staff were aware of who they were, stated that they had previously visited the wards and would be happy to approach them.

Staff were aware of the budget constraints placed upon the service and worked hard within their means. We saw creative redeployment of resources to create new and relevant posts required by each ward. There was a current 'wards living within your means project' in force against the service in which each ward had to report their spend for scrutiny to the monthly forensic board.

Culture

Staff reported feeling respected and supported in their roles and integrated fully within the team. Staff said they felt comfortable raising issues without fear of retribution and that their role was valued within the team.

All staff we spoke with felt a sense of pride working for the trust and within their local teams. Staff felt happy in their teams and whilst the job could be stressful at times, the teams all worked together to get through difficult periods.

Staff were aware of the whistle blowing process and policy and felt confident to raise concerns about the service.

Staff appraisals included conversation regarding career development and set our clear actions and opportunities for development. Managers supported staff to achieve development goals and progress professionally.

Staff reported that equality was promoted throughout the service and that there were well established support networks available.

The service participated in trust wide award events such as the positive practice awards held annually. Many staff were nominated and one staff member at The Hellingly Centre won the 'Shining Star (Clinical)' award at the most recent event. The service also received nominations for the National Service User Awards.

Governance

The service had efficient systems in place to ensure that managers had access to information pertinent to their roles, their wards and their staff. The service had oversight of supervision and appraisals, beds were managed well, and incidents, safeguarding's and complaints were appropriately logged, investigated and learned from.

Ward managers had the authority to adjust staffing levels dependant on the acuity of the ward. There were support systems in place to enable managers to do this.

The matrons for each site held weekly meetings with ward managers to discuss various performance indicators that fed into larger service wide weekly leadership meetings.

Staff had access to their own electronic portal to view their Human Resources details, supervision records and mandatory training records. The system allowed for staff to book onto future training courses and see their overall compliance rates for mandatory training.

There were clear frameworks and policies in place to ensure essential information and learning was shared and discussed in teams and at varying levels of the service.

There was an appropriate clinical governance structure in place to ensure information and risk was escalated and managed in a timely manner.

Lead staff were assigned to undertake a variety of local audits to ensure efficiency within their teams. We saw issues being flagged and actioned upon.

Ward staff understood local procedures and policies in place to enhance relationship building and working between internal trust and external staff to better meet the needs of their patients.

Management of risk, issues and performance

Staff had access to the overall risk register for the service and could filter results down to ward level. Ward managers could add items to the risk register and monitor current items.

The service had contingency plans for emergencies such as adverse weather, IT issues or sickness to ensure continuity of service. Whilst on inspection we saw these in practice due to the threat of adverse weather conditions.

Cost improvements were in place across the wards and whilst staff commented on the pressures of this, we did not see any direct impact direct patient care.

Information management

The service had systems in place that could collect data for the quality assurance team automatically, so not burdening frontline staff with analytical data collection tasks.

Staff had access to sufficient equipment and information technology to do their work. The secure record keeping system was easily available to staff to update patient care records and review during ward rounds and other team meetings.

Ward managers had access to information to support their management role with an online dashboard in which they could run reports from. This included information on staffing, incidents, complaints and staff records.

Systems and processes were in place to ensure notifications to external bodies could be made appropriately and in a timely manner.

Engagement

Staff, patients and carers were kept up to date regarding the service and trust wide initiatives via leaflets, emails and social media. Each hospital site also produced quarterly newsletters.

Both hospital sites had very active social media accounts and The Hellingly Centre had an additional online blog with contributions from both staff and patients. The blogs showcased their arts and media work and gave first hand anonymous insight into the recovery journey of patients.

Staff told us this was positively viewed upon by patients and helped them in their recovery to write about their journeys.

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 teams within this service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Core service	Service accredited	Comments
CCQI Forensic Services	MH - Secure wards/Forensic inpatient	Chichester Centre; Pine, Fir and Hazel Wards - 15/02/18. Hellingly Centre; Oak, Willow, Ash and Elm 20/03/18	
RCP Enabling Environments Award	MH - Secure wards/Forensic inpatient	Elm Ward - 26-02-2017	
RSQM Forensic Service	MH - Secure wards/Forensic inpatient	Forensic Services are a member of the Sussex Restorative Justice Partnership (SRJP) which hold accreditation for restorative justice services delivered in Sussex	

Staff were supported to take on additional responsibilities and lead or champion roles to enact change upon the wards.

Staff had opportunities to take part in or initiate quality improvement projects within the service. The trust had a drive on quality improvement training and projects and had a central team dedicated to supporting staff realise and deliver their ideas, based on recognised quality improvement methodologies.

There were innovations and quality improvement projects in place across the service. On Fir ward, the team were developing a zoning approach to patient status to enhance and streamline the handover process. The team were adopting this from acute mental health wards and trialling it within their ward.