

# Derbyshire Healthcare NHS Foundation Trust

## Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall rating for this trust

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?

Requires improvement 

# Summary of findings

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

## Background to the trust

Derbyshire Healthcare NHS Foundation Trust was formed in 2011 and became a Foundation Trust in February 2011. The trust employs 2167 staff; serves a population of about one million people living in an area of 983 square miles; including the city of Derby. The trust provides 271 beds and runs 191 clinics. The trust annual operating income is £140 million. The trust has a public membership of 6,256 people and has 28 governors.

The trust delivers community and mental health services, including those with learning disabilities, people with substance misuse needs and community children and family services. The trust runs services from 60 sites and has eight neighbourhood teams.

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

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

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 2011 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, chief executive officer.

# Summary of findings

There have been 14 unannounced Mental Health Act reviewer visits between May 2016 and July 2018.

A well led review was carried out in January 2016.

A comprehensive inspection was carried out in June 2016 of all core services. We found the trust did not comply with regulations 9 (person centred care), 11 (need for consent), 12 (safe care and treatment), 13 (safeguarding patients from abuse and improper treatment), 15 (premises and equipment), 17 (good governance) and 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We carried out a focussed inspection of community services for children, young people and families in January 2017 and found the regulations had been met.

We carried out a focussed inspection of community mental health services for people with a learning disability or autism in February 2017 and found regulations 9 and 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had not been met.

We carried out a focussed inspection of forensic inpatient ward and wards at London Road Community Hospital in December 2017 and found regulations 9, 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had not been met.

We carried out a focussed inspection of wards for older people with mental health problems in January 2017 and found the regulations had been met. We carried out another focused inspection of wards for older people with mental health problems at Cubley Court in March 2018 following concerns raised. We found regulations 11 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had not been met.

## Overall summary

**Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement**



## What this trust does

The trust provides inpatient and community mental health services. The trust also provides community health services for children and young people, these include health visitors and school nurses.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of people's experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

# Summary of findings

We inspected seven complete mental health core services (three inpatient and four community). These were selected due to their previous inspection ratings or, our ongoing monitoring identified that an inspection at this time was appropriate to understand the quality of the service provided.

Four core services were rated as overall requires improvement and one service as inadequate. Four core services were rated as good, one had previously been rated as outstanding. Of these services we rated two domains as inadequate.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed Is this organisation well-led?

## What we found

### Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe, effective, responsive and well-led overall as requires improvement and caring as good. This includes the previous ratings of three services that we did not inspect on this occasion. We rated four of the trust's 10 core services as good and four as requires improvement, one as inadequate and one as outstanding.
- Although the trust leadership team had a comprehensive knowledge of current priorities and challenges and acted to address them, the pace of change was slow, which we highlighted in previous inspection. This meant that we did not see enough improvement in clinical services, and a deterioration in the acute admission wards. We found a lack of leadership in some core services such as the acute admission wards and crisis service.
- The quality committee did not have robust oversight and assurances of drug and therapeutics and medicines management in the trust. There were no clear measures for performance management of the pharmacy service or evaluation of the impact of staff shortages.
- Staff in four clinical settings did not check the fridge temperatures for stored medication regularly. This meant that there was a risk that medicines would deteriorate and be unfit to use. We flagged up this problem at our last inspection.
- Four core services did not have enough staff. For example there was a shortage of, speech and language therapists, psychologists. This meant that longer waiting times occurred for dysphagia assessments and psychologist assessments. There was also a shortage of nurses and psychiatrists. Besides the care coordinators, we found this in the previous inspection.
- There was a lack of trained staff for the health based place of safety. Staff mandatory training, supervision and appraisals still did not meet the trust targets.
- We found there were small groups of staff who did not feel valued and involved in strategic decision making, for example, allied health professionals and psychologists. We found this in our previous inspection.
- Not all staff had heard of the Speak Up Guardian role. There was a perceived conflict of interest between the post holder carrying out the Speak Up Guardian role and being a human resources manager at the same time.
- Staff in three clinical services did not check emergency bags regularly in accordance with trust policy, to make sure they were ready to use.
- Staff in three clinical services had not completed incident forms when making safeguarding referrals in accordance with trust policy. This meant they would not have accurate data.

# Summary of findings

- Some staff did not implement the smoking policy as they did not wholly agree with the non smoking policy directives, this meant smoking occurred within buildings and within hospital grounds posing a fire risk.
- The quality of care plans, physical health assessments and physical health care plans undertaken by staff was still not consistent across clinical services. This meant staff would not have all the information required about a patient to provide care.
- We continued to find that not all patients were involved in their care plans or given copies of their care plans. Not all patients had crisis plans in place. There was variability in the use of advance decisions across core services. Patients make advance decisions to indicate their preferred treatment in particular situations.
- The ward environments did not support safe care. Acute admission wards had blind spots along their bedroom corridors and lacked parabolic mirrors, and staff were not always present in these areas. The cleaning trolleys used on the wards at Hartington Unit held hazardous cleaning materials but had broken doors that did not lock. The health based place of safety had ligature points ( these are places were a ligature could be tied to self harm).
- Slow IT systems impacted on the quality of care, for example staff found the log in and log out process for recording 15-minute observations hindered the recording of real time observations.
- The trust did not have up to date service level agreements with one local acute trust to support Mental Health Act functions and psychiatric liaison services.

However:

- The trust board had the range of skills, knowledge and experience to perform its role. Significant improvement had occurred in the stability of the trust board and board development since our earlier inspection. The trust chief executive continued to give good systemic leadership in the Sustainable Transformation Partnership and the mental health workstream.
- There was improvement in the extent most staff felt respected, supported, and valued in the trust since our previous inspection. The trust recognised staffing challenges and had a robust recruitment strategy using a range of initiatives.
- Since our previous inspection the trust had made improvements in the human resources department, in relationships with trade unions and in its approach to equality and diversity.
- Since the previous inspection the trust had improved its governance structures to support the delivery of its strategy. Non-executive and executive directors were now clear about their areas of responsibility.
- There was improvement in the relationship between the trust board and council of governors'. Improvements in the composition, accountability, functioning and training of the governors' council had occurred since our previous inspection. The governors held the non executives to account.
- The wards and clinical bases that we visited were clean.
- There were good systems in place to support staff, patients, and carers when serious incidents occurred.
- There was good management of complaints and there was an increase in compliments.
- Patients had safety plans and recovery hubs provided patients with a range of activities. Care and treatment followed the National Institute Health and Care Excellence (NICE) guidance. Information was available to patients on a range of issues. .
- Patients and carers said staff were compassionate, caring and kind. Staff listened and treated patients with dignity and respect. Staff knew their patients and patients gave positive feedback on the quality of care.

# Summary of findings

- Staff had good knowledge of the Mental Health Act. Improvements had occurred in relation to the Mental Capacity Act and recording of capacity and consent.
- Good multi agency working occurred and staff said there was good team working. This resulted in good discharge planning.

## Are services safe?

Our rating of safe stayed the same. We took into account the previous ratings of services not inspected this time. We rated it as requires improvement because:

- Four clinical services did not have enough staff. These were older peoples' wards, crisis services, acute admissions, and community learning disability service. This led to increased waiting times for speech and language therapists and psychologists. In acute admission wards it was difficult to keep safe staffing levels all of the time, resulting in delays in activities, leave and medication administration.
- Staff in three clinical services did not check emergency bags regularly in accordance with trust policy to make sure the bags were ready for use.
- Staff in four clinical settings did not check the stored medication fridge temperatures regularly. This meant that there was a risk that medicines would deteriorate and be unfit to use.
- In three core services, staff did not complete incident forms when making safeguarding referrals in accordance with trust policy which effected the quality of information.
- Staff mandatory training, supervision and appraisals did not consistently meet the trusts targets
- Some staff did not implement the no smoking policy and did not wholly agree with the non smoking policy directives and smoking occurred within buildings and on grounds.
- The ward environments did not support safe care. Acute admission wards had blind spots along their bedroom corridors and lacked parabolic mirrors, and staff were not always present in these areas. Rooms in the acute admission wards did not have nurse call alarm systems. The cleaning trolleys used on the wards at Hartington Unit held hazardous cleaning materials but had broken doors that did not lock. The health based place of safety had ligature points (these are places a ligature could be tied to self harm).
- A number of wards had dormitory-style bedrooms. This meant that some patients had to share a bedroom; which compromised their privacy and dignity.
- Community teams did not always have sufficient space to see patients or work.

However:

- The wards and clinical bases that we visited were clean.
- Patients had safety plans in place to support the management of risks.
- There were good systems in place to support staff, patients, and carers when serious incidents occurred.

## Are services effective?

Our rating of effective stayed the same. We took into account the previous ratings of services not inspected this time. We rated it as requires improvement because:

- Staff poorly recorded the results of; screening tools for people on anti-psychotic medication, physical health questionnaires and observations. This meant that physical care plans were not consistently done or of good quality.
- The quality of care plans and assessments written by staff were not consistent

# Summary of findings

- Patients lacked access to speech and language therapists resulting in long dysphagia waiting lists.
- Patients lacked access to psychologists and psychological assessments resulting in longer waiting lists.
- Staff lacked training to support them in working in the health based place of safety.
- Staff reported computers were slow and hindered the recording of observations in real time.

However:

- Staff had good knowledge of the Mental Health Act. Improvements had occurred in relation to the Mental Capacity Act and recording of capacity and consent.
- Good multi agency working occurred and staff said there was good team working. This helped patients during discharge planning.
- Staff used National Institute Health and Care Excellence (NICE) guidance, for example in relation to violence and aggression and care of older people. This meant evidence base care was given.

## Are services caring?

Our rating of caring stayed the same. We took into account the previous ratings of services not inspected this time. We rated it as good because:

- Patients and carers said staff were compassionate, caring and kind. They listened and treated patients with dignity and respect.
- There was good carers involvement and carers assessment in place.
- Staff knew their patients and patients gave positive feedback on the quality of care.

However:

- We continued to find that not all patients were involved in their care plans or given copies of their care plans. Not all patients had crisis plans.
- There was variability in the use of advance decisions. These are plans that patients make to enable staff to carry out their wishes when situations arise.

## Are services responsive?

Our rating of responsive stayed the same. We took into account the previous ratings of services not inspected this time. We rated it as requires improvement because:

- Patients had long waits for care coordinators, psychologists and speech and language therapists. We found this at the last inspection
- Staff did not have enough space in all community bases to see patients.
- A number of wards had dormitory style provision of bedrooms. This meant that some patients had to share a bedroom; which compromised their privacy and dignity.

However:

- The trust had a good complaints management system. Patient compliments had increased.
- We found good discharge planning occurred in clinical services, supported by good multidisciplinary and multi agency working.
- Recovery hubs provided a range of activities for patients who were able to leave the ward.

# Summary of findings

- Information was available to patients on a range of issues to support their understanding of medication, support available, rights and conditions.

## Are services well-led?

Our rating of well-led improved. We took into account the previous ratings of services not inspected this time. We rated it as requires improvement because:

- Although the trust leadership team had a comprehensive knowledge of current priorities and challenges and acted to address them, the pace of change was slow, which we highlighted in previous inspection. This meant that we did not see enough improvement in clinical services, and a deterioration in the acute admission wards. We found a lack of leadership in some core services such as the acute admission wards and crisis service.
- The quality committee did not have robust oversight and assurances of drug and therapeutics and medicines management in the trust. There were no clear measures for performance management of the pharmacy service or evaluation of the impact of staff shortages.
- We found there were small groups of staff who did not feel valued and involved in strategic decision making, for example, allied health professionals and psychologists.
- Staff perceived a conflict of interest between the post holder carrying out the Speak Up Guardian role and being a human resources manager at the same time.
- Staff mandatory training, supervision and appraisals did not meet the trust targets.
- Staff team meetings did not have a standardised approach to make sure all governance issues were covered..
- Access to electronic patient records was slow and inconsistent storage of information in the same place within the record, made it difficult to find. Recording of observations in real time was onerous.
- The trust did not have up to date service level agreements with local acute trusts to support mental health act functions and psychiatric liaison team services.

However:

- Staff understood the trust vision and values
- The culture and staff morale had improved since our last inspection.
- There was visibility of senior leadership
- Staff felt able to raise concerns and knew about the whistleblowing, bullying and harassment policies.
- Staff received awards from the trust for good work undertaken.

## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found the following outstanding practice:

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

# Summary of findings

- The purpose-built seclusion suite at Radbourne Unit had an adapted room that met the needs of people with limited mobility. Staff had the opportunity to offer sensory-based interventions to secluded patients such as music and aromatherapy that helped them relax.
- Each unit had a recovery hub that had a range of facilities and equipment, and offered a structured programme of therapeutic activities. Staff and patients spoke highly of the hubs.

## **Community mental health services for people with a learning disability or autism:**

- Staff collaborated with a national charity, the Anne Craft Trust, to create a simplified and pictorial form to help patients and their families to recognise and understand what constitutes abuse. We saw this was an area of innovative practice to support the patient group and tackle abuse.

## **Areas for improvement**

We found areas of improvement including 37 breaches of legal requirements that the trust must put right to comply with its legal obligations. We found 54 things that the trust should improve to comply with minor breaches that do not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

### **Action the trust MUST take to improve**

We told the trust that it must take action to bring six services into line with legal requirements.

#### **Wards for older people with mental health problems:**

- The trust must ensure that all systems and processes in place to identify and manage patients with deterioration effectively are followed.
- The trust must ensure that effective policies are in place to allow staff to identify, escalate and treat deteriorating patients (including sepsis).

#### **Community-based mental health services for older people:**

- The trust must ensure that staff follow policies and procedures when transporting medicines in the community.

#### **Mental health crisis services and health-based places of safety:**

- The trust must ensure that all blind spots and points where a ligature could be anchored to be reduced in the health based places of safety.
- The trust must ensure that staff clean all areas that people who use the service use.
- The trust must ensure that all staff consistently check the emergency equipment so it is safe to use.
- The trust must ensure that it recruits sufficient staff to safely support people who use the service.
- The trust must ensure that staff robustly assess and handover the risks of all people who use the service.
- The trust must ensure that all staff follow the lone working practices.
- The trust must ensure that all documents used by staff to record people's risks are available electronically so that all staff can access people's current risks.
- The trust must ensure that staff assess all the needs of people who use the service and plan for their care.
- The trust must ensure that staff monitor the physical health needs of each person who uses the service to reduce the impact of this on their mental health.

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

# Summary of findings

- The trust must ensure that all wards and shifts have safe staffing levels.
- The trust must ensure that all staff are fully aware of the trust's policy and guidance on contraband or risky items, and apply it consistently across all wards.
- The trust must ensure that staff receive training in searching before they undertake any searches.
- The trust must ensure that it complies with the national gender separation requirements.
- The trust must ensure that staff recognise, report and follow up safeguarding issues.
- The trust must ensure that cleaning trolleys have lockable areas for hazardous substances.
- The trust must ensure that the electronic care records system is fit for purpose, and allows staff quick and easy access to essential information.
- The trust must ensure that its observations process is safe and fit for purpose.
- The trust must ensure that medicines management practices are safe and effective.
- The trust must ensure that patients have access to the range of care and treatment interventions recommended for the patient group.
- The trust must ensure that staff full complete and regularly update patients' assessments and care plans.
- The trust must ensure that staff complete and record any physical health observations required after rapid tranquillisation, and oral medication given for agitation.
- The trust must ensure that staff complete and record the necessary observations and checks required when a patient is secluded.
- The trust must ensure that staff complete, record and respond appropriately to patients' physical health needs.
- The trust must ensure that staff are up-to-date with their mandatory training and receive any additional specialist training required for their roles.
- The trust must ensure that patients on section 17 leave have the correct authorisation and legal documentation in place, and that such documentation is easy to locate.
- The trust must ensure that the core service has a robust programme of clinical audits and that identified actions are addressed.

## **Community-based mental health services for adults of working age:**

- The trust must ensure there is a plan in place to show how waiting lists for care coordinators, psychology and outpatients would be reduced.
- The trust must ensure that it is clear what interventions each patient is waiting for, their level of risk and whether they are open to another part of the service.
- The trust must ensure all teams checked fridge and room temperatures daily.
- The trust must ensure all teams check their emergency bag in line with policy.
- The trust must ensure all team managers use a caseload management tool.

## **Community mental health services for people with a learning disability or autism:**

- The trust must ensure every patient has an up-to-date risk assessment in place.

# Summary of findings

- The trust must ensure prescription charts contain allergy information.
- The trust must ensure average waiting times for speech and language therapy are reduced.

## **Action the trust SHOULD take to improve:**

### **Wards for older people with mental health problems:**

- The trust should ensure clinic room temperature recordings are kept accurately
- The trust should ensure a clear process is put in place for staff to review patients' risk before they access Section 17 leave.
- The trust should ensure staff are appropriately trained in sepsis awareness and management.
- The trust should ensure staff complete the self-harm risk assessment section within patients' treatment cards.
- The trust should ensure patients have personalised physical health interventions detailed in their care plans.
- The trust should ensure all staff have access to the required training syllabus during their induction.
- The trust should ensure patients are made aware of the role of the advocate.
- The trust should ensure all patients have a specific discharge care plan and that patient care plans refer to Section 117 aftercare services where appropriate.
- The trust should ensure all patients are offered a copy of their care plan
- The trust should consider reviewing their processes to ensure all safeguarding concerns that are escalated to the local authority are also documented on the trust's incident recording form.

### **Forensic inpatient or secure wards:**

- The trust should consider replacing the flooring in the shower room on Curzon Ward.
- The trust should consider how they ensure that staff clean all areas of the clinic rooms.
- Staff should consider how they consistently record the rationale for any blanket restrictions.
- The trust should consider landscaping the occupational therapy horticulture garden so that patients' opportunities to use this are not limited.

### **Community-based mental health services for older people with mental health problems:**

- The trust should ensure that staff regularly check clinic room and medicine fridge temperature.
- The trust should ensure that staff regularly check emergency equipment.
- The trust should ensure they are able to provide access to psychology services in a timely manner across all teams.
- The trust should ensure that staff follow policy guidance in relation to reporting safeguarding concerns as an incident.
- The trust should ensure that staff complete physical health questionnaires with all patients entering the service. Staff should record baseline physical observations, and undertake any necessary monitoring of physical health.
- The trust should ensure that there is a consistent approach and guidance for staff when planning care to meet the needs of patients.
- The trust should ensure that staff embed discussions around advance decision into everyday clinical practice.

# Summary of findings

- The trust should ensure that all staff are aware of arrangements to monitor and audit the Mental Health Act and the Mental Capacity Act.
- The trust should ensure that operational policies and procedures are available to guide staff working in all teams.
- The trust should consider a standardised approach to what should be discussed at team meetings to ensure that all staff have access to essential information.

## **Mental health crisis services and health-based places of safety:**

- The trust should consider training staff who cover the health based place of safety specifically in use of the 136 suite.
- The trust should consider how it enables staff to record that they involve people who use the service in their care plans.
- The trust should consider producing all information in easy read formats.
- The trust should consider how it can support the operational lead recruited in the City and County South crisis resolution and home treatment team to ensure they can effectively manage the team.
- The trust should consider how the electronic patient record system could be improved to ensure that all information is easy to access about the person using the service.

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

- The trust should ensure that it addresses the risks presented by the location of the radiator in the ensuite bedroom on Tansley ward.
- The trust should ensure that there are appropriate safety alarms throughout the wards at Radbourne Unit, and in the communal rooms at Hartington Unit.
- The trust should ensure that it assesses and adequately mitigates the risks presented by the blind spots on the wards.
- The trust should ensure that storerooms are re-organised so that they do not compromise infection control and patient safety.
- The trust should ensure that repairs are completed in a timely manner.
- The trust should ensure that searches of patients' property take place in private.
- The trust should ensure that it reviews the level of restrictive interventions such as restraint to help identify opportunities for reducing such interventions.
- The trust should ensure that all wards have consistent and robust systems and processes for the safe and secure storage of patients' possessions.
- The trust should ensure that the service offers a recovery-based model of care that is underpinned by a multidisciplinary approach.
- The trust should ensure that patients have regular access to a structured programme of recovery-based therapeutic activities both on and off the wards.
- The trust should continue to work with local stakeholders to consider the need for a local psychiatric intensive care unit to help patients stay in the local area.
- The trust should continue to work with local stakeholders to develop its estate so that each patient has a single room with an ensuite bathroom.
- The trust should consider reviewing the external area to ward 35 and ensure it is safe and secure for patients.

# Summary of findings

- The trust should consider reviewing the external area to the enhanced care ward to ensure that patients have privacy and dignity.

## **Community-based mental health services for adults of working age:**

- The trust should ensure that rating scales and outcome measures are routinely collected and analysed to improve service delivery and ensure interventions offered are effective.
- The trust should ensure there are enough rooms across the teams to see patients in.
- The trust should ensure that all environments are free from clutter and in a good state of repair.

## **Community mental health services for people with a learning disability or autism:**

- The trust should ensure risk assessment can be found within patient records as needed and staff record/capture risk in a consistent manner.
- The trust should ensure information is available and assessable by all staff for the purposes of carrying out patient care.
- The trust should record patient consent before sharing information.
- The trust should ensure information within assessments considers a range of needs and includes all information necessary to form a full picture of the persons circumstance including safeguarding individuals who might come into contact with the patient.
- The trust should ensure that every patient has a care plan and that care plans contain the views of the patient, be recovery orientated and document that parents and carer were given a copy.
- The trust should ensure staff implement actions from audits and there are processes and systems in place to enable and support improvement.

## **Action we have taken**

We issued 37 requirement notices to the trust relating to six of core services. This meant the trust had to send us a report saying what action it would take to meet these requirements.

We issued an enforcement notice to the trust. The notice related to breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

- The trust must ensure that patient observations are conducted in accordance with each patient's individual risk assessment. These observations must be recorded in a timely manner.
- The trust was responsive in immediately increasing staffing levels, enhancing its monitoring of observations undertaken in each ward and by member of staff. The trust intended implementing a hand held electronic device to record observations by the 3 August 2018.

For more information on actions we have taken, see the sections on Areas for improvement and regulatory action.

## **What happens next**

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

# Summary of findings

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as requires improvement because:

- Although the trust leadership team had a comprehensive knowledge of current priorities and challenges and acted to address them, the pace of change was slow, which we highlighted in previous inspection. This meant that we did not see enough improvement in clinical services, and a deterioration in the acute admission wards. We found a lack of leadership in some core services such as the acute admission wards and crisis service.
- The quality committee did not have robust oversight and assurances of drug and therapeutics and medicines management in the trust. There were no clear measures for performance management of the pharmacy service or evaluation of the impact of staff shortages.
- We found there were small groups of staff who did not feel valued and involved in strategic decision making, for example, allied health professionals and psychologists.
- Staff perceived a conflict of interest between the post holder carrying out the speak up guardian role and being a human resources manager at the same time.
- Mandatory training, supervision and appraisals did not meet the trust targets.
- Slow IT systems impacted on the quality of care, for example the log in and log out process for recording 15 minute observations hindered the recording of real time observations. Information was not consistently stored in the same place in the patient electronic record.
- The trust did not have up to date service level agreements with local acute trusts to support mental health act functions.

However:

- The trust board had the range of skills, knowledge and experience to perform its role. Fit and Proper Person checks were in place.
- Significant improvement had occurred in the stability of the trust board and board development since our previous inspection. When senior leadership vacancies arose, the remuneration committee undertook a review of board capacity and capability needs to make sure people with the right skills were appointed.
- The trust identified and developed successors for critical posts to ensure it had a pool of potential future leaders. It had rolled out a talent management programme across the organisation.
- There was an annual programme of board visits to service areas and most staff said leaders were approachable and visible. The trust had refreshed its vision, values and strategy following staff feedback. Staff knew how the vision and values applied to the work of their teams.
- There was improvement in the extent most staff felt respected, supported, and valued in the trust since our previous inspection. The trust recognised staffing challenges and had a robust recruitment strategy using a range of initiatives.

# Summary of findings

- The trust planned services to consider the needs of the local population. The trust chief executive provided good systemic leadership in the Sustainable Transformation Partnership and the mental health workstreams.
- Since our previous inspection the trust had made improvements in the human resources department, in relationships with trade unions and in its approach to equality and diversity.
- There were clear responsibilities at every level in the trust for the management, investigation and response to complaints.
- Since the previous inspection the trust had improved its structures to support the delivery of its strategy. Non-executive and executive directors were now clear about their areas of responsibility.
- An improvement in the relationship between the board and council of governors' had occurred. Improvements in the composition, accountability, functioning and training of the governor's council had occurred since our previous inspection. The governors held the non-executives to account.
- The trust had appropriate governance arrangements in relation to Mental Health Act administration and compliance.
- The board knew its most significant risks and how to monitor and manage them.
- The trust assessed the impact on patient care before approving cost improvements.
- The trust had effective systems for investigating deaths, in line with national guidance. It had good processes for engaging with family and carers of deceased patients.
- Sub-committees provided the board with reports on quality and performance. Team managers had access to a range of performance information to support them with their management role. In 2018, Derbyshire Healthcare was the top mental health trust for information governance toolkit results.
- The trust was in the early stages of implementing a quality improvement strategy. The trust actively took part in clinical research studies and undertook audits. The trust shared learning with staff in a range of ways, including newsletters, electronic alerts, supervision, and meetings.

## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

\* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Sept 2018	Requires improvement ↔ Sept 2018	Good ↔ Sept 2018	Requires improvement ↔ Sept 2018	Requires improvement ↑ Sept 2018	Requires improvement ↔ Sept 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

### Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children and young people	Good Apr 2017	Good Apr 2017	Outstanding Apr 2017	Requires improvement Apr 2016	Requires improvement Apr 2016	Requires improvement Apr 2017

\*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ↓ Sept 2018	Requires improvement ↔ Sept 2018	Good ↔ Sept 2018	Requires improvement ↓ Sept 2018	Inadequate ↓ Sept 2018	Inadequate ↔ Sept 2018
Long-stay or rehabilitation mental health wards for working age adults	Good Sept 2016	Requires improvement Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Forensic inpatient or secure wards	Good ↑ Sept 2018	Good ↑ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018
Wards for older people with mental health problems	Requires improvement ↔ Sept 2018	Good ↑ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018
Community-based mental health services for adults of working age	Requires improvement ↔ Sept 2018	Good ↑ Sept 2018	Good ↔ Sept 2018	Requires improvement ↔ Sept 2018	Requires improvement ↔ Sept 2018	Requires improvement ↔ Sept 2018
Mental health crisis services and health-based places of safety	Requires improvement ↔ Sept 2018	Requires improvement ↔ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018	Requires improvement ↔ Sept 2018
Specialist community mental health services for children and young people	Good Sept 2016	Good Sept 2016	Outstanding Sept 2016	Outstanding Sept 2016	Good Sept 2016	Outstanding Sept 2016
Community-based mental health services for older people	Requires improvement ↓ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018	Good ↑ Sept 2018	Good ↔ Sept 2018	Good ↔ Sept 2018
Community mental health services for people with a learning disability or autism	Requires improvement ↓ Sept 2018	Good ↑ Sept 2018	Good ↔ Sept 2018	Requires improvement ↔ Sept 2018	Good ↔ Sept 2018	Requires improvement ↔ Sept 2018
<b>Overall</b>	Requires improvement ↔ Sept 2018	Requires improvement ↔ Sept 2018	Good ↔ Sept 2018	Requires improvement ↔ Sept 2018	Requires improvement ↑ Sept 2018	Requires improvement ↔ Sept 2018

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

# Wards for older people with mental health problems

Good  

## Key facts and figures

Ward 1 is a 16-bedded assessment and treatment unit for both men and women with a functional mental illness and is based at London Road Community Hospital. Cubley Court is a 36-bedded assessment and treatment unit for both men and women with an acute organic illness, such as dementia who require a period of assessment. There is one ward for men (Cubley male) and one ward for women (Cubley female).

We inspected all three wards within this service and looked at all five domains (safe, effective, caring, responsive and well-led). The inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We undertook an inspection of this core service in January 2017 following the comprehensive inspection in June 2016. We rated the core service as Requires Improvement following the inspection in January 2017. The concerns from that inspection were:

- Staff did not receive the necessary specialist training for their role so they could safely meet all patients' needs.
- Staff had not received regular supervision with their manager.
- Staff had not fully completed Mental Capacity Act documentation and assessments at London Road.
- Some staff did not apply the Mental Capacity Act correctly or fully understand how it related to the patient group that they cared for.

In March 2017, we carried out an unannounced responsive inspection to Cubley male due to receiving information of concern following a serious untoward incident. We focused our inspection on Cubley Court male ward only as the concerns related to there. At the March 2017 inspection, the concerns were:

- Staff did not always carry out mental capacity assessments in a consistent way.
- Staff did not record observations of patients in a timely way. Staff did not complete all assessments of patients.

During this inspection we:

- spoke with 37 staff members, including nurses, student nurses, healthcare assistants, doctors, ward managers, specialist nursing staff, physiotherapists, occupational therapists, psychologists, pharmacists, pharmacy technicians, security staff and domestic staff.
- spoke with 13 patients and two carers/relatives of patients who were using the services.
- looked at 31 sets of patient records, including mental and physical health records.
- observed several activities taking place on the wards including clinical handovers, therapeutic groups, multidisciplinary team meetings.
- reviewed several documents relating to the running of the service, including audits, fire safety procedures, records of equipment servicing, environmental risk assessments and minutes of meetings that had taken place.
- carried out Short Observational Framework for Inspection observations.

# Wards for older people with mental health problems

## Summary of this service

Our rating of this service improved. We rated it as good because:

- Lessons learned were shared and staff were supported following serious incidents. Staff felt able to report incidents.
- Staff were observed to be caring and respectful of patients' privacy and dignity.
- A number of measures had been implemented to try and reduce short staffing on the wards, although they remained regularly short staffed.
- Staff undertook risk assessments to identify patients who might be at risk of falling. They also ensured that patients had access to good physical healthcare.
- Staff provided appropriate support to patients to ensure that they ate sufficient food and drank enough to keep properly hydrated.
- Ward staff worked closely with the community teams that would provide care for the patients after they were discharged. They also planned discharge well to ensure that services met patients' care needs when they left the ward.

However:

- We found several omissions from patient observations and a need for increased observations were not always recognised and responded to.
- Staff reported difficulties using the electronic record system for recording patient observations.

## Is the service safe?

**Requires improvement** ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- Staff did not always follow procedures for the observation of patients at risk; including those at risk of self harm. We found there were several omissions in observations, including of patients who were being nursed on 'level three observations'. Patients who were on 'level three' observations were to be observed every 15 minutes and staff were to record these observations in real time on the electronic system. We found examples where records indicated gaps as long as two hours between observations of patients on level three. CQC had previously issued a Requirement Notice in relation to this issue following its unannounced inspection of Cubley male ward on 13 March 2018.
- When increased observations were advised by a doctor, these were not always carried out by ward staff. The tool used for physiological observations did not always highlight the need for increased observation levels.
- There was potential for local authority safeguarding referrals to be made without an incident form being completed. This meant that the trust may not maintain oversight of the safeguarding needs of their patients.
- Wards were regularly short staffed.
- On ward 1 it was still not clear if risk assessments were reviewed prior to detained patients going on leave and there was no document to record risk assessments prior to patients going on leave.
- Self-harm risk assessments were not completed on treatment cards.

# Wards for older people with mental health problems

- Temperatures of the clinic room fridge and food store where patient supplements were stored were not always recorded.
- Completion of mandatory medication competency training was below the trust target across all three wards and staff had not received sepsis awareness training.

However:

- Staff were supported following serious incidents and lessons learned were shared within the multidisciplinary team.
- Staff adhered to infection control and waste disposal policies.
- The service had introduced a number of recruitment and retention measures to fill registered nurse vacancies and had introduced a bleep holder initiative to cover staff shortages.
- The trust were aware of the difficulties in recording observations and were considering the implementation of hand held computers to overcome this.

## Is the service effective?

**Good** ● ↑

Our rating of effective improved. We rated it as good because:

- Mental health assessments were completed by staff within 24 hours of admission.
- Patients had appropriate access to physical healthcare.
- Falls assessments were completed and reviewed regularly by staff.
- Patients were appropriately supported to meet their dietary requirements and access physical activity.
- The service had improved its staff supervision and appraisal processes and compliance.
- The service completed audits regularly and responded to appropriately to improve practice.
- Ward staff developed good relationships with staff in community teams.
- Staff had good knowledge of the Mental Health Act and worked in accordance with it.
- Capacity assessments were good and carers were involved in best interest decisions.
- Patients were involved in care planning.

However:

- Patient care plans did not show ongoing individualised physical healthcare plans.
- There was no evidence that recognised measures were used to monitor screening and intervention for physical health conditions in patients on antipsychotic medication.
- Staff did not know what to do if a patient did not give consent to sharing information with professionals.
- Care plans did not include information about Section 117 aftercare services for detained patients, although staff were familiar with the aftercare process.

# Wards for older people with mental health problems

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- We observed positive, compassionate interactions between staff and patients.
- Staff respected patients' privacy and dignity.
- Staff took appropriate measures to meet patients' additional communication needs.
- Carers were involved in patient care, ward meetings and activities where appropriate.

However:

- Patients with capacity were not always given a copy of their care plan and there was no documented reason for this.

## Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- Staff held regular and effective discharge planning meetings to ensure patients were discharged at the earliest appropriate stage for each patient and with the most suitable support in place.
- Patients had appropriate space for activities and access to outside areas.
- Staff were able to facilitate flexible visiting hours.
- Patients had a range of meal choices and food and drinks could be provided flexibly.
- Staff knew how to manage complaints and were provided with feedback from managers following complaints.

However:

- Although staff planned patient discharges well, the recording of these meetings and plans on the electronic recording system was not consistent for all patients. For example, not all patients had a specific discharge care plan recorded in the correct place on the electronic recording system.

## Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- Leadership had improved since our last inspection.
- Ward managers were visible on the wards.
- Staff morale had improved since our last inspection.
- Staff felt able to report concerns and incidents and knew how to do this.

# Wards for older people with mental health problems

- Poor staff performance was dealt with promptly.
- Measures were in place to mitigate against staff vacancies.
- Incidents and feedback were responded to by staff.

However:

- There were difficulties with the computer system used to record patient observations.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Forensic inpatient or secure wards

Good ● ↑

## Key facts and figures

The Kedleston Low Secure Unit provides a low secure service for male patients. Its purpose is to deliver intensive, comprehensive, multidisciplinary treatments and care by qualified staff and healthcare assistants.

The service provides care for men aged 18 years and above who suffer from a mental disorder, and are detained under the Mental Health Act 1983. They require treatment in a specialist low secure service, and usually have complex and challenging forensic and mental health needs.

There are two wards at the Kedleston Unit: Curzon is the admission and assessment ward, and Scarsdale is the rehabilitation ward. Curzon Ward has eight beds and Scarsdale Ward has 12 beds. Bedrooms on Scarsdale Ward have en suite shower, toilet and wash hand basin. Bedrooms are not en suite on Curzon Ward and patients have access to shared bathroom facilities.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We visited both wards, looking at all five key questions. This was because at our previous inspection we identified that a number of improvements were needed so we wanted to see if these had been made.

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited both wards at the Kedleston Unit, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with four carers of patients who were using the service by telephone.
- spoke with the ward manager and the clinical lead
- interviewed 12 staff including activities coordinators, domestic staff, healthcare assistants, nurses, occupational therapists, pharmacists, psychiatrists and psychologists
- reviewed eight care records of patients and one record of the use of seclusion
- reviewed 12 patient medication charts
- attended and observed two ward reviews and one staff handover meeting
- carried out a specific check of the medication management on both wards
- looked at policies, procedures and other documents relating to the running of the service.

## Summary of this service

Our rating of this service improved. We rated safe, effective, caring, responsive and well led as good because:

# Forensic inpatient or secure wards

- The ward manager had taken action to make sure that requirement notices made at our previous inspection had been met to improve the service. These requirement notices were about the safety of the environment, staff understanding of the Mental Capacity Act 2005, staff training and staff assessment of patient risk.
- Staff consistently assessed patients for their risk of violence through completion of risk assessments.
- The trust made sure that staff had the training they needed to ensure patients' safety and wellbeing.
- The trust had completed the refurbishment of the unit which included the seclusion suite and reduced environmental and ligature risks to patients.
- The trust had bought new furniture for the unit which was clean and in good condition.
- Patients were involved in their care plans and this included ongoing monitoring of their physical health needs.
- Staff managed patient's medicines well and where appropriate staff supported patients to manage their own medicines.
- Staff had formally assessed and recorded patients' capacity to consent to care and treatment.
- Staff offered patients the opportunity to record their preferences in an advance directive (a statement written with the patient about their decision to refuse treatment at a time they may not have the mental capacity to make this decision).
- Staff offered patients scheduled activities in the evenings and at weekends.
- Staff displayed information relating to the complaints procedure, patient advice and liaison service and the Care Quality Commission on the wards.

## Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- The trust had refurbished the seclusion facilities so they complied with the standards set out in the Mental Health Act (1983) or the Code of Practice (2015). For example, there was now two-way communication, patients had access to toilet and bathroom facilities in the seclusion room and it was clean.
- Through refurbishment of the unit, the trust had addressed all environmental risks. This included ligature risks, which created a safer environment for patients.
- Managers regularly reviewed staffing levels and there were sufficient staff on duty to safely support patients.
- Staff used de-escalation techniques when patients became agitated or distressed. This reduced the need for physical restraint.
- In June 2016, low numbers of staff were up-to-date with basic life support and intermediate life support training. This had improved at this inspection and the trust had trained 95% of staff in basic life support and 84% in intermediate life support. This meant there were enough staff trained to ensure there was always a first aider on every shift.
- Staff completed the historical clinical risk version 3 (HCR20v3) risk assessment consistently for each patient. This is a comprehensive set of professional guidelines for the assessment and management of violence risk.
- Robust systems and processes were in place to support safeguarding patients. Safeguarding concerns were reported when appropriate.

# Forensic inpatient or secure wards

- Staff managed, recorded and stored patients' medicines safely so they were effective in treating patients. However, we saw some dust at the top of the medicine cabinet in the clinic room on Curzon Ward.
- Staff recognised incidents and reported them well. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

## Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- Doctors examined the physical health of each patient on admission. Staff monitored patients' physical health during their stay on the unit.
- All patients' care plans we looked at were personalised, holistic and recovery oriented. A range of professionals supported patients in their care and treatment. Patients attended their meeting with the multidisciplinary team fortnightly to review and update their care plans. The multidisciplinary team worked together well to support patients care and treatment.
- Staff offered patients a range of psychological therapies appropriate to their individual need in one to one and group sessions.
- Managers supported staff effectively through formal supervision.
- Staff understanding of mental capacity had improved. The trust had trained 90% of staff in the Mental Capacity Act 2005. Staff had appropriately recorded assessments of patients' capacity to consent to decisions about their care and treatment.
- The trust had trained 89% of staff in the Mental Health Act 1983 which meant that most staff knew under which legal authority they were providing care and treatment.

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff were kind, caring and respectful to patients. They respected patients' privacy and treated them in a friendly yet professional manner. All patient feedback about staff was positive. Patients said they felt staff genuinely cared about their wellbeing.
- Staff involved patients and their relatives in decisions about their care. A carers' forum had started to involve relatives and listen to their views.
- Staff involved patients in their care plan and offered patients a copy of this.
- Staff informed patients about their right to have an advocate and how to contact them. Staff listened to advocates and made changes to how they supported patients as a result of this.

# Forensic inpatient or secure wards

## Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- The trust had provided new furniture and furnishings on both wards to make the environment more comfortable for patients. Refurbishment works had greatly improved the comfort and variety of rooms available to patients. However, some work had not been completed, for example, landscaping the horticultural garden and replacing flooring in one shower room.
- Each patient had an individualised meaningful activity schedule. This included links with the local community to promote their recovery.
- All staff and patients knew the provider's complaints procedure. They supported and encouraged patients to make complaints. Managers informed staff about outcomes from complaints investigations in supervision and in monthly staff meetings. If it was a trust wide issue, the provider would email an alert to all staff.
- The trust was proactive in assessing patients' individual needs before they were admitted.
- Patients with particular dietary requirements had their needs and wishes met. Patients could access spiritual support from local spiritual leaders if they wished to do so. Staff could contact the spiritual leader and arrange for visits. Space was available in the quiet rooms for patients to use for prayer, if they wished. Staff had a proactive approach in supporting patients with their individual needs associated with their sexuality. For example, patients were supported to explore and express their identity through psychology and the men's health group.
- The service reported no readmissions in the period 1 March 2017 to 28 February 2018. This was good as it meant that patients had received the treatment they needed during their admission. Patients were discharged when they had received the treatment they needed. Staff started to plan with the patient their discharge soon after admission which helped to avoid potential delays.

## Is the service well-led?

Good ● ↑

Our rating of well-led improved. We rated it as good because:

- The ward manager had been in post since our previous inspection in December 2016. Staff told us that the manager had provided stability and led the service well.
- Staff understood and could describe the vision and values of the trust. Staff knew who senior managers were and they had recently visited the service.
- Managers had improved governance systems so they identified all the risks to the safety and welfare of patients.
- Managers were involved with and followed national guidance on forensic services which had improved the quality of the service provided.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Community-based mental health services for older people

Good   

## Key facts and figures

Community-based mental health services for older people are located at nine neighbourhood bases across the county. Neighbourhood teams follow an integrated service approach, providing mental health support to adults regardless of age; support is based on individual needs. The trust reports that 'neighbourhood team members work closely with each other and other local health and social care professionals, whilst drawing on local community resources to help people rebuild their lives after an episode of mental ill health'. During the inspection we visited neighbourhood team bases for North Dales, Chesterfield Central, Bolsover and Clay Cross, Amber Valley, Erewash, and Derby City.

The trust also supplies several specialist services that are attached to neighbourhood teams.

These include dementia rapid response teams, the memory assessment service, day hospitals, in-reach and home treatment teams, and discharge and liaison team. Dementia rapid response teams are provided from three locations across the county. The south team had been fully operational since October 2016. The trust was rolling out the model in the north of the county from two locations and planned for the teams to be fully operational by December 2018. During the inspection we visited the South Derbyshire dementia rapid response teams, and High Peaks and North Dales dementia rapid response team. During the inspection we did not visit the memory assessment service, day hospitals, in-reach and home treatment teams, and the discharge and liaison team.

At the last comprehensive inspection in June 2016, community-based mental health services for older people were rated 'Good' overall. The domains of safe, effective, caring and well-led were rated 'Good', and responsive was rated 'Requires Improvement'. The inspection identified concerns and the trust was told that it must act to:

- improve timely access to psychological assessment and/or treatment to patients who require this intervention.
- ensure that all Mental Health Act documentation is present within patients care records and that patients have their Section 132 rights read to them regularly, and this is recorded within the patient's care record.

Our inspection between the 22 and 24 May 2018 was unannounced (staff did not know we were coming) to enable us to observe routine activity. We re-inspected all the key questions to see if the trust had made improvements.

During the inspection the team:

- visited the neighbourhood team bases for North Dales, Chesterfield Central, Bolsover and Clay Cross, Amber Valley, Erewash, and Derby City. We looked at the quality of the care environment and spoke with staff based there.
- visited the South Derbyshire and High Peaks and North Dales dementia rapid response teams.
- spoke with 30 members of staff from different teams including team managers, nurses, doctors, psychologists, occupational therapists and support workers.
- accompanied staff on nine community visits to observe how staff cared for patients.
- spoke with 14 patients currently using the service.
- spoke with 18 carers of patients that were currently using, or had recently used the service.
- reviewed the care and treatment records of 41 patients.
- observed one multi-disciplinary review meetings.

# Community-based mental health services for older people

- looked at a range of policies, procedures and other documents relating to the running of the service.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to provide care and treatment. Staff had access to a range of training opportunities that included courses about caring for patients with dementia. Managers ensured staff had regular access to supervision practices and appraisals.
- Teams were multi-disciplinary and met regularly to review patient care and treatment. Staff reported effective working relationships with other teams within the trust and external to the trust. Staff worked with external organisations and supported carers to assist patients to remain in their own homes
- Staff provided patients with advice, help and support. These were delivered professionally with warmth and respect. Staff used an electronic patient record to document the care and treatment provided to patients. Staff involved patients in their care and, where appropriate, involved and supported families and carers.
- The trust provided a range of community services to meet the mental health needs of older adults. Services were accessible for disabled people and those with communication needs. The trust had processes in place that enabled everyone who had contact with services to provide feedback on their experience.
- The trust had a vision for what it wanted to achieve. The trust demonstrated how it was working to meet the recommendations of previous inspections and address areas of service delivery where challenges had been identified.

However:

- Staff did not always follow policies and procedures to ensure that medicines and emergency equipment remained safe for use. This included failing to transport medicine in the community safely.
- Staff practices around assessing patients' physical health and care planning were not consistent across the teams visited.
- All teams continued to have waiting times to access psychology services.

## Is the service safe?

**Requires improvement** ● ↓

Our rating of safe went down. We rated it as requires improvement because:

- Staff did not always follow trust policies and procedures to ensure that medicines remained safe for use. Records at the Bolsover and Claycross neighbourhood team base did not demonstrate that staff completed daily clinic room and medicine fridge temperatures checks. During the inspection we found one example of staff keeping a box of injectable patient medication in their car boot.
- Records at two team bases did not demonstrate that staff completed regular checks of emergency equipment. This included checks of oxygen and automated external defibrillators.

# Community-based mental health services for older people

- Staff did not report all safeguarding concerns raised with the local authority as an incident on the trust electronic incident system. This was not in line with the trust policy guidance. This affected the quality of data.

However:

- Staff used risk assessment tools. Response to sudden deterioration in patients health was prompt. Patients on waiting lists were discussed and those on waiting lists longer than 16 weeks were contacted by telephone.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide care and treatment. Teams reported no use of bank or agency staff, and only one team used a locum psychiatrist.
- Staff kept appropriate records of patients care and treatment. The trust used an electronic patient record that was shared by all staff in the trust. Community staff could use the electronic patient record outside of trust locations when they had access to an internet connection.
- The service planned for emergencies and staff understood their roles if one should happen. Alarm systems were in place at all sites where patients attended. Staff were familiar with, and followed trust guidance on working alone in the community.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Supervision sessions followed an agenda, were recorded, and signed on completion.
- The trust offered staff training specific to dementia. Dementia awareness training was mandatory for all staff, and further training was available to all staff involved in looking after patients with dementia.
- Staff of different kinds worked together as a team to benefit patients. Each team held regular multidisciplinary team meetings. Staff reported effective working relationships with other teams within the trust and external to the trust.
- Staff used a range of interventions, guided by National Institute for Health and Care Excellence recommendations, to meet the needs of older people in the community. This included use of a range of tools to assess and rate the severity of symptoms experienced by patients.
- Staff understood their roles and responsibilities under the Mental Health Act and the Mental Capacity Act. Staff were aware of the requirement to explain rights under the Mental Health Act or Community Treatment Orders to those patients subject to them. The trust's electronic patient record incorporated mental capacity assessments, providing staff with prompts and a process to follow.

However:

- In our review of records, 12 did not show that staff had always completed physical health questionnaires. Staff did not routinely take physical health observations of all patients entering the service, but did so for those patients prescribed medicine by the service.
- Teams took different approaches to care planning practices. Not all care plans reviewed demonstrated specific, measurable, achievable, realistic, and time framed care planning principles.

# Community-based mental health services for older people

- Staff were not routinely aware of the trust's arrangements to monitor and audit the Mental Health Act and the Mental Capacity Act.

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Staff interactions with patients were delivered professionally and with respect to provide advice, help and support. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in discussions about their care and treatment. This included being offered choice to accept or decline treatments suggested by staff. Records demonstrated that staff shared copies of care plans with patients.
- Staff supported patients to understand and manage their care, treatment or condition. This included discussions, providing information leaflets, and working with other local services.
- Family members and carers reported that staff supported, involved, and kept them informed about the care provided to patients. This included identifying and contacting local carer organisations.
- The trust provided opportunities for patients, family and carers to give feedback on the service they received. This included providing feedback cards and boxes in waiting areas, and contact details for the patient experience team in information leaflets and on the trust's website.

However:

- Staff reported that practices to assist patients in making advance decisions were not yet embedded.

## Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people. There were a range of services to assist patients to remain in their own homes. When necessary, staff worked with organisations outside of the trust and supported carers to achieve this.
- People could access the service when they needed it. There were specified target times from referral to assessment, and all teams had duty workers able to triage and see urgent referrals quickly. Staff ensured appointments ran on time, were rarely cancelled and offered patients flexibility in the times of appointments.
- The service took account of patients' individual needs. Adjustments to premises ensured disabled people had access to premises and met patients' communication needs. Staff reported how they provided information in accessible formats for older adults, and had access to interpreters and/or signers where needed.

# Community-based mental health services for older people

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. The trust had a policy to guide staff in dealing with complaints or concerns. Staff knew how to respond locally when patients raised a concern or complaint, and when necessary staff assisted patients to escalate this.

## Is the service well-led?

Good ● → ←

Our rating of well-led stayed the same. We rated it as good because:

- The service had managers with the right skills and abilities to lead teams. The trust provided leadership opportunities to develop managers in their role. Staff knew who their senior managers were and gave examples of the visiting team bases.
- The trust had a vision for what it wanted to achieve. This had been updated following feedback from staff and was on display at the locations we visited.
- The trust had undertaken a review of neighbourhood structure following concerns being identified. The review identified a number of difficulties and the trust is continuing to work with neighbourhood services to address these.
- Staff reported feeling respected, listened to, involved and supported in their roles. Teams reported working well together and systems were in place to effectively address staff performance concerns. The trust ran an awards programme to recognise the contributions of teams and individual staff.
- The trust demonstrated how it had acted, and was continuing to act, on recommendations identified in the Care Quality Commission's 2016 inspection.
- The trust was implementing a strategy to better manage referrals from care homes. This included having an identified link nurse, training and development of a resource file.

However:

- Operational policies and procedures were not yet available to guide staff working in the memory assessment service and dementia rapid response teams.
- Staff reported difficulties with the trust's electronic patient record and online learning system. This included being slow, difficult to navigate and difficult to access learning.
- Resources on the trust's website did not always appear to be up-to-date. This included information for carers and trust members.
- There was no standardised approach to what should be discussed at team meetings and ensure that all staff had access to essential information.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Mental health crisis services and health-based places of safety

Requires improvement   

## Key facts and figures

Derbyshire Healthcare NHS Foundation Trust provides three crisis resolution and home treatment teams and two health based places of safety.

The three crisis resolution and home treatment teams are Chesterfield, High Peak and Dales, and Derby City and County South. They are located in Chesterfield, Chapel-en-le-Frith and Derby respectively. The High Peak and Dales team is a small 'satellite' team closely linked to the larger Chesterfield team, and has the same clinical management team. The teams offer crisis resolution and home treatment services to patients who would otherwise need hospital admission. The services run for 24 hours a day, seven days a week.

The two health based places of safety, also known as 136 suites, are located in the Hartington Unit in Chesterfield Royal Hospital, and the Radbourne Unit in Royal Derby Hospital.

The Hartington Unit and the Radbourne Unit are registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury.

This was the second CQC inspection of mental health crisis services and health based places of safety. At the previous inspection in June 2016, we rated this service as requires improvement overall so we inspected all five key questions at this inspection.

Our inspection was short-notice announced (staff knew we were coming a few days before) to ensure that everyone we needed to talk to was available.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

We visited all three crisis resolution and home treatment teams and both health based places of safety. We also:

- spoke with 40 staff members, including doctors, nurses, social workers, occupational therapists and four other health and social care and police professionals who worked with the teams.
- spoke with 21 patients and five of their carers.
- visited four patients at home with staff from the trust.
- looked at 35 patient records and 24 patient prescription charts.
- observed two handover meetings and four multi-disciplinary team meetings.
- visited the crisis house in Derby.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- We rated safe and effective as requires improvement, and caring, responsive and well-led as good.

# Mental health crisis services and health-based places of safety

- The environments of the health based places of safety did not ensure patients were safe at all times. Staff working in the health based places of safety did not robustly assess all patients' risks.
- There were not enough staff in the City and County South crisis resolution and home treatment teams to meet the needs of all patients. There was a lack of operational leadership in the City and County South crisis resolution and home treatment team.
- The safety plan was new and there were some delays in how staff accessed this so they could clearly know patients' risks.
- Lone working practices were not robust enough to ensure the safety of all staff.
- Staff did not always assess and monitor patients' physical health needs. Staff did not assess all patients' needs.
- Staff did not record patients' involvement in their care plans.

However:

- Staff knew how to safeguard patients from abuse and harm.
- Staff made sure patients had their prescribed medicines at the right time and stored these safely.
- Managers supervised and appraised staff.
- Staff had a better understanding of the Mental Capacity Act 2005 than at our previous inspection.
- Staff were kind, caring, compassionate and respected patients and carers.
- The crisis resolution and home treatment teams responded to individual patients' needs and helped to prevent them being admitted to hospital.
- All staff knew the vision and values of the trust and agreed with them. Senior managers in the trust were more visible.

## Is the service safe?

**Requires improvement** ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- There were blind spots in the health based places of safety at the Radbourne Unit and the Hartington Unit. As at our previous inspection in June 2016, there were some features in the environment to which a patients could tie a ligature at the Hartington Unit.
- There were not enough staff employed in the City and County South crisis resolution and home treatment team to meet the needs of all patients.
- The lone working practice was not robust at the health based place of safety at the Hartington Unit at night. Staff did not always follow the lone working policy at the City and County South crisis resolution and home treatment team.
- Staff did not consistently check the emergency equipment in the health based place of safety at the Hartington Unit.
- Staff did not robustly assess the risks of patients using the health based places of safety.
- Staff did not record the handover in the City and County South crisis resolution and home treatment team. This meant that staff on the next shift might not be fully aware of patient risks.

# Mental health crisis services and health-based places of safety

- The safety plan was not available on the electronic records system but staff had to hand write and scan into the system. This could cause delay in all staff knowing patients' risks.
- Staff had not regularly cleaned the shower in the health based place of safety at the Radbourne Unit.

However:

- The trust had identified there were not enough staff employed in the City and County South crisis resolution and home treatment team and had secured funding to recruit to these posts.
- Staff were aware of safeguarding procedures and raised safeguarding concerns when needed.
- The figures for mandatory training had improved since our previous inspection. Managers block booked staff to do a week of mandatory training. The trust had trained staff in safeguarding patients from abuse and basic lifesaving skills.
- Staff recorded the medicines they prescribed and gave to patients. Staff stored medicines safely so they were effective in meeting patients' needs.
- All staff knew how to report incidents and were able to do this. Staff supported patients and their families following incidents. Managers and staff from psychology teams offered debrief to staff in the teams following incidents.

## Is the service effective?

**Requires improvement** ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff could not easily access an overview of patients' current needs in the electronic patient records system.
- Care plans did not show that staff had assessed all patients' needs and how staff should support patients. Staff did not always record in patients' care plans how to meet their physical health needs and monitor these.
- The trust had not trained staff in how to support patients who used the health based place of safety.

However:

- Staff offered psychological support to patients and referred them for specialist psychological therapy when needed.
- We observed that staff worked well as a multidisciplinary team.
- Managers had supervised more staff since our previous inspection and each staff member had an allocated supervisor.
- Staff understood the Mental Health Act 1983 and recorded that they had told patients about their rights under Section 132 of the Act.
- Staff had a better understanding of the Mental Capacity Act 2005 than at our previous inspection. Staff assessed patients' capacity to make specific decisions about their care and treatment.
- The trust participated in a multi-agency group with other agencies involved in the operation of Section 136 of the Mental Health Act.

## Is the service caring?

**Good** ● → ←

# Mental health crisis services and health-based places of safety

Our rating of caring stayed the same. We rated it as good because:

- Staff were kind and respectful to patients and carers and took time to listen to them. Some patients told us that the service was amazing and most patients said staff were caring and genuinely interested in helping them. Carers told us that staff supported them well.
- Patients told us that staff were flexible and tried to arrange appointment times to suit them. They said that staff were always available and never cancelled their appointments.
- The trust produced information about the service and mental health for patients and carers. Patients told us this information was useful and helped them to make choices about their care and treatment.

However:

- Staff did not routinely record that they had offered patients a copy of their care plan. Care plans did not always show that patients were involved.

## Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- The crisis resolution and home treatment teams provided short term support to patients in their own home which helped to prevent hospital admissions. The teams operated 24 hours a day and seven days a week. They provided a service to anyone whose main issue was mental ill health.
- The trust had employed staff who were able to give housing and welfare advice to patients. This meant patients could manage their mental health better and reduce the impact of their crisis.
- The crisis resolution and home treatment teams tried to offer patients a consistent and continuous service from the same small team of staff.
- Staff offered patients support tailored to their individual needs, which included patients' gender, disability, sexual orientation and ethnicity. The trust had access to an interpreting service that staff used where appropriate.
- Patients and carers knew how to make a complaint. Staff knew how to deal with complaints and compliments and used these to make improvements to the service.

However:

- The health based place of safety at the Hartington Unit did not have anything for patients to lie down on although staff could bring a mattress from a storeroom.
- Information about the service was not provided in an easy read format.

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- Staff understood and could describe the vision and values of the trust. Staff said senior managers and the board members were more visible to teams and had a better understanding of how the teams worked.

# Mental health crisis services and health-based places of safety

- Staff in all teams said that the culture within the organisation had changed for the better and that their morale had increased. Staff described good team working and support from managers.
- The teams worked in line with the Department of Health's mental health crisis concordant 2014, which aimed to improve outcomes for people experiencing mental health crisis. The trust participated in the multi- agency group concerned with the operation of section 136 of the Mental Health Act 1983.
- Staff were able to raise concerns and knew who the trust Freedom to Speak Up Guardian was and how to contact them.
- More staff had supervision and an annual appraisal than at our previous inspection in June 2016.

However:

- There was a lack of leadership and governance in the City and South County crisis resolution and home treatment team. The trust had advertised to recruit an operational manager.
- The electronic patient record system was not easy to use so that staff could clearly see patients' risks and needs in one place.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

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

Inadequate ● ↓

## Key facts and figures

The acute wards for adults of working age are provided from two sites. The Hartington Unit is located on the site of Royal Chesterfield Hospital and the Radbourne Unit is located on the site of Royal Derby Hospital. At the time of our inspection, the trust did not have any psychiatric intensive care units.

This core service provides the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury.

Hartington Unit has three wards:

- Morton ward: 24 beds, mixed gender
- Tansley ward: 24 beds, mixed gender
- Pleasley ward: 20 beds mixed gender, some patients are above working age.

Radbourne Unit has five wards:

- Ward 33: 20 beds, female
- Ward 34: 20 beds, male
- Wards 35: 20 beds, mixed gender
- Ward 36: 20 beds, mixed gender
- Enhanced care ward: 10 beds, mixed gender .

At the last inspection, we rated the service as requires improvement overall. We rated the safe, effective and well-led key questions as requires improvement and the caring and responsive key questions as good. We undertook this inspection to find out whether the trust had made improvements. We inspected all eight wards across the two sites and looked at all five key questions. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection, the inspection team:

- visited all eight wards, looked at the quality of the ward environment, and observed how staff were caring for patients
- spoke with 37 patients and six relatives
- spoke with the ward managers or acting ward managers of each ward
- spoke with 53 staff including nurses, doctors, healthcare assistants, psychologists, occupational therapists, occupational therapy assistants

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

- spoke with 12 other staff including pharmacists, senior managers, safeguarding leads, administrative and domestic staff
- attended and observed 14 handover and multidisciplinary team review meetings
- observed and attended patients' activities such as groups and community meetings
- looked at the care records of 46 patients
- reviewed 101 medication charts
- reviewed 17 sets of Mental Health Act paperwork
- reviewed the human resources files of eight staff.

## Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- Most wards at Radbourne Unit still had high numbers of vacancies for registered nursing staff, and had difficulties in filling shifts with the appropriate skill mix. Not all staff were up-to-date with their mandatory training and most ward staff at Radbourne Unit did not receive regular supervision or their annual appraisals.
- The trust's new system for recording observations electronically in real time was onerous for staff and potentially unsafe as it did not allow them to maintain patients' observation levels at the assessed levels. The electronic records system placed a burden on staff in accessing, locating and updating patients' records due to technical issues and inconsistent records management and documentation processes.
- Staff on the wards at Hartington Unit did not always recognise and report safeguarding concerns and incidents. Assessments and care plans lacked detail and staff did not always update them routinely or following changes.
- Staff on all the wards were unaware of the trust's policy and guidance on contraband and risky items. Some staff conducted searches of patients' property without adequate training.
- Staff on Pleasley ward did not comply fully with the guidance on eliminating mixed sex accommodation, for example, male patients used the female-only lounge.
- Staff and patients at both units struggled to comply with the trust's smoke-free policy. Some staff tolerated smoking to prevent incidents.
- The service lacked a multidisciplinary approach to assessment and treatment, and had an over reliance on a medical approach to treatment. Patients had little or no access to psychological assessments and therapies. The wards had a lack of ward-based therapeutic activities for patients who were not well enough to leave the wards to attend the recovery hubs.
- Records showed gaps in the monitoring of patients' physical health, and gaps in the reviews required for secluded patients in line with the Mental Health Act Code of Practice and the trust's policy.
- The enhanced care ward at Radbourne Unit had an outside area that did not give patients privacy and dignity. Not all patients had access to safe storage in their bedroom areas and not all of the wards had robust systems for safekeeping patients' valuables.

However:

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

- Wards at Hartington Unit now had stable staff teams and low vacancy levels, and a good supervision programme for staff. The staff reported good morale and teamwork, and felt looked after.
- Staff now had good knowledge of the Mental Capacity Act. Mental Health Act administrators kept Mental Health Act documentation up-to-date and in good order.
- Wards were spacious, tidy and uncluttered. Staff had a good awareness of ligature risks on their wards and took action to reduce the risks.
- Patients described the staff as caring, supportive and non-judgemental. Patients felt staff listened to them and provided them with appropriate emotional and practical support.
- Each unit had a recovery hub away from the wards that had a range of facilities and activities, including a gym, for patients who were well enough to attend safely.

## Is the service safe?

**Inadequate** ● ↓

Our rating of safe went down. We rated it as inadequate because:

- Most wards at Radbourne Unit still had high numbers of vacancies for registered nursing staff, and had difficulties in filling shifts with the appropriate skill mix.
- All wards had blind spots along their bedroom corridors. None of the wards had parabolic mirrors, and staff were not always present in these areas.
- Most of the rooms at Radbourne Unit and the communal rooms at Hartington Unit did not have nurse call alarm systems fitted.
- The cleaning trolleys used on the wards at Hartington Unit held hazardous cleaning materials but had broken doors that did not lock.
- Staff were unaware of the trust's policy and guidance on contraband and risky items. Some staff conducted searches of patients' property without adequate training.
- Some staff tolerated patients smoking tobacco on the wards and in the grounds on both units.
- Staff on Pleasley ward did not fully comply with the guidance on eliminating mixed sex accommodation as male patients sometimes used the female-only lounge.
- The trust's new observations process and the expectation that staff record observations electronically in real time was onerous for staff and potentially unsafe as it did not allow them to maintain observations of patients at the assessed levels.
- Staff found it difficult to quickly and efficiently access essential information on the electronic care records system.
- Records did not clearly indicate where seclusion took place on Tansley ward. Staff did not always complete the necessary reviews required for secluded patients in line with the Mental Health Act Code of Practice and the trust's policy.
- Records showed gaps in the monitoring of patients' physical health. Staff did not always complete early warning score tools fully or escalate any concerns identified. Staff did not always complete and record physical observations following administration of rapid tranquillisation. Staff on the wards at Hartington Unit did not always recognise and report safeguarding concerns and incidents.

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

- Staff did not comply fully with the requirements for the receipt of controlled drugs.

However:

- Wards at Hartington Unit now had stable staff teams and low vacancy levels.
- Staff had a good awareness of ligature risks on their wards and took action to reduce the risks.
- Wards were spacious, tidy and uncluttered.

## Is the service effective?

**Requires improvement** ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- Most ward staff at Radbourne Unit still did not receive regular supervision or their annual appraisals. Staff had limited access to team meetings and other support forums due to staffing issues.
- Assessment and treatment lacked a multidisciplinary approach. The service had an over-reliance on a medical approach to treatment. Patients had little or no access to psychological assessments and therapies. There were insufficient clinical psychologists to meet the needs of patients on the acute wards.
- Assessments and care plans lacked detail and staff did not always update them routinely or following changes. It was difficult to locate section 17 leave forms for patients at Radbourne Unit. We found that one patient had left the ward on leave without the correct legal paperwork.
- Staff frequently experienced issues with the electronic records system that included slow access, technical glitches, and application failure.

However:

- The acute wards at Hartington Unit now had a good supervision programme for staff.
- Staff now had good knowledge of the Mental Capacity Act and recorded decisions about capacity fully and appropriately.
- Mental Health Act administrators kept Mental Health Act documentation up-to-date and in good order.

## Is the service caring?

**Good** ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff attitudes and behaviours showed that they treated patients with dignity and respect. Patients described the staff as caring, supportive and non-judgemental. Patients felt staff listened to them and provided them with appropriate emotional and practical support.
- Staff on all the acute wards showed a strong commitment to patient care and knew their patients well. At Radbourne Unit, we saw that staff maintained a supportive and responsive approach to patients in spite of the staff shortages they faced.

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

- Most patients and their relatives gave positive feedback about the ward environment, the quality of care and staff. Family members felt involved in their relative's care and said that staff invited them to ward reviews and kept them informed.
- Most patients had access to regular community meetings on their wards. Wards had "you said, we did" noticeboards.

However:

- We found little recorded evidence of patients' involvement in their care planning, and few patients had crisis or advanced care plans. Patients did not always receive a copy of their care plan.

## Is the service responsive?

**Requires improvement** ● ↓

Our rating of responsive went down. We rated it as requires improvement because:

- Pleasley ward, which admitted older and frail patients, had no assisted bathrooms.
- The trust had no psychiatric intensive care beds and still relied heavily on out-of-area placements.
- All the wards had a lack of structured ward-based activities. Not all patients were well enough to leave the wards to attend the recovery hubs. Wards that had ward-based occupational therapists used them as healthcare assistants most of the time.
- Most patients still slept in dormitory-style bedrooms that had up to five beds.
- Not all patients had access to safe storage in their bedroom areas, and not all wards had robust systems for safekeeping patients' valuables.
- The enhanced care ward at Radbourne Unit opened out to a garden that did not give patients privacy and dignity.

However:

- Each unit had a recovery hub separate from the wards that had a range of facilities and activities, including a gym, for patients well enough to leave the wards.
- Staff had good access to interpreters and used them to support patients and their relatives, when required.
- The wards had a wide range of useful information displayed for patients on physical health, mental health conditions, complaints, activities and advocacy.

## Is the service well-led?

**Inadequate** ● ↓

Our rating of well-led went down. We rated it as inadequate because:

- The core service had not addressed all the issues identified from our last inspection, and on this inspection, we identified additional issues.
- The service lacked effective leadership and governance. Ward systems were not robust or effective enough to ensure that operational requirements were met. The service lacked a consistent and structured programme of clinical audits, and actions did not always address the issues identified or prevent recurrence.

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

- Wards at Radbourne Unit did not always have a sufficient number and skill mix of staff required to cover shifts. Staff on these wards reported low morale due to staffing pressures and changes of ward managers. Not all staff received and were up-to-date with their mandatory training, supervision and annual appraisals.
- The trust's governance systems and processes did not always identify and respond to risks effectively. Staff did not always recognise or report safeguarding concerns and incidents. Staff and patients struggled to comply with the trust's smoke-free policy. Patients smoked on the wards and staff tolerated it to prevent incidents.
- The trust's new paper-free observation process was onerous for staff and potentially unsafe as it required staff to record observations electronically in real time as well as maintaining observation levels.
- The electronic records system placed a burden on staff in accessing, locating and updating patients' records due to technical issues and inconsistent records management and documentation processes. The service experienced poor management of patients' care records due to issues with the electronic systems and technology.
- The service continued to show issues with medicines management. Staff did not always complete or record the physical observations required after rapid tranquillisation and during seclusion, or respond appropriately to patients' physical health needs.
- The service did not offer patients the recommended care and treatment interventions to meet their needs. The service lacked a multidisciplinary approach to assessment and treatment. It had an over-reliance on a medical approach to treatment. Patients had little or no access to psychological therapies or ward-based therapeutic activities.

However:

- The wards at Hartington Unit had good staff morale and teamwork, and staff felt looked after.
- Healthcare assistants had access to development opportunities such as the nurse associate training.
- The trust had implemented the safewards programme.

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Community-based mental health services for adults of working age

Requires improvement   

## Key facts and figures

Community-based mental health services for adults of working age are part of the neighbourhood community teams that include the older adult community mental health teams.

The neighbourhood teams are commissioned for the people of Derbyshire with mental health needs but they will consider referrals from other areas.

The functions of the service are; assessment, recovery and assertive outreach. The teams are multi-disciplinary and include; consultant psychiatrists, mental health nurses, support workers, occupational therapists and psychologists.

At the last inspection in June 2016, community based mental health services for adults of working age were rated as requires improvement because:

- Not all locations where patients were seen and treated had access to emergency equipment.
- Waiting lists for psychological interventions were long.
- Levels of training and appraisals for staff were below the targets set by the trust.
- Not all areas of the buildings were clean and well maintained.
- Staff did not routinely participate in clinical audit.
- Staff did not routinely give patients on community treatment orders their section 132 rights in line with the Mental Health Act Code of Practice.
- Care plans did not consistently demonstrate patient involvement.
- Staff felt there was a lack of leadership from board level in the organisation and staff did not consistently report that senior managers were visible or accessible.

Our inspection between 12 and 14 June 2018 was announced 48 hours in advance to ensure all the people we needed to speak to were available.

Before the inspection visit, we reviewed information that we held about the service and information requested from the trust.

During the inspection visit, the inspection team:

- visited seven neighbourhood team bases (Dale Bank View, Ilkeston Resource Centre, Amber Valley, St Andrews, High Peaks, Chesterfield Central and Killamarsh) and completed a tour of all the premises, including the clinic rooms.
- spoke with seven team managers.
- spoke with 26 nurses.
- spoke with two support workers.
- spoke with three psychiatrists and one medical secretary.
- spoke with eight psychologists.

# Community-based mental health services for adults of working age

- spoke with five occupational therapists.
- reviewed 41 patient records.
- reviewed 15 Mental Health records.
- spoke with 18 patients and nine carers and observed 15 appointments, both in the bases and in patients' homes.
- observed three multi-disciplinary meetings.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Waiting lists for care coordinators, clinical psychology, outpatients were long across the service and there was no plan in place to show how these would be reduced.
- Waiting lists did not show what interventions each patient was waiting for, their level of risk and whether they were open to another part of the service.
- Staff relied on patients and/or referrers to alert them if their mental health deteriorated while waiting.
- Records showed not all teams checked fridge and room temperatures daily. The emergency bag in one team had not been checked for a year.
- There was no psychiatry cover at Dale Bank View and the manager was unable to tell us what actions have been taken by the trust to improve recruitment or provide adequate cover.
- Team managers did not use a caseload management tool, this meant managers did not have effective tools to monitor the high caseload numbers in order to support staff.
- Rating scales and outcome measures were not being routinely collected and analysed to improve service delivery and ensure interventions offered were effective.
- There were not enough rooms across the teams to see patients in and some environments were cluttered and in need of repair.

## Is the service safe?

**Requires improvement** ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- Staff and team managers did not have knowledge of environmental risk assessments including ligature risks.
- The environment at High Peaks was small, cluttered and there was visible damage on the walls and furniture.
- Staff in High Peaks did not check fridge and room temperatures daily.
- Killamarsh staff had not checked the emergency bag for 12 months.
- Caseload numbers were high and managers did not use a caseload management tool to review them.

# Community-based mental health services for adults of working age

- Waiting lists for first appointments after initial assessment were between 12 weeks and 68 weeks there was no indication on the waiting list as to whether cases on the waiting list were open to other parts of the service.
- There was no system for monitoring the welfare and safety of patients on the waiting lists and their level of risk as there was an expectation that the patient or another service would contact the team if a patient's mental health deteriorated while on the waiting list.
- There was no psychiatry provision at Dale Bank View, which meant staff had to phone psychiatrists at other bases if they needed support.
- Staff training rates for mandatory training were below trust target.

However:

- Clinic rooms were clean and tidy and there was necessary equipment available to carry out physical observations.
- Staff completed a safety plan of every patient and updated it as required.
- There were good examples of crisis plans and advance statements.
- All staff had a good understanding of safeguarding and knew when and how to raise a concern.
- Staff followed the lone working policy and had good safety protocols.
- All staff could give examples of when and how they would report an incident.
- Staff regularly reviewed physical healthcare in line with guidelines.

## Is the service effective?

**Good** ● ↑

Our rating of effective improved. We rated it as good because:

- We saw comprehensive assessments had been completed including physical healthcare and care plans were personalised, holistic and recovery focused.
- Doctors followed National Institute of Health and Care Excellence guidelines when prescribing.
- Staff supported patients to live healthier lives.
- There was a good range of experiences and skills across all teams.
- Managers said they could address poor performance promptly.
- There was good multi-disciplinary working across teams.
- Community Treatment Order paperwork was correct and in date.
- Staff demonstrated knowledge and understanding of the Mental Capacity Act and we saw examples of advance statements.

However:

- Rating scales and outcomes measures were not routinely collected and analysed and used to inform the development of the service and to ensure the interventions provided were effective.

# Community-based mental health services for adults of working age

## Is the service caring?

**Good** ● → ←

Our rating of caring stayed the same. We rated it as good because:

- We observed all staff were respectful and sensitive to the needs of their patients throughout the appointments we observed.
- Patients spoke positively about community psychiatric nurses and said they went the extra mile for them.
- Staff maintained confidentiality.
- Records showed patients had been offered a copy of their care plan and patients told us they felt involved in their care.
- Staff supported carers and referred them for carers assessments where appropriate.

## Is the service responsive?

**Requires improvement** ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- At the time of inspection, the average wait for an initial clinical psychology assessment was 12.82 weeks, there were 297 patients on the waiting list and the longest wait was 68.71 weeks.
- The average waiting time from initial assessment to first contact for a care coordinator/community psychiatric nurse appointment was just over 11.55 weeks and there were 995 patients on that list. The longest wait was 68.71 weeks. It was not clear from the waiting lists how many patients were already open to the service.
- The average waiting time from initial assessment to first contact for occupational therapy was 9.57 weeks and there were 209 patients on the list.
- The average waiting time from an initial assessment to first contact for an out-patient appointment (with a doctor) was 11.26 weeks and there were 915 patients on the list, with the longest wait being 70.71 weeks.
- At some of the bases there were not enough rooms to see patients in.

However:

- Each team had a duty worker that could respond to urgent referrals and telephone calls from patients and carers.
- Derby City team and Chesterfield Central had a Clozaril monitoring machine.
- Staff supported patients in maintaining relationships with friends and family.
- There was a good range of leaflets including how to complain in the waiting areas.
- One of the managers had responded to the increase in complaints about lack of psychiatry cover by putting aside dedicated time in the diary to meet with patients.

# Community-based mental health services for adults of working age

## Is the service well-led?

**Requires improvement** ● → ←

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Team managers did not use a caseload management tool to review caseloads.
- Team managers did not have a sustainable plan on how waits could be reduced in any meaningful way.
- Team managers were not able to easily identify what each patient on the waiting lists were waiting for, whether they were open to any other part of their service and their level of risk.
- Teams did not have a standardised approach to what was discussed in team meetings.

However:

- All staff spoke positively about the service managers and said team morale had improved.
- The trusts vision and values were discussed in away days and staff were given opportunities to feed into service development.
- All staff felt able to raise concerns to their service managers without fear of victimisation.
- Staff were supported with their own physical and mental health needs.
- Managers could access their teams risk assessments and take appropriate action. Team managers and area managers met regularly to discuss any issues regarding risk or performance.
- Teams collected feedback from patients and carers and made changes following that feedback.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Community mental health services for people with a learning disability or autism

Requires improvement   

## Key facts and figures

The community learning disabilities teams provided a specialist health service to people with a learning disability living in Derbyshire. The teams operated between 9am and 5pm weekdays only. The teams consisted of nurses, physiotherapists, occupational therapists, speech and language therapists, doctors and assistant practitioners that supported people to understand their health needs and get the treatment they needed. The city and south teams were based at locations around the county including St Andrews House, Amber Valley, Erewash and Swadlincote.

The assessment and treatment support service was based at St Andrews House in Derby City and covered South Derbyshire. The team operated flexible hours to meet the needs of the patients and had on call staff out of hours and weekends. It provided extensive support to people assessed as having high needs or risk. The assessment and treatment support service offered crisis and home assessment and treatment services to avoid unnecessary admissions to inpatient services. The team also supported people with challenging behaviours or mental health needs to be assessed and treated at home where ever possible.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During the inspection visit, the inspection team :

- spoke with 10 people using the service.
- spoke with 37 staff. These included managers, nursing and medical staff, allied health professionals and psychologists.
- looked at 21 care records.
- carried out 3 observations of staff meetings.

We carried out a comprehensive inspection in June 2016. A focused inspection was carried out in February 2017 to look at the effective domain.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff reported low morale due to shortage of staff and impact on workloads. Staffing shortages were significantly impacting the average waiting time for patients to access speech and language therapy.
- Patient records were not always complete and actions from audits had not been completed. Patient assessments, risk assessments and care plans and prescription charts were all areas where we found out of date or incomplete documents. Staff could not always locate documentation in electronic records or had completed documents inconsistently across the service.
- Care plans did not all reflect the views of patients and carers and staff had not always recorded whether they had been offered a copy.
- There was no consistent application of use of outcome measures with patients. Staff did not routinely monitor the effectiveness of care and treatment. We requested evidence of specific outcome measures used with patients and the service was unable to provide a consistent response or demonstrate how outcome measures were recorded or used.

# Community mental health services for people with a learning disability or autism

However:

- Staff were skilled and knowledgeable in working with people with learning disabilities. Staff had completed mandatory training and were up to date with supervision and appraisal.
- Staff recognised and responded to safeguarding concerns without delay. Staff reviewed and made changes to the service following lessons learnt through the Learning Disabilities Mortality Review.
- Staff knew their patients well and understood individual needs. They treated patients with kindness and dignity and feedback from carers and patients was overwhelmingly positive. Observations of staff demonstrated they were respectful towards their patients and responsive to their needs.
- Staff worked well with internal and external organisations to ensure good handover of patient care. Multi-team working between the assessment and treatment support service and the community learning disabilities team was good.
- Information given to patients was presented in accessible and learning disability friendly formats to ensure patients understood their treatment. Patients could access advocacy and were supported to do so.
- The trust had a vision for what it wanted to achieve for learning disability services and was going through consultation with involvement from staff, patients, and carers.

## Is the service safe?

**Requires improvement** ● ↓

Our rating of safe went down. We rated it as requires improvement because:

- Staff had not completed a risk assessment and risk management plan for every patient and had not updated all risk assessments at least six monthly in line with trust policy. Only 17 out of 30 patient records we inspected contained an up-to-date risk assessment and four records did not contain a risk assessment at all.
- Staff did not record patient risk assessments in a consistent manner across the service. Staff were recording risks regarding patients in different ways, making it difficult for staff to locate information quickly.
- Staff did not always record allergy information on prescription cards. Seven out of nine prescription charts we reviewed did not list patient allergy information.
- Staff did not always keep up-to-date records of patient care and treatment. Staff consistently told us across all teams that they had difficulty with recording and locating information through the electronic recording system.
- Staff did not have sufficient desk space to complete their duties in a multidisciplinary team environment. All staff we spoke with across all teams told us at times they found it difficult to find a suitable workspace and that the team was often spread out across community venues.
- The service was short staffed in speech and language therapists and psychology staff. This meant that some patients were waiting for a long time to access these parts of the service.
- Staff shortages were affecting the ability to deliver parts of the service. As a result, within assessment and treatment support, the trust had suspended the out-of-hours service for two months in 2017.

However:

- Staff we spoke with told us caseloads were manageable, except for speech and language staff. Managers were supportive in adjusting caseload numbers in line with risk and the intensity of the workload.

# Community mental health services for people with a learning disability or autism

- The service had access to doctors within the trust and out-of-hours through the on-call rota for the trust. Staff responded promptly to deterioration in patient health and wellbeing.
- Staff had good relationships with external providers of care including statutory services, community services and residential services. Feedback about the service from external agencies was consistently positive.
- Staff monitored patients on the waiting list to ensure patients and carers were kept up to date with their progress and knew where to seek support while on the waiting list.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff worked with the wider multidisciplinary team and external agencies to safeguard patients from harm.
- Staff were up-to-date with their mandatory training. Across the core service, 84% of staff had completed mandatory training.

## Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and demonstrated a good understanding of Mental Capacity Act and the five principles. Staff recorded capacity assessments in patient records and detailed best interest decisions.
- Staff ensured patients were receiving appropriate physical health care. Nursing staff routinely carried out physical health observations at the beginning of treatment and in conjunction with prescribing medications and staff liaised with GPs to ensure annual health checks had been carried out.
- Where care plans were in place, they were up to date and contained a range of patient problems and needs, including those identified at assessment. We reviewed 30 care records and found 21 records contained an up-to-date care plan for the patient. Care plans contained easy read information and pictorial representations to clearly show what was contained within them.
- The service offered a range of interventions and therapies in line with guidance recommended by the National Institute for Health and Care Excellence. Staff discussed application of the guidance within monthly clinical review group meetings and this information was shared with the wider team.
- Staff participated in clinical audits and attended clinical audit group. Actions from audits were reviewed through team meetings and direct line management supervision.
- There was a range of staff available to support patients across the service. This included doctors, nurses, psychologists, speech and language therapists, physiotherapists, occupational therapists, and health care facilitators.

However:

- Staffing shortages in speech and language therapists, patients who required support for speech and language, including dysphagia, were experiencing long waits for treatment.
- There was no format for gaining or recording consent from patients or carers to share information with external services.

# Community mental health services for people with a learning disability or autism

- Patient assessments were not always completed fully or reflective of a full range of issues. In nine records there was no record of religion, sexual orientation, ethnic status or nationality. One record we reviewed had identified a family member as living in the household, but had not indicated the age, therefore we could not determine whether the person was a child.
- Care plans did not all contain the views of the patient and did not always document when patients or carers had been given a copy. Five records did not contain a care plan and staff could not locate this at the time of inspection.

## Is the service caring?

**Good** ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients and carers confirmed that staff treated them well and with kindness. Staff we spoke with could confidently discuss their patients in a way that showed they knew them, their life circumstances and their needs well.
- Staff communicated with patients using a range of methods to ensure they understood their care and treatment. We saw good use of easy read and pictorial leaflets on a range of mental health conditions, medication and information about the staff and service.
- Staff gained feedback from patients through friends and family surveys and experts by experience who visited patients to ask for feedback on their care experiences. There was a monthly patient and carer engagement group where they could raise any concerns or give feedback about the service.
- Staff were aware of how to access advocacy services for patients. Families, carers and patients were given easy read leaflets that contained information about advocacy services.
- Patients were involved in decisions about their service. The trust trained people with learning disabilities to take part in interviews for staff recruitment. The trust had actively recruited people with learning disabilities.
- Staff involved patients and those close to them in decisions about their care and treatment. Staff maintained good contact with parents and carers and included them appropriately in patients care.

## Is the service responsive?

**Requires improvement** ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Waiting times for patients who required treatment for speech and language therapy were significantly above target waiting time of 18 weeks. The average waiting list for speech and language therapy had only reduced to 37 weeks, 19 weeks over target.
- Staff shortages meant that the out of hours service for the assessment and treatment support service was not provided for two months in 2017 and there were plans to suspend the service for a further two months in 2018.

However:

# Community mental health services for people with a learning disability or autism

- The trust met their targets for days from referral to initial assessment within the services we looked at during this inspection. For the 126-day target, Derby City team had achieved a longest wait of 108 days while the shortest wait was South Derbyshire team with 27 days.
- Staff monitored patients on waiting lists and gave priority to patients whose risk or needs had changed or increased. Patients whose risk escalated had been moved to the assessment and treatment support service team for support.
- Staff responded promptly to referrals and prioritised those assessed as urgent. The assessment and treatment support service responded to crisis care and managed complex needs and behaviour. Staff ensured that patients likely to be at increased risk out hours were supported and were flexible in their approach to working with patients and carers when they needed urgent or additional support.
- The service actively engaged patients who found it difficult to engage with services. Teams were flexible in where they saw patients within the community, dependant on risk, and did everything possible to ensure they saw patients where they were most comfortable.
- Staff provided information in an accessible way. Information was provided in easy read and pictorial forms on a range of services and telling patients about their rights. Staff had easy access to interpreters and information in languages spoken by people using the service
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. This service had received 46 compliments during the last 12 months from 1 March 2017 to 28 February 2018.

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- The trust had managers at all levels with the right skills and abilities to run a service. The service had profession specific managers within the community learning disabilities team who managed their professional teams individually, except assessment and treatment support service who had one manager for the team.
- There were opportunities for staff to develop and lead within the service. We saw staff members had moved teams, changed roles and acted up into management roles within the service to gain leadership experience or experience of working in other teams.
- The trust had a vision for what it wanted to achieve for learning disability services and plans to turn it into action. These were being developed with involvement from staff, patients, and carers.
- The trust had a facility to recognise staff contribution to the service. The trust used monthly emails to circulate examples of exceptional work from individual staff nominated by their peers.

However:

- Staff consistently told us shortage in staffing and a perceived lack of understanding from senior management about learning disabilities services was impacting negatively on morale.
- Actions from audits had not been implemented effectively as we still found systemic issues with where and how staff were recording in patient records. We saw information missing in care records, including in assessments, care plans and risk assessments.

# Community mental health services for people with a learning disability or autism

- Staff we spoke with expressed challenges with the computer system, including ability to locate information, ability to input information and effectiveness of tools available on the system in relation to their work.

## Outstanding practice

We found an area of outstanding practice in this service. See the Outstanding Practice section above.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### 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 9 HSCA (RA) Regulations 2014 Person-centred care

#### 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 10 HSCA (RA) Regulations 2014 Dignity and respect

#### 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 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### 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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

#### Regulated activity

#### Regulation

This section is primarily information for the provider

## Requirement notices

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

### 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

# Our inspection team

Kathryn Mason, Head of Hospitals Inspection, led the well-led inspection. The inspection team included two inspection managers, five mental health inspectors, one acute inspector, one mental health act reviewer and four specialist advisers. The well-led inspection team reviewed information governance, finance, safeguarding and serious incidents, equality and diversity, mortality, patient and staff experience and complaints.

Surrinder Kaur, Inspection Manager, led the core service inspections. The inspection team across seven core services included one inspection manager, 11 mental health inspectors, three acute inspectors, two assistant inspectors, one CQC inspection planner, 27 specialist advisers and nine experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.