Sussex Partnership 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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

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.

Summary of findings

Background to the trust

Sussex Partnership NHS Foundation Trust is one of the largest mental health trusts in the country providing mental health, specialist learning disability, secure and forensic services for Brighton and Hove, East Sussex and West Sussex and specialist community child and adolescent mental health services reaching into Hampshire. The trust was established as Sussex Partnership NHS Trust in April 2006 and became an NHS foundation trust with teaching status in August 2008. It is a teaching trust of Brighton and Sussex medical school and the University of Sussex, and has a national reputation for research into mental health issues. The trust operates from over 100 sites including the community services and serves a population of 1.6 million people in Sussex and 1.3 million in Hampshire. The trust employs approximately 4617 staff through 430 teams.

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

Overall summary

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

What this trust does

The trust provides 11 of the core mental health services:

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

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

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' 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?

Summary of findings

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.

Between 29 – 31 January 2019 we inspected the following core services:

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

• Forensic inpatient/ secure wards

• Wards for older people with mental health problems

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. The inspection of the mental health crisis services and health-based places of safety core service was prompted in part by notification of an incident at Mill View Hospital. This incident is subject to ongoing separate investigation and as a result this inspection did not examine the circumstances of the incident.

We also inspected the well-led key question for the trust overall between 27 – 28 February 2019. Our findings are in the section headed Is this organisation well-led?

What we found

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

• We rated safe, effective, responsive and well-led as good, and caring as outstanding. We also took into account the current ratings of the eight core services not inspected this time.

• We rated two of the three core services that we inspected on this occasion (forensic inpatient/ secure wards; and wards for older people with mental health problems) as good. For these core services, we rated the key questions of safe, effective, caring and well led as good.

• There was an improvement in the rating of a key question in the forensic inpatient or secure wards, where responsive moved from being rated good to outstanding.

• The adult social care locations of Lindridge and Avenida Lodge were rated good. Lindridge had moved from being rated requires improvement to good in December 2018.

• We rated well-led at the trust level as good. The senior leadership team changes had strengthened the board and enabled a collective leadership approach, increased innovation and confidence in the board. There was strong leadership at all levels across the trust, with the focus on patient care at the forefront of decision making.

• Staff across the trust had become more confident and willing to develop their services, using quality improvement methods. Staff were proud of the areas in which they worked. They felt encouraged and supported by the trust to try out new ideas and improve the experience of people using their services.

• There was a continuing improving culture at the trust at all levels, led by the senior leaders and the support and respect they showed for each other and staff across services.

Summary of findings

• The senior leaders worked well together and had a clear understanding of issues inside and outside of their line of responsibility and how these impacted on each other.

• The lead governor was outstanding and an excellent role model to the governors. She clearly understood her role and the impact of this on the trust, as well as developing local networks to promote more integrated systems working.

• Medicines safety was effectively integrated into the governance structure of the trust. The chief pharmacist led the development of the medicines optimisation strategy, providing annual updates to the board on achievements and challenges.

• Staff assessed and managed risk. They minimised the use of restrictive practices and followed good practice with respect to safeguarding. Staff discussed risks and safeguarding concerns during regular handovers. Ward managers were able to adjust the staffing levels based upon the acuity on the wards.

• Since April 2018 the trust had been successful in adding 100 people to its experts by experience database and offered supervision and training to support them in their role.

• There was good evidence that the trust was implementing the triangle of care across its services which meant closer working with carers and a more holistic view of the needs of people using the service.

• Patients and carers gave positive feedback about the care received. Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients. They actively involved patients, families and carers in care decisions.

• People using services were supported through good multidisciplinary team working. They provided a range of treatments suitable to the needs of the patients and in line with national best practice guidance. There was effective multi-agency working with external partners to support the needs of people in the community.

However:

• The core service rating for mental health crisis services and health-based places moved from being rated good to requires improvement.

• The key question of effective in the forensic inpatient or secure wards moved from being rated outstanding to good.

• There was a risk that the threshold for the investigation into the serious incident at Mill View Hospital was set too high, although this had been done in consultation with other agencies. There was evidence of involving families and carers in investigations, though their involvement in setting the terms of reference for each investigation was not always clear.

• Improvements were needed to ensure that the premises and equipment continued to be safe across the acute wards for adults of working age and psychiatric intensive care units.

• The appropriate complement of non-executive directors was not always present at board committee meetings to ensure appropriate scrutiny, challenge and assurance was sought. This was reflected in the minutes of committee meetings.

• All members of the board team needed to ensure they were involved in the programme of board member visits to services and wards. The trust needed to ensure that evidence of qualifications of non-executive directors was obtained where relevant. Succession planning was not established amongst the executive team and needed to be developed.

• Staff network groups did not always feel that there was senior leadership support for changes that needed to be made.

• Medicines and clinic room management needed to be improved across some core services to ensure that medicines and medical equipment was safely monitored for use.

Summary of findings

• There was work to do to ensure the trust data management systems accurately reflected the completed statutory and mandatory training, supervision and appraisals that were taking place in services, as the data provided to the CQC did not show these were taking place regularly.

Overall trust

Are services safe?

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

• Nine of the 11 trust core services are rated as good for safe. We took into account the previous ratings of the six services not inspected this time.

• The trust was working creatively to increase recruitment and retention of staff. There were a number of incentives to attract nurses and doctors to work for the trust. This had reduced the agency spend by 50%. There were still vacancies across services, and ward managers were able to adjust the staffing levels to account for the acuity on the wards.

• Staff followed best practice when storing, prescribing, administering and recording the use of medicines. The chief pharmacist was the lead for the development of the medicines optimisation strategy and provided annual updates to the board on achievements and challenges. The trust had appointed a medicine safety officer. Staffing levels were at establishment and input to the community teams was being increased to reduce hospital admissions and improve community-based care.

However:

• The trust had recently pleaded guilty for the failure to provide safe care and treatment to a patient. This was in relation to a young man who died whilst a patient in the prison healthcare unit at HMP Lewes in February 2016. A recent inspection of the prison healthcare carried out by the CQC Health and Justice team and HMI Prison found that improvements were still required to ensure patients care and treatment needs were met safely at HMP Lewes.

• The rating for the core service of the mental health crisis services and health-based places of safety moved from good to requires improvement. We identified particular concerns at Mill View hospital crisis team. However, within the mental health crisis services and health-based places of safety the trust had not made sure that comprehensive risk assessments and care plans were completed so that patients received person-centred safe care and treatment.

• There was a risk that the threshold for the investigation into the serious incident at Mill View Hospital was set too high although this had been done in consultation with other agencies.

Are services effective?

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

• All 11 of the trust core services were rated as good for effective. We took into account the previous ratings of services not inspected this time.

• The trust provided care and treatment to patients based on national guidance. There were many examples of the implementation of best practice being followed across the services.

• Staff assessed the physical and mental health of all patients on admission or during the initial assessment. Care plans were individualised and reviewed regularly through multidisciplinary discussion. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

• Physical healthcare was led by a centralised team who supported and promoted this within services across the trust. A lead physical health practitioner was assigned to each ward. The trust worked hard to encourage patients to make healthy lifestyle choices.

Summary of findings

• The trust ensured care and treatment interventions were suitable for the patient group and consistent with national guidance on best practice. For example, we found good implementation of national institute for health and care excellence across the services. Care planning for patients on Iris ward included the use of a therapy doll (a robotic seal). Studies have shown that use of these toys on wards for older people or those with dementia stimulates social interaction between patients and carers.

• The trust monitored the effectiveness of care and treatment and used the findings to improve them. The trust had strong links to the local university and medical schools and was involved in a number of clinical audits and research trials. Quality improvement was being rolled out across the trust, with staff encouraged to use different methodologies to improve patient experience and the areas in which they worked.

• The trust made sure staff were competent for their roles. Staff received an annual appraisal and regular supervision sessions to ensure they were developing and effective in their work with patients.

• There was strong multi-disciplinary working across the services. Psychologists, doctors, nurses and other healthcare professionals worked jointly in all services to provide good care. Ward teams had effective working relationships with other teams within and external to the trust. Inpatient services engaged with them early in the patient's admission to plan for discharge. For example, in the mental health-based places of safety and crisis services we saw effective multiagency working with a variety of services including the police, ambulance services, approved mental health professionals, street triage and in-patient wards.

• The trust had secure electronic care records systems which enabled relevant staff to access up-to-date, accurate and comprehensive information on patients' care and treatment.

• Staff had a clear understanding of their roles and responsibilities under the Mental Health Act and Mental Capacity Act. They received good support from the Mental Health Act officers at the trust.

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 outstanding because during the inspection period:

• Three of the trust core services were rated as outstanding for caring. The eight other core services were rated as good for caring.

• Feedback from people who use the service, those who are close to them and stakeholders is continually positive about the way staff treat people. We received feedback from a wide range of stakeholders who said that staff at all levels of the trust demonstrated a caring and compassionate approach with patients. Throughout the core service inspections we received positive feedback from patients and their carers of how well they are treated.

• There was a strong, visible person-centred culture. Patients were truly respected and valued as individuals and were empowered as partners in their care. Staff were highly motivated to work with patients and carers to ensure that the care was what they needed and they had a good patient experience. When we joined home visits with the crisis team we observed that staff worked collaboratively with patients; sensitively discussing care and treatment and ensuring patient understanding. In the places of safety patients said that staff had spent time talking with them and explained what would happen next. Within the wards for older people with mental health problems we observed staff treating patients with compassion and care by taking time to listen to them and answering their questions. Patients we spoke with told us staff were always respectful towards them. Patients said the staff tried to meet their needs, that they worked hard and had patients' best interests and welfare as their priority.

Summary of findings

• Staff recognised and respected the totality of patients' needs. They always took patients' personal, cultural, social and religious needs into account. All staff we spoke with had an in-depth knowledge of their patients' likes and dislikes. Patients' individual preferences and needs were always reflected in how care was delivered. Patients spoke positively about the care they had received. They said that staff were easy to talk to and they had found their support invaluable.

• Work with carers was enhanced through the triangle of care approach that we saw in use in the wards and service we inspected. Relationships between patients, carers and staff were strong and supportive. These relationships were highly valued by staff and promoted by leaders. Feedback from patients, those who are close to them and stakeholders was positive about the way staff at all levels treated patients. One of the wards for older people with mental health problems had signed up for the nationally recognised 'John's Campaign' which was an application of evidence of how they supported carers of people with dementia.

• The trust promoted patient and carer involvement at various opportunities. The trust had recruited over 100 experts by experience since April 2018 and over a third of trust committees included people with lived experience. Befriending volunteers worked in two-thirds of inpatient units. The peer supporter role had developed along with peer apprenticeships. Team Springwell was the trusts' learning disability experts by experience group who worked on the Springwell project. This was an area of the trust website for people with learning disabilities to access advice, information and support, and to enable people with learning disabilities to have a voice in their care. The trust working together groups had matured over the past year and were chaired or co-chaired by an expert by experience. Representatives fed into service wide leadership meetings and changes were enacted on the wards as a result of feedback. This enabled people to have a real say about how their local services were run and delivered.

• Staff provided emotional support to patients and those close to them to minimise their distress. The core service had different ways of supporting patients and their significant others to help alleviate their anxieties, such as when they or their relative were admitted to hospital.

Are services responsive?

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

• Ten core services were rated as good for responsive. We took into account the previous ratings of services not inspected this time. The forensic inpatient or secure wards moved from being rated good to outstanding for responsive.

• The trust had systems in place to support good discharge planning. Staff planned and managed discharges well. In many of the services discharge planning started at the point of admission and they liaised well with services that would provide aftercare, transition to another service or discharge into the community. Within the forensic inpatient or secure wards an 'assertive transitions team' aided patient discharge and support beyond the ward. In the mental health crisis services there was an early discharge nurse who bridged the gap between the wards and the crisis team and ensured early discharge was appropriately planned.

• During out of hours people were able to access the mental health line for support. A street triage service was available, which had improved patient treatment journeys. All places of safety were open 24 hours a day, seven days a week. An urgent care lounge had recently been opened at Langley Green Hospital to provide a calm environment for patients waiting to be assessed. The trust planned to open a psychiatric decision unit at Mill View Hospital in April 2019 which would cover the whole of the county. This will be a five-bedded ward to offer an alternative to people attending accident and emergency in a mental health crisis.

• Within the forensic inpatient or secure wards, we found excellent patient engagement with the wider community. This included vocational courses, recovery college, volunteering and work opportunities.

Summary of findings

• The wards met the needs of all people who use the service including those with a protected characteristic. Staff supported patients with communication, advocacy and cultural and spiritual support. Langley Green Hospital wards for older people with mental health problems was awarded a gold inclusion award for their lesbian, gay, bisexual, transsexual, questioning (LGBTQ) work. Staff had access to interpreters and information leaflets in a range of languages was available on the intranet.

• The trust ensured that wards had a good range of rooms to aid patient recovery including activity rooms, therapy rooms, clinical rooms. The forensic inpatient or secure wards at the Hellingly Centre had a pottery room that was frequently used for activities. Dormitories were still present on three of the wards for older people with mental health problems. Whilst the patients we spoke with were happy with the arrangement, this was on the trust risk register to monitor risk management and as part of their plans to eliminate mixed sex accommodation.

• The trust complaints procedure was on display throughout the services. Patients confirmed they were given information about how to complain or provide feedback when they were admitted.

However:

• The trust did not yet have a 24-hour crisis service but had recently received funding for this to be implemented in April 2020.

• Due to high demand for admissions on Heathfield ward for older people with mental health problems, beds were not always available to patients when returning from leave.

• The four dormitories on Heathfield older people ward had only one sink each. This meant if a patient was using the dormitory sink another patient wishing to also use the sink might have to go out to use the ward bathroom or use a bowl in their bed space.

• Approved mental health professionals and police informed us there were sometimes delays in identifying an available place of safety because the referral process involved a pager, which then delayed a response to their initial contact.

Are services well-led?

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

• All 11 of the trust core services were rated as good. We took into account the previous ratings of services not inspected this time.

• The two adult social care services provided by the trust are rated as good.

• Leaders at all levels within the trust had the skills, knowledge and experience to perform their roles. They had a good understanding of their lines of responsibility and how changes in these impacted on other areas of the trust services. Local leaders understood their services well, were visible in the service and approachable to patients and staff.

• There had been a sustained improvement in the culture of the trust. There was high morale amongst staff who were proud to work for the trust and felt valued and supported. Ward managers encouraged staff to recognise and celebrate their success. Staff felt able to raise concerns without fear of retribution. They felt inspired and able to be innovative and make changes in the services in which they worked.

• Quality improvement had been embraced by the trust and developed well since the previous well led review. There was a continued drive on quality improvement training and staff getting involved in projects. There was a quality house that accommodated the central team who were dedicated to supporting staff to realise their ideas, based on recognised quality improvement methodologies. Staff spoke of the developments in the quality improvement work and methodologies gave them the structure and tools to experiment with new ideas. Staff did not feel they would be rebuked if something didn't work out, and understood it was a process of improvement where they were allowed to not always get it right. Further work was needed to ensure that the learning and improvements of projects and best practice

initiatives were shared across services, particularly core services. For example, in the wards for older people with mental health problems we found wards carrying out excellent work to improve the patient experience. However, there was a lack of sharing, as other older people wards were not aware of the good work taking place in other older people wards across the trust.

• The chief executive was well respected by all staff and stakeholders. Her visibility across services was highly valued and appreciated by staff, particularly when she visited every ward on Christmas day. Staff found her to be very approachable, responsive, decisive and understanding of the daily challenges they faced in their work.

• Staff knew and understood the trust vision and values and how they were applied in the work of their team and influenced objectives at service level.

• Good collaborative partnership working by services across the trust with external stakeholders ensured that services could be shaped to meet local needs.

• The trust had a number of ways to involve people with lived experience, carers, staff and the public in the work and direction of the care delivery services. Training and support was provided to enable people to have a voice and get involved.

• The trust had systems for identifying risks and the mitigation of these, though some further alignment and strengthening of these to ensure that it was clear how local risks were monitored and planned for at trust level.

• The trust had systems to manage information securely. Staff at different levels of the organisation were able to access the data they needed to deliver services and gain assurance. Further work was needed to ensure all staff were updating their 'my learning' supervision and training record to ensure this reflected what was happening at local level and provide ongoing assurance to the board.

Ratings tables

The ratings tables later in our report 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 previous 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 examples of outstanding practice in each of the three core services we inspected. For more information, see the Outstanding practice section in this report.

Areas for improvement

We found areas for improvement, and four breaches of legal requirements. We found 32 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information see the Areas for Improvement section of this report.

Action we have taken

We issued two requirement notices to the trust.

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

Summary of findings

What happens next

We will make sure 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.

Outstanding practice

We found the following outstanding practice:

• In July 2018 the trust became one of only six trusts to become Cyber Essentials PLUS accredited. This is a scheme designed to help UK organisations with limited experience of cyber security improve their defences and demonstrate publicly their commitment to cyber security.

• In October 2018 the trust's child and adolescent mental health (CAMHS) community teams were highly commended by the mental health collaborative judges after being shortlisted in two awards. Hampshire CAMHs specialist eating disorder team was commended in the community mental health services for eating disorders for adults or children and young people (supported by NHS England) category and the Hampshire CAMHS New Forest team was commended in the innovation in children and young people's mental health services category.

• In October 2018 Langley Green Hospital became the first mental health hospital in the country to receive the gold lesbian, gay, bisexual, transsexual, questioning (LGBTQ) inclusion award for the improvements they had made for the service to be more inclusive of the LGBTQ community. This included all ward staff being trained in LGBTQ awareness to silver standard and ward toilets were gender neutral.

• In October 2018 the team at Langley Green Hospital won the positive practice in mental health collaborative national clinical team of the year award in in recognition of the outstanding mental health care they provide. The collaborative is a user-led multi-agency collaborative of 75 organisations, including NHS trusts, commissioners, police forces and third sector organisations. It was established to recognise and share excellence in mental health and mental health services.

• In February 2019 staff from Langley Green Hospital went to Parliament to mark the publication of 'A Happy, Healthy Workplace', a report co-produced by The Positive Practice in Mental Health Collaborative and The National Collaborating Centre for Mental Health. The report shared several examples of practice from Langley Green Hospital and staff presented some of these.

Within the forensic inpatient or secure wards there was some outstanding practice:

• The service developed excellent links with the local community and worked collaboratively with external agencies. Patients had many volunteering opportunities including the local theatres, radio stations and supporting local wildlife, dog walking and canal conservation groups.

• There was a well-established patient run corner shop and café at Hellingly that offered vocational opportunities for patients and access to local college courses to gain official qualifications. Additionally, patients attended regular recovery college seminars and courses.

• There was a strong patient voice throughout the service that was largely as a result of the active 'working together group'. This gave a platform for real patient representation from ward level to service wide level and there had been a number of changes enacted on the service as a result of this.

• The service delivered an assertive transitions team within the service which was delivered in line with the new care models introduced by NHS England. As one of only three trusts in England chosen to pilot this team, patients received input at six months prior and six months post discharge from a variety of healthcare specialists as well as housing, benefits and work specialists to improve outcomes and aid transitions and discharges.

Summary of findings

Within the wards for older people with mental health problems there was some outstanding practice:

• Langley Green Hospital was awarded a gold inclusion award for their LGBTQ work. The LGBTQ Inclusion Award helps healthcare facilities to address historical inequalities in healthcare outcomes for LGBTQ people and is a partnership between Switchboard and Trans Alliance Brighton.

• A project called 'pimp my Zimmer' was undertaken in Autumn 2018 between Brunswick ward and a local primary school where young students decorated patients' Zimmer frames according to the patients' wishes. This encouraged patients' identification and use of their Zimmer frame to reduce falls risks and raised the profile of dementia among the school children.

• Brunswick and Iris wards had installed infra-red falls detection technology in patient bedrooms.

• Opal ward had a full time substantive carer's lead to offer support to carers and increase knowledge among staff regarding carer issues.

• Patients on Iris ward had access to a robotic seal and doll which responded with sounds and movement to human interaction. Studies have shown that use of these toys on wards for older people or those with dementia stimulates social interaction between patients and carers. These innovations are useful in environments where live animals or infants cannot be present due to treatment or logistical difficulties.

• The quiet lounge on Brunswick ward had a virtual aquarium which both relaxed and stimulated patients including those with dementia. Research has shown that placing an aquarium in environments with patients with dementia has links to aiding in reducing disruptive behaviour and even improving the eating habits of those suffering with the disease.

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

• The psychologist attached to Grove ward had developed a form of management of violence and aggression training specifically for patients with dementia. The training was presented at the National Psychology Conference.

• All wards were part of the Coastal West Sussex Clinical Commissioning Group initiative 'let's get you home' to ensure that patients spend no longer than they need to in hospital. There is good evidence to show that patients recover better outside hospital when they are well enough to leave. Patients are supported to return home, to a care home or supported housing safely once their treatment in hospital is complete.

Within the mental crisis services and health-based places of safety there was some outstanding practice:

• The trust was due to open a five-bedded psychiatric decision unit in April 2019. The unit would act as an alternative to patients using the accident and emergency department. There was an urgent care lounge at Langley Green which provided a calm environment for patients following assessment.

• A pilot to reduce the number of assessments and streamline a patients' journey was taking place in Chichester. The team leader reported a noticeable improvement in the referral process since the pilot had been introduced.

• The trust offered a street triage service where mental health professionals worked alongside police officers to provide support to people experiencing mental health issues and avoid them being taken into a place of safety or police custody.

Summary of findings

• There was a mental health helpline available for everybody, not just patients who were open to the service although commissioning arrangements affected the availability of the service, dependent on the geographical location of the caller.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

Action the trust MUST take to improve

From the December 2018 well led review there remained one outstanding breach of regulations. This was in relation to maintaining the premises and equipment in the acute wards for adults of working age and psychiatric intensive care units.

We identified two regulatory breaches during this inspection. These were in relation to the care planning, risk assessment and governance of these in the mental health-based places of safety and crisis teams.

Action the trust SHOULD take to improve

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

• Trust should ensure there is clear oversight of all risks through the strategic risk register and board assurance framework.

• The trust should consider a review of the thresholds for serious incident investigations.

• The trust should ensure minutes of committee meetings are strengthened to ensure they provided assurance of concrete challenge and action.

• The trust should ensure all members of the board are involved in the programme of board member visits to services and wards.

• The trust should ensure succession planning is established amongst the executive team.

• The trust should ensure there is an executive sponsor for each staff network group.

• The trust should ensure the full involvement of families and carers, in setting the terms of reference for investigations involving their relative/ significant others.

• The trust should ensure that medicines and medical equipment was safely monitored for use in services.

• The trust should ensure that evidence of qualifications of non-executive directors is obtained where relevant.

• The trust should ensure the trust data management systems accurately reflected the completed statutory and mandatory training, supervision and appraisals that were taking place in services.

In the mental health crisis services and health-based places of safety:

Action the trust MUST take to improve

• The trust must make sure that comprehensive risk assessments are completed to prevent avoidable harm or risk of harm to patients.

Summary of findings

• The trust must make sure that comprehensive and holistic care plans are completed so that patients receive person centred care based on assessment of their needs and preferences.

• The trust must make sure that staff follow policies and procedures for managing medicines and that medicines are managed safely and dispensed accurately in accordance with prescriptions so that patients are not put at risk.

• The trust must make sure that there is comprehensive oversight of record keeping and governance. They must securely maintain accurate, complete and detailed records in respect of each person using the service and ensure consistency of documentation used.

Action the trust SHOULD take to improve

• The trust should make sure that patients who have completed treatment are discharged appropriately.

• The trust should make sure that the time is recorded when an approved mental health professionals and section 12 doctor has been requested.

• The trust should review the pager referral process to avoid delays in identifying an available place of safety.

• The trust should monitor and act on reports of ambulances not meeting the policy agreed response time.

• The trust should address the culture and team dynamics at Mill View crisis team to ensure the safety of patients through accurate record keeping.

• The trust should have greater oversight and management where caseloads are held up because of the capacity of the onward referrals.

In forensic inpatient or secure wards:

Action the trust SHOULD take to improve:

• The trust should ensure that all patients receiving high dose antipsychotic medicine have their physical healthcare regularly monitored as per trust policy.

• The trust should ensure expiry dates of items within clinic rooms are continuously monitored and immediately removed and replaced when expired.

• The trust should ensure the fridge and thermometer on Fir ward is appropriately maintained and that staff record temperature readings correctly.

• The trust should ensure all incidents are reported immediately through relevant systems and escalated appropriately.

In wards for older people with mental health problems:

Action the trust SHOULD take to improve:

• The trust should work towards elimination of dormitory sleeping arrangements to ensure the dignity and privacy of patients is protected. Additional sinks should be made available for patients admitted to dormitories on Heathfield ward.

• The trust should ensure that care plans are available in accessible easy read for patients and their carers.

• The trust should ensure that care planning regarding mixed sex breaches on Opal ward are accurately recorded in patients' care plans.

• The trust should ensure that the Grove ward dining room is decorated in dementia friendly colours.

• The trust should ensure that care plans for patients on St Raphael ward detail patients' likes and dislikes.

Summary of findings

• The trust should ensure that Opal and Heathfield wards have access to junior doctors in shift numbers.

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.

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

• There had been a sustained improvement in the culture of the trust. There was an open and transparent culture across the trust which gave staff confidence in the leadership and increased morale. Staff were motivated and keen to make changes in the services in which they worked.

• Changes to the senior leadership team were viewed as positive to strengthen the trust board and support the direction of the trust into the next stage of its improvement journey. New members brought new energy, skills and innovations. There were clear strategies to support the improvement, and the new IT and digital plans were crucial in the realisation of this and achieving the overall aims and vision of the trust.

• The trust had clear structures for overseeing performance, quality and risk to enable oversight of what was happening across the trust, themes and potential issues. Though some further alignment and strengthening of these was needed to ensure that themes arising in local teams had oversight and assurance at trust level.

• The vision and values fed through the all the work within the organisation. Staff understood how these were woven into their work and the overall aims of the trust.

• The trust was proactively engaged in working with others and were key partners in the local sustainability and transformation plans. The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services. The trust saw co-production as integral to their work, and this was supported through the working together groups and the increasing opportunities for people with lived experience to get involved in the work and development of the trust. Stakeholders spoke of an open and culture within the trust, with the senior leaders being role models for engagement with others.

• The trust had good systems for managing its finances. Examples of this included the reduction of paying for inpatient beds in the independent sector and 50% reduction in agency staff spending. This was partly due to the strong recruitment drives and focus on patient journeys.

• The trust had built upon its range of learning and development opportunities to not only try and attract new staff to the trust, but to also retain and develop existing staff. This included the nurse associates role and apprenticeships for healthcare assistants and administrative staff. The preceptorship training for newly qualified nurses and those returning to practice had grown to provide a structure programme of support and training for these staff, which they really appreciated and gave them confidence in their new roles. Succession planning was in place for the nonexecutive directors but still needed to be implemented across the executive team to ensure that appropriate support and plans were in place.

• The ongoing development of the staff networks supported the inclusion and diversity aims of the trust. However, more work needed to ensure each had an executive sponsor who could attend network meetings and raise the profile of the needs and work of the staff network members.

• Fit and proper person checks were carried out on board members on appointment.

Summary of findings

• Duty of Candour requirements were met by the trust.

• The trust continued to share learning from when things went wrong and look at ways to develop and improve from these.

However:

• The quality committee held a large portfolio for a bi-monthly meeting. The paper for this and other committees did not always evidence clear challenge and action.

• Board members recognised that there was still work to do to ensure staff consistently uploaded supervision, appraisals and training appraisals onto the centralised system.

• The trust needed to ensure that evidence of qualifications of non-executive directors was obtained where relevant.

• The programme of board visits to wards and services did not evidence that all members of the board were regularly involved in these.

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
Good →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019

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 mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement →← Oct 2017	Good ↑ Oct 2017	Outstanding ↑ Oct 2017	Good ↑ Oct 2017	Good ↑ Oct 2017	Good ↑ Oct 2017
Long-stay or rehabilitation mental health wards for working age adults	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Forensic inpatient or secure wards	Good →← Apr 2019	Good ↓ Apr 2019	Good →← Apr 2019	Outstanding ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019
Child and adolescent mental health wards	Good Sept 2016	Good Sept 2016	Outstanding Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Wards for older people with mental health problems	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019
Wards for people with a learning disability or autism	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Community-based mental health services for adults of working age	Good ↑ Nov 2017	Good ↑ Nov 2017	Good →← Nov 2017	Good →← Nov 2017	Good ↑ Nov 2017	Good ↑ Nov 2017
Mental health crisis services and health-based places of safety	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Requires improvement ↓ Apr 2019	Requires improvement ↓ Apr 2019
Specialist community mental health services for children and young people	Good ↑ Nov 2017	Good →← Nov 2017	Outstanding ↑ Nov 2017	Good ↑ Nov 2017	Good ↑ Nov 2017	Good ↑ Nov 2017
Community-based mental health services for older people	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Community mental health services for people with a learning disability or autism	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Overall	Good →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019

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.

Ratings for adult social care services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lindridge	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Requires improvement Dec 2018	Good Dec 2018
Avenida Lodge	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017

Mental health crisis services and health-based places of safety

Requires improvement 

Key facts and figures

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

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

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

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

- Oaklands Centre, Chichester
- Meadowfield Hospital, Worthing
- Mill View Hospital, Hove
- Langley Green, Crawley
- Department of Psychiatry, Eastbourne
- Woodlands Hospital, Hastings

The trust has six health-based places of safety (HBPOS) at:

- Meadowfield Hospital, Worthing
- Mill View Hospital, Hove
- Langley Green, Crawley
- Department of Psychiatry, Eastbourne
- Woodlands Hospital, Hastings
- Chalkhill, Haywards Heath

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

Mental health crisis services and health-based places of safety

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

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

We inspected this core service as part of our next phase mental health inspection programme. The inspection of this core service was prompted in part by notification of an incident at the Mill View Hospital health-based place of safety. This incident is subject to ongoing separate investigation and as a result this inspection did not examine the circumstances of the incident.

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

Our inspection took place between 29 and 31 January 2019. The inspection was unannounced, which means that staff did not know we were coming, to enable us to observe routine activity.

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

During the inspection visit, the team:

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

Mental health crisis services and health-based places of safety

- reviewed supervision and training records

Summary of this service

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

- We had very significant concerns about the crisis team based at Millview.
- The amount of medical cover varied across services as most of the consultants worked part time. Staff told us that there were sometimes problems because the junior doctors that provided cover were sometimes reluctant to prescribe medicines because they didn't know the patients.
- There was evidence that the low morale, resistance to change and culture of the crisis team at Mill View Hospital was having a negative impact on the care and treatment that some patients received. Care plans and risk assessments were not kept up to date to ensure patients were receiving the care and treatment they needed.
- The care records reviewed across the four teams varied with respect to their quality and level of detail. The risk assessments and care plans at Meadowfield, Chichester and Langley Green were comprehensive, holistic and recovery orientated. At Mill View, of the six risk assessments reviewed, one had no risk assessment and five contained limited information that did not accurately reflect the current clinical presentation of the patient. In four of the six records reviewed care plans were missing in two of these patients with high risk and complex needs were identified. The remaining two records that had care plans, were not holistic and did not reflect the full range of needs of the patients. Staff did not always act on review of overdue care plans that had been flagged on the whiteboard. An investigation into a serious incident at Mill View in December 2017 had identified the lack of a crisis personalised care plan as a contributory factor. The investigation into the incident recommended that all patients should have an individualised care plan in place by March 2019.
- Staff from the places of safety did not always record the time that the approved mental health professional and section 12 doctor had been requested. This meant that the nurse could not accurately calculate the time from request to completion of assessment.
- Staff told us that there were sometimes delays in accident and emergency due to a place of safety not being available, approved mental health professionals and police said there were sometimes delays in identifying an available place of safety because of the referral process involved a pager, which then delayed a response to initial contact. Staff said that because ambulances did not always meet the trust policy's agreed response time, an alternative health ambulance company was used to transport patients to the place of safety.

However:

- Staffing numbers were based on caseload and patient needs. Managers used regular bank staff who knew the patients and service well. The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff discussed risks and safeguarding concerns during regular handovers. Staff held meaningful discussions and spoke about patients in a respectful and caring manner. Staff had access to psychiatrists, to ensure all risks from patients on their caseload were safely managed. Staff saw all patients daily for the first three days and then reviewed frequency of visits. We saw evidence that staff saw patients twice a day where risk was considered high.
- There was a range of disciplines in the crisis teams which included doctors, nurses, psychologists, occupational therapists and social workers. All staff we spoke with were appropriately experienced and qualified to meet the needs of patients.

Mental health crisis services and health-based places of safety

- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned. The trust sent a bulletin to all staff with information about recent incidents and any learning identified. Staff had access to debrief sessions after serious incidents that were facilitated by senior managers and psychologists.
- We saw effective multi-agency working with a variety of services including the police, ambulance services, approved mental health professionals, rapid response team, street triage and in-patient wards.
- Patients at Langley Green could access the day service for daily group therapy in a range of psycho-social interventions Monday to Friday. Groups offered included mindfulness, managing anxiety and art therapy.
- We observed staff from the mental health telephone service who were supportive, kind and caring in their conversations with callers.
- Patients from the crisis teams spoke positively about the support they had received. They said that staff were responsive, listened and were easy to talk to and they had found the support invaluable. People who had used the places of safety said that staff had treated them with kindness and respect and had done their best to make them feel comfortable.
- The trust had introduced initiatives including a pilot to improve the referral process in Chichester and the introduction of an early discharge nurse to bridge the gap between wards and the crisis teams.
- An urgent care lounge had recently been opened at Langley Green to provide a calm environment for patients waiting to be assessed. The trust planned to open a psychiatric decision unit at Mill View in April 2019 which will cover the whole of the county.
- The managers and team leaders demonstrated the skills, knowledge and experience to perform their roles. All leaders showed a good understanding of the service and could clearly explain how to provide high quality care.
- A lead nurse for quality and compliance had been in post since October 2018. They were responsible for standardising processes and improving services to patients in the places of safety. Staff reported an improvement in clinical practice and cascading information since they had been in post.

Is the service safe?

Requires improvement 

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

- The amount of medical cover varied across services because most of the consultants worked part time. This meant that SHOs provided cover when a consultant wasn't available. Staff told us that they sometimes experienced problems because the senior house officers that provided cover were sometimes reluctant to prescribe medicines because they didn't know the patients.
- The 29 risk assessments that we reviewed across the four crisis teams varied with respect to their quality and level of detail. Twenty-four of the risk assessments were thorough, up to date and reviewed as required. At Mill View, we found a risk assessment was missing from one of the records and the remaining five contained limited information that did not accurately reflect the current clinical presentation for the patient.

However:

- Staffing numbers were based on caseload and patient needs. Managers used regular bank staff who knew the patients and service well. The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Staff discussed risks and safeguarding concerns during regular handovers. Staff saw all patients daily for the first three days and then reviewed frequency of visits. We saw evidence that staff saw patients twice a day where risk was considered high.
- A lead nurse for quality and compliance had been appointed specifically to standardise and improve the places of safety across the trust. This had enhanced clinical oversight of the services and had been positively received by staff.
- Staff from the places of safety completed a place of safety risk plan at the point of admission with the police or ambulance service. The 30 risk assessments reviewed in the places of safety contained detailed risk assessments and included any risks reported from the police when the patient was bought to the place of safety.
- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned. The trust sent a bulletin to all staff with information about recent incidents and any learning identified. Staff had access to debrief sessions after serious incidents that were facilitated by senior managers and psychologists.

Is the service effective?

Good 

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

- We saw evidence of staff considering a range of care and treatment interventions for patients during handovers and team meetings. Staff considered least restrictive practice when discussing patient needs.
- Patients at Langley Green could access the day service for daily group therapy in a range of psycho-social interventions Monday to Friday. Groups offered included mindfulness, managing anxiety and art therapy.
- Staff discussed patients' physical health during handover meetings. We saw evidence of staff completing a physical health screening tool and observations during the initial assessment.
- There was a range of disciplines in the crisis teams which included doctors, nurses, psychologists, occupational therapists and social workers. All staff we spoke with were appropriately experienced and qualified to meet the needs of patients. One of the doctors from Mill View was a lead for 'open dialogue' treatment. The clinical lead nurse at Mill View was a nurse prescriber. A support time and recovery worker based at Mill View provided practical support to patients.
- New staff received an induction to the trust and within their local team. New staff were supernumerary to staffing numbers during their two week induction.
- The lead nurse for quality and compliance for the places of safety was standardising processes to improve the service for patients. They had introduced a multi-disciplinary place of safety forum. During the meeting, staff shared knowledge and good practice across all places of safety.
- A range of disciplines including doctors, nurses, psychologists, occupational therapists and managers attended the twice daily handovers where possible. Staff demonstrated knowledge of patients during the patient centred discussions. There were regular team meetings and clinical review meetings where staff discussed patients in greater detail. Street triage workers attended their local crisis team and attended meetings where possible.
- We saw effective multi-agency working with a variety of services including the police, ambulance services, approved mental health professionals, rapid response team, street triage and in-patient wards.
- Social workers were integrated in each of the crisis teams inspected. The senior social worker based with the Mill View crisis team was also a trained approved mental health professional (AMHP).

However:

- The care records reviewed across the four teams varied with respect to their quality and level of detail. However, of the six records reviewed at Mill View, four did not contain a care plan or consent. Two of the patients without a care plan were high risk. The two records that did contain a care plan were not holistic and did not reflect the full range of needs of the patient. Staff from Mill View recorded the review date for care plans on the office whiteboard, but had not acted on the information.
- Staff from the places of safety did not always record the time that the approved mental health professional and section 12 doctor had been requested. This meant that the nurse could not accurately calculate the time from request to completion of assessment.

Is the service caring?

Good 

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

- Staff demonstrated a good knowledge and understanding of individual patient needs and risks during handover meetings. Staff held meaningful discussions and spoke about patients in a respectful and caring manner.
- Staff worked collaboratively with patients in their care during home visits. We observed staff sensitively discussing care and treatment and ensuring patient understanding.
- Staff supported patients with social issues. There was a dedicated support and recovery worker at Mill View who supported patients with housing, benefits, shopping, attending appointments and any other identified social needs.
- Patients who were under the care of the crisis teams spoke positively about the support they had received. They said that staff were responsive, listened and were easy to talk to and they had found the support invaluable. People who had used the places of safety said that staff had treated them with kindness and respect and had done their best to make them feel comfortable.
- We observed staff from the mental health telephone service who were supportive, kind and caring in their conversations with callers.
- Patients said that staff from the places of safety had spent time talking with them and explained what would happen next. They asked patients if they could contact their nearest relative when they were in the place of safety.
- Patients and carers could provide feedback using the friends and family survey. The survey could be completed electronically, or paper copies of the survey were available.

Is the service responsive?

Good 

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

- Staff told us they met the service targets to respond to urgent referrals within four hours and non-urgent referrals within 24 hours. Assessment to treatment times were captured within this contact.
- A pilot was being run in Chichester working closely with the accident and emergency liaison team to reduce the number of assessments and improve the patient experience.

Mental health crisis services and health-based places of safety

- There was an early discharge nurse available for all teams inspected who bridged the gap between the wards and the crisis team and ensured early discharge was appropriately planned. They attended ward rounds and meetings to discuss patient specific cases as requested, identify patients with barriers and overcome barriers to discharge.
- Staff discussed 'hard to engage' patients during handovers and actively tried to engage patients who did not attend appointments or found it difficult to engage with the service.
- Staff were flexible with appointments, including medical reviews, to accommodate patient needs.
- All places of safety were open 24 hours a day, seven days a week, unless the place of safety was already occupied by a patient who had been brought in under Section 136 and for whom there was no bed on the ward. Staff did not exclude people who may be intoxicated or under the influence. Doctors were able to prescribe detox medicines if appropriate.
- Staff reported improvements in patient treatment journeys because of the street triage service.
- An urgent care lounge had recently been opened at Langley Green to provide a calm environment for patients waiting to be assessed. The trust planned to open a psychiatric decision unit at Mill View in April 2019 which will cover the whole of the county. The unit will be a five bedded ward to offer an alternative to accident and emergency.
- Patients from the places of safety told us that staff regularly offered them food and drink. Staff told us that there was a range of food available to meet all dietary needs.
- Staff, including consultants, saw a majority of patients at home. Staff made arrangements to see patients at other venues if preferred.
- Staff had access to interpreters and information leaflets in a range of languages was available on the intranet. We heard an example of staff arranging a signer for a patient who was deaf.
- Patients we spoke with from the places of safety confirmed they were given information about how to complain or provide feedback when they were admitted.

However:

- Staff told us that there were sometimes delays in accident and emergency due to a place of safety not being available.
- Approved mental health professionals and police said there were sometimes delays in identifying an available place of safety because of the referral process involved a pager, which then delayed a response to initial contact.

Is the service well-led?

Requires improvement 

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

- Staff from Mill View said that although they felt supported and able to raise concerns, morale was low because of tension between staff and managers. Staff spoke of strong personalities in the team and resistance to change of some staff which affected team dynamics. The culture of the team was affecting the patients' care and treatment because record keeping was not up to date and reflective of a patient's needs.

Mental health crisis services and health-based places of safety

- An investigation into a serious incident in December 2017 had identified the lack of a crisis personalised care plan as a contributory factor. The investigation into the incident recommended that all patients should have a personalised care plan in place by March 2019. We would expect all patients to have a care plan in place in line with national guidance. During this inspection we saw that four of the six care records reviewed at the service did not contain a care plan, and the two that did, were not holistic and did not reflect the full range of needs of the patients.
- Staff kept patients on their caseloads because of the capacity of the onward referrals. This meant that caseloads for some teams were larger than they needed to be.

However:

- The managers and team leaders demonstrated the skills, knowledge and experience to perform their roles. All leaders showed a good understanding of the service and could clearly explain how to provide high quality care.
- A lead nurse for quality and compliance had been in post since October 2018. They were responsible for standardising processes and improving services to patients in the places of safety. Staff reported an improvement in clinical practice and cascading information since they had been in post.
- Staff told us that the chief executive had visited Chichester and Worthing crisis teams and had a good understanding of the service. The chair of the board had visited Chichester team.
- There were several pilot projects across this core service, which demonstrated a commitment to innovation and continuous improvement.
- The service maintained operational oversight through a structured schedule of meetings that communicated relevant information from senior managers to front staff and vice versa.
- Administrators in teams created spreadsheets to capture performance and monitor gatekeeping. Team leaders had devised a range of spreadsheets to monitor performance including supervision and time in treatment. Managers could monitor training and supervision using the trust's 'My learning' dashboard.
- The policy for places of safety was under review during our inspection. The policy included changes to legislation so that staff were able to support a smooth transition when helping people in crisis.
- The electronic care notes system allowed staff to access and record data as required. Staff were trained in using the electronic care notes during their induction. Staff from the mental health helpline and street triage team had access to the system so could update records if contacted by patients in service.

Outstanding practice

We found examples of outstanding practice in this service.

- A pilot to reduce the number of assessments and streamline a patients' journey was taking place in Chichester. The team leader reported a noticeable improvement in the referral process since the pilot had been introduced.
- There was a mental health helpline available for everybody, not just patients who were open to the service although commissioning arrangements affected the availability of the service, dependent on the geographical location of the caller.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

Mental health crisis services and health-based places of safety

We found areas for improvement in this service.

- The trust must make sure that comprehensive risk assessments are completed to prevent avoidable harm or risk of harm to patients.
- The trust must make sure that comprehensive and holistic care plans are completed so that patients receive person centred care based on assessment of their needs and preferences.
- The trust must make sure that staff follow policies and procedures for managing medicines and that medicines are managed safely and dispensed accurately in accordance with prescriptions so that patients are not put at risk.
- The trust must make sure that there is comprehensive oversight of record keeping and governance. They must securely maintain accurate, complete and detailed records in respect of each person using the service and ensure consistency of documentation used.
- The trust should make sure that care records include information about consent.
- The trust should standardise audits used across each of the crisis teams
- The trust should keep clear records to demonstrate calibration of medical equipment
- The trust should ensure sufficient medical cover for crisis teams who have knowledge of the patients.

Action the trust SHOULD take to improve

- The trust should make sure that patients who have completed treatment are discharged appropriately.
- The trust should make sure that the time is recorded when an approved mental health professionals and section 12 doctor has been requested.
- The trust should review the pager referral process to avoid delays in identifying an available place of safety.
- The trust should address the culture and team dynamics at Mill View to ensure the safety of patients through accurate record keeping.
- The trust should have greater oversight and management where caseloads are held up because of the capacity of the onward referrals.

Wards for older people with mental health problems

Good  

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.

Key facts and figures

The Sussex Partnership NHS Foundation Trust provides inpatient wards for older adults with mental health conditions who are admitted informally or detained under the Mental Health Act 1983. The trust provides 165 beds across eight sites throughout Sussex. The wards are outlined below:

The Harold Kidd Unit, Chichester:

Grove ward is a 10 bedded ward for older men who experience dementia.

Orchard ward is a 12 bedded ward for older men and women experiencing functional mental health conditions including anxiety, depression and psychosis.

Department of Psychiatry, Eastbourne General Hospital:

Heathfield ward is an 18 bedded ward for older men and women experiencing functional mental health conditions including anxiety, depression and psychosis.

Horsham Hospital:

Iris ward is a 12 bedded ward for older women who experience dementia.

Salvington Lodge:

The Burrowes, (patients have been temporarily moved to Brunswick ward in Millview Hospital) is a 10 bedded ward for older men and women who experience dementia.

Langley Green Hospital:

Opal ward is a 19 bedded ward for older men and women experiencing functional mental health conditions including anxiety, depression and psychosis.

St Anne's Centre:

St Raphael Ward is a 17 bedded ward for older men and women experiencing functional mental health conditions, including anxiety, depression and psychosis.

Uckfield Hospital:

Beechwood Unit is a 15 bedded ward for older men and women who experience dementia.

Meadowfield Hospital:

Wards for older people with mental health problems

Larch ward is an 18 bedded ward for older men and women experiencing functional mental health conditions, including anxiety, depression and psychosis.

Mill View Hospital:

Meridian ward is a 19 bedded ward for older men and women experiencing functional mental health conditions, including anxiety, depression and psychosis.

Brunswick ward is a 15 bedded ward for older men and women who experience dementia.

We inspected this core service as part of our next phase mental health inspection programme.

Our inspection between 29 and 31 January 2019 was unannounced, which means that staff did not know we were coming, to enable us to observe routine activity. During this inspection we inspected a sample of seven out of ten wards of this core service.

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

During the inspection visit, the team:

- visited seven of the service's 10 inpatient wards (Heathfield, Grove, Orchard, Iris, Opal, St Raphael, and Brunswick wards), looked at the quality of the environments and observed how staff were caring for patients
- spoke with 23 patients who were using the service
- spoke with seven family members and carers
- spoke with the managers of each ward
- spoke with 64 other staff members; including consultant psychiatrists, junior doctors, pharmacists, service managers, matrons, occupational therapists and their assistants, psychologists, nurses, healthcare assistants, domestic team supervisor, occupational therapists and administrative staff
- attended and observed two 'safety huddles', two patient clinical meetings, one staff handover and two patient activities
- undertook a short observation framework for inspection (SOFI) assessment of a group of four patients
- reviewed 32 patient medicine charts
- carried out a specific check of the medicine management on the wards
- reviewed 30 treatment records including the Mental Health Act documentation of detained patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Sussex Partnership NHS Foundation Trust provides wards for older people with mental health conditions who are admitted informally or detained under the Mental Health Act 1983.

To get to the heart of patients' 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?

Wards for older people with mental health problems

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.

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

Where necessary, we take action against registered service providers and registered managers who fail to comply with legal requirements, and help them to improve their services.

At the last comprehensive inspection of this core service in October 2017, we rated the wards as good for the five key questions (safe, effective, caring, responsive and well-led). We re-inspected all five key questions during this inspection.

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

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding
- Staff developed a holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialities required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients. They actively involved patients, families and carers in care decisions.
- The service managed beds well in most wards and many patients were discharged once their condition warranted this.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- Although we concluded that staff actively involved patients in their care, on St Raphael ward the plans did not contain patients' preferences including their likes and dislikes around their care. Also, there were no accessible or easy read care planning tools available for patients who might need them on most wards including St Raphael, Opal and Brunswick wards.
- Due to high demand for admissions, patients on Heathfield ward did not always have beds available to them when returning from leave.
- Heathfield and St Raphael wards had shared sleeping arrangements where more than one patient had to sleep in the same bedroom. The four dormitories on Heathfield ward had only one sink each.
- The dining room on Grove ward was very enclosed and was not decorated in dementia friendly colours.

Is the service safe?

Good 

Wards for older people with mental health problems

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

- All wards were safe, clean, well equipped, clean and fit for purpose.
- The service had enough nursing and medical staff who knew the patients and received mandatory training to keep patients safe from avoidable harm. Ward managers adjusted staff numbers to meet patient and ward safety needs including observation levels and activities on and off the wards. There was adequate medical cover over a 24-hour period, seven days a week across all wards.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. The psychologist on Grove ward developed management of violence and aggression training specifically for patients with dementia. The training was presented at the National Psychology Conference.
- All wards worked towards reducing and managing patient falls risks. The ward worked with a local primary school in October 2018 to deliver a project called 'pimp my zimmer'. Children decorated patients' zimmer frames to encourage patients to use their zimmer frames to reduce falls, help patients identify which zimmer was theirs, and to increase awareness around dementia amongst the young student group
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had safeguarding training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic. The ward manager on Iris ward had developed an electronic dashboard which contained links to shift planners, all essential nursing forms, useful contact details, policies and guidance
- Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medicines on each patient's physical health. Each ward we inspected had a clean and tidy clinic room which contained emergency equipment and medicines which was checked regularly.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff shared information about incidents and incident learnings at shift handover and in daily 'safety huddles'. De-briefing sessions were available for staff and patients as required. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- In October 2018, 18 electric radiators were installed on Iris ward and they were uncovered at the time of our inspection while waiting for bespoke protective covers to be produced. Patient observations levels had been increased to mitigate risk. Covers had been installed when we re-visited on 26 February 2019.

Is the service effective?

Good 

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Wards for older people with mental health problems

- Care planning for patients on Iris ward also included the use of a therapy doll, a robotic seal. Studies have shown that use of these toys on wards for older people or those with dementia stimulates social interaction between patients and carers.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives. Patients on Grove ward had activity plans on the walls in their bedrooms which were rated red, amber or green to indicate if the patient needed full assistance, prompting or was independent.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation including primary care and community nursing teams.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. When patients lacked capacity, best interest meetings were held involving a patient's family members, social worker, consultant, nurse known to the patient, to agree a plan of action which was in the best interest of the patient.

However:

- Patient care plans on St Raphael ward did not contain patients' preferences including their likes and dislikes around their care, however staff we spoke with were aware of patients' preferences.

Is the service caring?

Good ➔➔

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

- We observed staff treating patients with compassion and care by taking time to listen to them and answering their questions. Patients we spoke with told us staff were always respectful towards them. Patients said the staff tried to meet their needs, that they worked hard and had patients' best interests and welfare as their priority. During our inspection, we observed consistent positive interactions between staff and patients. Patients and staff were heard laughing with fun during some crafting activities on St Raphael ward. Staff spoke with patients in a calm, friendly, professional and respectful manner and responded promptly to any requests made for assistance or time. We saw some instances where staff tended to patients' requests who required personal care with kindness, respect and dignity.

Wards for older people with mental health problems

- We undertook a short observation framework for inspection (SOFI) assessment of a group of four patients for a short duration on St Raphael ward. SOFI is a tool developed with the and used by our inspectors to capture the experiences of people who use services who may not be able to express this for themselves. During the assessment we observed good interactions from staff with the patient group when the staff member initiated working on a crossword as an activity.
- Staff supported patients to understand and manage their care, treatments and conditions.
- Staff assisted patients to access other services to help meet their needs such as referring patients to a variety of primary care healthcare professionals and housing.
- Patients were complimentary about the staff providing their care. Patients told us they were treated with respect and dignity and staff were polite, friendly, and always willing to help.
- The atmosphere throughout the wards was calm and relaxed. Staff were particularly patient focused and not rushed in their work so their time with patients was meaningful. Staff could spend time individually with patients, talking and listening to them.
- All staff we spoke with had a thorough knowledge of their patients' likes and dislikes. Staff understood the individual needs of their patients, including their personal, cultural, social and religious needs.
- Patients received a comprehensive welcome pack on admission to the wards containing information about the multidisciplinary team, care and treatment options, medicines, physical and mental health needs and care plans.
- Staff communicated well with patients so that they understood their care and treatment. Accessible information about medicine was available for patients.
- Staff told us how patients were involved in service development. For example, patients on Opal ward were preparing to attend a 'dragons' den' style panel to propose project ideas to enhance services available on the ward which they would develop and be involved in.
- Staff gathered patient feedback through a range of forums and activities including daily morning meetings and 'feedback Friday' sessions.
- Patients told us that their families were included in their care planning. Staff explained it was important to involve families and carers to ensure that a holistic picture was developed of a patient to ensure their needs were met. The wards had embedded the 'triangle of care' initiative that attempts to improve carer engagement in inpatient units by ensuring staff worked closely and in partnership with families and friends.
- Where carers or family members were unable to attend care review meetings, they were invited to dial into meetings to stay involved.
- Carers' forums were held across all wards. All wards offered individual and ad hoc telephone support to families and carers to answer their queries and receive feedback.
- We spoke with seven carers and they told us about the various ways they could give feedback on services. For example, a carers' appreciation day was held at Langley Green Hospital. Staff offered carers' the opportunity to complete 'family and friends' tests online. Carer visiting times were unrestricted to enable visiting at times which suited families and friends. On Iris ward the 'Improving carers experience project' produced a carers' information booklet which contained information covering common mental health conditions, managing day to day living, staying well and accessing local support across Sussex. All wards had carers' leads. Opal ward had recruited a full-time carers' support lead. We observed them throughout the day welcoming carers onto the ward and arranging for them to get the information and advice they required.

- On Opal Ward the team held afternoon tea parties and coffee mornings which were popular with the patients. Patients on this ward also participated in the ENRICH programme; a peer support randomised control trial where patients were screened and paid to participate in the trial. Patients in the trial were allocated peer support workers in the community once discharged. Opal ward also developed letters of care in collaboration with the patients. The letters of care invited patients to write a letter to explain how they would like to be cared for on Opal Ward. These have been instrumental in developing a holistic and collaborative care plan. Several patients from the ward also participated and sang in a concert in January at Langley Green Hospital run by 'music in detention', which works with immigration detainees, bringing them together with musicians and local communities to create and enjoy music.
- Staff encouraged the use of comment cards so that carers and family members could submit feedback. The carers' champion on Grove ward developed a satisfaction survey for carers.
- The Grove ward team had signed up for the nationally recognised 'John's Campaign' which was an application of evidence of how you support carers of people with dementia.

Is the service responsive?

Good  

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

- Staff did not move patients between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons such as difficulty in accessing appropriate packages of care.
- On the remaining wards where patients had their own bedrooms, they were personalised if this is what patients wanted to do, with for example their photos and personal items on show. Patients could access their bedrooms at any time.
- The quiet lounge on Brunswick ward included a screen displaying a virtual aquarium to help soothe and relax patients. The dining area on Brunswick ward was café style with vintage advertising signs which patients would remember.
- The food was of a good quality and patients could make hot drinks and snacks at any time. Boards in all ward kitchens displayed patients' dietary requirements which were reviewed and updated daily
- The wards met the needs of all patients who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.
- On Brunswick ward, a framed 'memory' box outside each patient's room, along with the patient name, contained photographs and pictures of things they liked and were interested in and topics to start conversations. Patient bedroom doors had a list of their interests, hobbies and previous jobs along with their name on Grove ward.
- Patients had access to psychological and social groups and training courses which had a focus on education, recovery and rehabilitation. Trained therapy dogs visited all wards every week, external pilates trainers offered sessions both on the wards and in the community.
- Most areas on all wards were decorated in dementia friendly colour schemes, for example high contract coloured hand rails, and red toilet seats.

- Langley Green Hospital was awarded a Gold inclusion award for their lesbian, gay, bisexual, transsexual, queer or questioning (LGBTQ) work. The LGBTQ Inclusion Award helps healthcare facilities to address historical inequalities in healthcare outcomes for LGBTQ people and is a partnership between Switchboard and .

However:

- Due to high demand for admissions on Heathfield ward, beds were not always available to patients when returning from leave.
- Heathfield and St Raphael wards had patient dormitory sleeping arrangements. This did not ensure that patients had privacy and dignity when in their sleeping area. The four dormitories on Heathfield ward had only one sink each. This meant if a patient was using the dormitory sink another patient wishing to also use the sink might have to go out to use the ward bathroom or use a bowl in their bed space.
- The dining room on Grove ward was very enclosed and was not decorated in dementia friendly colours.
- There were no accessible or easy read care planning tools available for patients who might need them on most wards including St Raphael, Opal and Brunswick wards.

Is the service well-led?

Good

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Ward managers had successfully gone through the trust's leadership development and emerging leaders programme. Staff gave a mention to the Chief Executive who often visited the wards and recently had visited some wards on Christmas Day to speak with patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. Ward managers encouraged staff to recognise and celebrate their success. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.
- Staff had opportunities and were encouraged to take part in or initiate quality improvement projects within the service. The trust had a drive on quality improvement training and projects and had a central team dedicated to supporting staff realise and deliver their ideas, based on recognised quality improvement methodologies. Larch ward was awarded an accreditation for the Wards for Older People AIMS scheme in 2017. An NHS service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area.

However:

- Heathfield and St Raphael wards had patient dormitory sleeping arrangements which meant that patients had to sleep in shared rooms.
- Due to high demand for admissions on Heathfield ward, beds were not always available to patients when returning from leave.

Outstanding practice

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

- A project called 'pimp my zimmer' was undertaken in Autumn 2018 between Brunswick ward and a local primary school where young students decorated patients' zimmer frames according to the patients' wishes. This encouraged patients' identification and use of their zimmer frame to reduce falls risks and raised the profile of dementia among the school children.
- Brunswick and Iris wards had installed infra-red falls detection technology in patient bedrooms.
- Langley Green Hospital was awarded a gold inclusion award for their lesbian, gay, bisexual, transsexual, queer or questioning (LGBTQ) work. The LGBTQ Inclusion Award helps healthcare facilities to address historical inequalities in healthcare outcomes for LGBTQ people and is a partnership between Switchboard and .
- Opal ward had a full time substantive carer's lead (who worked across Langley Green Hospital) to offer support to carers and increase knowledge among staff regarding carer issues.
- On Opal Ward the team held afternoon tea parties and coffee mornings which were popular with the patients. Patients on this ward also participated in the ENRICH programme; a peer support randomised control trial where patients were screened and paid to participate in the trial. Patients in the trial were allocated peer support workers in the community once discharged. Opal ward also developed letters of care in collaboration with the patients. The letters of care invited patients to write a letter to explain how they would like to be cared for on Opal Ward. These have been instrumental in developing a holistic and collaborative care plan. Several patients from the ward also participated and sang in a concert in January at Langley Green Hospital run by 'music in detention', which works with immigration detainees, bringing them together with musicians and local communities to create and enjoy music.
- Patients on Iris ward had access to a robotic seal and doll which responded with sounds and movement to human interaction. Studies have shown that use of these toys on wards for older people or those with dementia stimulates social interaction between patients and carers. These innovations are useful in environments where live animals or infants cannot be present due to treatment or logistical difficulties.
- The quiet lounge on Brunswick ward had a virtual aquarium which both relaxes and stimulates patients including those with dementia. Research has shown that placing an aquarium in environments with patients with dementia has links to aiding in reducing disruptive behaviour and even improving the eating habits of those suffering with the disease.
- The ward manager on Iris ward had developed an electronic dashboard which contained links to shift planners, all essential nursing forms, useful contact details, policies and guidance. Step by step guides to completing all Mental Health Act (MHA) documentation had been developed and stored on the dashboard to ensure all staff could complete this paperwork properly. Each document a member of staff needed to view or print could be found following links contained on the dashboard. The dashboard was also interactive as it contained links to enable staff to email or telephone other teams including the MHA administrator and external teams via their websites. This database system also contained training videos for staff to access to aid their development.
- The psychologist attached to Grove ward had developed a form of management of violence and aggression training specifically for patients with dementia. The training was presented at the National Psychology Conference.

Wards for older people with mental health problems

- The trust informed that all wards were part of the Coastal West Sussex Clinical Commissioning Group initiative 'let's get you home' to ensure that patients spend no longer than they need to in hospital. There is good evidence to show that patients recover better outside hospital when they are well enough to leave. Patients are supported to return home, to a care home or supported housing safely once their treatment in hospital is complete.

Areas for improvement

Action the trust SHOULD take to improve:

- The trust should work towards elimination of dormitory sleeping arrangements to ensure the dignity and privacy of patients is protected. Additional sinks should be made available for patients admitted to dormitories on Heathfield ward.
- The trust should ensure that care plans are available in accessible easy read for patients and their carers.
- The trust should ensure that care planning regarding mixed sex breaches on Opal ward are accurately recorded in patients' care plans.
- The trust should ensure that the Grove ward dining room is decorated in dementia friendly colours.
- The trust should ensure that care plans for patients on St Raphael ward detail patients' likes and dislikes.
- The trust should ensure that Opal and Heathfield wards have access to junior doctors in shift numbers.

Forensic inpatient or secure wards

Good 

Key facts and figures

Sussex Partnership NHS Foundation Trust forensic inpatient service comprises seven wards at two hospital sites. The trust provides both medium and low secure services. Wards at The Hellingly Centre were Willow, Oak, Ash and Elm. They were all medium secure units for either male or female patients. Wards at the Chichester Centre were all low secure. These were Fir, Hazel and Pine wards, accommodating male or female patients.

We inspected this core service as part of our next phase mental health inspection programme. Our inspection was unannounced which meant that staff did not know we were coming. This enabled us to observe routine activity on the wards.

Before the inspection visit, we reviewed information that we held about these services, requested information from the trust and stakeholders and held focus groups with staff of all levels and grades.

During the inspection visit, the inspection team:

- visited six of the seven wards within the service;
- spoke with all ward managers, matrons and nurse consultants;
- spoke with 15 patients;
- spoke with two consultant psychiatrists across the service;
- spoke with 32 other members of the multidisciplinary team including, nurses, occupational therapists, psychologists, students, peer support workers, advocates and administration and domestic staff;
- reviewed 35 care records including patient risk assessments, risk management plans and care plans;
- carried out a specific check of the medicines management on all wards;
- observed five meetings including multidisciplinary team meetings, handovers, working together groups, friends and family groups and community groups;
- carried out specific checks of the environments on all wards including clinic rooms and observed how staff were caring for patients
- looked at a range of policies, procedures and other documentation 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:

- We rated four key questions as good (Safe, Effective, Caring and Well-led) and one key question as outstanding (Responsive).
- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors and ward managers could adjust the staffing levels based upon the acuity on the wards. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.

Forensic inpatient or secure wards

- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- Not all patients prescribed high dose antipsychotic medicine had their physical healthcare appropriately monitored. High dose antipsychotic medication is medicine that is prescribed in excess of the upper limits recommended by the British National Formulary
- Fir ward at The Chichester Centre was storing patient bank cards and money in the medicine cupboard temporarily. This was inappropriate and posed a risk to the security of the cards. The service immediately rectified the issue when we highlighted it to them.
- Ash and Hazel wards had items in their clinic rooms that were past their 'use by' date. These included oral syringes, urinalysis test strips and disposable tourniquets. This was immediately rectified when highlighted to the service.
- On two wards, staff were not ensuring that medicines were stored at the correct temperature. Fir ward's fridge temperature was consistently recorded as above eight degrees celsius whilst storing patient medicines. This posed a risk to the efficacy of the medicines. This was immediately rectified when highlighted to the service who moved the medicine into a different medicine fridge. The trust advised us that this was a recording error by staff reading the thermometer temperatures. Additionally, Hazel ward's clinic room was consistently recorded as above the maximum temperature threshold stated in trust policy. The ward had ordered an air conditioning unit and the pharmacy team reduced the medicine expiry dates in accordance with trust policy in response to the raised temperatures.

Is the service safe?

Good ➔➔

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

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose. All seclusion rooms were appropriately maintained. Each ward completed daily environmental risk assessments and annual ligature risk audits with appropriate actions and mitigation where new risks were identified.
- The service had enough nursing and medical staff, who knew the patients well and received training to keep people safe from avoidable harm. Ward managers could adjust the staffing levels to account for the acuity on the wards.
- On inspection, mandatory training was above trust target with 89% of staff having completed mandatory training.
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. There was a 'hands off' culture on the wards and as a result, they used restraint and seclusion as a last option only. The service had a reducing restrictive interventions programme in place.

Forensic inpatient or secure wards

- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- Staff had easy access to clinical information and they maintained high quality clinical records.
- In most respects, staff were monitoring patients' physical healthcare appropriately, with lead practitioners assigned for each ward. The Chichester Centre was supported by a visiting GP each week and a registered general nurse at The Hellingly Centre. At the Chichester Centre the trust were in the process of appointing a GP practice to register patients with to ensure the patients received a consistent standard of primary care services. The service appropriately referred patients to physical health specialists when required.
- The wards had a good track record on safety. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- We found three patients, who were prescribed high dose antipsychotic medicine, for whom staff had not monitored their physical health as per policy. High dose antipsychotic medication is medicine that is prescribed in excess of the upper limits within the British National Formulary
- Patient wallets, bank cards and money was being temporarily stored in the drug cupboard in the clinic room on Fir ward and had been for a period longer than one month. This posed a potential infection control risk. The service immediately rectified the issue when we highlighted to them.
- We found some expired items on Ash ward and Hazel ward including oral syringes, urinalysis test strips and disposable tourniquets. These were immediately removed and replacements ordered when highlighted to the service
- On two wards, staff were not ensuring that medicines were stored at the correct temperature. Fir ward's fridge temperature was consistently recorded as above eight degrees celsius whilst storing patient medicines. This posed a risk to the efficacy of the medicines. This was immediately rectified when highlighted to the service who moved the medicine into a different medicine fridge. The trust advised us that this was a recording error by staff reading the thermometer temperatures. Additionally, Hazel ward's clinic room was consistently recorded as above the maximum temperature threshold stated in trust policy. The ward had ordered an air conditioning unit and the pharmacy team reduced the medicine expiry dates in accordance with trust policy in response to the raised temperatures.
- Staff recognised incidents and reported them, though improvements were needed to ensure this were consistently reported at the time of incident and escalated appropriately.

Is the service effective?

Good 

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

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed.
- Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Forensic inpatient or secure wards

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. The service offered patients a 'menu of care' to facilitate patient choice and influence over their own recovery.
- The service ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- The ward teams included a full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. The service provided an induction programme for all new staff.
- The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan for discharge.
- There was effective handover meeting between shifts and also during new admissions.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them and the Mental Health Act office appropriately monitored this.

Is the service caring?

Good ● →←

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- There was a high level of patient representation across the whole service with a well-established 'working together group'. Representatives fed into service wide leadership meetings and changes were enacted on the wards as a result of feedback.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Outstanding ☆ ↑

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

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service, prison or discharge into the community.

Forensic inpatient or secure wards

- The service implemented an 'assertive transitions team' to aid patient discharge and support beyond the ward. The team provided additional intensive patient support six month pre and post discharge. This was implemented in response to the new care models introduced by NHS England.
- The service recently introduced the 'DUNDRUM' toolkit, a process of measures to aid the triaging of patients, assessment of treatment completion and readiness for discharge.
- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with ensuite toilets and could keep their personal belongings safe. There were quiet areas for privacy.
- The service had a good range of rooms to aid patient recovery including activity rooms, therapy rooms, clinical rooms, de-escalation rooms, family rooms and gymnasiums. The Hellingly Centre additionally had a pottery room that was frequently used for activities.
- The Chichester Centre and The Hellingly Centre recently had art work commissioned and chosen by patients. The Hellingly Centre were awarded their art work as part of one of six units across the country working in collaboration with 'hospital rooms'.
- There was excellent patient engagement with the wider community. Patients accessed vocational courses, recovery college, undertook work at a patient led café at The Hellingly Centre and had volunteering opportunities with the local theatre, radio station, Chichester canal conservation group and local dog kennels. There was also a visiting 'pet as therapy' dog that patients were able to take for walks when on leave.
- The Chichester Centre secured funding for four patient bicycles and safety equipment for use both on site and in the community and invited the local authority to the hospital to deliver the 'bikeability' training programme for patients.
- The Chichester Centre employed two full time education and vocation staff members to support patients accessing appropriate work and volunteering opportunities based upon their interests.
- The food was of a good quality and patients could make hot drinks and snacks at any time. Dietary requirements and food choices were respected at all times.
- The wards met the needs of all people who use the service including those with a protected characteristic. There were active support networks in the service for patients and staff with protective characteristics. Staff supported patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Is the service well-led?

Good  

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- The service had efficient systems in place to ensure that managers had access to information pertinent to their roles, their wards and their staff. The service had oversight of supervision and appraisals, beds were managed well and incidents, safeguarding's and complaints were appropriately logged, investigated and learned from.

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team and influenced ward level objectives.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression and leadership opportunities. Staff felt able to raise concerns without fear of retribution.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. The service provided good engagement with patients, carers and staff through active social media and blogging profiles.
- Staff had opportunities and were encouraged to take part in or initiate quality improvement projects within the service. The trust had a drive on quality improvement training and projects and had a central team dedicated to supporting staff realise and deliver their ideas, based on recognised quality improvement methodologies.

However;

- Our findings from the other key questions demonstrated that governance processes did not always identify issues, such as security risks and clinic room issues.

Outstanding practice

The service developed excellent links with the local community and worked collaboratively with external agencies. Patients had many volunteering opportunities including the local theatres, radio stations and supporting local wildlife, dog walking and canal conservation groups.

There was a well-established patient run corner shop and café at Hellingly offering vocational opportunities for patients and access to local college courses to gain official qualifications. Additionally, patients attended regular recovery college seminars and courses.

There was a strong patient voice throughout the service that was largely as a result of the active 'working together group'. This gave a platform for real patient representation from ward level to service wide level and there had been a number of changes enacted on the service as a result of this.

The service delivered an assertive transitions team within the service which was delivered in line with the new care models introduced by NHS England. As one of only three trusts in England chosen to pilot this team, patients received input at six months prior and six months post discharge from a variety of healthcare specialists as well as housing, benefits and work specialists to improve outcomes and aid transitions and discharges.

Areas for improvement

Action the trust SHOULD take to improve:

- The trust should ensure that all patients receiving high dose antipsychotic medicine have their physical healthcare regularly monitored as per trust policy.
- The trust should ensure expiry dates of items within clinic rooms are continuously monitored and immediately removed and replaced when expired.
- The trust should ensure the fridge and thermometer on Fir ward is appropriately maintained and that staff record temperature readings correctly.
- The trust should ensure all incidents are reported immediately through relevant systems and escalated appropriately.

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)

This guidance (see 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	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

Pauline Carpenter, Head of Hospitals Inspection (Mental Health) led this inspection. An executive reviewer Angela Hillery, Chief Executive of Northamptonshire Healthcare NHS Foundation Trust, supported our inspection of well-led for the trust overall. Two specialist advisors, who were leads in quality, performance, serious incidents and governance also supported the well-led inspection.

The inspection team covered three core services and included eight inspectors, two inspection managers, an assistant inspector, two Mental Health Act reviewers, a pharmacy specialist inspector, specialist advisors and experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisors 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.