Derbyshire Healthcare NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Community Health Services for children, young people and families		RXM04
Specialist community mental health services for children and young people		RXM04
Mental health crisis services and health-based places of safety		RM02/RXM03
Community mental health services for adults of working age		
Community mental health services for people with learning disabilities.		RXM
Community based mental health services for older people		RYM02 RXM04
Wards for older people with mental health problems		RXM
Forensic wards		RXM04
Acute wards for adults of working age		RXM
Long stay/rehabilitation mental health wards for working age adults.		RXM

Summary of findings

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We have rated Derbyshire Healthcare NHS Foundation Trust as requires improvement overall because:

- The trust lacked robust leadership. This had resulted in variation in the quality and safety of services provided. The CQC had undertaken a joint inspection of the trust with Deloitte in January 2016. This criticised the quality of leadership. Although some improvements had been made since that joint inspection, the pace of change and ability of the senior leadership to grasp the seriousness of the deficits has not been quick enough. As a group, the executive team lacked the full depth and breadth of skills required to enable the improvements needed in culture, governance and HR throughout the trust.
- Trust assurance and reporting systems had failed to recognise serious safeguarding issues that had occurred on the wards for older people with mental health problems since 2011. Although senior staff were aware of the issues, no decisive action had been taken to effectively safeguard and protect patients from potential abuse.
- Some front-line staff lacked confidence in the leadership team and felt detached from the central management functions. Although the trust leadership team has started work to improve engagement with staff, there is still much to be done in this area.
- The quality of clinical services varied. We have rated the forensic wards and wards for older people with mental health problems as inadequate. This was mainly due to the safety of the environments, concerns about safeguarding and a lack of staff understanding on how to interpret and apply the Mental Health Act and the Mental Capacity Act. In a number of core services, staff were not recording risk assessments, best interest decisions or care plans well.

However:

- We found the staff to be consistently caring and they treated patients with kindness, dignity and respect. The feedback received from both patients and carers regarding the quality of care was positive and demonstrated a staff group who have the patients' best interests continually in mind.

Following our inspection, CQC has issued the trust with a Section 29a warning notice.

NHS Improvement launched an investigation into Derbyshire Healthcare NHS Foundation Trust in 2015, in respect of governance concerns identified from the judgement of an Employment Tribunal, and concerns raised by other third parties. In February 2016, based on evidence from independent reviews commissioned by the Trust, a focussed inspection by the Care Quality Commission and an independent review of governance arrangements, NHS Improvement formally found the Trust to be in breach of its licence. The Trust has agreed a number of enforcement undertakings with NHS Improvement which it is required to implement, and has developed an action plan to secure delivery of the enforcement actions and return to compliance with its licence.

The CQC and NHS Improvement meet with the trust leadership on a monthly basis; we will be continuing this approach to agree an action plan to assist them in improving the standards of care and treatment.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated Derbyshire Healthcare NHS Foundation trust as requires improvement for safe because:

- Teams were not consistently learning from incidents. This was due to either low levels of reporting incidents in some areas or because of a lack of dissemination of potential learning among some teams.
- Across most services, staff did not always follow national institute of clinical excellence guidelines when prescribing rapid tranquilization medication. Monitoring of patients' physical health post-rapid tranquilization was not being consistently recorded.
- Safeguarding referrals to local authority safeguarding teams were not always being made which compromised the safety of people using the services
- Completion rates for mandatory training were low within some core services
- Staffing levels in the health based place of safety were not always sufficient to provide effective cover. In the acute wards, there was not always the correct grade or skill mix of staff on shifts.
- The trust had not taken robust action to reduce risks to patients following environmental risk assessments.
- Lone working procedures were not being consistently followed by staff in the teams based in the community

However:

- Ward environments and community team bases were generally clean and well maintained
- Staff in the community mental health teams assessed patients who were awaiting treatment so as to monitor for signs of any deterioration or emerging risks
- Staff were able to respond appropriately to patients who were in crisis
- Caseload sizes for community care co-ordinators were generally manageable

Are services effective?

Requires improvement

We rated Derbyshire Healthcare NHS Foundation Trust as requires improvement for effective because:

Summary of findings

- Staff did not consistently follow best practice with regards to the recording and implementation of the Mental Health Act and the Code of Practice. In most teams, we found that staff understanding of their role in applying the Mental Health Act was poor.
- The recording and application of the Mental Capacity Act was poor in most of the services that we inspected.This meant that documentation related to consent and best interest decisions made on patients behalf was not completed or lacked robust detail.
- Although most trust services completed care planning following admission, inspection teams observed the quality to be variable. In several of the services that were inspected, we found that care plans often lacked detail and were neither personalised, recovery focussed or holistic.
- Staff participation in clinical audit was limited

However:

- There was a range of community engagement initiatives across the trust to improve patient care and outcomes. For example, there were good links with GP and primary care services, end of life care and community facilities such as Chesterfield football club to improve activity for patients with long term mental or physical health conditions.
- Staff within the local acute NHS trusts were complimentary regarding the partnership working that had been developed for mental health patients who also came into contact with staff in accident & emergency and clinical decisions units

Are services caring?

Good

We rated Derbyshire Healthcare NHS Foundation Trust as Good for caring because:

- We consistently observed staff treating patients' with kindness, respect, compassion and empathy.
- Most patients we spoke to were positive in their views of staff
- Patients across core services felt staff listened to and made time for them.We heard individual stories from patients and carers on how lives had been changed and improved following contact with staff and the trust.
- Carers we spoke to were positive in their views of staff and stated that they were fully involved in the care of their family member and felt well supported.

Summary of findings

- Patients felt that staff maintained their confidentiality. We consistently saw that staff stored information securely and maintained confidentiality when working across the trust and with external stakeholders.

  However:
- Not all patients were offered or given a copy of their care plan
- Within the forensic wards, care records did not demonstrate patients being actively involved in care planning and they did not have advance decisions in place

Are services responsive to people's needs?

Requires improvement

We rated Derbyshire Healthcare NHS Foundation trust as requires improvement for responsive because:

- Waiting lists for psychological therapies were long within some of the core services that we inspected.This meant that patients did not always receive treatment in a timely manner
- The acute wards had dormitory style bays that did not promote the privacy and dignity of patients.
- There were high levels of patients who required access to a psychiatric intensive care unit bed being placed out of area
- Planning of discharge was poorly recorded within the wards for older people with mental health problems

However:

- The crisis resolution teams negotiated visiting times with patients that met their needs.
- The CAMHS teams saw new referrals within six weeks of referral and urgent referrals were seen within 24 hours of the referral being received.
- The occupational therapists within the rehabilitation services provided a range of community based activities that were innovative and engaging

Are services well-led?

Inadequate

We rated Derbyshire Healthcare Foundation NHS trust as inadequate for well led because:

- The inspection team found the skill-set among the trusts senior leaders to lack robustness. We identified a limited ability of directors in key areas to be able to proactively identify gaps in governance, HR and in the quality and safety of services.
- At our last inspection of the trust in January 2016, the informality and lack of procedure regarding HR processes was identified as a requirement notice. We saw, that although some

Summary of findings

improvements had been made in this area, the pace of change and failure to grasp the seriousness of a lack of HR processes was not enough to ensure that a structured and effective process was in place.

- The trust was not meeting compliance with regards to equality and diversity obligations. The board assurance framework and risk register did not include any equality related risks. Directors and staff responsible for equality and diversity were not aware of any equality risks relating to their non-compliance.
- The trust had introduced a 'neighbourhood model' with the aim of integrating care pathways for people who used services within geographical areas of Derbyshire. Staff told us of a lack of ongoing guidance in the practicalities of implementing the model effectively.
- However:
- We some good examples of local leadership where team managers had effectively implemented a strong team ethic and morale amongst their staff
- The trust was a key partner in engagement with external organisations and they were heavily involved in transformation within the local health economy in implementing the NHS England 5 year forward view

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Vanessa Ford, Director of Nursing and Quality, South West London and St George's Mental Health NHS Trust

Team Leader: James Mullins Head of Hospital Inspections, Care Quality Commission

Inspection Manager : Surrinder Kaur , Inspection manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists:

- CQC managers, inspectors, assistant inspectors, inspection planners
- Mental Health Act Reviewers
- Specialist professional advisors e.g. consultant psychiatrists, mental health social workers, nurses, occupational therapists, non-executive director, nursing director, information governance manager, equality and diversity manager and a human resources director
- Experts by experience that have personal experience of using or caring for someone in the services we were inspecting.

The team would like to thank all those we spoke with during the inspection. People were open and balanced in sharing their experience and perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about Derbyshire Healthcare NHS Foundation Trust and asked other organisations to share what they knew. These included clinical commissioning groups, NHS England, NHS Improvement, and Healthwatch, voluntary groups such as Alzheimer's Society, carers' representatives, and local authority safeguarding representatives.

During the visit we:

- Held 16 focus groups with a range of staff who worked within the service, such as nurses, doctors, psychologists, allied health professionals, black and minority ethnic staff, non-executives, governors, and advocacy
- Spoke with executive directors and non-executive members of the board
- Spoke with 33 managers in clinical areas
- Spoke with 240 staff in clinical areas
- Talked 110 with people who use services.
- Talked with 140 carers and/or family members
- Reviewed 143 care or treatment records of people who use services.
- Reviewed 96 medication charts
- We observed how people were being cared for
- Observed seven handover meetings
- Observed 14 multidisciplinary meetings
- Observed two referral meetings and three assessment meetings
- Observed five therapy groups
- Received 65 comment cards.

Summary of findings

After the announced site visit, we carried out an unannounced visit of the community mental health teams for adults of working age.

Information about the provider

Derbyshire Healthcare NHS Foundation Trust was formed in 2010 and became a Foundation Trust in February 2011. The trust employs 2,383 staff serving a population of around one million and they have 311 beds. The trust annual operating income is £132million.

The trust provides community services to children and families, mental health services to people, including those with learning disabilities, and people with substance misuse needs. The trust has a public membership of 6,256 people and has 20 governors.

The trust operates from 66 sites and has eight emerging neighbourhood teams.

Trust activity during 2015/2016 was:

- 1,630 inpatient admissions
- 39,504 adults treated at any one time
- 4,586 follow ups for patients in learning disability services
- 70,571 children treated at any one time
- 3,755 babies cared for in Derby City
- 74,897 referrals received
- 520,843 attended contacts

The trust delivers the following mental health services across Derby city and the county of Derbyshire:

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

And the following Community Health Services:

- Community health services for children, young people & families

Derbyshire Healthcare NHS Foundation Trust has four registered locations:

- Hartington Unit,
- London Road Community Hospital,
- Radbourne Unit
- Kingsway site trust HQ.

The trust registered with the CQC in 2010 to provide the following regulated activities:

- The treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act.
- Diagnostic and screening procedures

The nominated individual responsible for the services is Ifti Majid, interim Chief Executive Officer.

The CQC inspected Derbyshire Healthcare NHS Foundation Trust under the new methodology of inspection in an announced visit in January 2016 due to concerns that were raised by a whistle blower.

The following were actions that the trust was informed they must or should make:

- The trust must ensure HR policies and procedures are followed and monitored for all staff
- The trust must ensure that a fit and proper person review is undertaken for all directors in light of the findings of the employment tribunal
- The trust should ensure that all board members and the council of governors undertake a robust development plan.
- The chairman should ensure that a unitary board culture is achieved by focusing on positive working relationships between board members and the council of governors.
- The trust should ensure that the outcome of this focussed inspection impacts directly upon the organisational strategy.

Summary of findings

- The trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded.
- The trust should ensure that training passports for directors reflect development required for their corporate roles.
- The trust should introduce and effectively monitor 360 degree feedback all senior managers and directors.
- The trust should ensure that recruitment processes for all staff are transparent, open & adhere to relevant trust policies
- The trust should continue to proactively recruit staff to fill operational vacancies.
- The trust should continue to make improvements in staff engagement and communication.

There have been 11 unannounced Mental Health Act reviewer visits between 1 April 2015 and 18 April 2016. Action plans were put in place following these visits.

What people who use the provider's services say

- Patients stated they were provided with information about the service on admission. Patients said they felt safe on the wards
- In all services inspected, patients told us they were treated with respect and dignity. Staff were polite, kind and willing to help. All patients and carers considered the staff to be compassionate towards them. Patients gave examples of occupational therapists and psychologists who had helped them in their recovery and staff who had helped them practically and emotionally.
- Patients said discussion with staff could take place during the day, evening and weekends, patients told us that could air their views.
- Patients in community teams said that the services were responsive to their needs and received information about how to contact the teams and what to do in a crisis.
- Although no patients and carers we spoke with wanted to complain, they had not received written information on how to do so.
- Carers and relatives gave positive feedback about the staff and the services Families felt the support was there for families as well as patients and described in particular the support at Audrey House as 'brilliant'. Children and young people and their carers praised staff for their support.
- There were 65 comment card responses in total. 50 comments (77%) were positive in nature, 6 (9%) were negative in nature and 9 (14%) were mixed in nature.
- Ten out of 12 sites with responses had comments praising the staff for being friendly, caring and welcoming.
- Patients we spoke with described the clinical areas as clean and tidy. From the comment cards received, four sites had comments that the sites were clean and safe. There were however five comments that were critical of the environment. Three of these were in adult mental health services and two were in older people's community mental health services.
- There were reports across children's services, adult services and older people's services that the trust provided activities to keep patients occupied. However, there was a report in forensic services that there was a 10-week wait for a patient to have a gym induction. There were two comments (in CAMHS and adult community mental health) that were positive about trust communication. There was one comment (in adult community services) that suggested that communication where staff were away could be improved.

Good practice

Children, young people & families

Summary of findings

- The Children and Young People's Neurodevelopmental Team improving services for neurodevelopmental issues including ADHD and ASD.
- Single Point of Access multi-agency meetings prioritising the children with the most complex needs.
- The Cygnet programme in the children and young people and families service.
- In the children and young people and families service The ADHD parents programme and follow up after the programme

Specialist community mental health services for children & adolescents

- The level of participation of young people and parents throughout the whole of child and mental health service (CAMHS) was significant and included fundraising, recruitment of staff, development of self-referral forms, contribution to pathway model of care and development of social media presence and website.This level of participation contributed to the service being able to be responsive and effective in how they met the needs of children and young people with mental health difficulties.
- The development of the Rapid Intervention Support and Empowerment (RISE) team increased accessibility to CAMHS and ensured children and young people who were experiencing mental health distress and needed to be seen urgently were not waiting for long periods of time.
- In 2011, Derbyshire CAMHS was successful in its bid to join the first phase of CYP-IAPT which was the National Children and Young People's Improving Access to Psychological Therapies four year Department of Health initiative.The aim of CYP-IAPT was to transform services in response to the CAMHS Review and National Advisory Council.They said CAMHS needed to become more accessible, have clear evidence based pathways and work in partnership with children, young people and their families to develop services and to start using a more robust system to collate outcome performance data that is clinically meaningful.

Long stay rehabilitation mental health wards

- Wards and the rehabilitation occupational therapy service demonstrated a strong commitment to quality improvement through the development of community partnerships. These included those with Chesterfield football clubs "Spireites Active for Life" courses, the local neighbourhood networks such as Kilmarsh, Bolsover and Cross Hands and Cycle Derby. A new initiative called "Growth", which involved using a piece of disused land by a social enterprise involving the whole community. These projects allowed patients to develop support networks within their local communities.
- Within the CAMH service partnership work between a volunteer recovery champion patient and the rehabilitation occupational therapy service to develop a community based Recovery College was an equal partnership, which the patient described as a combination of experts by profession and experts by experience. This delivered courses based around education, health, and wellbeing.
- A staff member at Audrey House had developed the "Angling 4 You" group for their patients. Following its success, the staff member sought additional funding so patients at Cherry Tree Close and those in the community could also access it.
- At Audrey House, all staff including the cooks, domestic staff, and the manager were involved in supporting patients, which made this a holistic and engaging place for patients.

Mental health crisis & Health-based places of safety

- The Crisis resolution home treatment (CRHT) teams encouraged staff to act as champions for specific areas of practice based on their special interests. For example, staff acted as champions for medicines management, dual diagnosis (learning disability and mental health), The CRHTs aimed to develop champions for a range of issues such as transgender, domestic violence, and drugs and alcohol. The teams benefited from this local expertise, which enhanced practice. The team's specialists also extended to charitable practices, for example, staff had started a food bank.

Community mental health teams for older people

- All community older people's teams participated in monthly meetings within their respective GP surgeries, to discuss referrals and any problems or concerns they

may have. These meetings were multidisciplinary and included other professionals such as district nurses, which meant consideration of patients holistic needs occurred. Feedback from GPs and staff was that communication had improved and professional relationships had developed which had improved patient experience and care.

- At the Erewash community older peoples team, staff participated in a dementia question and answer meeting, which was widely publicised, inviting the general public, patients and carers to attend and learn about living with dementia.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

Forensic inpatient/secure wards

- The trust must ensure that patients are fully involved in care planning.
- The trust must ensure that patients are offered the opportunity to record their preferences in an advance directive.
- The trust must ensure that patients have their medicines dispensed in a location which upholds their privacy, dignity and confidentiality Forensics
- The trust must ensure that patients' capacity to consent to care and treatment is formally assessed and recorded.
- The trust must ensure that second opinion approved doctors (SOADs) are requested in a timely manner.
- The trust must ensure that patients are consistently provided with HCR20V3 risk assessments and that these are reviewed and updated to reflect changes in risks.
- The trust must ensure that staff compliance with key training is significantly improved.
- The trust must ensure that facilities used for the purpose of seclusion are of sufficient size to safely accommodate a resistive patient and a minimum of three staff when implementing seclusion.
- The trust must ensure that mitigating actions identified in relation to environmental and ligature risks are undertaken as soon as possible.
- The trust must ensure that medicines are stored at the correct, safe temperature.
- The trust must ensure that robust systems and processes are in place to support safeguarding patients. Safeguarding referrals must be made when appropriate.
- The trust must ensure that seclusion facilities are cleaned and bedding changed between uses.
- The trust must ensure that a clock is visible from the seclusion room to allow patients to independently orient themselves to time.
- The trust must ensure that information relating to the complaints procedure, PALS and the Care Quality Commission is displayed on the wards.
- The trust must ensure that all patients are provided with a physical health assessment on admission to the service.
- The trust must ensure that patients' detention papers are appropriately filed and complete.
- The trust must ensure that patients are provided with community meetings.
- The trust must ensure that there is a way of informing ward staff if temporary staff booked to work are not competent and up-to-date with 'control and restraint' training.
- The trust must ensure that gender ratios of staff are appropriate to meet the needs of patients in a timely manner.

Long Stay rehabilitation mental health wards

- The trust must ensure staff have adequate training in the Mental Capacity Act and understand how to use this.

Community mental health teams for people with a learning disability

- The trust must ensure that all patients have care plans in place that contain patients' views, strengths and goals. The care plans must have agreed dates of review.
- The trust must ensure that staff demonstrate and apply good practice in Mental Capacity Act.

Summary of findings

Mental health crisis services & health-based places of safety

- The trust must ensure that the health-based place of safety at the Hartington Unit in Royal Chesterfield Hospital is anti-ligature and adequately mitigate the risks present.
- The trust must ensure that health-based places of safety are used for their intended purposes only.
- The trust must ensure emergency equipment is available in health-based places of safety.
- The trust must ensure staff complete medicines reconciliation and record the allergy status for their patients.
- The trust must ensure that staff receive regular supervision and the appropriate training for their roles.

Acute wards & psychiatric intensive care units

- The trust must consistently maintain medication at correct temperatures in all areas.
- The trust must ensure all emergency equipment is within its expiry date and accurately checked.
- The trust must ensure that the prescribing, administration and monitoring of vital signs of patients are completed as detailed in the NICE guidelines [NG10] on-Violence and aggression: short-term management in mental health, health and community settings.
- The trust must ensure that clinical staff have a consistent approach to the use of rapid tranquillisation, understand its risks and record its usage.
- The trust must ensure that all equipment is well maintained and checked in accordance to manufacturers guidelines.
- The trust must ensure that staffing levels and grade on shift meet the agreed standard.
- The trust must ensure that mandatory training is completed for all staff to achieve the trust target of 80%
- The trust must ensure that staff receive regular managerial and clinical supervision, as well as yearly appraisal.
- The trust must ensure all staff understand the application of the Mental Capacity Act in practice. Documentation should contain evidence of recording of any decisions made about a patient's capacity.
- The trust must ensure that all long term segregation and seclusion is undertaken in line with trust policy and documented accordingly.
- The trust must ensure that environmental risk assessments are updated and reviewed.
- The trust should ensure that patients are prescribed medications in accordance with the Mental Health Act, Mental Capacity Act and revised Code of Practice.

Wards for older people with mental health problems

- The trustmust ensure that learning from incidents & safeguarding alerts is captured in a way that allows for managers to identify themes and trends in order to keep people who use the service safe
- Managers must ensure that potential themes or hot spots that relate to patient safety are captured on the trust risk register in order for the executive team to be fully aware
- The trust must ensure that Mental Capacity Act documentation and assessments are fully completed and filed correctly in patients' records. The trust should also ensure that staff apply the Mental Capacity Act correctly and that they fully understand how it relates to the patient group that they are caring for
- The trust must ensure that documentation relating to section 17 leave is completed, up to date and filed correctly
- The trust must ensure that detained patients are reminded of their rights under Section 132 of the Mental Health Act on a regular basis
- The trust must ensure that the discharge process is properly documented and that it demonstrates that planning begins at the point of admission.

Community mental health team for adults of working age

- The trust must ensure that locations where patients are seen and treated have access to emergency equipment.
- The trust must ensure that there are processes in place to safely track and record the blood test results of patients receiving treatment with lithium.

Summary of findings

- The trust must ensure that there are processes in place to ensure that patients treated under the Mental Health Act are given their rights in accordance with the Code of Practice.
- The trust must ensure that there are processes in place to ensure a consistent approach to care planning.
- The trust must ensure that patients are able to access psychological therapies in a timely manner.
- The trust must ensure that there are systems in place to ensure that equipment to monitor physical health is regularly cleaned and checked.
- The trust must ensure that all portable electrical equipment and fire extinguishers are regularly checked and recorded for safety

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

Children, young people & families

- The trust should ensure that the transcription of medicines is in accordance with trust policy.
- The trust should ensure that enteral feeds are administered in accordance with best practice medicines management procedures.
- The trust should ensure that infection prevention and control policies are adhered to with regard to robust system to establish equipment and toys have been cleaned.
- The trust should ensure all staff perform best practice handwashing techniques.
- The trust should continue the recruitment drive to employ staff to further reduce waiting times for community paediatric appointments.
- The trust should ensure staff are aware of the trust's risk register, strategy, and vision for the future.
- The trust should ensure all senior staff are visible in all of the areas of the service.

Forensic inpatient/secure wards

- The trust should ensure that items not required in the secure garden are removed, and that all items within the secure garden are subject to security checks.
- The trust should ensure that training provided to staff is factually accurate.
- The trust should ensure that audit processes readily identify any deficits in patients' care records.
- The trust should ensure that all policies are accurate.
- The trust should ensure that all furnishings for use by patients are clean and in good condition. The trust should ensure that there are scheduled activities available for patients in the evenings and at weekends.

Specialist community mental health teams for children & adolescents

- The trust should ensure supervision is recorded.
- The trust should create a cleaning schedule for the toys.
- The trust should ensure it is clear in the electronic notes whether/when/if young people have received a copy of their care plan and that all care plans are written in the first person.
- The trust should ensure wider learning from incidents and complaints is shared.
- The trust should ensure weighing scales are calibrated and moved to a more private area.

Long stay Rehabilitation mental health wards

- The trust should review the five week rotation of multidisciplinary meetings at Cherry Tree Close to ensure this is meeting the needs of patients.
- The trust should consider developing a community rehabilitation team to support patients once they have moved from the wards.
- The trust should ensure all staff receives regular clinical supervision as set out in the trusts targets.
- The trust should review the activities for daily living kitchen at Audrey House consider improving the meeting space at Cherry Tree Close.
- The trust should review the occupational therapy team lead post to ensure that they can continue to provide a wide range of services.

Community mental health teams for people with a learning disability

- The trust should ensure that staff participate in a wide range of clinical audits and use the findings to identify and address changes needed to improve outcomes for patients.
- The trust should ensure that cleaning records are in place at Rivermead and the Resource centre.

Summary of findings

- The trust should ensure that staff consistently record next review dates on all risk assessments.
- The trust should ensure that advanced decisions are recorded where appropriate. The trust should ensure that staff consistently record the room temperature for the room where the medicines are stored at Council house.

Mental health crisis services & health-based places of safety

- The trust should ensure the privacy and dignity of patients using the health-based place of safety at the Hartington Unit in Royal Chesterfield Hospital.
- PAT testing
- The trust should ensure there is a robust and safe system for lone working for staff in the High Peak and Dales CRHT team.
- The trust should ensure sufficient and effective staffing arrangements for the health-based places of safety. The provider should ensure that staff record that s136 patient patients have received their rights under s132 of the Mental Health Act.

Acute wards & Psychiatric intensive care units

- The trust should review how care records are integrated
- The trust should bench mark the need for Psychiatric intensive care units.
- The trust should review dormitory wards impact upon patients' privacy and dignity.
- The trust should ensure that all staff have the opportunity to discuss and reflect on lessons learnt, feedback, complaints and compliments.

Community mental health teams for older people

- The trust should ensure all patients provide consent to treatment and decision making regarding capacity if properly recorded within the care record.
- The trust should ensure that all Mental Health Act documentation is present within the care record and that patients have their section 132 rights read to them regularly.
- The trust should ensure that all incidents are recorded within their Datix system.
- The trust should ensure all patients receive written information and guidance on how to make a complaint.
- The trust should ensure all patients are offered copy of their care plan, and this is appropriately documented within the care record.
- The trust should participate in clinical audits, to ensure they measure the quality of the service they offer and identify areas for improvement.
- The trust should ensure that implementation of the neighbourhood model is consistent across the county, to reduce potential differences within practice and services offered.

Wards for older people with mental health problems

- The trust must ensure patient involvement in their care consistent and well documented in care plans.
- information on how to access independent advocacy should be publicised across OPMH
- Structured psychological therapies should be available to all patients and detailed in care records.
- The trust should ensure that room & fridge temperatures are consistently checked to ensure that medicines are stored in correct conditions.
- The trust should ensure that regular audits are carried out to minimise the risk of gaps on medicines charts not being picked up
- The trust should ensure that information is available to people who do not speak English as a first language
- The trust should ensure that information on how to complain is clearly displayed

Community mental health teams for adults of working age

- The trust should ensure that levels of staff training meet the local target set.
- The trust should ensure that levels of staff appraisal meet the local target set.
- The trust should ensure that all clinical staff are involved in clinical audits for their area of work.
- The trust should ensure that there are systems in place to ensure that clinical areas clean and well organised.

Summary of findings

- The trust should ensure that patients advanced decisions are routinely collected and recorded.
- The trust should ensure that electronic equipment in waiting areas is maintained in working order.
- The trust should ensure that staff and patients routinely use hand-sanitising stations when visiting locations.
- The trust should ensure that clinical storage facilities are only used for that purpose.
- The trust should ensure that all staff are familiar with and comply with the lone working policy.
- The trust should ensure that all areas promote the comfort, privacy and confidentiality of patients and staff using their services.
- The staff should ensure that all patients know how to complain and access advocacy services.
- The trust should ensure that teams receive ongoing guidance and support in the implementation of the service transformation with regards to the neighbourhood model.
- The trust should ensure that the outcomes of investigation and incidents at all levels of the organisation are communicated to all staff.

Derbyshire Healthcare NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

The trust's systems supported the appropriate implementation of the Mental Health Act 1983 (MHA) and its Code of Practice. The Mental Health Act department managed the trust's responsibilities in relation to the MHA and related legislation and case law

During the inspection, we found limited evidence of a consistent programme of audits during the year which covered the use of the MHA in community settings and the use of the MHA in in-patient settings. Although audits were evident in some services, there was no evidence that they had taken place in others.

MHA training was provided as a mandatory course, the trust had achieved its target of 85% compliance with this training. However, this was not reflected in the knowledge of staff.

The Trust had reviewed all its policies and procedures to make them compatible with the Code of Practice. Although the seclusion and long-term segregation policy had been updated to reflect changes to the Mental Health Act Code of Practice (2015), it contained inaccuracies in that the word "ordinarily" had been added to a statement.

We found evidence that detention paperwork was not consistently completed, dated and stored correctly. We also found that in some teams, patients were not consistently having their rights under the Section 132 of the MHA explained to them.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Health Act department managed the trust's responsibilities in relation to the Mental Capacity Act 2005 (MCA) and related legislation and case-law.

We found an inconsistency with regards to audits regarding the Mental Capacity Act.

Mental Capacity Act training was provided as part of the trust's overall mandatory training schedule. Compliance with the training among staff was above the trust target of 85%. However, we found that staff knowledge of the MCA in some areas was poor. Within the wards for older people with mental health problems and the community mental health teams for people with learning disabilities, staff were not consistently recording or documenting mental capacity assessments or decisions made in the best interest of the patient. However, in the specialist community mental health teams for children and adolescents and within the children, young people & families services, staff had a clear understanding of Gillick competence and how this applied to young people.

The trust provided information about the Deprivation of Liberty Safeguards applications they have made between 1

Detailed findings

August 2015 and 31 January 2016. There were 54 mental health Deprivation of Liberty Safeguards applications made during the six month period. Thirty nine of the 54 were from the same location – Cubley Court, an older people's mental health ward. Records show that the CQC received four Deprivation of Liberty Safeguards applications from the trust between the same period (between 1 August 2015 and 31 January 2016).

Requires improvement

Are services safe?

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

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

Summary of findings

Our findings

Safe and clean care environments

- The physical environment around the trust was clean, well-maintained and kept people safe.
- The Trust scored 99% on its 2015 patient led assessment of the care environment (PLACE) test. The trust scored higher than the England average of 97.6% for all four sites.
- All wards had up-to-date environmental risk assessments in place. Control measures were in place to minimise the risk to patients included patient risk assessments, use of observations and increased staff supervision of the environment.
- The trust became a non-smoking environment in May 2016. There had been an increase in smoking related incidents reported by staff in the acute services. For example, patients had been smoking in bedroom and bathroom areas causing fire alarms to signal.
- An estate strategy dated 2014 -2019 was in place and reviewed by the board twice a year. The strategy assessed the estate to be in a fit and reasonable condition. Forty one per cent of the estate required major changes and these were identified for action. Seventy per cent of the buildings complied with all statutory requirements. Patients had an individual risk assessment and management plan in place in relation to ligature risks. Ligature risk audits and action plans were in place. However, not all risks were identified or actions implemented. Ligatures are fixtures and fittings that can be used for tying or binding as a means of hanging oneself. Acute and some of the older peoples wards had anti-ligature fixtures and fitting, however, long stay rehabilitation, forensic service and health based place of safety had some ligature risks that were not fully mitigated.
- The design of some ward environments did not consistently enable staff to observe the patient communal areas. However; we saw examples of mitigation of risk to enhance patient observation in key areas. Staff were aware of the risks to patients' safety caused by the layout. To reduce these risks, some acute wards had a fixed open nursing station placed in front of the main lounge and staff assessed patients' individual risks and increased observation in key areas as needed. Staff supervised patients in communal areas and carried out hourly general observations. Staff at Audrey House had a visible presence and were aware of the whereabouts of patients who were on site. Staff at Cherry Tree Close moved across the site visiting all bungalows regularly to check on patients.
- The inpatient wards complied with the Department of Health guidance on mixed gender accommodation. In acute wards, all male and female sleeping, bathing and toilet areas were separated. Female only lounges were available. Morton ward shared good examples of considerations made when a trans-gender patient was admitted.
- Across all services, teams had access to equipment necessary to carry out physical health examinations. We saw that systems were routinely in place to ensure that staff regularly cleaned or checked equipment. Systems were in place to check and monitor fridge temperatures.
- Not all clinic rooms were clean and well maintained; we saw untidy and unorganised areas that could pose a risk to infection control principles and patient safety. In Chesterfield, we saw evidence of food and drink being stored in a fridge intended for the storage of bloods, the team manager took immediate action to resolve this when we brought this to their attention. At Century house there was no evidence to show the weighing scales had been calibrated. Staff had access to emergency resuscitation equipment and emergency drugs. However, we found one oxygen cylinder on ward 33 past its expiry date of 09/05/2016.
- We observed good hand hygiene and infection control practice in the majority of services. Staff completed

infection control audits. Infection control leads were present in the teams. There were laminated hand hygiene posters displayed in clinic, patient and toilet areas. Hand gel dispensers were available and used by staff. Not all staff in children, young people and family services adhered to good handwashing practices. However, some demonstrated a good understanding of infection control prevention and adhered to safe standards.

- Across most services, staff had access to a range of alarms and systems to ensure their safety when seeing patients. However, staff did not have access to personal mobile alarms and clinic rooms did not contain alarms call systems at High Peak and Dales crisis teams.
- A lone worker policy was in place across the trust. There were a number of protocols to reduce risk, for example, staff checking in and out of offices when carrying out home visits. Staff were issued with mobile phones, which meant staff could have contact with their office base and colleagues during working hours. However, in some of the community teams, we found that staff were not always adhering to the lone working procedures.

Safe Staffing

- The trust reported safe staffing levels monthly to the clinical commissioning groups. The trust had a high vacancy, turnover and sickness rate and had a recruitment plan in place.
- The Total number of substantive staff as at 31/01/2016 was 2413. There had been 242 substantive staff leavers in the last 12 months. The trust had a vacancy rate of 16% and sickness rate of 5.5% which was above the NHS average of 4.4%.
- As at 31/03/2016 there were 856 whole time equivalent qualified nurses and 316 whole time equivalent nursing assistants. There were 134 whole time equivalent qualified nurse vacancy and 34 vacancies for nursing assistants. There were 6371 shifts filled by bank or agency staff to cover sickness, absence or vacancies between December 2015 and February 2016. There were 664 shifts not filled by either bank or agency staff for the same period.
- On the acute wards, there was an over-reliance on the use of bank and agency staff due to high vacancy rates and on occasion the wards operated short of staff or the ward manager would undertake the shift. All staff that we spoke to describe the wards being short of permanent staff and felt that it affected upon the continuity of care for patients, staff wellbeing, staff sickness levels and turnover. Ward managers block booked bank staff where they could and used staff familiar with the ward.
- The trust average for staff leavers across the core services was 10.03% with mental health wards for older people having the highest rate of 14.3%.
- There are 55 courses which the trust has classed as mandatory, with a target of 85% compliance; the overall compliance rate for mandatory training is 71.6%. Fourteen courses achieved the compliance rate of 85% or higher. They are as follows; Authorised Person Low Voltage, Commercial Gas Course (5 yearly), Deprivation of Liberty Standards (DoLS includes MHA), Domestic Unvented Hot Water Storage Systems (5 yearly), Food Hygiene Training, both Infection Control courses, Legionella Awareness, Mental Capacity Act, Mental Capacity Act 2007, Moving & Handling & Basic Back Awareness (E & F), Paediatric Prescribing, Safeguarding Children Level 2 and Section 12 Approval (5 Yearly).

Assessing and monitoring safety and risk

- On the older adult inpatient wards, risk management plans were basic in formulation and in their identification of strategies to reduce risk. In particular, there was an absence of mitigation against ligature risk. On the forensic wards, patients jointly completed their risk assessments with the multidisciplinary team and they were following incidents. We observed in the long stay service that staff discussed changes in a patient's level of risk in a ward handover. In children and young people services, we observed risk assessments for a variety of health conditions in medical records along with plans of care. Occupational therapists carried out activity of daily living assessments within the home and ward areas, and made sure patients had access to equipment to promote independence. In the children, young people and families services, records showed risk assessments for a variety of health conditions along with plans of care. All children seen by the health visiting teams were assessed using an evidence based assessment framework. Children or young people with a medical condition were included, with their parents, in a

multidisciplinary approach to teach them how to recognise the symptoms which would cause their child's condition to deteriorate. It was offered in a group setting or one to one depending on the family's needs.

- The trust used the Functional Analysis of Care Environment risk assessment tool to assess each patient's risks during initial assessment. All records had an up to date risk assessment and risk management plan and these were updated when patient needs changed or during a planned review. The crisis team used a range of assessments which identified the frequency of visits and interventions required. Records reviewed showed that the trust also used a series of universal screening tools to establish nutritional risk and the Waterloo scale for measuring the risk outliers such as of pressure sores, falls assessments.
- Patients' crisis plans were in place in the community older adults, child and adolescent mental health services; however, it was not always clear from the electronic records whether the young person had received a copy.
- Staff in older adult services monitored patients on the waiting list by ensuring that patients and carers were aware of how to contact the team. Staff discussed patients on the waiting list on a weekly basis and could prioritise patients whose risks had increased. The team informed the referrer, patient and carer of the interim plan and kept in close contact by letter and phone calls. Similarly, in child and adolescent mental health services Care and treatment records to show the service was able to respond promptly to any sudden deterioration in young people's mental health via the care co-ordinator who was responsible for managing and monitoring the risk while the young person waited for a specific intervention; for example family therapy.
- The trust had up to date policies on positive and safe management of violence and acute psychological distress.
- Wards were in the process of using and developing interventions from the Safe wards initiative. This international project aims to reduce rates of behaviours that threaten safety and reduce restrictive containment practices on wards (such as special observations, seclusion).
- All staff we spoke with were knowledgeable about de-escalation techniques to use to reduce challenging behaviours. Nursing staff only resorted to restraint when de-escalation failed. We saw staff dealing effectively with aggressive and violent incidents in the forensic and acute services.
- All acute wards had a de-escalation room. Staff told us they would encourage patients to spend time in these rooms if they were becoming agitated or needed a calming space. However, we were concerned that not all staff were aware of restrictive practices and the difference between de-escalation and de-facto seclusion. Most staff we spoke to said they would not stop a patient leaving these rooms if they remained agitated. However, one member of staff told us that sometimes if the room was used for a short period of seclusion, for example 10 – 15 minutes, it was not always recorded as seclusion.
- Between 1 August 2015 and 31 January 2016, there were 225 uses of restraint on 100 different services users during the six-month period. Nine of these were uses of restraint in the prone position (face down with the head turned to the side) on the acute wards. The highest use of restraint occurred on acute wards (202) for adults of working age and enhanced care ward. None of the instances resulted in rapid tranquilisation. The Department of Health guidance does not recommend prone restraint. However, when patients were secluded in the forensic service, staff held them in the prone position on the seclusion room bed until all staff exited the seclusion room. Furthermore, the position the last staff in the room had to adopt could compromise the patient's breathing. It is important to ensure that there is no interference with a patient's breathing when under restraint as people can die from positional asphyxia. Section 11.2.11 of the trust 'Positive and Safe in Our Trust' policy advised staff that there should be no planned or intentional restraint of a patient in the prone position on any surface not just the floor; therefore, the technique used by staff to seclude patients was in conflict with this policy. In addition, in section 11.2.10 of the same policy advised staff that a patient should not be restrained in a way that affects the patient's airway, breathing and circulation. Potentially the technique used by staff to exit the seclusion room following placing a patient in seclusion could potentially affect a patient's breathing.
- Between 1 August 2015 and 31 January 2016 there were 125 uses of seclusion. One hundred and fifteen of these occurred on acute wards for adults of working age and

enhanced care ward. The policy governing the use of seclusion contained inaccuracies. Section two of the policy presents a paragraph relating to the appropriate facilities to undertake seclusion as a direct quote from the Mental Health Act Code of Practice 2015. It is not a direct quote; it has been qualified by the addition of the word "ordinarily". This meant that staff could be secluding patients in various environments without being clear about legal expectations in terms of suitable, safe environments. Section 5.1 relates to the use of seclusion with an informal patient; the fifth paragraph is presented as containing a quote from the Mental Health Act Code of Practice, section 26.106, but it is not a quote. The paragraph has been altered and the meaning has been changed. Instead of advising staff that an informal patient should only be secluded as a last resort, the guidance advises staff "seclusion of an informal patient should be used in an emergency situation". The trust reported that there were four instances where staff used seclusion in the forensic service. However, we identified that the use of seclusion was being under-reported to the Mental Health Act (MHA) office. We spoke with the MHA lead for the trust and they told us it appeared that this had been happening since 2011. Staff had only notified them of 'exception reports' which were only reported if the episode of seclusion was of eight hours duration or more. We requested an updated data set on the use of seclusion following our inspection. The trust provided updated figures, which showed that in the period August 2015 to January 2016 there were four episodes of seclusion. Three of these involved patients on Curzon ward, and one involved a patient on Scarsdale ward. The updated figures included data relating to seclusion use from March 2016 to May 2016. There were nine episodes of seclusion in this period, all of which involved patients on Curzon ward.

- In the forensic service we could find no evidence that staff had physical monitored patients subject to restraint, seclusion or rapid tranquillisation medicine following any of these interventions. It is essential to monitor patients' physical observations, as there is a risk of positional asphyxia or adverse effects of rapid tranquillisation medicine. The trust had a recognised tool to guide staff in undertaking such physical observations. The tool was called the Derbyshire Early Warning Score and was referenced in the associated policies for restraint, seclusion and rapid tranquillisation.
- In the forensic service, staff had not always filed seclusion records appropriately in care records. In addition, the unit did not inform the Mental Health Act department of all episodes of seclusion used.
- Records showed during three weeks in February and March 2016, staff secluded an inpatient in the health based place of safety at the Radbourne Unit on four occasions. A health based place of safety should not be used for inpatient care. This was because the seclusion room was occupied or under repair. Records also showed one use of the health based place of safety suite at the Hartington Unit for in patient seclusion in March 2015. In January 2016, a manager had agreed for an inpatient transfer from the Radbourne unit to the seclusion suite at in the forensic service. This was because there was no seclusion room available at the Radbourne unit. Managers at the forensic refused to admit the patient into seclusion, as the unit is commissioned to take forensic patients. This lack of clear discussion between managers in a challenging crisis affected the safety, privacy and dignity of the patient and staff.
- During the period of 1 August 2015 and January 31 2016, there were 51 episodes of long-term segregation. The highest amount was on the enhanced care ward with 23. Whilst reviewing care records, we found an unreported episode of long-term segregation within a dormitory area of an acute ward. Staff had recorded the incident in the patients care records. The clinical reasons for the segregation were satisfactory. However, staff had not accurately reported it as an incident of segregation on the electronic incident reporting system. We informed the trust of this during inspection and the ward manager sought to address the issue.
- All acute wards had open entrance doors. Staff said they only locked when there was a serious incident or increased risk of a detained patient absconding. Patients confirmed the majority of the time doors were unlocked. This meant informal patients could leave at will. Staff told us they would have a discussion with patients prior to them leaving to check their wellbeing. However, we found one blanket restriction in place on the enhanced care ward whereby staff had locked the door to the outside area in order to prevent one patient going outside. This was not individually care planned.
- Patients were subject to a pat-down search upon return from unescorted leave in the forensic service. Staff obtained consent from patients prior to undertaking

searches. Patients were taken on to the ward to be searched. This meant there was a potential for risk items to be taken on to the ward. Patients' bedrooms were searched as per the random room search schedule, unless there was a reason to believe they may have risk items in their room. Staff sought consent from patients prior to undertaking room searches. If patients did not consent to personal searches or to room searches, staff were guided by the trust search policy. Searches on long stay wards occurred if there were concerns that patients were bringing illegal substances, weapons, or alcohol into the ward following a period of leave or if the patient was intoxicated.

- Staff used blanket restrictions only when justified on the basis of identified risk. In March 2016, the Positive and Safe steering group in the trust had audited the use of blanket restrictions in all services in the trust. Outcomes for example on the forensic service were that patients no longer had a fixed bed- time enforced upon them
- The trust did not report any safeguarding alerts to the local authority between 1 April 2015 and 31 March 2016. Five safeguarding concerns were received by CQC during the same period. Safeguarding alerts describe instances where the CQC are the first receiver of information about abuse or possible abuse, or where we may need to take immediate action to ensure that people are safe. Safeguarding concerns describe instances where the CQC are not the first receiver of information about abuse, and there is no immediate need for us to take regulatory action. For example, where the CQC are told about abuse, possible abuse or alleged abuse in a regulated setting; by a local safeguarding authority or the police. The trust had a 'Safeguarding vulnerable adults and children committee'. Safeguarding Children Procedures were in place. Safeguarding training fell below the trust's targets in some services. Staff understood the procedures to follow in reporting safeguarding concerns. The children and young people's service staff knew the safeguarding children's trust leads. However not all staff did in the forensic service. There was an electronic system in place to highlight vulnerable and at risk children and families. We observed accurate records detailing plans of how the child and their family were being supported. In the children and young people's service staff routinely talked to mothers about domestic violence, and we observed posters which provided information on where to get help. During a consultation we observed staff discussing domestic violence with a parent, the member of staff made an appropriate referral to support the woman and her children.
- Eighty three per-cent of staff completed safeguarding level two training, this did not meet the trust target of 95%. Safeguarding children level three training completion rate was 46%, so significantly short of the trust target of 95%. This meant that staff may not have the most current information to enable them to identify and report safeguarding concerns. Safeguarding supervision was not always performed in line with the trust's safeguarding policy. Staff told us this was often provided within their one to one sessions or at clinical supervisions, but was not given an allocated regular forum and not always documented. Some staff had not received formal safeguarding supervision with a member of the safeguarding team. Managers did not keep accurate records of how often staff received safeguarding supervision, this meant there was no assurances of staff receiving the recommended safeguarding supervision. The lack of any data for the crisis service Derby City and County South team indicated that staff made no referrals to the local authority. This meant that either the team did not have any concerns that needed referring to the local authority or if they did, they did not refer them. The managers acknowledged that the Derby City and County South team had a number of improvements to make, including reporting incidents generally.In the forensic services, staff compliance with safeguarding adults training was 85%. Information showed there had been two safeguarding referrals completed for patients at the Kedleston Unit in the six months prior to our inspection. Fifty-one per cent of community adult mental health staff had completed Level three safeguarding children training; this fell below the trust's target completion rate of 85 per cent
- The trust has supplied a Pharmacy Risk Register that detailed 16 risks. The pharmacy department was based at the Ashbourne Centre in Derby, with a pharmacy supply service provided at various levels for the south of Derbyshire Healthcare NHS Foundation Trust. Supplies of medicines to the Hartington Unit and North CMHTs were made by the pharmacy at a local hospital, under a service level agreement. Pharmacists and pharmacist technicians visited wards to check patients' prescription

charts and ensure medicines were available. They were involved in patients' medicine requirements from the point of admission through to discharge. This included undertaking a check of patients' medicines on admission to check what current medicines the patient was prescribed. Checks were also made to ensure that any known allergies or sensitivities to medicines were recorded accurately on inpatient patients' prescription charts. Clinical pharmacists were regularly involved in inpatient multidisciplinary team meetings to discuss patients' medicine requirements. All adult, older adult and learning disability community teams, special schools and child health facilities receive scheduled pharmacy technician visits for the purposes of stock check (ranging from every 3 months to annual). Crisis teams received daily visits from a pharmacy technician for stock management purposes and to resolve any medicines process related issues. However, pharmacy risk register on 31/03/2016, noted that there was no clinical pharmacy service within these teams. This was in the process of being changed as we inspected, with a limited service to crisis and specialist schools being introduced.

- Arrangements were in place to check that medicines were stored securely and within safe temperature ranges. We found that medicines were stored securely with access restricted to authorised staff. Temperature records of medicine refrigerators and clinic rooms were recorded daily with were also further checked by pharmacy to ensure this was done.However, the temperature in the rooms containing medication on some of the inpatient wards was consistently recorded as above 25 degrees. This issue been presented to the Trust board by the Chief pharmacist in July 2015.This information had further been discussed at Medicines Safety Committee in November 2015 and presented in a briefing paper for Quality Leadership Teams, in March 2016. This was not actioned until a Care Quality Commission inspection raised it as a concern.In the children, young people and families services, nursing teams based at school premises kept a stock of medicines on site. We found prescription charts were being transcribed (copied), by nurses with one signature; these were copied from treatment plans in the children's records which were completed by medical staff. The trust policy 'Transcribing Procedure for the Lighthouse Short Break Service and Special Schools' expired in June 2013 and was under review. This meant there was a risk of out of date non-ratified guidance being used. We observed staff taking enteral feeds (tube feeds which go directly into the child's stomach) to two, different children at once to save time due to staffing shortages. We escalated this to the manager who ensured this practice was discontinued immediately and treatments administered one at a time. Some staff in the community had completed the medicines prescribing course had not always put this extended role into practice, because they found it difficult to obtain prescription pads. This meant that another appointment was needed with their doctor.
- The Chief pharmacist also raised concerns at the Trust's board meeting in July 2015 regarding medicine related training and mandatory training models. Trust figures accurate as at 4 May 2016, indicated medicines management training within the Trust was between 8.8% and 58.9% for the various modules. Staff we spoke to indicated a lack of time available to complete the training, difficulty accessing the training due to capacity on the courses and lack of available equipment to be able to access online training. The Trust has a target of 85% for Mandatory courses.
- In response to the NHS England and MHRA patient safety alert: Improving medication error incident reporting and learning (March 2014) the trust had appointed a Medicine Safety Officer (MSO) who had the responsibility to oversee medication error incident reporting and who attended the Medicine safety committee formed in September 2015. Medicine alerts were cascaded via e-mail throughout the trust to ensure that staff were made aware and kept up to date. The Medicine matters newsletter, which provided updates and advice about medicines including learning points on medication related issues.
- When people were detained under the Mental Health Act (1983), we saw that the legal documentation for the treatment with medicines for mental disorder was completed accurately.
- Staff reported medicine errors using the incident reporting system and resulting information was cascaded to the nursing staff team in ward team meetings

Track record on safety

Requires improvement

Are services safe?

- The trust reported 3,017 incidents to the NRLS between 1 January 2015 and 31 December 2015. When benchmarked, the trust were in the middle 50% of reporters of incidents when compared with similar trusts. Sixty five per cent of incidents (1,975) reported to NRLS resulted in no harm, 25.7% (775) of incidents were reported as resulting in low harm, 4.9% (149) in moderate harm, 2.6% (78) in severe harm and 1.3% (40) in death. The NRLS considered that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture.
- Of the incidents reported to NRLS, 22.8% were related to 'Self-harming behaviour' (includes patient-to-patient), 20.8% to 'Patient Accident' and 18.1% to 'Access, admission, transfer, discharge (including missing patient)'.
- Trusts are required to report serious incidents to STEIS. These include 'never events' (serious patient safety incidents that are wholly preventable). The trust reported 74 serious incidents between 1 January 2015 – 31 December 2015. None of these were Never Events. 23 of the incidents occurred in Adult Community Services (31%). 27 of the incidents concerned Apparent/actual/ suspected self-inflicted harm meeting serious incident criteria.
- In the period 1 January 2015 to 31 December 2015, the trust reported 81 serious incidents through its SIRI reporting system, of these, 28.4% were related to adult community mental health services. Of the mental health services 22.2% related to adult acute mental health wards/PICUs.
- A majority of incidents were unexpected/ avoidable death or severe harm (59.3%) followed by allegations, or incidents, of physical abuse and sexual assault or abuse (14.8%)
- The NHS Safety Thermometer measures a monthly snapshot of areas of harm including falls, pressure ulcers and catheter with new urinary tract infections. The trust recorded five new pressure ulcers on the older adult wards March 2015 and March 2016. During this period the trust reported seven falls in the older adult service with harm during this period. The trust reported no catheter and new UTI cases during this period.

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. The trust submitted two Prevention of Future Death reports which they received in the 12 month period up to 23 February 2016.
- In most services, staff knew how to report and record all risk incidents and all near misses, and did this consistently.
- Most staff in the different services received feedback from investigation of incidents at monthly staff meetings, in clinical supervision and through the trust's 'blue light' system on the trust's intranet. All staff were obligated to check their emails regularly to ensure they did not miss a 'blue light' alert. However, in the acute service not all staff had the opportunity to discuss lessons learnt with each other; staff business meetings were irregular and time limited due to wards being short staffed. Staff in the CAMHS told us that whilst there was learning from incidents within the service, any relevant lessons learned in the rest of trust were not shared with CAMHS staff. Similarly in the crisis team staff and managers reported delays in receiving feedback from the trust on any investigations undertaken outside the local team. Staff in the CMHT were not confident that lessons learnt from one of their incidents would be communicated across the organisation
- Teams had introduced changes to working practice as a result of feedback from serious incident investigations. For example, the learning disability service was on a drive to improve awareness, understanding and identification of sepsis for all staff following a related incident.
- Staff and patients received de-briefings following incidents. Psychologists also provided group support.

Duty of candour

- The trust employed a family liaison co-ordinator and a family liaison facilitator, specifically to analyse serious incidents and complaints in order to ensure families' concerns are heard and they are fully supported during the process. A narrative on how the trust deliver their obligations with regards to Duty of Candour, in relation to serious untoward incidents, was included in the monthly Serious Incident Report which is reviewed by the Quality Committee and Trust Board. An additional

field had been added to the Datix electronic information management system to record actions taken in response to the Trust's Duty of Candour requirements and an auditable trail of all reviews of incidents, involvement of families and letters sent to families in line with Being Open and Duty of candour requirements and regulations.

- The trust had a duty of candour policy and a standard written letter of apology to send out to patients when needed. The trust employed a family liaison coordinator and a family liaison facilitator, specifically to analyse serious incidents and complaints in order to ensure families' concerns were heard and they were fully supported during the process. Information about the delivery of the duty of candour, in relation to serious untoward incidents, was included in the monthly serious incident report which is reviewed by the Quality Committee and Trust Board. The electronic incident reporting system contained an additional field to record actions taken in response to the trust's duty of candour, requirements and an auditable trail of all reviews of incidents, involvement of families and letters sent to families in line with "Being Open" and duty of candour requirements and regulations.
- Staff were open and transparent and explained to patients when things went wrong. We saw an example of this regarding a confidential letter sent to the wrong address in the forensic service. Patients in the learning disability service told us that they were informed and given feedback about things that had gone wrong In the long stay service an incident occurred where a patient on the self-medication protocol had been on weekend leave and staff failed to notice that medication had not been taken. Staff informed his family as soon as they realised the incident had occurred. A new protocol was put in place for checking medication after leave for all patients rather than on the ad hoc basis they had used previously.

Anticipation and planning of risk

- The trust considered risk as part of the board assurance framework. Nine 'principal risks' were included in the Board Assurance Framework documentation provided by the trust, of these, the risks deemed to be high included a lack of pharmacists currently contracted to participate on the Pharmacy On-call rota, basic concerns relating to the safe and secure handling of medicines, concerns relating to limited or no pharmacy input and support into high risk clinical areas such as Crisis teams, RAID teams, EIP teams, mental health community teams and within specialist services such as Children's services, CAMHS, Learning Disability services, Substance Misuse services (City).Also, concerns pertaining to service use and carer support being provided by pharmacy in relation to medicines use
- The trust has a current business continuity plan in place.The policy states that in the event of a major incident or disruption to business continuity, the trust would implement the Emergency Plan and establish an Incident Control Team which would be led by an Incident Director. In the event of larger scale incidents, the Trust would be part of a collective health and/ or multi-agency response which bring together the Trust with local authorities, the emergency services and other health organisations.

Requires improvement

Are services effective?

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

Summary of findings

Our findings

Assessment of needs and planning of care

- In all mental health services, patients received timely assessments, which were up-to-date. The Derby City and County South crisis team had recently improved its assessment process to help ensure staff better understood patients' needs.
- Care records showed in most trust services that staff completed care planning processes in a timely manner following patients' admission. Care plans completed by the long stay, child and adolescent mental health, crisis and learning disability services were holistic and outcome focussed. Across community mental health teams, 19 out of 33 care plans reviewed were good, however 14 care plans showed poor patient involvement and were not recovery focused or personalised. Patient involvement in care planning was not routinely recorded in acute services. All 19 records reviewed in the forensic services were not holistic, personalised or recovery orientated. In the older adult inpatient wards the care plans were almost exclusively for physical health and did not reflect all the patients' needs. Not all patients across the trust were given or offered a copy of their care plan. In the acute service, 20 out of 40 records showed patients had been offered a copy of their care plan. In forensic, child and adolescent, community, and older people services, there was no record of patients being offered a copy of their care plans. However, children and adolescents we spoke with had a good understanding of their care plan.
- Patients had access to physical healthcare assessments across the trust. However, not all patients had ongoing monitoring of physical health problems. Staff followed the trust early warning assessment for acute illness and deterioration. Crisis services assessed and responded to physical health needs, however; records in the Derby City and County South teams did not reflect this. Patients in forensic services were seen annually by a GP; however, care records did not show assessments had taken place. Community mental health teams had strong links to GPs and five learning disability health facilitators worked directly with GPs. Smoking cessation programmes were run across the whole trust.

Best practice in treatment and care

- Trust staff had access to national institute for health and care excellence (NICE) guidance on the intranet. Trust policies and procedures were based on NICE and national guidance. Care was planned and delivered in line with this guidance in most services. Doctors wrote to GPs about planned monitoring of physical health as part of medication management such as intramuscular (Depot) injections. The trust policy on rapid tranquilisation (dated March 2016) was based upon NICE guidance. However, not all staff in acute mental health services adhered to it, meaning five patients were not prescribed medication in line with the policy. Physical observations were not carried out in accordance with NICE guidance following rapid tranquilisation. In accordance with NICE, community mental health teams ran clozapine clinics that monitored the physical healthcare of patients. Clozapine is a medication used in the treatment of psychosis. Community older adult services demonstrated adherence to NICE guidance through low dose depot medication prescribing.
- The trust was able to offer a range of psychological therapies recommended by the National Institute of Health and Care Excellence. NICE guidance for post-traumatic stress disorder was followed in forensic services. Child and adolescent mental health services offered evidence based care pathways and psychological interventions to improve access to a psychological therapies programme. Psychologists offered therapies based on NICE guidance such as dialectical behaviour therapy and cognitive behaviour therapy.

Requires improvement

Are services effective?

- Patients across trust services had access to physical healthcare and when required, to specialist staff. Staff in older adult inpatient services used NICE guidance to underpin physical healthcare plans and accessed specialist advisors such as tissue viability nurses. A Macmillan nurse was employed to support end of life care.
- All applicable staff reported they followed the national dementia strategy, which is the government five year plan for improving health and social services in England for people with dementia and their carers.
- The trust had participated in 74 clinical audits and the outcomes of audits were shared in team meetings. There was inconsistency across the trust in the levels of participation of staff in audit. The trust completed the green light toolkit self-assessment audit in 2013 with the aim to improve services for people with a learning disability and/or autism. The trust, based on the audit, had developed workplace champions to affect change, including the introduction of communication and planning sheets.
- The national audit of schizophrenia was conducted in 2014 that demonstrated poor monitoring of the physical health of patients.
- Data relating to the quality of care was reviewed and compared with national data from the Royal college of Psychiatrists' National Audit of Schizophrenia. In 2014, the results indicated that, although feedback from patients on their experience of care was positive, monitoring and interventions for physical health risk factors and problems was still below what should be provided. The results indicated poor monitoring of body mass index, glucose control lipids and blood pressure. Intervention for elevated BMI, blood pressure and alcohol consumption was poor also.
- The trust had a priority to reduce suicides wherever possible. It had a suicide prevention strategy-working group trust held a national conference in January 2015 on suicide prevention. Following the conference, the trust worked with Derbyshire County's Health and wellbeing Board to re-establish the Derbyshire-wide suicide prevention group, which is composed, of public health representatives in partnership with key providers and community partners. As part of their quality agreements with commissioners, their work on suicide prevention remains a priority, with an emphasis this year into patient safety planning and a trust-wide roll out of this approach led by their medical Director.
- The Trust had a Positive and Proactive Care Strategy Group, made up of clinical staff and staff who specialise in risk and assurance, training, and moving and handling, produced a strategy entitled 'Positive and proactive care: reducing the need for restrictive intervention in our Trust'. It aimed to minimize the need for staff to restrain patients. The strategic aim was to work with staff, and partners in the community including Derbyshire Voice, Mental Health Action Group, clinical commissioners, social care and police. The strategy set out the trust's two-year plan to reduce the need for restrictive intervention. Data reviewed as part of this priority includes the number of seclusions, incidents of restraint and in a prone position, in particular, which can sometimes be associated with patient safety concerns. The trust Mental Health Act committee annual report compared the number of seclusions over two years. Overall seclusion incidents were reducing; September 2012 to September 2013 saw 163 seclusion incidents. In comparison, September 2013 to September 2014 saw 109 seclusion incidents. National benchmarking available on restraint indicates that the trust is a low user of this practice.
- The trust had a priority to continue to work, monitor, and improve outcomes, as evidence that they are making a difference for their patients. The trust reviewed data from the information collected through the National Tariff Payment System (formerly payment by results) approach to help in planning the future of trust services. The focus for 2015/16 will be to establish additional care pathways across trust services and make the information accessible to service receivers, carers and other stakeholders. . Staff in the community mental health teams were using clinical reported outcome measures to inform improvements in practice, leading to reduced length of time in treatment, the principles have been achieved by; listening to the service receiver through their self-directed goals and the use patient reported outcome measures; shared decision making with the service receiver when planning their care; everyone working together.

Requires improvement

Are services effective?

- In learning disability services psychologists had produced a patient-reported outcome measure and patient-reported experience measure to obtain service satisfaction data from service receivers. User-friendly graphics were developed and checked with a focus group of people with learning disabilities, whose ideas were incorporated into the finished measures. Psychologists have successfully been using the measures and analysis of 94 questionnaires showed 79% felt better after interventions, with 100% reporting that they would come and see a psychologist again if needed.
- The trust undertook the Friends and Family Test, services responded to the results through a 'you said, we said' mechanism. For example **You said** 'More activity, perhaps dance or movement', 'staff were caring, approachable, listened and professional', 'The staff were available', 'The food was lovely', 'Friendly atmosphere'. **We did** 'Ward 33 is piloting a 16 week dance movement psychotherapy course which is receiving very positive feedback from the patients. This will be evaluated once the pilot is complete. In 2015 the trust introduced 'your feedback cards'; these set out how people can provide the trust with feedback, including signposting to Health watch derby and Health watch Derbyshire, their own website, the Friend and Family Test and NHS Choices.
- The trust had made a priority of ensuring that services were co-ordinated and focussed on the whole family and to make sure that the 'Think! Family principles were a reality in day-to-day practice. The data the trust received was reviewed and assessed on an electronic baseline self-assessment questionnaire which was piloted in three community areas: Bolsover and Clay Cross Recovery, Pathfinder Service Chesterfield, High Peak Crisis Team, Pear tree Child and Family Team. In total, 64 questionnaires were issues with a return rate of 49 (76.5% response rate). The initial review of the completed questionnaires demonstrated an encouraging picture of staff understanding of the Think! Family principles. Children's safeguarding services, including the safeguarding children service, had successfully integrated them within the organisation, and this has helped the Think Family approach to become embedded within the organisation too. Think Family training was an on-going rolling programme for all clinical staff.
- The trust had a priority to implement a true recovery model, where health professionals recommend care pathways and options for individuals to weigh up and decide upon the best route for them, making an informed choice about how best meet their individual needs. The recovery approach was gradually being woven into work throughout the trust. The first principle of recovery practice is that the trust have a true co-production. Co-production means utilising the skills of people who use their services to inform practice and service development, this ensures they are moulding their services to reflect what people using the service need. It was recognised that as an organisation, the trust a long journey to travel in terms of recovery-orientated practice and this includes the expansion of the peer recovery workforce. The trust remains committed to their journey with their local communities. Recovery education will continue to develop in each neighbourhood.

Skilled staff to deliver care

- Across the trust, there was a range of staff with the necessary skills to deliver care. Services had access to multi-disciplinary staff, including doctors, nurses, occupational therapists, psychologists and administrators to support patients and carers.
- The trust had many experienced and qualified staff across services that in turn mentored new staff into the organisation. For example, the newly qualified health visitors were mentored by more experienced health visitors whilst they gained confidence and completed their preceptorship pack. New staff from other areas completed a staff induction pack.
- The trust had a supervision policy. The Trust had set a minimum standard for clinical supervision that was 10 - 12 hours per year. Data from the trust and feedback from staff showed that the take up and recording of supervision was variable across services. We found evidence of variability for example, in child and adolescent mental health services, staff said they received regular supervision. However, it was not always recorded and data showed supervision rates at 59%. In forensic services, 84% of non-medical staff were up to date however, 58% of medical staff and 56% of psychology staff were recorded as having supervision. In community mental health teams, rates of access to supervision widely varied, for example, Chesterfield

recorded 74%, High Peaks had no-one recorded, and Derby City achieved 13%. Staff accessing supervision reported it as useful and they also approached their line managers informally to discuss their clinical activity.

- The NHS Staff Survey 2015 reported that 83% of staff said they had been appraised in the last 12 months compared to a national average of 91%. The trust score had decreased by eight per cent between 2014 and 2015. The trust had an overall appraisal target rate of 85%. The highest average rate of appraisal was community mental health services for people with a learning disability at 90%. Acute wards for adults of working age had the lowest appraisal rate of 43% for permanent non-medical staff. The trust reported that 69% of non-medical staff had an appraisal in the 12 months ending January 2016.
- Records showed that 102 doctors had been revalidated by the end of January 2016, which iso 92% of all doctors. The trust provided a copy of their revalidation and appraisal action plan and aimed to complete by the end of May 2016.
- Most trust staff had access to regular team meetings. For example, monthly team meetings occurred in community mental health, long stay, older adult, and learning disability services. A range of topics were discussed including training, complaints and compliments, follow up from incidents and records management. In all the crisis service teams, staff had regular access to support and supervision in team meetings. The acute service records showed they did not have regular team meetings.
- Across all services, staff had access to ongoing training that was specific to their role and service. Doctors reported they were supported to undertake continual professional development. Non-medical staff told us they had undertaken training relevant to their role. Staff had completed a range of training including: positive approaches to challenging environments, suicide awareness, personality disorder, female genital mutilation, compassion focused therapy, think family, diabetes awareness, epilepsy, clinical risk management and positive behaviour support. Since the launch of the care certificate standards in 2015, six out of 29 inpatient health care assistants had completed the care certificate and the remaining staff were undergoing training. Staff received specialist dementia training in older adult inpatient teams and the community team undertook compassion focussed delirium and dysphagia training. Community teams had two nurse prescribers and further training for staff to administrate patient group directives for medication was booked. Staff in community teams had received specialist training in cognitive behavioural therapy (CBT), open dialogue and family therapy. In the crisis service, staff had the opportunity to develop special interests in areas related to their work and become champions. For example, a support worker had become an expert in housing and welfare issues, a nurse had taken a lead in medicines management, and another nurse had started the green light toolkit for learning disabilities.
- Managers were able to identify poor performance and discuss these in supervision meetings. Team leaders knew how to escalate issues higher in the trust. One manager in acute services gave us examples of staff performance issues and we saw an action plan to support and rectify issues identified. Support and advice was provided by human resources.

Multi-disciplinary and inter-agency team working

- We found that teams across the trust were working effectively between themselves and with external agencies. The NHS staff survey in 2015, showed trust staff reporting effective team working was comparable to the national average. There was a range of meetings across the trust that involved multi-professional staff including, daily nursing handovers, and regular multi-disciplinary team, referral and access meetings.
- All acute service wards had daily 'purposeful inpatient planned admission" (PIPPA) meetings. All members of the multidisciplinary team (MDT) attended as well as staff from the in-reach team, which is part of the crisis team. Staff from the in-reach team support patients with early discharge from wards. In the older adult inpatient, forensic and long stay services, multi-disciplinary meetings took place weekly or fortnightly when ward teams reviewed care and treatment plans. These meetings included patients and carers however, in the long stay Cherry Tree service; patients were seen every five weeks. All community services had regular team meetings.
- A single point of access initiative was embedded in children's and young people's services and meetings

were attended by child and adolescent mental health services (CAMHS), community paediatricians, clinical psychology, school health and multi-agency teams. Care records in children and young people services showed good multi-agency working. CAMHS also offered training and consultation to other organisations like education, social services and GPs around mental health and self-harm and supported them to work with young people. Clinical teams in older people's services had access to specialist nurses such as tissue viability and physiotherapists. We observed effective handovers for patients due to be discharged from acute mental health wards to community teams. Acute mental health services however were without a psychologist and had been unsuccessful in recruiting one. The crisis teams worked closely with other health care staff, for example, diabetic nurses, community mental health team care coordinators and district nurses. The teams occasionally experienced challenges when trying to work with services provided by other trusts because of different access criteria or operating systems outside of the Derbyshire area. Staff we spoke with in the community older adults' service said they had good communication links with other teams within the trust, including in-patient services and the dementia rapid response team.

- There were effective working relationships between the trust and external agencies, although we did not see evidence of this in the forensic service in relation to GPs, local safeguarding teams, and limited evidence in relation to care co-ordinators. The long stay service had developed "Spireites Active for Life" courses in conjunction with Chesterfield football club All teams in the older people service had developed effective links with their GPs. On a monthly basis, allocated staff attended community support team meetings. These meetings included the GP, district nurses and other members from the primary care service. We spoke with a social services manager working in Derby, who reported good working relationships with the community teams and stated when problems had arisen, staff from both services liaised to resolve them.

Information and records systems

- The trust held records in both paper and electronic versions. The trust however was migrating to an electronic patient record system. Staff showed good awareness of the trust policy on confidentiality and information governance. We found that records were stored securely but were not always accessible. In the older adults inpatient service area on call doctors told us that it was difficult to access electronic records as they did not have log in details. In addition partially inputted patient data and slow migration of patient data meant there was a delay in accessing timely information to make clinical decisions. The crisis service was able to access electronic patient notes on any site, this helped staff collate and share information. Child and adolescent mental health services were in the process of migrating to electronic patient records and staff experienced issues of accessing all of the information. Community older people's service staff had hand held tablets to access information off site. Community learning disability services were able to access electronic records and share information with relevant teams.

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

- Trust governance of the Mental Health Act (MHA) was in place through a MHA committee which reported to the trust board.
- The Mental Health Act administration office monitored the implementation of the MHA. Staff knew how to contact the Mental Health Act administrator for advice when needed and knew where to find information on the intranet. Evidence of audits related to the use of the MHA were not evident in some of the services that we visited. Staff were able to access legal advice via the MHA office. Policies had been reviewed and updated in relation to the Mental Health Act Code of Practice (2015. Although the seclusion and long-term segregation policy had been updated to reflect changes to the Mental Health Act Code of Practice (2015), it contained inaccuracies in that the word "ordinarily" had been added to a statement.
- Out of 1078 staff, 944 (87%) had completed Mental Health Act mandatory training. Detention papers were available for all patients. The assessment records we reviewed showed that patients stayed in the health based place of safety (Section 136) suites for an average of five hours. We found evidence that Section 5(2) of the MHA was used five times on the same patient in a five week time period. The care records did not evidence any crisis management plans or multi-disciplinary

discussion about the least restrictive approach to take. Section 5(2) is a temporary holding power of an informal or voluntary service user on a mental health ward in order for an assessment to be arranged under theMental Health Act1983. Seclusion practice did not follow the Mental Health Act Code of Practice (2015).

- Not all consent to treatment and capacity forms were appropriately completed. In acute services, for example, we saw consent to treatment and capacity requirements recorded within some care records but this was not consistent and not easily accessed. Authorised treatment certificates for medication were attached to medication charts. This meant that nurses knew the legal authority under which they were administering medicines.
- Staff had a duty to read patients their rights under Section 132 to them on admission and every three months thereafter. However, we found that this was not consistently happening. Patients on community treatment orders were not always being reminded of their rights.
- The documentation we reviewed for patients on community treatment orders was up to date, stored appropriately and compliant with the MHA. Mental Health Act documentation was not filed appropriately in the forensic service and inconsistently filed in crisis and health based place of safety services. Staff did not always complete risk assessments related to section 17 and we could not access any Ministry of Justice letters permitting Section 17 leave for two patients that this applied to.
- All patients were informed about independent mental health advocates who could provide them with support to exercise their rights. Staff were aware of how to refer patients to engage with an independent mental health advocate when needed.

Good practice in applying the Mental Capacity Act

- Ninety per cent of staff had completed mandatory Mental Capacity Act (MCA) training. Between 1 August 2015 and 31 January 2016. The Mental Capacity Act training package contained inaccuracies. The training package (which was delivered by e-learning) contained inaccuracies such as a statement regarding parental consent. The trust was in the process of reviewing this training provision. Knowledge of the MCA was variable across the trust and some staff did not understand the five statutory principles. In the acute adult service when we spoke with staff there was varying degrees of knowledge about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We observed the multi-disciplinary team discussing capacity within ward rounds. However, staff reported it was for doctors to assess and record. Staff understanding of mental capacity was poor in the forensic service. In the learning disabilities service staff applied the MCA in an inconsistent way. The way that MCA was applied in practice demonstrated that staff had different levels of knowledge about how they used the MCA. In community older people services, staff we spoke with were knowledgeable and understood the principles of the MCA and DoLS. In the crisis service, staff had a good understanding of, and applied, the principles of the MCA, in particular, the presumption of capacity and its decision-specific application.
- There was a trust policy in place for the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knew where to access information related to the policy.
- There was inconsistency across the trust in assessing capacity to consent and how it was recorded. In the child and adolescent mental health services, doctors' letters stated that mental capacity was assessed for their patients aged 16 years and above. For patients less than 16 years old we saw competency was thought about and the staff we spoke with were able to give us definitions and examples of Gillick competence. This is a term used to decide whether a child under 16 years old is able to consent to treatment without the need for parental consent or knowledge. In the learning disability services, we did not consistently see evidence of capacity to consent or refusal of treatment being assessed and recorded appropriately. We saw that patients were given time to make specific decisions but this was not always recorded. Two records showed that someone had signed for consent to treatment on behalf of the patient who lacked capacity. The people that signed the consent forms had no legal right to do so. In the crisis teams, medical staff completed capacity to consent or refuse treatment assessments. Patients signed consent forms to give permission for information to be shared with family members

Requires improvement

Are services effective?

- Staff knew where they could ask for help regarding the Mental Capacity Act within teams, however, staff in acute mental health services did not know if the trust had a MCA lead.
- There were 54 mental health Deprivation of Liberty Safeguards (DoLS) applications made during the six month period. 39 of the 54 were from the same location – Cubley Court, an older people mental health ward. CQC records show that the CQC received four Deprivation of Liberty Safeguarding applications (DoLS) from the trust between the same period (1 August and 31 January 2016).

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

- Throughout our visit, we saw staff interacting with patients in a positive, friendly, polite and respectful manner. We saw that staff listened to and showed empathy towards patients. We observed many examples of staff treating patients with care, compassion and communicating effectively to engage the patients at their level of understanding.
- Patients and carers were generally very positive in their views of staff and the care they received. Most patients we spoke with said that staff were supportive of their individual needs and treated them with care, respect and compassion. Patients across the core services reported that they felt listened to. However, negative comments received from patients were about staff being too busy to spend time with them, specifically within the acute services. Some patients in the forensic service also expressed concerns about access to the gym due to a lack of trained staff to support them.
- There were 65 CQC comment card responses in total. 50 comments (76.9%) were positive in nature, 6 (9.2%) were negative in nature and 9 (13.8%) were mixed in nature. Ten out of 12 sites with responses had comments praising the staff for being friendly, caring and welcoming.
- Staff demonstrated a good understanding of the individual needs of patients. We saw that staff were sensitive to patients needs and worked creatively to support them in the most appropriate way. For example, within the older people's inpatient service, we observed a nurse sat with an elderly patient who did not speak English. The nurse spent time searching for songs on the internet in the patient's language so that she could sing along with him. This demonstrated consideration for patients' individual needs, as well as kind and compassionate care.
- Throughout our visit, we saw that staff maintained confidentiality. Staff used only trust-approved electronic communication systems, stored records correctly and showed a good understanding of how to maintain patient confidentiality when out in the community. Patients also told us that they felt confident that the staff maintained confidentiality.
- The friends and family test was launched in April 2013. It asked people who used services whether they would recommend the services they have used. The percentage of respondents who would recommend the trust as a place to receive care was below the England average during January and February 2016. The results, in September 2015, showed 8% of respondents would not recommend the trust. However, the response rates were very low, and may not be representative of the standard of care delivered overall.
- The trust's overall score for privacy, dignity and wellbeing in the patient led assessments of the care environment (PLACE) 2015 was 94.6% and was above the England average of 86%. All trust locations were above the England average.
- At the start of 2015, a questionnaire was sent to 850 people who received community mental health services Responses were received from 252 people at Derbyshire Healthcare NHS Foundation Trust. The trust scored 'about the same' for all questions in the survey.

The involvement of people in the care they receive

- We received mixed feedback from patients about their involvement and participation in the care they received. The majority of patients told us that they had been involved in their care and we saw evidence that patients were often included in care planning and decision making during multi-disciplinary team meetings and community meetings. However, written care plans varied in their level of patient involvement. For example, in acute services, not all of the care plans contained

evidence of patient involvement. Similarly, in forensic and CAMHS services, it was not always recorded whether the patient had been given a copy of their care plan. However, patients reported being actively involved in their care planning across all of the services and were familiar with their care plans.

- Within the CAMHS Community service, we saw that the staff team had supported the personal and professional development of a former patient by giving them the opportunity to volunteer to develop the CAMHS website, in exchange for vouchers. The young person had reached adulthood and was successfully recruited to a paid position to lead the further development of CAMHS social media presence and their website.
- We saw that patients had access to advocacy services and we saw these services promoted across the different locations. Some patients told us that staff did not routinely provide them with information about advocacy services. However, we saw that staff supported patients to access these services.
- Throughout our visit, we saw that when consent had been given by patients, their carers and parents were involved in their care and treatment. We saw that family members' were encouraged to attend and contribute to Care Programme Approach (CPA) and, multi-disciplinary team meetings, and that their views were taken into account. Carers we spoke to said that they felt well informed about patient care and some reported that they had been actively involved in the patient's assessment and activity planning.
- In addition, we saw a variety of initiatives across the different services to support carers and families. For example, there was a variety of carers groups available, some of which had become so popular that they were planning on setting up additional groups. The learning disability community service also offered to support to families and carers in the form of counselling and emotional support and how to get support from other organisations. Erewash older peoples' community team had developed a widely publicised question and answer monthly session held in the community, inviting patients, carers and the public to discuss all matters regarding dementia.
- There were reports across children's services, adult services and older people's services that the trust provided activities to keep patients occupied. However, there was a report in forensic services that there was a 10 week wait for a patient to have a gym induction. There were two comments (in CAMHS and adult community mental health) that were positive about trust communication. There was one comment (in adult community services) that suggested that communication when staff were on leave could be improved.

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

Our findings

Service planning

- On 1 April 2015, the Trust formally launched its preparations to transform its services. From 1 April 2016, the trust announced plans to safely and effectively deliver services through a neighbourhood-based approach. The trust is committed to working with local Health Care Economy partners to achieve this transformation vision, through the STaR (System Transformation and Re-configuration) programme in the City and South of the county and through the 21C #JoinedUpCare programme in the North. Both groups are responsible for working to the Health and Well-being Boards' visions for a combined Derbyshire-wide health and care system. Both systems have five-year plans to re-design services, locate care closer to home and drive cost efficiencies.
- Pre-inspection, we held focus groups with a range of external stakeholders including clinical commissioning groups. The feedback from these sessions was very positive and it was clear that the trust is a valued partner in the wider health economy

Access and discharge

- The trust provided details of bed occupancy rates for 19 wards between 1 August 2015 and 31 January 2016. The average bed occupancy rate was 86.4% across all wards. Thirteen out of 19 wards had bed occupancy over 85% four core services : Acute wards for adults of working age, forensic inpatient wards, long stay/rehabilitation mental health wards for working age adults and wards for older people with mental health problems. There were four wards where bed occupancy was over 100%. Three of these were acute wards for adults of working age all adult acute wards based at the Radbourne Unit, Royal Derby Hospital) and the fourth was Kingsway Cubley Court (female) OP, an older peoples' ward based at Kingsway site.
- The trust did not have a psychiatric intensive care ward (PICU). It admitted patients whose individual needs required PICU to out of area beds. PICU beds were accessed from a wide geographical area and often far away from the county. This would restrict visiting for some carers. The number of out of area placements for patients requiring admission to a psychiatric intensive care unit between April 2015 and March 2016 was 48. These patients required admission to a (PICU). Between 1 August 2015 and 31 January 2016, there were six out of area placements for forensic inpatient and one for community adult mental health services to NHS providers and private providers. The trust did not have inpatient child and adolescent mental health beds. Young people requiring this service went out of area. If the CAMHS assessment indicated that an admission to the paediatric ward was appropriate, this was facilitated and the paediatric team supported the admission. It was clear from talking to the paediatric staff that they now felt more confident in nursing children and young people with mental health difficulties and said they understood it to be their responsibility as children's nurses whereas previously they would have felt differently and thought these children should be CAMHS patients' only.
- The trust provided details on the average length of stay of patients discharged between February 2015 and January 2016, and their patients as at 31 January 2016.The average length of stay at the time was higher than the average for the previous 12 months for acute wards for adults of working age, and was lower for all other core services. Overall, the trust had an average of 194.9 days length of stay across all wards for discharged patients over the past 12 months, and 137.5 days for current patients. At ward level, the average length of stay was higher than it was in discharged patients over the past 12 months in six out of 19 wards. Five of these were acute wards and one forensic ward (Scarsdale).
- Between 1 August 2015 and 31 January 2016 there were 16 delayed discharges in the acute wards ward 33 had the highest number with six. Acute adult wards overall had a significantly higher number of delayed discharges and readmissions within 90 days than any other core service. Wards at Radbourne Unit, The Royal Derby

Requires improvement

Are services responsive to people's needs?

Hospital had the highest number of delayed discharges and the highest number of readmissions within 90 days over the period. The average across all wards for delayed discharges was 0.8 and readmissions was 11.9. Between August 2015 and January 2106 there had been 11 delayed discharges across the acute service. Staff said delays happened because of those patients complex care packages.

- The Quarterly Mental Health Community Teams Activity return collects provided data on the number of patients on Care Programme Approach (CPA) followed up within 7 days of discharge from psychiatric inpatient care. The trust recorded that 95.7% of patients on CPA who were followed up within 7 days after discharge in Quarter 3 2015/16. This was below the England average of 96.9%. In the previous three quarters the trust performance has been mixed, having been above the England average in the previous quarter but below it in the two quarters before that.
- There were a total of 226 readmissions within 90 days reported by the trust between 1 August 2015 and 31 January 2016 across 19 wards (eight acute adult wards, five wards for older people with mental health problems, three long stay/rehabilitation mental health wards for working age adults, two forensic inpatient wards and one mental health ward for other specialist services. The wards with the highest number of readmissions within 90 days were acute wards. Ward 34 with 48, Hartington Unit Tansley Ward with 36 and RDH Ward 33 with 36. Readmissions within 90 days in the acute wards was 212 , and in older adult services 12
- The trust provided details on referral to assessment and assessment to treatment times for 104 teams between February 2015 to January 2016. 33 of the teams listed a target time of 126 days from referral to treatment, with all but one stating that, "treatment starts at first outpatient appointment". Two of the 33 teams failed to meet the target. These were Derby City – Outpatients (with an average of 154.3 days from referral to treatment) and Perinatal South (with an average of 196.2 days). For the teams which listed referral to assessment times, the highest were ASD Assessment Service (average of 558.1 days), Inpatients (Trust wide) (average of 372.67 days) and LD Speech & Language (average of 259.42 days). The teams with the highest assessment to treatment times were ASD Assessment Service (average of 755.5 days), Psychodynamic Psychotherapy (average of 373 days) and Inpatients (Trust wide) (average of 280 days).
- The trust has an average of 54.93 days referral to assessment across all teams where details have been received and an average of 83.13 days from assessment to treatment across the same teams.
- There was a total of 946 delayed days between March 2015 and February 2016. The reasons with the highest number were as follows: 498 (52.6%) were due to awaiting residential home placement or availability, 173 (18.3%) were due to awaiting further non-acute NHS care, 124 (13.1%) were due to public funding, and 105 (11.1%) were due to awaiting nursing home placement/ availability.
- The trust data showed that between February 2015 and January 2016, the trust consistently met their target of 95% for checking infants within the 10 – 14 day time period after birth. The trust consistently met their target of 40% for the number of mothers' breastfeeding during the time period of 10–14 days after birth.

The facilities promote recovery, comfort, dignity and confidentiality

- The trust provided services from a variety of older and more modern facilities. We saw an example of where the trust had adapted the facilities for activity and therapy at the Radbourne unit in Derby. The wards had access to separate recreational and therapy areas that were based in hubs off the wards. The patients at Radbourne unit had named the hub area the 'Hope and Resilience Hub'. The hubs were open seven days a week, and offered different activities throughout. The hubs had an internet café with access to free Wi-Fi. The hub areas were relaxing and welcoming. Other facilities within the hub included a shop, a gym, pool tables, art, pottery and therapy rooms. There was direct access to a private outside space. Discharged patients could volunteer to work at the café to gain work experience.
- Quiet rooms were available across the ward areas
- People were able to make phone calls and had access to mobile phones, payphones or the ward phone if required.
- Access to outside space was provided on all of the inpatient services

Requires improvement

Are services responsive to people's needs?

- Patients told us that the food was of good quality and that they were offered choices and a variation in the menu
- People in all areas were able to personalise bedrooms
- There was access to activities across all inpatient services although the amount of activity on offer varied and was at times limited to week days. Within the long stay rehabilitation mental health wards activities were offered through the occupational therapists and occupational therapy assistants with support from nursing assistants. Staff planned activities and patients could sign up to them. They were encouraged to make suggestions about the type of activities they would benefit from. Audrey House had a 'you said, we did' board which showed suggestions from patients and actions taken. Staff organised fewer activities at weekend as patients were often on leave and it was felt this would be more in line with community living. The rehabilitation occupational therapy service organised community activities in partnership with local community based organisations. These included active confidence courses, art therapy, and a community based Recovery College, which had recently run six taster sessions on recovery. Both wards promoted healthy lifestyles through literature on notice boards and access to a dietician. At Cherry Tree Close, staff and the occupational therapists supported patients to give up smoking as the trust has recently become a smoke-free site. The wards also used a local community based project called Cycle Derby to encourage patients of all levels of mobility to be active. The community rehabilitation occupational therapy service also promoted healthy lifestyles through a range of projects in local communities, including the spireites project in conjunction with Chesterfield Football Club and the active confidence courses.

Meeting the needs of all people who use the service

- All trust buildings had access for people requiring disabled access
- Information leaflets were available across all services and were available in languages spoken by people who use the service
- Staff had easy access to signers or interpreters if required

Listening to and learning from complaints

- 125 written complaints were received in 2014/15 by the trust, 2 down on the 127 in 2013/2014 The number of upheld complaints has remained static at 47%. Complaints from profession defined as Nursing, Midwifery and Health Visiting has the highest number for second year running, equating for 43% of the total number of complaints.
- Between 1 February 2015 – 31 January 2016 there were 131 formal complaints received by the trust in total in the 12 month period. Of the total complaints 58% have been upheld (either fully or partially). Community mental health adults received the highest number of complaints with 48 (37%) and the highest number of complaints upheld with 24. Community health services for children, young people and families was the only service to receive a complaint which was referred to the ombudsman, it is unknown as to whether this was upheld. Community learning disability mental health services long stay/rehab mental health wards for adults and corporate services all received the lowest number of complaints with one. Three of the 12 core services had zero complaints either fully or partially upheld.
- The trust received 764 compliments during the 12 month period (1 February 2015 – 31 January 2016). Community mental health adult services received the highest number of compliments with 127 (17%). The trust received the highest number of compliments in the area of care with 436 compliments citing this reason. One compliment was received relating to the facilities at the Radbourne Unit, acute Ward 36.
- Reports are produced on the theme from complaints and incidents and the actions taken. This is fed into the Feedback intelligence Group. Reports were sent quarterly to the Division and to the Quality Committee and as part of the Patient Experience report to the Trust Board.

Inadequate

Are services well-led?

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

Summary of findings

Our findings

Vision, values and strategy

- The trust values were launched in May 2012, following consultation with staff, service users and partner organisations. The trust were in the process of re launching their revised trust values and vision following staff consultation in 2016. Staff in the acute, community and inpatient older adult, crisis, long stay, learning disability, children and young people services knew about the trust values and demonstrated these through the person centred support they offered to patients. Ward objectives followed these values. Wards had the visions and values displayed notice boards for patients and staff. Staff in the forensic service could not describe the trust vision and values. The participation group had devised CAMHS specific vision and values which reflected those of the wider organisation. The staff that we spoke with felt more connected to the CAMHS values rather than the trust wide ones.
- The trust strategic objectives were monitored and reported in the public session of the trust board every quarter. In the children and young people's service most staff had minimum knowledge of the trust strategy and of their service work streams, the majority told us changes were happening but they did not know what the service would look like after July 2016.
- Staff in the learning disability service told us that they knew who the most senior managers in the organisations were but that they rarely visited them. Most staff felt there was a gap between frontline staff and the senior management team.
- Staff in the crisis service were aware of future plans for their services but expressed concerns and anxieties about business continuity. Staff did not feel assured there were robust plans to ensure the delivery of safe and effective care during the transition period. Staff said senior managers had not listened to their concerns when their service was unsafe and in crisis.
- The trust's senior executive team visited the acute wards at Radbourne and Hartington units Staff in the forensic and long stay service knew who the most senior managers in the organisation were. They told us that these managers visited the service. Staff told us the area service manager was a visible presence on the wards and that she had often filled staffing vacancies and worked alongside them. Staff in the services for older people with mental health problems we spoke with were aware of the senior managers within their organisation and some teams had received visits from the interim Chief Executive to discuss the new neighbourhood model. Some staff had attended listening events, chaired by board members, which gave them opportunity to discuss concerns and receive information. Staff in CAMHS were aware of the senior managers but felt they did not have regular contact with anyone above service manager level. The service manager and clinical lead knew and had contact with the managers senior to them.

Good governance

- The trust's Board Assurance Framework contained four strategic outcomes with information on action plans to tackle the risks highlighted. The outcomes were; Outcome 1: People receive the best quality care, Outcome 2: People receive care that is joined up and easy to access, Outcome 3: The public have confidence in our healthcare and developments, Outcome 4: Care is delivered by empowered and compassionate teams.
- Staffing was on the risk register and was being monitored by the trust. Recruitment of staff was ongoing. Managers ensured shifts were covered by sufficient staff across services. However, the numbers of nurses identified in the staffing levels set by the trust did not always match the number on all shifts in acute services. Data from the safer staffing levels return (between April 2015 and January 2016) showed the

acute services consistently operated below the lower fill rate of 90% for nurses during the day for nine out of the 12 months. However the inpatient older adult service had an improved skill-mix management on each shift as requirements embedded in the electronic roster patterns made sure of this.

- Whilst there was a range of audits carried out corporately within the trust, clinical staff participated in the minimum of audits. A band 6 lead nurse development group met every six weeks to discuss specialist projects develop ideas for audits and promote innovation in the older adult services. Staff participated in clinical audit in the forensic service. However; the regular care record audits had not identified the absence of physical health assessments on admission and absent or incomplete HCR20V3 risk assessments. Staff in community older adult service participated in limited clinical audits. Some managers reviewed and audited care records, and on occasion adherence to patient physical health needs. This was not consistent across the teams and some did not participate at all. This meant they did not measure the quality of their service and missed opportunities to highlight good practice and identify areas for improvement. In learning disability services staff did not regularly participate in clinical audits used to monitor the effectiveness of the service provided. It was not clear that they used the findings to identify and address changes needed to improve outcomes for patients.
- Staff knew how to report incidents. Learning from incidents was shared in team meetings and supervision session where these occurred regularly. We were concerned about the robustness of governance mechanisms, for example there had not been investigation of a safeguarding alert made by staff in 2015 regarding a series of incidents relating to patients property. These incidents dated back several years and staff at many levels may have failed to link the events together in order to stop the abuse and learn lessons from the incidents.
- The trust shared lessons learnt from incidents and had a blue light system of communications for lessons and alerts of a serious nature. However, we saw little evidence of trust wide learning from incidents and complaints being shared with staff in order to change to practice in a number of services such as acute services, CAMHS. This means the governance systems for sharing and learning to change practice was not embedded consistently in the trust. We looked at four root cause analysis of serious incidents and two serious case reviews for children and found that there were good processes in place and learning reviews had taken place.
- There was inconsistent full understanding of the Mental Capacity Act across services, particularly in older adult and learning disability services. Local clinical leadership on the wards had not arranged to ensure all staff and medics developed necessary skills to formulate evidence for patients' best interest decisions within the care plans using the correct mental health act forms.
- All staff in acute, CAMHS services were aware of the whistle blowing policy and how to use it, and said that they felt able to raise concerns without fear of victimisation. However, there were staff we spoke with did not always feel confident about raising concerns above their immediate managers at local level. Staff described a 'glass ceiling' above their immediate manager. One whistleblowing enquiry was raised to the CQC between 22 March 2015 and 23 March 2016 which related to acute wards. It concerned inappropriate admissions made where staff do not have the necessary training and senior staff were not understanding or supportive to staff. The CQC also received whistleblowing information arising following the employment tribunal case in 2015 which led to a focused inspection of the well led domain.
- Data received from the trust for clinical supervision rates of non-medical staff (for the 12 months between April 2015 and March 2016) showed the average rate across all (158) teams was 50.4%. The trust had set a clinical supervision target of 'minimum of 10 hours per annum, adjusted for whole time equivalents. Of the 158 teams, 77 (49%) had a clinical supervision rate lower than 50%. 19 teams recorded no clinical supervision had taken place. Community-based mental health services for older people (81.44%) had the highest clinical supervision rate against other core services, whereas acute wards for adults of working age (26.02%) had the lowest. Services we visited and staff we spoke with

identified there was variation in the take up of clinical supervision. Governance arrangements were not embedded as staff said they did not always record that supervision had taken place.

- Between February 2015 and January 2016 there were11 cases where staff had been either suspended or placed under supervision. Of these 11 instances, there were six suspensions, one case of staff being placed under supervision and four staff were re-deployed to non-clinical roles. Six of these cases were ongoing. There had been four instances at Kingsway and three instances at Radbourne Unit. There were a number of corporate cases which were still under investigation.
- We found overall that the trust had good systems, processes, and training in place for managing safeguarding. However, in the older adult service a safeguarding alert had been made in 2015 regarding the alleged theft of an individual patient's belongings. Local and senior staff within the trust had not investigated the possible links of this alert with other reported alleged thefts and losses of patients' belongings over a four-year period. There was a failure by clinical leads and staff at director level to investigate possible links between incidents to prevent further possible abuse of patients and learn lessons from the incidents. Local authority safe guarding leads that we spoke with had no knowledge of the long standing issue. We asked the trust to submit an alert to the local authority so that they could investigate.
- The trust reviewed its safeguarding governance structures in early 2016 in line with the "Safeguarding Children: 'Roles & Competences for Healthcare Staff, Intercollegiate Document 2014" which states that the Safeguarding Named Nurses and Doctors reports directly to the Executive Lead for Safeguarding Children. The 'Safeguarding Vulnerable Adults and Children Committee' now reported directly to the trust board and met every four months. The membership of the safeguarding committee included the local authority safeguarding leads, Health watch and the clinical commissioning groups.
- Safeguarding adults and families in the trust strategy 2016 -2019 proposed the trust way forward. The context took into account the Care Act 2014, the National Prevent Strategy, the Mental Capacity Act and Deprivation of liberties, the role of carers, positive and proactive care and the Duty of Candour. The safeguarding strategy was ratified and monitored by the safeguarding committee.
- There were concerns by commissioners as to the level of resource available in the trust to manage safeguarding given the additional responsibilities by the Care Act 2014 with only one adult safeguarding lead in the trust. The safeguarding adults' assurance framework had not been submitted by the trust to commissioners on time. Despite an extension to the end of May 2016, it had only partially been completed and not submitted. Safeguarding leads from the local authority described good relationships and interagency working. Agencies reported improvements over the last 18 months. The trust participated in multiagency audits.
- Multi-Agency Public Protection Arrangement meetings were attended by the trust (a set of arrangements established by Police, Local Authorities and the prison service in your area (known as the Responsible Authorities) to assess and manage the risk posed by sexual and violent offenders). We were informed that this led to frequent disagreements about the trust admitting adults with personality disorders. Local authority representative concurred with the latter view. We found that trust staff were divided as to whether people with personality disorder were given a service by the trust, senior executives said not, whilst operational staff said that they did provide a service.
- We reviewed three safeguarding alerts being jointly investigated by the trust and local authority, and found good processes and procedures. Local authorities received alerts directly from the wards. All alerts were also reported on the electronic incident reporting system and this alerted the trust safeguarding leads,
- Children and adult safeguarding training for level one and two had exceeded the trust targets set.
- We found the trust had acted responsibly in providing support to people who had suffered historical abuse in a service that had not belonged to them. Aston Hall was a learning disability hospital between the 1940 to the 1970s. A number of ex-patients had come forward describing historical abuse. The trust appointed a caseworker and a clinical psychologist to work with the victims. The Children's safeguarding board had oversight and a "gold inter-agency" carried out the safeguarding work.

Inadequate

Are services well-led?

- In the acute services, governance was weak. There was lack of clarity about the governance mechanisms in place. Most wards struggled to have regular business meetings to cascade and discuss governance. We did not see evidence of multidisciplinary engagement at a governance level
- The Chesterfield and High Peak CRHT teams had good governance systems and processes that helped ensure good practice. The managers regularly requested and received quality reports from the trust that showed a range of performance data, for example, staff turnover, the number of assessments and treatments, supervision and training rates, and the quality of patients' records. The Derby City and County South team had dedicated support from a nurse consultant who provided oversight and strategic direction to the team. The nurse consultant had good knowledge of the team's history and needs, having been instrumental in highlighting serious concerns in the past, and since then helping the team achieve stability. The nurse had direct access to senior managers to raise any issues that could affect safe care and treatment. The nurse worked closely with the team leaders to develop robust systems and processes and improve service delivery.
- The trust had governance processes to manage quality and safety; the team leaders in learning disability services used these methods to give assurances to senior management in the organisation. There was a clear operational structure and governance arrangements. Managers were experienced and knowledgeable and demonstrated strong leadership of the teams.
- The trust had set its own mandatory training targets. Not all services met these had achieved the training targets. Whist the trust had governance systems in place to monitor these; the trust was not responsive in acting swiftly to ensure targets were met, in particular for fire warden training, basic life support training skills and medicines management which could impact upon patient safety.
- Forensic service ward systems were not effective in ensuring that staff received mandatory training. Booking staff on to training was the responsibility of one of four band six nurses. This system had failed for booking staff on to the trust's violence and aggression (control and restraint) training. There was a lack of clarity regarding the availability of courses so training figures were low. In the children and young people service matrons of the services did not have good strategic oversight of their teams training and competence specifically relating to safeguarding training and supervision.
- All mental health wards and community teams had set key performance indicators. These monitored length of patient stay, delayed discharges, readmission rates, GP discharge notifications, Health of the Nation Outcome scales (HoNOS) and Care Programme Approach reviews (CPA's).
- All wards had access to the risk register. Ward managers placed items on the register and had responsibility to review each one.
- We found that the trust was not compliant with its Equality and Diversity obligations. The Board Assurance Framework and Risk Register did not include any equality related risks and directors and staff responsible for equality and diversity were not aware of any equality risks relating to their non-compliance.
- The Trust published its 2015 Workforce Race Equality Standard Report as required by NHS England. In previous years, the trust had undertaken work to improve the ethnic reporting amongst its workforce. The data presented in the report suggests that black minority ethnic (BME) staff fared less favourably than white staff across almost all areas measured by the standard (workforce representation, recruitment, disciplinary procedures, training, equal opportunities, bullying and harassment, Board representation).
- As part of the trust annual report, the trust had not produced and published the Annual Equality Report (demonstrating their compliance with section 2 of the Equality Act 2010 (Specific Duties) Regulation 2011). Interviews carried out with the director of workforce and organizational development confirmed this. A copy of the annual equality report was not provided when an evidence request was submitted via an additional evidence request. A board paper was supplied that alluded to the report being in progress but the actual annual equality report was not supplied.
- The trust had not produced and published its Equality Objectives (demonstrating their compliance with section 3 of the Equality Act 2010 (Specific Duties) Regulation 2011). Corporate interviews confirmed that these objectives were not in place and that that these would be produced as part of the People and Culture Strategy (to be finalised in July 2016). We looked at the draft People and Culture Strategy and we saw that it did

not include a separate Equality & Diversity section and had very little reference to Equality & Diversity. Moreover, the strategy was focused only on staff, meaning that there were no overarching strategic equality and diversity objectives, which focussed on service delivery.

- During the years 2015 to 2016 the trust had not implemented the Equality Delivery System (as required in SC 13 of the 2015/16 and 2016/17 NHS Standard Contract EDS2). The Trust had started their 2016/17 EDS2 implementation of Goal 3 and 4 (workforce and leadership focused outcomes), particularly the collection of evidence and self-assessment. From the interview with the director of workforce & organisational development, there was no evidence to suggest that the trust would be implementing EDS2 Goals 1 and 2 (patient-focused outcomes), or that a governance for these would be in place.
- The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. The Accessible Information Standard had been discussed in relation to the adoption of the new Patient Management System. However, there was no robust trust-wide implementation plan that would have been commenced within the timescales of 1 September 2015 required by NHS England and that would be addressing all aspects of the conformance criteria.
- The trust's 'Equality Impact Analysis' policy, which included a reference template and guidance with the scrutiny process was embedded in the organisation's "policy on policies". In the board papers we reviewed, this had been referred to as "EDS". The Policy Ratification Group was responsible for all aspects of equality analysis work. We found there was no clear centralised equality analysis governance for decisions other than policies. CQC was informed by the director of workforce and organisational development that the members of the policy group and individual project leads had not received equality analyses training and therefore did not have the relevant skills to quality assure and analyse the information they collated. When requested to provide equality analyses for six various decisions/policies/restructures, the Trust was unable to provide a structured process that would outline their compliance with the Brown principles (Case law sets out broad principles about what public authorities need to do to have due regard to the aims set out in the general equality duties underpinning the Equality Analysis process. This is referred to as the 'Brown principles'). Moreover, evidence has been collected to suggest that essential equality risks had not been identified and mitigated, for instance the Emergency Preparedness and Response Plan Policy did not include any reference to how emergency/evacuation situations should be managed for disabled staff, patients and visitors.
- The equality and diversity governance was segmented, disjointed and confusing. Interviews conducted with corporate staff indicated that Equality and Diversity sat in the HR directorate. E&D (HR) leads focused on HR related issues and work streams only and the patient focused work sat under the Quality Committee (particularly in the 4Es committee). However, the provided minutes and an interview with the Quality Management have suggested that the relevant agenda has not been discussed in a joined up way that demonstrates a cohesive approach.
- We saw some examples of staff being champions or leads on equality and diversity in order to meet the needs of patients that their particular service cared for. This seems to be predominantly local practice adopted by individual managers and was inconsistent across the trust. Staff we spoke with stated that there was a lack of strategic drive from the trust leadership to ensure that equality related issues were managed well across the entire organisation and that staff across the protected characteristics had their voices heard in a meaningful way.
- The trust had a Black and Minority Ethnic Staff Network which was keen to be proactive. However, they were not effectively supported and used to advise the organisation on improvements for both staff and patients. The group were part of the people and culture committee for one meeting only but this was stopped by the executive team

Leadership and culture

- Following an employment tribunal involving the trust in July 2015, CQC carried out a focussed inspection jointly with Deloitte to look at the well-led element of the trust. In the subsequent report, CQC described the culture within the senior leadership as informal with regards to following HR processes and in relation to governance.

Although some improvements had been made since, the seriousness of the lack of HR processes had not been grasped and as such had not brought about sustained improvement. We were informed during the inspection that two members of the executive team had been referred to their professional bodies. The culture of informality was evident when we asked the trust chairman how he had assured himself and the trust that referrals of senior staff were investigated by the trust and how he was assured that the staff were suitable to remain in post while the investigation by the professional body took place. The Chair advised that he had spoken informally with the senior staff, however, had not made formal records of the interviews or appropriately recorded the rationale behind his decision making.

- There was good local leadership within most services; staff felt supported and engaged with team leaders. However, there appeared to be a gap between leadership at local level and senior trust leadership.
- Some staff we spoke with said that morale was low and affected by recent media reporting of the employment tribunal in July 2015 which highlighted problems in the leadership of the trust. However, in learning disabilities service all staff spoke very highly of their team managers. Staff reported high morale, they told us that they liked their jobs and felt happy at work. Staff told us that they felt empowered and confident and that their team managers helped them to develop their skills. Teams consistently reported strong and supportive local management. Teams reported that they functioned well in respect of team working and mutual Staff we spoke with described a supportive culture and said they supported each other. Staff enjoyed working with each other and valued their teams. Staff said when they had capacity issues they pulled together and supported each other and other teams. Support. Team managers considered their line managers to be supportive and approachable.
- Relationships between the trust and staff-side representatives had been poor when we inspected in January 2016 and the situation was unchanged during this inspection. The staff side had no confidence in the management and had requested ACAS mediation. Whilst the trust had agreed to this, no date had been set for a mediation meeting at the time of our visit, there appeared to be no urgency. The trust leadership had neglected to actively manage and change this key relationship. The relationship had broken down due to failure to consult the staff side over workforce issues. Whilst JNCC meetings occurred and the interim CEO attended, other senior executives or key players did not attend consistently. There was lack of negotiation, with matters being announced at the last minute. The leadership of the trust were not open to challenge by the staff side. There had been a lack of negotiation over job descriptions, for example the children's consultation was stopped because job descriptions had not followed a job evaluation process. The staff side were concerned that the trust did not follow its own policies. There were concerns that people were given acting posts without proper processes being followed. Informal complaints were not acted upon. There was little confidence in the human resource department. The chair of the staff side had been invited onto the people's engagement committee, a meeting had not occurred at the time of the inspection.
- We found in the previous inspection that the human resources department was fractured as a consequence of events related to the employment tribunal. We were told of plans to bring about changes to increase capacity and to promote more unified relationships. However, we found during this inspection that the pace of change was slow and this impacted on the level of confidence operational staff and the staff side had in the department. Given the scale of change the trust was engaging in, a robust human resource department would be pivotal in supporting the transformational change required.
- New governors had been appointed and an induction and development programme was being implemented. Governors wanted to be able to rebuild relationships from the board to the clinical areas. This was being supported by the trust chair. Governors remained concerned about what had been the lessons learned following the employment tribunal and wanted to be kept informed about the investigations that were occurring with staff related to the employment tribunal aftermath knew what had happened with the investigations. Governors did not feel fully informed about what was happening and this made it difficult for them to fulfil their role of holding to account the non-executives of the board.

Inadequate

Are services well-led?

- Recruitment of vacant posts for non-executive directors was taking place and the trust was succession planning for non executives who would be retiring in the near future. A concern was the amount of time the non executives were providing to the trust over and above their contracted hours. Some non-executives were not confident in answering questions about quality. However, all non executives carried out board to service area site visits to the clinical service and gained assurance by going and seeing that quality of services and strategy was being delivered.
- A programme of board development was being planned and implemented.
- Occupational therapists were concerned about the management structure of their profession which made progress beyond a grade 7 difficult and supervision difficult to organise. Focus groups of clinical staff expressed concern about the transformation work, which they considered to be poorly planned and did not work. Staff required more support and suggestions on how to support. The impact of this was that referrals were not consistent, staff went to the wrong place and waiting lists were increasing. Staff acknowledged that senior managers were listening, however, did not feel heard as little action occurred. Staff expressed they required more clinical engagement and clinically driven decision making.

Fit and Proper Person Requirement

- The trust had a fit and proper person policy and duty of candour policy dated May 2016. We looked at 13 director files; these were structured to reflect how the requirements of the regulation were met. Fit and proper persons declarations were in place; all files contained evidence of an audit process with regards to bankruptcy and disclosure and disbarring service checks. Training passports reflected the development for the board roles. Recent appointments contained evidence of a competency based interview. Competency was reviewed through appraisals and regular one to one supervision which were in place. A register of directors' interests was in place.
- Subsequent to our focussed inspection of January 2016, CQC found the trust to be in breach of its fit & proper person requirements. However, we found that processes were in place and backed up by a robust audit system for all current and future directors within the trust and as such, the trust had met the fit and proper person requirements.

Duty of Candour

- The trust employed family liaison staff to liaise between clinical services, relevant directors and patients and families where incidents rated at moderate harm or above have been experienced. The role included monitoring and reviewing of information to identify those incidents that required family liaison and a formal duty of candour exercised. Formal letters were sent to patients and relevant others involved in incidents, on behalf of directors.
- Reporting of the duty of candour was through the serious incident meeting, this reported to the quality committee for the trust board who monitored the notification and assurance of the process.
- Staff had a good understanding of duty of candour and the need to be open and transparent. Ward managers were able to share examples of how this was implemented. For example, following an incident, staff in the acute service informed all patients of an incident at a community meeting. Staff also sent letters explaining the incident and action plan to all current and discharged patients that may have been involved. Staff in the long stay service gave numerous examples of contacting patients and families following incidents including medication errors and patients confirmed staff were open and honest with them.

Engaging with the public and with people who use services

- The Staff Friends and Family Test was launched in April 2014 in all NHS trusts It asks staff whether they would recommend their service as a place to receive care, and whether they would recommend their service as a place of work. The trust had a lower staff response rate than the England average (9.4% compared to 11.4%) from 1 July to 31 September 2015. The percentage of staff who would recommend the trust as a place to receive care is 12% lower than the England average - 67% compared to 79%. Staff who would not recommend the trust as a place to receive care is also higher than the England average - 13% compared to 7%.
- Staff in community older adult services told us they had attended consultation meetings in the planning stages

of the neighbourhood model changes. However, staff told us they did not feel confident working with younger adults and required additional training to develop their skills.

- In the learning disability service lead managers occasionally attended staff meetings to discuss ideas for improvement and feedback on the service provided. Staff in all the teams felt able to take ideas to their managers. Staff were able to give feedback on the service and input into service development through their staff meetings.

Quality improvement, innovation and sustainability

- The ECT Accreditation Service had accredited the electro convulsive treatment clinic in 2012. The trust had affiliated membership of the Memory Services National accreditation programme. The forensic service had received accreditation in 2015 with the Quality Network for Forensic Mental health services. The peri-natal services were part of the Quality Network for Perinatal Mental Health services.
- Quality visits were carried out by a Board member; most visits have a commissioner, staff or public governor and clinical expert on the panel. When a team has achieved platinum status the leader of the team is qualified to join the quality panel. This enables sharing of ideas and best practice at a team level. The trust has been complimented on the quality of the visit programme which has been in place since 2010. Individual teams are awarded at an annual awards ceremony for the high quality of care they have provided.
- Staff in the acute service on ward 33 had completed research into Metabolic Syndrome in women. Outcomes from this study had improved care. Ward 33 had won a trust innovation bid to provide dance and movement therapy on the ward. Since 2014, the trust has planned implementation of 'Safewards'. Safewards is an international initiative.
- The long stay wards were involved in a new initiative called Growth, which involved using a piece of disused land that would become a social enterprise involving the whole community. A staff member at Audrey House had developed the 'Angling 4 You' group for their patients.
- It was innovative and very unusual for a CAMHS (RISE) team to be based within a children's emergency department. The development of this team had depended on good partnership working between CAMHS, commissioners and the local acute hospital.
- The learning disability nursing team developed a pilot study for screening patients with learning disabilities for autistic spectrum disorder, attention deficit hyperactivity disorder and traumatic brain injury. They also conducted research into patients with a learning disability who self harm.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: • The trust must ensure that sufficient numbers of suitably qualified, skilled and experienced staff are employed to ensure that the physical health care needs of people at are being met. Regulation 22

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: • Patients were not involved in care planning. • Patients could not record their preferences in advance decisions. • Care plans did not consistently demonstrate patient involvement or a recovery focus. • There were long waits for the psychology service across all teams. • Across the all teams, the care plans did not have an agreed date of review. The care plans in Amber Valley CLDT lacked specific goals, strengths and patients' views. In all other teams we saw that some patients did not have a care plans in place. • There were long waits for the psychology service across all of the Community-based mental health services for older people teams. Because of this, patients were not always referred into the psychology service, which meant patients did not always receive the most appropriate treatment for their needs.

This section is primarily information for the provider

Requirement notices

- There was a lack of psychology available to patients at Audrey House and a limited amount of psychology time available for patients at Cherry Tree Close. Because of this, patients were not always able to access psychology, which meant patients did not always receive the most appropriate treatment for their needs.
- Care plans in the Derby City and County South team lacked detail and were not always up-to-date.

This was a breach of Regulation 9 (1)(3)(a)(b)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met:** • Patients' capacity to consent to care and treatment had not been formally assessed and recorded. • Second opinion approved doctors (SOADs) were not requested in a timely manner. • **Patients on a Community Treatment Orders were not routinely made aware of their section 132 rights.** • Staff did not always carry out assessment of capacity to consent in a consistent way in all teams. Some records where patients had been identified as lacking capacity had no documentation in place todemonstrate how capacity to consent or refuse care had been sought. Assessments of capacity were not followed with recorded best interests meetings. **This was a breach of Regulation 11(1)(3)(4).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • Patients had not been consistently provided with HCR20V3 risk assessments.

This section is primarily information for the provider

Requirement notices

- Identified environmental risks and ligature risks had not been addressed using the actions identified on annual assessments.
- Staff training figures such as for safeguarding and 'control and restraint' were too low.
- Seclusion rooms were too small and compromised the safety of staff and patients using them.
- Medicines were being stored at temperatures too high to support safe storage.
- **Not all locations where patients were seen and treated had access to emergency equipment.**
- **There was no process to safely track and record blood test results of patients receiving treatment with lithium.**
- The trust did not consistently maintain medication at correct temperatures in all areas.
- The trust did not ensure that the prescribing, administration and monitoring of vital signs of patients are completed as detailed in the NICE guidelines [NG10] on-Violence and aggression: short-term management in mental health, health and community settings.
- The trust did not ensure that clinical staff had a consistent approach to the use of rapid tranquillisation, understand its risks and record its usage.
- **The health-based place of safety in the Hartington Unit had multiple ligature points and other sources of risks for patients.**
- **The health-based place of safety at Hartington Unit did not hold ligature cutters or emergency equipment.**
- **The health-based place of safety at the Hartington Unit contained blind spots.**
- **Medicine reconciliation and patients' allergy status was not completed on all prescription charts.**
- **Medicine reconciliation for patients using the service had either not been completed or completed using only the patient as its source.**

This was a breach of Regulation 12(1)(2)(a)(b)(c)(d)(g)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** • We found an incident recorded on 7 May 2016 where a patient had been injured as a consequence of bank staff not intervening during a violent incident. We could find no record of a safeguarding referral having been made in relation to the patient who was injured. This was a breach of Regulation 13 (1)(2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **How the regulation was not being met:** • Seclusion rooms were not clean and bedding had not been changed between uses. • Staff could not use the clinic room to see patients and dispense medicines due to its location in the unit. • Systems were not in place to ensure that equipment to monitor physical health was regularly cleaned and checked. • Portable electrical equipment and fire extinguishers were not regularly checked and recorded for safety. • The trust did not ensure that all equipment was used, stored and maintained in line with manufacturers' instructions. This was a breach of Regulation 15 (1)(2)(a)(e)(f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • Patients' detention papers were often chaotically filed and difficult to find in their entirety.

This section is primarily information for the provider

Requirement notices

- Patients were not provided with community meetings.
- Systems to identify and manage all environmental risks in the patient care areas.
- Systems did not ensure that all long term segregation and seclusion was undertaken and documented in line with trust policy.
- Patient's capacity and ability to consent in the planning, management and review of their care and treatment was not routinely documented.
- There had been long average waiting lists of 27 weeks for psychology and 41 weeks for speech and language therapists across all teams.
- The provider did not ensure that the discharge process was properly documented or demonstrate that planning began at the point of admission.
- The provider did not maintain accurate and up to date records relating to service users utilising section 17 leave.

This was a breach of Regulation 17 (1)(2)(b)(c)(d)(e)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

- Staff training figures for key training such as safeguarding, basic life support, intermediate life support, clinical risk and 'control and restraint' was extremely low. No medical staff had attended training in the drug management of violence and aggression.
- Temporary staff were not always competent and up to date with 'control and restraint' training. This was directly linked to a patient sustaining an injury from another patient during a violent incident.
- Gender ratios of nursing staff on shifts were not always appropriate for an all-male service. This meant that patients often had to wait for a gender appropriate member of staff to have their needs met.
- Staff did not receive one-to-one supervision on a regular basis.
- Not all staff had completed mandatory and role specific training.

This section is primarily information for the provider

Requirement notices

- The trust did not ensure that all shifts had the required amount of staffing at the correct grade.
- There was an over-reliance on bank and agency staff across all of the acute wards.
- The Trust did not ensure that staff had received regular supervision.
- The trust did not ensure that all staff had yearly appraisals.

This was a breach of Regulation 18 (1)(2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulation 2014 Good governance. The trust did not have effective systems and processes to operate effectively to ensure quality and safety. The specific areas of concern are: a. Lack of fire warden training across all inpatient services b. The Trust is not compliant with its Equality and Diversity obligations. This was a breach of regulation 17(1)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA 2008 (Regulated Activities) Regulation 2014 Need for consent

This section is primarily information for the provider

Enforcement actions

The specific areas of concern are:

1. Patients' capacity to consent to care and treatment had not been formally assessed and recorded
2. Second opinion approved doctors (SOADs) were not requested in a timely manner
3. Assessments of capacity to consent were not carried out in a consistent way
4. Assessments of capacity were not followed with recorded best interests meetings
5. Nursing staff did not have a full understanding of the Mental Capacity Act
6. Sufficient capacity was not presumed where no evidence was available that there was a lack of capacity
7. Limited evidence was available to demonstrate the reasons for why patients had an assessed lack of capacity
8. In all except one case it was unclear why 'do not resuscitate' (DNAR) orders were in place
9. Patients' capacity and ability to consent in the planning, management and review of their care and treatment was not routinely documented.

This was a breach of Regulation 11 (1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA 2008 (Regulated Activities)** **Regulation 2014** **The specific areas of concern are:** 1. There was a failure by clinical leads and staff at director level to investigate possible links between incidents to prevent further possible abuse of patients and learn lessons from the incidents

This section is primarily information for the provider

Enforcement actions

2. Staff had not received the required safeguarding training for their role
3. Clinical staff who have direct contact with children and young people had not completed level three safeguarding training as identified through the Safeguarding Children and Young people: roles and competences for health care staff intercollegiate document (March 2014, v3)
4. Staff were not suitably trained to have the skills and knowledge to identify and report suspected abuse
5. Staff who have contact with children did not receive safeguarding supervision
6. Safeguarding supervision was not always performed in line with the trust's safeguarding policy.

This was a breach of Regulation 13(1)(2) (3)(6)