Derbyshire Healthcare NHS Foundation Trust

Evidence appendix

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

Facts and data about this trust

The trust had four locations registered with the CQC (on 23 May 2018).

Registered location	Code	Local authority
Trust HQ	RXM14	Derby
Hartington Unit	RXM51	Derbyshire
Radbourne Unit	RXM54	Derby
London Road Community Hospital	RXMF4	Derby

The trust had 271 inpatient beds across 16 wards, none of which were children's mental health beds. The trust also had 171 outpatient clinics a week and 20 community clinics a week.

Total number of inpatient beds	271
Total number of inpatient wards	16
Total number of day case beds	0
Total number of children's beds (MH setting)	0
Total number of children's beds (CHS setting)	0

Total number of outpatient clinics a week	171
Total number of community clinics a week	20

Is this organisation well-led?

Leadership

The trust board had the proper range of skills, knowledge and experience to perform its role. The trust ran as a unitary board, which meant executive and non-executive directors acted corporately and shared responsibility and liability for decisions. Trust board consists of five Executive Directors (voting), three non-voting Directors and six non-executive directors. Services run on a community neighbourhood model and three inpatient campus sites.

External stakeholders and staff confirmed significant improvement had occurred in the stability of the trust board since our last inspection. The permanent appointment of the acting chief executive occurred in 2017, and a new chair appointed in 2017, two non-executives retired and new non-executives appointed.

The trust covers a large geographical area and a diverse population of which 93.2% are white. Derby City has a black and ethnic minority population of 19.7% and there are fewer black and minority ethnic people in the rural areas of Derbyshire (2.5%).

The executive board had 12.5% black and minority ethnic members and 62.5% women.

The non-executive board had zero black minority ethnic members and 64.3% women.

	BME %	Women %
Executive	12.5	62.5
Non-executive	0	66.7
Total	7.1	64.3

The trust took part the NeXT Director scheme by hosting a placement for the development of those wishing to become non-executive director in the NHS such as people from a black and minority ethnic background.

The trust had a senior leadership team in place with the right range of skills, knowledge and experience. Non-executive directors had an impressive skill set covering strategic roles in health, human resources, legal, finance, business, clinical, audit and quality improvement. They had good strategic national links and networks.

When senior leadership vacancies arose the remuneration committee carried out a capacity and capability assessment to find the skill set needed for the board. Newly appointed non-executives undertook bespoke induction programmes, following the national good governance guide to support directors understanding their role. All directors attended the national executive director and non-executive courses to understand their duties.

Non-executives received regular one to ones with the chair to identify ongoing learning needs. All board members and directors received a 360 degree feedback from each other, direct reports, and a wider selection of people.

- The board reviewed leadership capacity and capability, through self-assessments and via external reviews commissioned in three phases. The third external review in 2017 gave a ‘amber–green’ rating for:
- clarity of vision, strategy, and robustness of plans for delivery

- effectiveness of processes for managing risks issues and performance
- robustness of systems and processes for learning, continuous improvement, and innovation
- appropriate information effectively processed challenged and action upon.
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The definition of this score by the external review is that the trust 'partially meets expectations, but are confident in management's capacity to deliver green performance within a reasonable timeframe.'

Board members reported board development sessions had taken place regularly since the last inspection. Documentation showed that the board development focused on the review of the refreshed strategy, strategic risks, working together on operational issues such as integrated performance and equality and diversity. One to one performance meetings reviewed the level of attendance at board meetings.

We observed very effective behaviours across the senior leadership team, in terms of levels of trusting relationships that supported differences of opinion and critical challenge. The trust board and senior leadership team displayed integrity on an ongoing basis. Interviews with non-executive and executive directors showed they had clear roles and accountabilities and could show progress in each of their areas of responsibility. They showed a very collegiate leadership approach, focussed on governance, cultural turnaround, building a competent top team with the right skill balance and shared values. They could give a cohesive story of priorities and developments taking place and the rationale underpinning them. There were examples given of strong values and behaviours and proper challenge relating to issues being dealt with. The leadership team gave examples of progress towards a continuous improvement culture, a valuable system leadership role and development through clinical engagement.

We reviewed director files and found fit and proper person checks were in place. The Trust agreed an updated fit and proper person policy at the trust board in 2018. A fit and proper persons checklist for each board member made sure the annual requirements were met. The chair completed a declaration to the board in May 2018 that all trust board directors met the fitness test and did not meet any of the 'unfit' criteria as per the Fit and Person's Test regulations (Health and Social Care Act 2008 Regulation 2014).

The trust leadership team had a comprehensive knowledge of current priorities and challenges and acted to address them. The board kept good oversight, however the pace of change needed improvement which we had highlighted in the last inspection. Improvements in the acute admission wards as part of the urgent care pathway were required since the last inspection and the trust had in July 2018 put in place a 100-day improvement plan. The leadership team focused on obtaining staff engagement and developing staff to implement sustainable change as part of their values and strategy, which meant the pace was slower.

Board meetings occurred on the trust headquarter site. There were plans for two out of ten meetings take place in other parts of the county. We saw two trust board meetings and partially saw a third. The trust board listened to patients and staff presenting their experiences from different services and discussed how service challenges could meet their needs, how this linked to the trust values and strategy, and commissioning conversations. The director for public health presented to the board to help them understand the needs of the population served.

The evaluation of the effectiveness of the trust board meeting occurred after each meeting. There was good non-executive challenge. We observed part of a confidential board meeting. The trust

secretary told us that the board were working to a principle of discussing issues in the confidential meeting that would not meet the freedom of information disclosure.

Trust board papers showed evaluation of each paper for its contribution or impact in relation to the trust strategy, public sector equality duty and equality impact assessment, governance and assurance, and consultation/legal requirements and requirements to minimise risk. Board papers reflected a forward view, identified current challenges, and included an integrated performance report giving workforce, finance, operational delivery and quality information. The board ascertained progress through the receipt of annual reports on various topics for example infection prevention and control.

There was an annual programme of board visits to service areas and most staff fed back that leaders were approachable and visible. Governors also joined the panel on some planned quality visits. This gave staff the opportunity to share their experience of working in the service and to highlight any key issues that might prevent patients from receiving high quality and safe care. Non-executives describe how the visits helped them triangulate the assurance reports received within board committees. Visits informed board meeting discussions.

Focus groups and staff interviews reported increased communication and visibility by senior leaders. For example, the chief executive's "on the road" visits. The chief executive gave a Friday email message to all staff. Staff gave examples of the chief operating officer meetings to discuss service development and the chair undertaking visits. A monthly team briefing process was in place to cascade information from board to clinical teams and receive feedback. There were signs in the 2018 staff survey that staff engagement was improving from the previous year.

Staff reported that senior executives were accessible and listened to their concerns for example in relation to car parking fees which staff could now claim on expenses. External stakeholders confirmed visibility of the executive team and described the trust as having developed a "people first" grassroots approach to strategic development over the last year.

Leadership development opportunities were available, including opportunities for staff below team manager level. Succession planning was in place at senior level throughout the trust. The trust refreshed its succession plan in March 2018, six monthly reviews by the remuneration committee occurred. The trust had identified where it had gaps in succession planning in relation to roles from band 8 to director level. Staff in focus groups said they had access to leadership training and programmes internally and externally through the East Midlands Leadership Academy, the Mary Seacole and Edward Jenner leadership programmes. Deputy directors gave examples of going on leadership programmes with the Kings Fund. Three staff from black minority ethnic backgrounds were on the "stepping up" leadership programme. The senior leadership had cited developing middle managers in leadership roles and provided coaching opportunities as a priority. A talent management programme was in place. The human resource director participated in the Midlands and East Regional Talent Board to develop a regional strategy and approach to talent management. The East Midlands Leadership Academy supported the roll out of talent management across the trust.

Vision and strategy

The trust had a clear vision and set of values with quality and sustainability as the top priorities. In December 2017 the trust reviewed the vision and values with staff through a range of initiatives for example by the chief executive caring out roadshows and creating opportunities for staff to contribute. The new vision is "To make a positive difference to people's lives and improve the

health and wellbeing of our population." The revised core value was "As a Derbyshire Healthcare employee I always put people first. I respect others, am honest in all I do and always strive to do my best." Staff spoken with knew their role in achieving the vision and values of the trust. The chief executive gave a good articulation of the forward external vision which needed strengthening in the published strategy.

There was a strategy for achieving the priorities and developing good quality, sustainable care, the trust strategy dated 2016-2021 was co-produced with staff and external stakeholders. It linked to the national five years forward view and to the Derbyshire Sustainable Transformation Partnership plans. It named four key priorities:

1. We will deliver quality in everything we do providing safe, effective, and person-centred care
2. We will develop strong, effective, credible, and sustainable partnerships with key stakeholders to deliver care in the right place at the right time
3. We will develop our people to allow them to be innovative, empowered, engaged, and motivated. We will retain and attract the best staff.
4. We will transform services to achieve long-term financial sustainability.

Following feedback from the 2017 external review in which staff reported they did not understand the strategy, the trust began refreshing its strategy in December 2017. The trust priorities for 2018 identified:

Quality improvement

1. Completing the CQC action plan and the preparedness plan for next year
2. Deliver the physical healthcare Commissioning for Quality and Innovation framework

Engagement

3. Developing empowered and compassionate leaders
4. Enhancing colleague voice through action

Financial sustainability

5. Create and deliver a recurrent cost improvement plan
6. Achieve agency ceiling

Operational delivery

7. Achieve a vacancy rate of minus 5%
8. Urgent Care and Neighbourhood Pathway

The trust had implemented a plan for engaging and communicating with staff about the strategy.

External stakeholders highlighted that strategic planning required strengthening. The trust had appointed a director of business improvement and transformation in June 2018 to address this.

The structure of services delivery occurred through divisions consisting of community neighbourhood teams, central services and three inpatient campus sites. Each of the divisions produced business plans linked to the trust strategies. Following the recommendations of the 2017 external review the trust had acted on refreshing the annual business planning process to include more oversight and scrutiny from the executive team in the development of plans, to ensure consistent quality across divisions. Monitoring implementation occurred in divisional meetings with oversight by the performance and finance committee.

Following the recommendation from the 2017 external review, the board sought to make clearer links to system wide plans as part of its refreshed trust strategy, with enough detail to help improvement planning with teams, with clear processes to measure success. It was too soon to evaluate the impact of these actions in embedding its refreshed strategy and how this applied to the work of their clinical teams.

The strategy documents linked to the wider health and social care economy and how services have been planned to consider the needs of the relevant population. The director of business improvement and transformations role was to manage the Sustainable Transformation Partnership programme.

External stakeholders said that there was good systemic leadership provided by the trust chief executive within the health and care economy. The Sustainable Transformation Partnership (now called Joined-up Care Derbyshire) reformed in the summer of 2017 and made clearer Derbyshire Healthcare part in the wider health and care economy. The trust took part in the mental health system delivery board which had a mental health sustainability and transformational partnership delivery plan dated February 2018 naming key milestone to be achieved between 2017-19. The chief executive led a workshop in March 2018 on the mental health work stream of the Sustainable Transformation Partnership showing progress made and reviewing further plans.

The trust was actively involved in four workstreams of the Sustainable Transformation Partnership:

1. primary care
2. responsive community delivery
3. rehabilitation and forensics
4. dementia and delirium

Through the Nye Bevan leadership programme, the head of performance and projects was undertaking project work on integrated care models and working in collaboration to understand problems. This led to work looking at common connections between the above streams and checking plans. Part of the collaboration involved personnel from different organisations working on the same streams together in one office and sharing resources. They were looking at patient flow and bed capacity, the urgent care pathway and out of area placement. Red2green initiatives had been successful. 'Red and Green Bed Days' are a visual management system to assist in the identification of wasted time in a patient's journey. Applicable to inpatient wards in both acute and community settings, this approach is used to reduce internal and external delays as part of the SAFER patient flow bundle. Out of area placements had dropped to zero in December 2017 and had risen to 18 in April 2018. The trust had negotiated the development of community forensic team as part of its work in looking at population needs within the health economy. The trust described how they intended to influence the wider healthcare system in relation to the urgent care pathway as well as reviewing their part of it.

The medical director led the physical healthcare strategy, which linked to the trust quality priorities. Physical health leads were in place. A physical health care trainer supported wards. Staff received physical health training such as wound management, nutrition, dehydration. Staff we spoke with described being confident to recognise physical health conditions and would be able to assess deterioration in patient conditions. Speciality nurses were available to give support for example for tissue viability, diabetes, and Parkinson's disease. Best interest meetings for end of life care occurred with support from the palliative care team from the acute trust. Out of eight patient records reviewed across two wards, two patients' diet and fluid charts were incomplete and two patients' safety assessments were not up to date. All other risk assessments and care plans were completed appropriately and individualised to the needs of the patient and were updated at regular intervals.

Culture

There was improvement in the extent most staff felt respected, supported, and valued in the trust since our last inspection. Staff in focus groups reported progress had been made. Service managers reported they had grown in confidence and had got their identity back. The governors focus group reported a positive improvement in culture. Consultant staff reported that since the

last inspection there had been improvements in engagement and they were being listened to more.

We found that there were small groups of staff who did not feel valued. Psychologists reported that decisions were top down and they were not involved in service development. Allied health professionals reported they did not have strategic professional leadership at senior level and there was lack of career progression opportunities within their field. School nurses reported that they did not feel part of the trust. Executive directors were aware of the concerns of professional groups, they were encouraging allied health professionals for example to work within divisional management teams to develop business cases that would show improved outcomes and were giving coaching sessions where needed. The trust planned to improve inclusivity within school nursing and health visiting and had met with these teams.

A few healthcare support workers and medical secretaries we spoke with did not feel well communicated with. Medical secretaries reported an administration review had been going on for two years and they had not heard the outcome, and they did not have an up to date job description.

Derbyshire Healthcare NHS Foundation Trust had 1019 out of 2279 staff take part in the staff survey. This is a response rate of 45%. which is average for combined mental health / learning disability and community trusts in England (45%), and compares with a response rate of 39% in this trust in the 2016 survey. The lowest response rates were from the consultants, neighbourhood, campus, and children's services. Similar results to the previous year were found in 78 questions.

The staff engagement score had increased from the previous year from 3.69 out of 5 to 3.74 out of 5 the national average is 3.79 for similar trusts. Scores had gone up by 9% from the previous year of the number of staff recommending the trust as a place to work and by 8% for action being taken by senior managers, staff looking forward to going to work had increased by 5%.

In the 2017 NHS Staff Survey the trust had better results than other similar trusts in one key area:

Key finding	Trust score	Similar trusts average
KF15. Percent satisfied with the opportunities for flexible working patterns	**63%**	**58%**

In the 2017 NHS Staff Survey: the trust had worse results than other similar trusts in 21 key areas

Key finding	Trust score	Similar trusts average
KF11. Percent appraised in last 12 months	**89%**	**92%**
KF12. Quality of appraisals	**3.01**	**3.10**
KF13. Quality of non-mandatory training, learning or development	**3.99**	**4.06**
KF21. Percent believing the organisation provides equal opportunities for career progression / promotion	**78%**	**86%**
KF 29. Percent reporting errors, near misses or incidents witnessed in last month	**90%**	**92%**

KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	**3.58**	**3.76**
KF31. Staff confidence and security in reporting unsafe clinical practice	**3.56**	**3.72**
KF17. Percent feeling unwell due to work related stress in last 12 months	**42%**	**40%**
KF18. Percent attending work in last 3 months despite feeling unwell because they felt pressure	**55%**	**53%**
KF19. Organisation and management interest in and action on health and wellbeing	**3.61**	**3.70**
KF1. Staff recommendation of the organisation as a place to work or receive treatment	**3.58**	**3.68**
KF7. Percent able to contribute towards improvements at work	**71%**	**73%**
KF9. Effective team working	**3.79**	**3.85**
KF14. Staff satisfaction with resourcing and support	**3.30**	**3.33**
KF5. Recognition and value of staff by managers and the organisation	**3.47**	**3.54**
KF6. Percent reporting good communication between senior management and staff	**30%**	**34%**
KF2. Staff satisfaction with the quality of work and care they are able to deliver	**3.79**	**3.85**
KF3. Percent agreeing that their role makes a difference to patients / service users	**87%**	**89%**
KF32. Effective use of patient / service user feedback	**3.44**	**3.69**
KF26. Percent experiencing harassment, bullying or abuse from staff in last 12 months	**23%**	**20%**
KF27. Percent reporting most recent experience of harassment, bullying or abuse	**55%**	**57%**

Staff felt more positive and proud about working for the trust and their team since our last inspection. Staff in focus groups and core service inspections described how they had chosen to work for the trust. The allied health professional focus group described how they were proud of the achievements in meeting increased demand.

The trust recognised staff success by staff awards and through feedback. A Delivering Excellence Every Day award scheme was in place within the trust and reported in a newsletter “team talk”.

Significant improvements had been made since our last inspection in relation to the human resources department. The trust agreed with Derbyshire Community NHS foundation trust to share the human resource function. A director of human resources sits on both boards. Both trusts have their own policies and separate workforce performance dashboards. The human resource team is more stabilised in its functions. Implementation and monitoring of the people and culture strategy occurred via the people and culture committee which reported to the board. We found the trust had made improved efforts to engage with the workforce since our last inspection.

The trust worked appropriately with trade unions who reported an improved relationship since our last inspection. A staff forum was in place based on a John Lewis model. This is a model of staff engagement in which staff propose the agenda and work with directors on the development and implementation of strategy. The meetings are externally facilitated.

Managers addressed poor staff performance where needed. We heard from staff and union focus group that the length of time to complete investigations was too long. There were no set key performance indicators for completing disciplinary and grievance investigation. An arbitrary 40 days was set as a target, however, the clock stopped if the staff member was on annual leave, off sick, if union representatives were unavailable, or if they were awaiting occupational health reports. This led to a prolonged timeframe to deal with cases. Obtaining agreement on terms of reference contributed to delays, so the terms of reference policy was being revised to simplify the process and include boundaries.

At the time of inspection, the trust had 18 disciplinary cases, 13 bullying and harassment cases and nine grievances. Streamlining of disciplinary and grievance processes occurred following the appointment of the deputy director of human resources in December 2017. We reviewed a selection of disciplinary, grievance and whistle blowing files and found that processes were followed and records kept well. We noted some improvement since the last inspection. The trust benchmarked its data in these areas with other trusts to measure its performance and learn lessons.

Staff we spoke with knew how to use the whistle blowing process. The trust had a raising concerns policy and most staff felt able to raise concerns without fear of retribution.

The trust had appointed a Freedom to Speak Up Guardian in December 2017, and provided enough resource and support to help staff to raise concerns. Staff told us that there appeared to be a conflict of interest between the post holder carrying out the Speak Up Guardian role two days a week and working as a human resource manager three days a week. Whilst processes were in place for cases to be turned down if the post holder's role as human resource manager would create conflict, staff told us that this could indicate to the Speak Up Guardian that they were being investigated by human resources or to the human resource managers that they had spoken with the guardian.

The Freedom to Speak Up role was being publicised through a variety of methods. However not all staff we spoke with knew about the role. Line management was through director of corporate affairs. The Speak Up Guardian told us that they could maintain their independence. They met with the chief executive every six weeks and had direct access anytime to the chief executive and the senior independent non-executive director. A spreadsheet of cases was securely stored with access only by the Speak Up Guardian. Staff could report anonymously through anonymous inbox or by phone. The board received the Freedom to Speak Up Guardian's report covering recommended themes from the National Guardian's Office on board reporting. Learning for workers speaking up has included a reluctance by managers to deal with concerns that do not fall under a formal process without terms of reference.

The Speak Up Guardian reported that between January 2018 and June 2018, 31 workers raised 39 concerns; the majority of which (18) related to attitudes and behaviours and nine to policy and procedure. The Speak Up Guardian cross referenced concerns raised through the electronic incident reporting system and the employee relations case tracker to enable checking of data.

There were plans to develop a speak up champions network with in teams. The Speak Up Guardian was part of the East Midlands Speak Up Guardian network which provided support, advice and shared good practice

Most staff we spoke with said they had the opportunity to discuss their learning and career development needs at appraisal. However, bank staff informed us that they did not get support for training. Healthcare assistants reported that once they were at band 3 there were no further career progression opportunities. Out of 345 healthcare assistants 295 (85%) had completed the care certificate.

Mandatory training did not consistently meet trust targets. The trust highlighted training compliance as a risk due to staff shortages, affecting staff being released from service areas. The people and culture committee January 2018 minutes showed discussion of managing training compliance. The safeguarding level 3 adults training target reduced to 65%. Many annual mandatory training courses extended to 18 months and others to two or three years. Overall compliance for role specific training had gone down from 74.61% to 70.02%.

As at 28 February 2018, the training compliance for trust wide services was 72% against the trust target of 85%. The training compliance for data security awareness was 91% against the trust target of 95%.

Sixty-one mandatory training courses provided by the trust had compliance rates below the trust target and of those 45 were below 75% compliant.

The training compliance reported for the trust during this inspection was lower than the 80% reported for the previous year.

The trust's target rate for appraisal compliance was 90%. As at 28 February 2018, the overall appraisal rates for non-medical staff was 77%.

One of the 13 core services 'Wards for older people with mental health problems' achieved the trust's target appraisal rate.

The rate of appraisal compliance for non-medical staff reported during this inspection is lower than the 79% reported for the previous year.

Service	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	Appraisals rate (%)
Wards for older people with mental health problems	**116**	**110**	**95%**
Community-based mental health services for older people	**206**	**177**	**86%**
Children, Young People and Families	**282**	**240**	**85%**

Community mental health services for people with a learning disability or autism	**103**	**83**	**81%**
Other Specialist Services	**42**	**34**	**81%**
Long stay/rehabilitation mental health wards for working age adults	**55**	**44**	**80%**
Mental health crisis services and health-based places of safety	**144**	**115**	**80%**
Secure wards	**43**	**34**	**79%**
Other	**685**	**505**	**74%**
Substance misuse	**39**	**28**	**72%**
Acute wards for adults of working age and psychiatric intensive care units	**244**	**173**	**71%**
Specialist community mental health services for children and young people.	**93**	**66**	**71%**
Community-based mental health services for adults of working age	**354**	**249**	**70%**
Total	**2406**	**1858**	**77%**

The trust's target rate for appraisal compliance is 90%. In 28 February 2018, the overall appraisal rates for medical staff was 68%. However we were informed that the trust compliance rate at the end of year was 100% to meet NHS compliance standards.

Three of the 12 core services achieved the trust's appraisal rate. The core services failing to achieve the trust's appraisal target were 'Other Specialist Services' with 40%, 'Community mental health services for people with a learning disability or autism' with 50%, 'Substance misuse' with 50%, 'Community-based mental health services for adults of working age' with 60%, 'Acute wards for adults of working age and psychiatric intensive care units' with 64%, 'Community-based mental health services for older people' with 67%, 'Mental health crisis services and health-based places of safety' with 78%, 'Specialist community mental health services for children and young people' with 82% and 'Children, Young People and Families' with 87%.

The rate of appraisal compliance for medical staff reported during this inspection is lower than the 87% reported for the previous year.

Service	**Total number of permanent medical staff requiring an appraisal**	**Total number of permanent medical staff who have had an appraisal**	**Appraisals rate (%)**
Other	**2**	**2**	**100%**
Long stay/rehabilitation mental health wards for working age adults	**2**	**2**	**100%**
Forensic inpatient	**2**	**2**	**100%**

Children, Young People and Families	**15**	**13**	**87%**
Specialist community mental health services for children and young people.	**11**	**9**	**82%**
Mental health crisis services and health-based places of safety	**9**	**7**	**78%**
Community-based mental health services for older people	**3**	**2**	**67%**
Acute wards for adults of working age and psychiatric intensive care units	**11**	**7**	**64%**
Community-based mental health services for adults of working age.	**42**	**25**	**60%**
Community mental health services for people with a learning disability or autism	**4**	**2**	**50%**
Substance misuse	**8**	**4**	**50%**
Other Specialist Services	**5**	**2**	**40%**
Total	**114**	**77**	**68%**

The trust did not meet its own supervision and appraisal targets. As part of a three month improvement plan in January 2018 the trust intended to benchmark its appraisal and supervision compliance with similar trusts, and review the quality of data recording. Figures from long term absence were counted and effected the compliance rate for appraisal and supervision. Appraisal training was based on the trust values and behaviours and a complete relaunch of the appraisal process was being finalised, including values based behaviours linked to pay progression.

The trust's target rate for clinical supervision was 85%. As at 28 February 2018, the non-medical clinical supervision compliance was 64%.

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

One of the 13 core services teams (Specialist community mental health services for children and young people) achieved the trust's clinical supervision target.

Service	**Formal supervision sessions each identified member of staff had in the period**	**Formal supervision sessions should each identified member of staff have received**	**Clinical supervision rate (%)**
Specialist community mental health services for children and young people	**1519**	**1744**	**87%**
Other Specialist Services	**397**	**488**	**81%**
Community-based mental health services for older people	**1121**	**1430**	**78%**
Mental health crisis services and health-based places of safety	**1116**	**1488**	**75%**
Children, Young People and Families	**1188**	**1630**	**73%**

Community mental health services for people with a learning disability or autism	**716**	**999**	**72%**
Community-based mental health services for adults of working age	**2797**	**3903**	**72%**
Forensic inpatient	**315**	**459**	**69%**
Other	**1436**	**2281**	**63%**
Long stay/rehabilitation mental health wards for working age adults	**327**	**563**	**58%**
substance misuse	**220**	**386**	**57%**
Wards for older people with mental health problems	**682**	**1374**	**50%**
Acute wards for adults of working age and psychiatric intensive care units	**826**	**2935**	**28%**
TOTAL	**12660**	**19680**	**64%**

The trust gave updated supervision figures which show that whilst some improvements may have occurred in areas, trust targets were not always being met. Staff we spoke with said they had received supervision.

Staff had access to support for their own physical and emotional health needs through occupational health. A staff health and wellbeing strategy dated 2017 – 2022 was being reviewed. Wellbeing leads were in place and health and wellbeing meetings occurred. Staff had a checklist of suggestions for what a wellness recovery action plan/psychological support plan for work might have in it. Three percent of staff used the employment assistance programme. One research nurse won a national Schwartz shining star award for helping staff deal with stresses in their job. The trust runs monthly Schwartz rounds to support staff to discuss emotional and social aspects of working in healthcare. This is good practice and supports staff stress reduction.

In response to the 2016 junior doctor contract the post of Guardian for Safe Working Hours for junior doctors in training was in place. The guardian presented an annual report to the board for 2017/18 and quarterly reports. Reports found risks in relation to trainee vacancies in relation to community and inpatient services. A small number of breaches of working additional hours after 5p.m occurred. A junior doctor forum met quarterly. Junior doctors we spoke with were generally positive about their experience of working in the trust, except for one doctor who did not have a positive experience.

We saw considerable improvement in the trust approach to equality and diversity since the last inspection. Staff said promotion of equality and diversity occurred in their day to day work and when looking at opportunities for career progression. There were established staff networks for black and minority ethnic and lesbian, gay, bisexual and transgender staff which promoted diversity. A disability network was being planned.

A board equality, diversity, and inclusion action plan 2017-2019 was in place, most of its actions were rated as amber meaning that they were not complete yet.

The workforce race equality standard became compulsory for all NHS trusts in April 2015. Trusts must show progress against nine measures of equality in the workforce. The trust published its

workforce race equality standard in 2017 showing it employed 2389 staff of which 294 staff were from black and ethnic minority backgrounds. There was a decrease in the likelihood of white staff being appointed to a post over a black minority ethnic candidate from the previous year.

We spoke with staff attending the black minority ethnic network conference who gave examples of positive action taken such as reverse mentoring to seven executives and said senior managers were genuinely interested in equality and diversity. This enabled staff to inform senior leaders about their experiences and to challenge constructively.

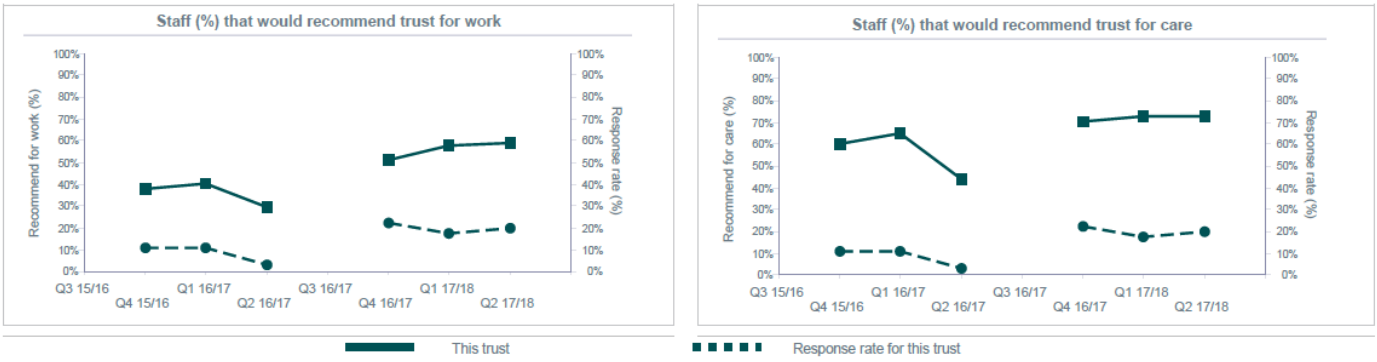
The group were knowledgeable about the workforce race equality standard data shared with the them. Unions reported that there was improvement in the senior leadership engaging with the black minority ethnic network. A lesbian gay bisexual transgender conference had taken place and the network was active. Equality standards were explored in services, for example following a deep dive in the children's service into the equality and diversity standard two resulted in the implementation of an action plan. Training in unconscious bias occurred in the trust.

The trust had signed up to the Armed Forces Covenant a national initiative, this meant the trust would support staff as army reserves and veteran employment was encouraged. The board had discussed and reviewed information relating to gender pay gaps.

Staff focus groups reported teams had positive relationships, worked well together and addressed any conflict appropriately.

The Staff Friends and Family Test asks staff members whether they would recommend the trust as a place to receive care and as a place to work.

There is no reliable data to enable comparison with other individual trusts or all trusts in England.



Please note: Data is not collected during Q3 each year because the Staff Survey is conducted during this time

There was a robust recruitment strategy in place and the trust used a range of initiatives to recruit including trust jobs popping up on computer browsers when people were searching for jobs on the internet. External stakeholders and staff told us that the trust needed to focus more attention on retention of staff. We saw a people flow metrics chart which showed the flow of new starters coming in and staff retiring from each of the services divisions. Between June 2017 and June 2018 there were 346 new starters coming into the trust and 250 employees leaving the trust. Unions informed us that there was more transparency in jobs appointments since our last inspection.

Definition

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

Substantive staff figures	Trust target

Total number of substantive staff	At 28 February 2018	2167.7	N/A
Total number of substantive staff leavers	1 March 2017 – 28 February 2018	219.3	N/A
Average WTE* leavers over 12 months (%)	1 March 2017 – 28 February 2018	10%	10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 28 February 2018	310.3	N/A
Total vacancies overall (%)	At 28 February 2018	12%	10%
Total permanent staff sickness overall (%)	Most recent month (At 28 February 2018	7%	5%
	1 March 2017 – 28 February 2018	5%	5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 28 February 2018	970.5	N/A
Establishment levels nursing assistants (WTE*)	At 28 February 2018	375.2	N/A
Number of vacancies, qualified nurses (WTE*)	At 28 February 2018	116.2	N/A
Number of vacancies nursing assistants (WTE*)	At 28 February 2018	34.3	N/A
Qualified nurse vacancy rate	At 28 February 2018	12%	10%
Nursing assistant vacancy rate	At 28 February 2018	9%	10%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (Qualified nurses)	1 March 2017 – 28 February 2018	1416 (1%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 March 2017 – 28 February 2018	5000 (2%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 March 2017 – 28 February 2018	293 (<1%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	15372 (18%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	0 (0%)	N/A
Shifts NOT filled by bank staff where there is sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	2497 (3%)	N/A

*Whole Time Equivalent

The people and culture committee reporting to the board monitored the implementation of the peoples' strategy dated March 2018. Documentation showed the trust had identified hot spots and had a list to the top 20 teams in need of attention and support to achieve key workforce performance indicator compliance. The trust was recruiting to heads of nursing posts and looking at new ways of working. Occupational therapy lead lead for Radbourne unit was a new role established in addition to the already existing post of allied health professionals for campus. Occupational therapists were working within ward numbers.

- The trust's strategy, vision and values underpinned a culture which was patient centred. The
- quality priorities for 2017/18 to improve the patient experience related to:
-
- improving physical health
- improving mental health services to patients presenting in emergency departments
- improving the experience and outcomes of young people transitioning from child and adolescent mental health services.
- preventing risky behaviours relating to alcohol and tobacco
- participating in the national patient safety campaign "sign up to safety" for all staff to have access to and undertake autism awareness training – the trust had achieved 68% uptake of training by March 2018 against a target of 50%
-

Commissioners reported an open and transparent culture within the trust and carried out quality assurance visits with unrestricted access to staff and patients in services. We saw a trust board meeting in which patients from the substance misuse service gave feedback to the board, this generated debate and areas for action. The trust used Health of the Nation Outcome scales to check patient improvement occurred.

The 2017 community mental health survey showed that when compared with the 52 trusts taking part in the survey 11 out of 32 questions were rated in the top 20%, with one score lower than 20%, and most scores being with in the intermediate 60%. The year on year comparisons did not show major shifts.

The inpatient survey results for 2017 showed an improvement, of the 17 trusts taking part the trust scores were within the middle 60%, with 11 scores in the top 20%. Care was described as excellent /very good by 59 % of respondents.

The NHS choices website had 18 reviews from January 2017 to July 2018 giving the trust a rating of two out of five stars which was not good.

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 1% and 12% lower than the England average for patients recommending it as a place to receive care for all six months in the period (October 2017 to March 2018). January 2018 saw the highest percentage of patients who would recommend the trust as a place to receive care with 87%.

The trust was lower than the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care in November 2017 and December 2017.

	Trust wide responses				**England averages**	
	Total eligible	Total responses	% that would recommend	% that would not recommend	England average recommend	England average not recommend
October 2017	15528	43	84%	7%	86%	6%
November 2017	16047	68	75%	1%	87%	5%
December 2017	13724	36	83%	3%	88%	4%

January 2018	15877	55	87%	4%	88%	4%
February 2018	15112	53	83%	4%	89%	4%
March 2018	15304	73	79%	10%	89%	4%

We found clear responsibilities at every level in the trust for the management, investigation and response to complaints. Recognition of complaint trends received action. The patient experience team produced quarterly reports to the patient experience committee, this reported to the quality committee and the trust board had oversight.

The 2017/18 quality report showed an annual increase in complaints. For the period 2017/18 there were 191 complaints. Of these complaints 16 were fully upheld, 88 partly upheld, five needed no investigation and 42 complaints were under investigation. Five cases were with the Parliamentary and Health Service Ombudsman of which two were under investigation. The main theme in relation to complaints was in relation to availability of services.

The electronic incident reporting system recorded complaints. The patient experience team gave the central point of contact for people to give feedback and raise concerns about the trust services. The trust had a database of 135 investigators to give complaint investigations to, they had received training in root cause analysis. All investigators had received the Patients Association standards for investigating.

The trust was asked to comment on their targets for responding to complaints and performance against these targets for 1 March 2017 to 28 February 2018. The patient experience team set their own target in relation to responding to complaints: Orange 40 days and Red 60 days. They had chosen to do this rather than following the national complaints process which talks about 'agreed targets' set in discussion with complaints.

	In Days	**Current Performance**
What is your internal target for responding to* complaints?	3 working days	96% Acknowledged within 3 working days
What is your target for completing a complaint?	40 working days	-
If you have a slightly longer target for complex complaints please indicate what that is here	60 working days	Six 'complex' complaints were opened for investigation in the reporting period; 2 investigations are now outside the 60 working days target and 1 investigation is still ongoing but within the time frame (60 working days).

	Total	**Date range**
Number of complaints resolved without formal process*** in the last 12 months	452 low-level complaints (i.e. concerns that do not require a formal investigation) have been logged on the reporting system.	1 March 2017 to 28 February 2018
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	1	1 March 2017 to 28 February 2018

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

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

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

We reviewed six complaints and found that the patient experience team had promptly allocated an investigating officer and completed report templates in line with their locally agreed targets. All records had an acknowledgement letter, sent within the deadline. We saw evidence that investigating officers followed a root cause analysis approach. Complainants received a letter informing them of delays and expected timescales, rather than there being a dialogue about an 'agreed target.' The electronic incident recording system checked actions arising from complaints. The quality of responses to patients were good.

The trust planned to audit its complaints policy against the national complaints policy using medical staff. There were plans to re-visit a review of complaint themes against the diagnosis of a patient to allow identification of actions to prevent future complaints, the trust had previously undertaken this exercise within personality disorder. The "Practice Matters" newsletter shared learning from complaints and feedback given to teams.

Derbyshire Healthcare took part as one of 100 organisations co-designing an Always Event framework with patients and families. This is the fourth phase of an NHS England project, always events are ''Those aspects of the patients experience that should always occur when patients, service users, their family members and carers, interact with health care professionals and the health care delivery system." The trust has chosen to look at substance misuse services, children's services, and rehabilitation as part of this project.

This trust received 1181 compliments during the last 12 months from 1 March 2017 to 28 February 2018. 'Acute wards for adults of working age' had the highest number of compliments with 26%, followed by 'Community-based mental health services for adults of working age and older adults' with 20% and 'Mental health crisis services and health-based places of safety' with 12%. The 2017/18 quality accounts show that compliments had risen annually to 1222 compliments. The main theme was in relation to the caring, kindness and compassion given by staff.

Governance

- Following an external independent assurance review of the trust's implementation of the governance improvement action plan in May 2017, NHS Improvement issued a compliance certificate, confirming that the trust was free from licence breaches. This resulted in the trust being moved into segment two under NHS Improvement Single Oversight Framework. This framework groups trusts according to the level of support they need across many different criteria. Segment two confirms there are no longer any significant concerns with the trust. This is the segment that the clear majority of NHS providers are in.

- Following our last inspection and in response to three external reviews the trust had improved its governance structures, processes, and systems of accountability to support the delivery of the strategy, which provided regular review and improvement, however the pace of change did not effectively impact on the sustainability of quality of some services. There is a governance structure in place consisting of committees reporting directly to the board such as:

- audit and risk
- quality

- remuneration and appointment
- people and culture
- finance and performance
- Mental Health Act
- safeguarding

- The board received an assurance report in July 2017 on the effectiveness of the board committees, following the review of year end reports by the audit and risk committee. Each committee was expected to set a clear development plan and objectives annually.
-

The trust had made improvements to the levels of governance and management function to interact with each other appropriately. The introduction in 2016/2017 of Clinical and Operational Assurance Teams occurred across the Campus, Neighbourhood, Children's, and Central Services divisions to give equal priority for quality and performance at every level of the organisation. The group attendance consisted of senior clinicians and managers from across a division, who take a lead in the delivery of quality care in their respective services. The reviewed the performance in areas such as clinical supervision, waiting times, learning from complaints and compliments, workforce, and finances. Escalation to the trust management team occurred relating to areas of concern, where discussion of all areas of performance for that division, both quality and operational occurred. Executives confirmed that regular challenges of the risks that divisions had not escalated did not occur, although there was oversight of the divisional meeting minutes.

We observed in two trust board meetings discussing detailed performance and activity report at its public meetings, which outlines the trust's workforce, finance, operational delivery and quality performance against key performance indicators, alongside any actions in place to ensure that performance is maintained. There was an ongoing focus on improving performance using in-depth reports and staff presentations to the board and its committees.

We saw improvements in composition, accountability and functioning of the governor's council since our last inspection. There were regular governor's council meetings where members of board presented and discussed key issues, reports, and developments. The governor's council met on the same day as the public trust board meeting, allowing attendance at both.

We attended a governor's council meeting prior to the inspection and saw public and staff governors challenge the board members on report content and key issues. Board members were open to and responded to the challenges made by the governors. The governors focus group reported that governor and board development had taken place to improve accountabilities. Governors reported there had been improvement in relationship with the board members and holding the non-executives to account. Chairs of board governance groups provided information to the governor's group, governors wanted more assurance that changes had occurred. Governors were involved in task and finish groups for recruitment and retention. They had been involved in the recruitment of non-executives and the recruitment of the trust chair.

Some governors reported a lack of understanding of mental health issues leading prolonged governor's meetings. The trust board secretary had since our last inspection developed externally facilitated monthly training with governors e.g. on the Mental Health Act, Clinical Commissioning Groups, research, and development they had now commenced quarterly block training based on collaboratively identified needs.

Staff at all levels were clear about their roles and understand what they are accountable for and to whom.

We observed arrangements with partners and third-party providers were governed and managed to encourage appropriate interaction and promote coordinated, person-centred care. For example the expansion of the dementia rapid response team in the north of the county occurred through Joined Up Care Derbyshire (Sustainable Transformation Partnership), where funding has transferred between two different provider organisations to provide care that best meets the needs of the communities. The trust implemented the Red2Green initiative during the year; this is a visual way of helping to minimise the number of days in hospital that do not directly contribute to discharge. This reduces the need to admit people to hospital outside of the area and keep people nearer home.

Public Health England reported good working relationship with the trust in respect of the substance misuse service which involved voluntary groups and other partners. The trust was responsive to making improvements and data quality issues were being worked on. Substance misuse had improved links with GPs through IT Systems. The eating disorder services had good multi agency working. Development of a new forensic community team with clinical commissioning groups was occurring in response to community needs.

We found governance oversight of pharmacy needed strengthening. The chief pharmacist attended the trust medical advisory committee, however concerns had been raised about the process by which the quality committee retained oversight and assurances of the business of drug and therapeutics and medicines management in the trust. We found no process for performance management of the pharmacy team meetings and there was a lack of board assurance of the efficacy of the team and current staffing pressures could not be formally acknowledged or evaluated. The medicines optimisation strategy recognised the staffing issues and the overall review of the workforce strategy for the trust would take it into account. The trust is managing a level of uncertainty in the pharmacy team relating to the loss of a service level agreement with a local trust, this was adversely affecting staff morale. We heard that data on pharmacy team interventions had been collected historically but due to staffing pressures this was not currently done.

The medicines optimisation strategy priorities were reflected in the medicines optimisation dashboards separated into clinical and operational areas to aid clarity. The trust management team received the dashboards. The pharmacy team provided a five-day service with an on-call system to ensure access to medicines and advice out of hours. The trust was in the very early stages of developing an electronic prescribing strategy with no provider currently identified. The trust had regular representation at local health community prescribing committees resulting in co-ordinated approaches to medicines issues and coordination of patient care. The trust had a controlled drugs accountable officer which is a statutory role for the trust. Attendance at the controlled drugs local intelligence network regional meetings to review controlled drug incidents and share learning occurred and the medicines safety officer produced the obligatory quarterly occurrence reports accordingly.

Appropriate governance arrangements were in place in relation to the Mental Health Act administration and compliance. However, for associate hospital managers the full functions under the Mental Health Act code of practice required strengthening.

A Mental Health Act committee reported directly to the board. A non-executive director chaired, with representation for trust executive directors, associate hospital managers, Mental Health Act manager, representative of consultant medical staff, local authority leads for allied health professionals amongst others. The role of the committee was to ensure the trust had discharged its functions under the Mental Health Act, performed its duties under Mental Capacity Act and Deprivation of Liberty Safeguards and other relevant legislation. The committee met on a quarterly basis. The Mental Health Act committee annual report (1 October 2017 – 31 March 2018) provided the board with oversight of the use and application of the Mental Health Act across the trust. There was monitoring of the board assurance framework risks allocated to the Mental Health Act committee, Care Quality Commission Mental Health Act visits and emergent themes. We reviewed the Mental Health Act committee year-end effectiveness report (2017/18) it concluded that it had proved fulfilment of its terms of reference and its primary purpose. The Mental Health Act Committee is a standalone meeting only. The chair would ensure cross triangulation of information across committees such as safeguarding, audit and risk and quality meetings, which are all attended by the chair.

- The Mental Health Act committee had identified five recurrent themes that it was working on to improve. These were:
- patient involvement in their care plans
- family/carer involvement in care plans
- capacity assessment to underpin above
- physical healthcare reporting
- Section 17 (leave) process

To address mental capacity assessment issue there were two Mental Capacity Act leads across the trust delivering training and developing systems to better capture Mental Health Act assessments. Monthly audits occurred on underperforming wards. During our core inspection of the older adult services we noted there was a marked improvement in mental capacity assessments since our last inspection.

We found good example of a range of audits carried out such as the use of Section 62 in 2018. This showed there were effective systems in place to identify themes and trends and demonstrated oversight. An audit completed regarding patient rights. showed the trust had a compliance rate between 91% to 93% for the inpatient services and 90% to 97% for patients on community treatment orders. We saw a trust wide audit in relation consent to treatment resulting in action plans to address recommendations. The Mental Health Act committee and clinical teams received the audit results.

The trust did not have up to date service level agreements with the acute trusts in the area. The trust had a service level agreement with one out of the two local acute trusts for services provided dated November 2010, to support Mental Health Act administration and clinical functions when detained patients needed care in an acute trust.

The local authority provided approved mental health professionals to carry out Mental Health Act assessments and provide reports the patient. The trust and local authority held registers of section 12 approved doctors. The medical director and clinical managers ensured S12 doctors were competent and available to undertake Mental Health Act assessments. The trust and local authority both held a Section 117 register which is for patients who have a discharge plan and

need support in the community. The trust has a good relationship with the local authority and shared information.

The trust had robust arrangements in place for the receipt and scrutiny of detention paperwork. There were no second opinion advisory doctors within the trust, although the trust would support doctors to apply. This meant the trust was not contributing to the national pool of second opinion advisory doctors.

We observed a trust board meeting in July 2018 in which the plans to revise recruitment of associate hospital managers to meet the Mental Health Act Code of Practice requirements and to put in place systems of supervision, training, and appraisal. We interviewed two Associate Hospital Managers and they told us they were not a cohesive team and felt disconnected from the trust. There was no mechanism in place to enable discussions around practice issues within the team. Associate hospital managers reported there was no formal induction on appointment. They received five days of training.

The trust had 10 hospital managers. The role of the associate hospital managers was solely to review appeals. They did not have wider responsibilities within the trust. We found they had a good knowledge of their discharge powers under Section 23 of the Mental Health Act.

Managers described circumstances where they had refused to review. This was related to insufficient reports, out of date reports, poor quality reports or contradictory reports. In these cases, the managers would escalate the issue to the Mental Health Act manager and medical director. Where a patient was on a community treatment order the associate hospital managers were not aware of hearings taking place at a location convenient to the patient and their nearest relative/family. Associate hospital managers reported they had discharged eight patients.

Associate hospital managers raised concerns about their experiences of uncontested renewals. These hearings were paper based. The managers did not meet with the patients and were unsure of whether they could meet with the patient to assure themselves that the patients were truly contesting a renewal of a section. Where a patient lacked capacity, the managers were not confident in requesting a meeting with the patient to make sure the patient did lack capacity.

The trust signed up to restrictive intervention reductions programme “sign up to safety campaign.” Governance arrangements were in place for the use of restrictive practices. There were policies in place for example regarding seclusion, long-term segregation, managing violence and aggression and rapid tranquillisation. All policies were in line with the Mental Health Act Code of Practice and available on the trust intranet.

The trust had formed a positive and safe steering group. The group met every eight weeks. The purpose of the group was to make key decisions and support the work of positive and safe champions within teams to identify, promote and embed positive, safe best practice and act to continuously reduce restrictive practices. The group reported to the executive director of nursing who reported to the board. Review of meeting notes from the group meetings dated 15 March 2018, 19 October 2017 and 15 June 2017 indicated the group was not meeting every eight weeks in line with the terms of reference. The last audit to review primary, secondary, and tertiary interventions occurred in 2011. The trust planned to undertake an audit of a random sample looking at primary, secondary and tertiary interventions over the last 12 months.

Awareness of room and personal searches was raised through the pod cast, lectures, through role play and e-learning on the trust intranet. The aim was to get staff to think about why they were completing room and personal searches.

We looked at the six monthly restrictive practice updates provided to the board. This provided clear evidence of the work completed so far, for example around the implementation of the Safewards model. This model identifies a range of possible interventions which are proved to make a difference. It promotes positive support and engagement whilst reducing restrictive interventions and patient aggression. The Safewards model emphasises therapeutic activity to engage patients to prevent boredom that could lead to potentially challenging behaviours. Benchmarking of data on the use of restraint and seclusion against the national average and presented a favourable picture.

The trust followed the National Institute for Health and Care Excellence guidelines regarding violence and aggression: short-term management in mental health, health and community settings (NG10) 2016. We reviewed the restrictive practice report (June 2018) about restrictive practices and care plans across the inpatient units at Kingsway, Hartington and Radbourne sites. This laid out areas of concern and an action plan.

The head of nursing completed audits in relation to the use of seclusion and long-term segregation. Simulation training on seclusion was in its early stages and the training is interdisciplinary. We saw evidence of the promotional materials promoting the training and the course content for scenario based training. Patients had been involved in the development of this training programme. The training takes place in seclusion rooms and is scenario based. The training focus was on junior doctors and training timed for when medical staff rotation started. The trust had recently delivered a training session to the Royal College of Psychiatrists. The aim was to try and reduced the use of seclusion by ensuring staff were thinking about the primary and secondary techniques.

Dashboard development was occurring to measure reductions in restrictive practice, to enable staff to review the rationale for the use of a restrictive practice, for example was it linked to staffing levels, activities or training.

The trust has provided their board assurance framework, which details any risk scoring 15 or higher and gaps in the risk controls which impact upon strategic ambitions. The four strategic ambitions outlined by the trust relating to this service are as follows:

1 - We will deliver **quality** in everything we do providing safe, effective, and service user centred care
2 - We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time
3 - We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.
4 - We will **transform** services to achieve long-term financial sustainability.

The board assurance framework was very good with clear accountabilities and oversight. Good examples were given of the board assurance framework driving agenda’s and priorities for both the board and governance sub-committees. Gaps in control, and the mitigating actions to address them, were very clear and informative, and the actions taken were detailed and updated regularly.

We found that the trust took a cautious approach to changing its red ratings to amber or green, so all risks appeared red even when significant mitigating action had occurred

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

Key:

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

P	Title	Description	Risk level (initial)	Last review date
21223	Exceeded waiting times for dysphagia referrals	SLT LD currently accepts referrals for dysphagia classed as routine and urgent Due to only 1.3 therapists currently available to provide this service, there are 52 people waiting for a service following a telephone screen, with 14 classed as urgent. Recent ISMR's and Leeder reviews have shown that people who are on the waiting list for this service have died from aspiration pneumonia whilst awaiting an assessment. CQC raised concerns regarding waiting times for SLT service and we have been unable to meet this target due to limited resources This is unsatisfactory and is putting people with an LD at risk and increasing the risk of complaints, reputational damage and potential litigation.	Extreme	27 April 2018
867	Commissioned Care Co-ordination Capacity within Neighbourhood Teams	Commissioning Gap - Insufficient care co-ordination capacity This risk assessment applies to all neighbourhood teams Identified gap in resource requirement has led to significant pressure on care co-ordination capacity. Economies of scale issues at times of sickness and vacancy may lead to lower levels of clinical care coordinator capacity and lead to even higher waits. Demand for service over the past 12 months has increased by 16% which has also led to pressure on capacity and waits for care coordination. Overall pressure of workload has meant that adherence to the waiting list policy is very difficult, as the duty role is picking up more urgent work and ability to communicate with those waiting is affected. Care co-ordination capacity is also impacted by levels of vacancies, sickness and absence within the teams which is included in risk assessment 3264.	High	30 April 2018
2772	Insufficient resources CAMHS workforce	Insufficient CAMHS workforce resources to ensure safe reliably consistent, high quality care. Vacancies, sick leave and maternity leave leading to a lack of care coordination within new pathway model leading to increased reliance on medical team. 1.75 Consultant substantive vacancies and 0.6 adoption leave and therefore reliance on locum and agency usage. This is having an impact on the out of hours rota which is being staffed on a paid volunteer basis however this is not sustainable and the existing Consultant group have	High	12 March 2018

		expressed that they feel unable to continue this all but in the very short term. It is unclear if the move to pathway model is viable due to staffing shortages. There is a lack of local tier 4 service provision resulting in delays in accessing a safe tier 4 service in a timely way.		
3262	Long waiting lists following reduction in paediatrician staffing levels	Children and young people and their families are not being seen and assessed within a timely and appropriate manner. Ability to complete EHC Plans within 28 day timescale is considerable challenge and during 15/16 achieving 27% compliance. As of 28/06/16 there are a total of 1323 cyp waiting to be seen for an initial appointment with a paediatrician with 163 of those waiting over 52 weeks. Both measures were on a reducing trajectory since August 2015 however since February 2016 this has been slowly increasing again. There are currently 4 vacant posts within the service and interviews on 24/06/16 appointed one paediatrician. Interviews for Speciality Dr take place on 20th June 16. It has not been possible to secure suitable temporary cover against all vacancies and only two posts are covered on a temp basis. There is the potential of significant deterioration of child's health while on waiting lists and detrimental impact upon family functioning. Correspondence has been sent to GPs to inform them of the situation and remind them how to raise priority if aware of deterioration. There is also significant impact on the health, wellbeing and morale of the medical staff working within this context.	High	27 Februar y 2018
3385	Waiting Times for Psychological Assessment and Intervention	There are continued long waits across areas of the neighbourhood, although these are variable depending upon referral practice by team members and psychiatry. Additional resources have been agreed to support the cover of maternity leave in Amber valley and Derby City. There are three vacancies from staff leaving, these are out to advert.	High	28 Februar y 2018
3386	Radbourne Unit - Staffing risk assessment	Nursing - Nursing staff (Band 5) vacancies currently sit at 30.6 wet across the unit (34.45%). This does not include new starters which currently equate to 8.0wte starting in OCT. There are 6 RNs currently out of post due to ML/ LTS/ redeployment/ sabbatical. There are further 6.0wte leavers over JUL/AUG/SEPT. Approx. 50% of nursing shifts across the unit are being covered by HCAs or unfilled. There is currently insufficient nursing staff to cover all shifts at the required skill mix 3-3-2. Nights are particularly difficult to cover due to resource being directed to times of highest activity. Ongoing staffing pressures are having an impact on ability to maintain supervision and operational duties. 136 suite and unfunded day bleep shifts continue to draw on staffing resource, in the absence of commissioned staffing for this area. Medical - Update, all wards now have substantive RC in post except for ward 35 who have secondment cover for the next 6 months whilst recruitment process is underway. all wards	High	27 Februar y 2018

		now have substantive SPR cover, with the exception of Ward 35 who have locum cover in place until Sept.		
21002	Withdrawal of police support for inter-facility transport of patients	Patients can be admitted to beds that are out of area. This can include Acute placements Psychiatric intensive care CAMHS Tier 4 Learning Disability Eating Disorder The police have supported to transfer patients to Psychiatric Intensive care units - this will be stopped in Jan 2017. EMAS currently do not transport people out of the county. The Trust has utilised private transport providers to support transporting patients, this is on an ad hoc basis with no governance structure in place There is not a transport policy or contract in place between the commissioners and the Trust on transport provision.	High	31 January 2018
21068	Medicines Management - providing effective care for patients	Failure to achieve clinical quality standards required by our regulators in relation to providing effective care for our patients Impact: May lead to our service users not receiving effective treatment leading to delays in recovery and longer episodes of treatment Root causes: a) Lack of investment in pharmacy workforce and medicines management services Limited or no pharmacy input and support into high risk clinical areas within neighbourhoods such as Crisis teams, RAID teams, EIP teams, mental health community teams, and within specialist services such as Children's services, CAMHS, Learning Disability services, Substance Misuse services (City) b) Capacity to deliver effective care across all services Limited capacity to support some existing services that were unfunded when set up e.g. Hartington unit, and any new services - from existing pharmacy team. These risks have been highlighted to the Trust Board by the Chief Pharmacist in a Medicines Management Update report, presented on the 29th July 2015, and also at subsequent Quality Committee meetings. This risk assessment is linked to another (previous): record ID = 3301	High	19 March 2018
21106	Sexual Abuse Referrals	Services for providing an examination service for children who may have been sexually abused were put out to tender earlier in the year. The plan was for there to be a regional service including Notts (SARC). The basis for this change was around the identification that current services do not individually deal with enough cases. The medical college issued a guidance that anyone working in this area should see a minimum of 20 cases per year. Paediatricians struggle to meet this threshold. The Trust were part of the tender –	High	31 March 2018

		offering to contribute a certain proportion of the service with a resulting concentration of expertise within the team. The cases included are both forensic cases seen jointly with a FME (Forensic Medical Examiner), children with historical disclosures of sexual abuse, and children who need a genital examination for other reasons such as certain infections The tender was not taken up, feedback suggested that it was too expensive. The service they had requested had been extremely comprehensive and actually more involved than the service which is currently provided. The resultant provision is:- 1) Community paediatrics are told they are not expert and experienced in SA examinations 2) Community paediatrics have not developed their provision over the past 3 years as they were awaiting commencement of new SARC model 3) Community paediatrics team have not actively recruited in for the past 3 years for the above reason. Concerns: As a result of insufficient numbers coming to for assessment members of the team are concerned that they will be held up in the court as being not adequate or credible witnesses and therefore we will let down the children as a result of this.		
21209	Contracting and financial risk	Ivy House school nursing service is contracted via Local Authority, previous contract with school. Contract novated as not renegotiated. Risks emerged in 2017 as the funding and commissioning transferred to local authority and lack of clarity of financial value of contract. Currently operating service at financial deficit and in contract discussion with local authority. Financial discrepancy is circa £90k per annum. Issues with payment of invoices.	High	28 Februar y 2018

- Derbyshire Healthcare NHS Foundation Trust has submitted details of six external reviews which began or were published in the last 12 months (1 March 2017 to 28 February 2018) related to independent homicide investigations, triangle of care, dementia rapid response team, quality effectiveness safety trigger tool and learning from deaths and serious incidents.

- The trust stated that they ‘have an embedded culture of clinical research and organisational learning’ and that they are engaging in national audits, reviews and internal audits. The trust has an extensive internal audit program and that has driven numerous changes within the organisation to improve systems and processes. This has been evidenced by an extensive set of reviews of the risk and audit committee papers.

In 2017 the trust undertook an internal review of the crisis service with the peer review of a good rated CQC trust and an external review of the service as part of the peer review network to benchmark their practice. In 2016/2017 the trust worked with the patient safety collaborative to develop their family and carer communication tool. This has been rolled out across other East

Midlands regions as a good practice model. This was part of a triangle of care submission in 2017 which has resulted in a two-star rating.

Overall, the trust had a developing sense of learning from extensive internal and external reviews. The trust acknowledged they need to further refine their internal monitoring and the early warning system to ensure that they can have a substantial impact and prevent any of their services failing or having reductions in the quality of the service that they provide.

Management of risk, issues and performance

The trust had comprehensive assurance systems, and performance issues were escalated through clear structures and processes which were regularly reviewed and improved. The trust applied duty of candour appropriately when incidents occurred (this is a duty to be open and honest with patients and carers when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress). The trust took appropriate learning and action resulting from concerns raised.

A comprehensive annual safeguarding report went to the board level safegauarding committee and the board. The board discussed safeguarding quarterly. Reports went out to the external safeguarding boards. The trust had implemented the commissioning for quality and innovation "think family" framework since 2014 which they have continued to implement as a golden thread since the target ended. A trust named safeguarding lead doctor and named nurse was in place and a safeguarding team.

External provision for safeguarding training had reduced, making multi agency level training a challenge. Level four training had achieved 100% uptake, adult level three training achieved 54% uptake. Children's safeguarding uptake was 75% in April 2018. Staff received good feedback from safeguarding issues raised. We saw robust supervision structures in place for safeguarding leads. Forty five percent of teams had an adult safeguarding link worker, the trust intended every team to have one. The link workers met quarterly, their role was to make safeguarding everyone's business. The trust had discussed data reporting challenges and had in place accessible data at team level.

There were positive established relationships with external partners, joint working occurred in multidisciplinary meetings and discharge planning. The multiagency safeguarding hub met every three months and the trust took part in the strategic multiagency safeguarding board. The trust hosted a joint trauma conference in October 2017 with Derby police which focused on lessons learnt.

School nurses and health visitors told us that they had high caseloads of families under safeguarding and it made following things through difficult. In the acute admission wards we found not all staff had been identifying and reporting safeguarding appropriately.

Staff understood how to report incidents via the electronic incident reporting system. A risk management strategy was in place. Risks were categorised and reviewed through the governance meetings from divisional level to board level. There was good integrated working between risk, complaints, and the patient experience teams. A robust risk training programme was in place for staff and the board. Ward managers received dashboards of their incidents and risks.

There was no stand-alone corporate risk register and the trust operated an integrated model, connecting the front line risks to the corporate risks to the board assurance framework. The trust

had received external assurance that their approach was satisfactory. Since March 2018 an escalation process for the review of risks had been introduced. Risk handlers received an email a month prior to the risk becoming due for review and then a weekly reminder sent if the risk became overdue. The process was having an impact on overdue risks in reducing them, in May 2018 there were 32 risks out of 1537 (2%) that were overdue for review. We found that there were some residual recommendations on the electronic risk management system that remained open because not all team members had received the outcomes of the investigation, although immediate actions had been undertaken. Sharing of learning occurred through staff "huddles," a "Quality Matters" newsletters and a blue light alert system.

The medicines safety officer within the trust received all medicine incidents via the electronic incident reporting system and followed up to ensure actions occurred. Medicines risks were included in the trust risk register. Risks included poor medicines reconciliation levels in crisis teams, mitigation took place using pharmacy technicians in the crisis teams. Other risks related to storage temperatures of medicines (this was found in our last and current inspections), expiry date checking of oxygen cylinders, pharmacy staffing and gaps in medicines administration record.

We saw evidence of learning from medication incidents resulting in amendment of trust policies and sharing of this with relevant external organisations. The medicine safety officer produced quarterly reviews of medicines safety themes and shared it through the internal newsletters, bulletins and we saw evidence of external sharing.

External stakeholders reported improvement in serious incident processes following a notice served by a clinical commissioning group in 2017 (lifted in January 2018). They told us that the quality of investigation reports and action had improved. The number of open serious incidents and actions had decreased. Action plans had improved in quality. General managers undertook serious investigations and complaints. There were 135 trained investigators in the trust, they had received training in root cause analysis. There were constraints in staff undertaking investigations due to staffing pressures.

Trusts must report all serious incidents to the Strategic Executive Information System within two working days of finding an incident. The trust report incidents via the National Reporting and Learning System in line with national reporting rates.

Between 1 March 2017 and 28 February 2018, the trust reported 81 Strategic Executive Information System incidents. The most common type of incident was apparent/actual/suspected self-inflicted harm with 48. Twenty-two of these incidents occurred in community based mental health services for adults of working age.

Never events are serious incidents that are entirely preventable as guidance or safety recommendations providing strong systematic protective barriers are available at a national level and should have been implemented by all healthcare providers. The trust reported one never event during this reporting period. This incident related to a medication incident within wards for older people with mental health problems.

We asked the trust to provide us with the number of serious incidents from the same period on their incident reporting system. The number of the most severe incidents was broadly comparable with the number the trust reported to Strategic Executive Information System.

Type of incident reported on STEIS

	CHS Children, Young People, Families	MH Acute / PICU	MH Community LD or Autism	MH Community Adults of Working Age	MH Community for Older People	MH Forensic	MH Long Stay / Rehabilitation	MH Crisis HBPOS	MH Other Specialist Services	MH Community Children & Young People	MH Substance Misuse	MH Older People	Other	N/A	Total
Apparent/actual/suspected self-inflicted harm		8	1	22			1	4		1	6		3	2	**48**
Apparent/actual/suspected homicide				4	1						2				**7**
Abuse/alleged abuse of adult patient by staff		3		1									1		**5**
Disruptive/ aggressive/ violent behaviour		1		2											**3**
Abuse/alleged abuse of child patient by third party	1									1				1	**3**
Medication incident				1								1			**2**
Unauthorised absence						2									**2**
Pressure ulcer												2			**2**
Treatment delay				1				1							**2**
Failure to obtain appropriate bed for child who needed it		2													**2**
Diagnostic incident including delay (including failure to act on test results)									1		1				**2**
Slips/trips/falls				1											**1**
Commissioning incident		1													**1**
Major incident/ emergency preparedness, resilience and response/ suspension of services											1				**1**
Total	**1**	**15**	**1**	**32**	**1**	**2**	**1**	**5**	**1**	**2**	**10**	**3**	**4**	**3**	**81**

Trusts are encouraged to report patient safety incidents to the National Reporting and Learning System at least once a month. They do not report staff incidents, health and safety incidents or security incidents on the system.

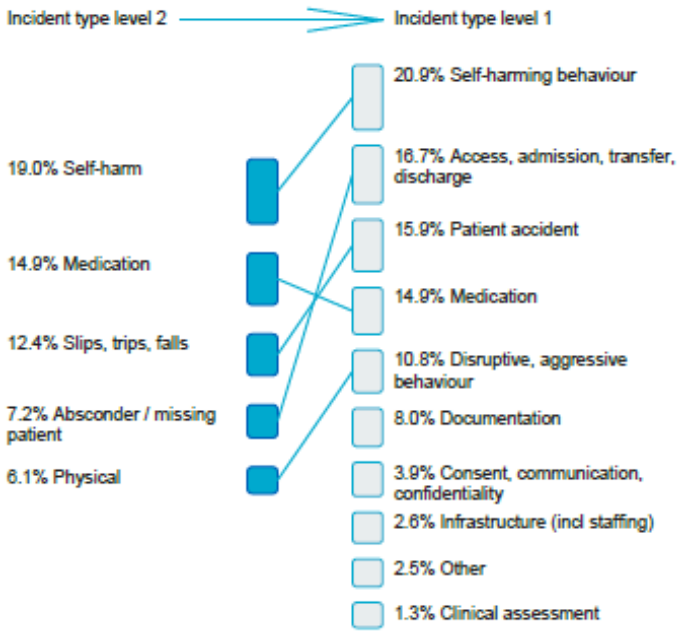
The highest reporting categories of incidents reported to the National Reporting and Learning System for this trust for the period 1 March 2017 to 28 February 2018 were self-harming behaviour, patient accident and access, admission, transfer, discharge. These three categories accounted for 1666 of the 3026 incidents reported. Self-harming behaviour accounted for 36 of the 46 deaths reported.

Ninety percent of the total incidents reported were classed as no harm (73%) or low harm (17%).

Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Self-harming behaviour	308	208	92	15	36	**659**
Patient accident	310	163	23	8	0	**504**
Access, admission, transfer, discharge (including missing patient)	458	23	11	11	0	**503**
Medication	357	23	7	3	0	**390**
Disruptive, aggressive behaviour (includes patient-to-patient)	225	59	25	2	3	**314**
Documentation (including electronic & paper records, identification and drug charts)	230	4	5	5	0	**244**
Consent, communication, confidentiality	121	5	9	0	0	**135**
Infrastructure (including staffing, facilities, environment)	78	2	4	9	0	**93**
Other	37	9	6	4	5	**61**
Clinical assessment (including diagnosis, scans, tests, assessments)	27	3	5	3	0	**38**
Patient abuse (by staff / third party)	16	4	2	11	2	**35**
Implementation of care and ongoing monitoring / review	9	4	3	2	0	**18**
Medical device / equipment	14	0	0	0	0	**14**
Infection Control Incident	9	2	0	0	0	**11**
Treatment, procedure	0	4	3	0	0	**7**
Total	**2199**	**513**	**195**	**73**	**46**	**3026**

According to the latest six-monthly National Patient Safety Agency Organisational Report (April 2017 to September 2017), the trust was in the middle 50% of reporters nationally for similar trusts.

Self-harming behaviour and access, admission, transfer, discharge accounted for a higher proportion of the total number of incidents by the trust.



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

Derbyshire Healthcare NHS Foundation Trust reported fewer incidents from 1 March 2017 to 28 February 2018 compared with the previous 12 months.

Level of harm	1 March 2016 – 28 February 2017	1 March 2017 – 28 February 2018
No harm	2239	2199
Low	601	513
Moderate	178	195
Severe	77	73
Death	31	46
Total incidents	**3126**	**3026**

The trust had effective systems in place for the prevention, review and investigation of deaths, in line with national guidance. The trust's quality strategy sets out their ambitions in relation to suicide prevention and mortality surveillance and monitoring. The 2016 -2018 suicide prevention strategy development occurred in consultation with staff, patients, carers and stakeholders such as Public Health Derbyshire in line with national guidance and the national strategy. It contained ten priorities whose progress was reported upon in the 2017/18 quality report. Progress of the priorities were monitored by a clinical dashboard and reviewed by the suicide prevention group. There was board oversight and discussion about progress.

Seventy percent of eligible staff received suicide prevention training by December 2017, giving them licence to use evidence based clinical tools. The trust delivered suicide prevention training to GPs. Information exchange about high risk locations occurred with external agencies such as railways, British Transport Police and local councils. The trust used opportunities such as the

“world suicide prevention day” to build community resilience by accessing potential crowds of up to 30,00 people at football matches on this day. The trust worked with newspapers to improve suicide reporting and publicise crisis telephone numbers, and hard to reach groups given buddy cards. The trust is a partner in a multicentre study of self-harm with two universities in England. Public Health data showed that that there had been an annual reduction in suicides in the trust from 113 in 2014 to 58 in 2017.

The trust website provided mortality information, such as the number of case note reviews undertaken and elements of the mortality dashboard and lessons learnt. Publication had led to increased freedom of information requests. The trust benchmarked its mortality rates against trusts of a similar size and makeup as well as looking at how other organisations used their staff and created capacity to undertake mortality reviews. Revision of policies to support the monitoring and investigation of deaths occurred following their development.

The 2017/18 quality report identified 2472 deaths of which 31 had a case record review through the mortality process and of which none were judged to have be due to problems in the care provided to the patient. Of the STEIS reportable incidents which were reviewed through the serious incident group process 39 investigations completed and 46 investigations were ongoing. 159 deaths were reported via the electronic incident reporting system of which 89 were externally reportable, of which 86 investigations were commissioned. The trust expanded its substance misuse service following successful tender in April 2017. The Trust attributes the increase of deaths to the substance misuse service due to deaths in the community

All deaths were reported through the trust NHS spine system. The deaths were reviewed by either the serious incident group or the mortality review group. They reported to the quality committee every two months, who presented a quarterly mortality report to the board. The electronic incident reporting system monitored overdue actions and the quality committee monitored for oversight and scrutiny. Trust board papers showed the board challenged the lack of analysis of mortality figures by ethnicity and the mortality within trust waiting lists numbers. Deaths of people on waiting lists were reviewed by the board. Of the 105 people who died on waiting lists most received assessments but were waiting for other services. Seven had not been seen, of these of these four were being reviewed as part of the serious incident process, one had died of natural causes and two had an unknown cause of death.

The trust sends all reported learning disability deaths through the electronic incident system to the National Learning Disability Mortality Review Programme. The trust was trying to build positive working links with this group to share information more effectively. The trust reviewed deaths related to learning disabilities through the same process as all other deaths. Escalation by the executives to the board occurred about a known risk, identified through the learning disability mortality review programme of patients dying due to swallowing difficulties. As a result there was a review of speech and language therapy waiting lists for assessment of dysphagia. A waiting list project had been developed and a trajectory of improvement was planned.

Deaths were subject to an initial service management review and were either closed or escalated for further investigation by the serious incident group at the initial review stage. The serious incident group split into an operational serious incident group that reviewed the initial service management reviews and non- Strategic Executive Information System peer reviews that were non-reportable to clinical commissioning groups, to decide next course of action. There was an executive serious incident group who reviewed all Strategic Executive Information System reportable incidents for themes, including all inpatient deaths. Core group members including the

patient safety lead sat in both groups to communicate key messages and share learning. This split was in response to an improvement notice issued by a local clinical commissioning group, because of several overdue serious investigations. Following improvements, removal of the notice occurred in January 2018. This change in format has reduced the number of overdue investigations. The challenge the trust was working on was to make the actions that arise from serious incidents into smarter and higher impact actions.

The investigation process involved interviews with staff and triangulation with other services including social care, private providers and police. Contact occurred with GPs to give them an opportunity to contribute to the investigation and recommendations for learning. The investigation analysed that care and treatment was it compliant with national polices and practice and to identify root cause contributing factors. The report was shared with the teams and the investigation facilitator met with the staff involved. If incidents occur across teams, the investigator facilitator would meet with all the teams involved.

The mortality review group undertook desk top case reviews for cases that did not fall under the remit of the serious incident group. This group met twice a week with a range of clinical and non-clinical professionals and required a medic, a mental health nurse, a general nurse, and a mortality review technician to be quorate. However, lack of medical attendance delayed some reviews. The trust was mitigating this issue by creating a pool of staff who could support with the process and included it in some clinicians' job plans to increase capacity. The group used a specific form to review the deaths, called Preventable Incidents, Survival and Mortality (a national multi-disciplinary review tool to look at problems or omissions in healthcare).

Every six months, the mortality review group selected four key topics from the red flag system for review such as patients on anti-psychotics or clozapine, these deaths that were reviewed in the group. The choice of the four red flag key topics were based on current risk and trends identified through the quality committee.

The mortality review group completed a complaint audit every three months and cross referenced this data against the mortality database to check if a complaint or concern occurred prior to their death. We were shown an example where this had occurred and how this had been immediately escalated to the serious incident group.

We saw good processes in place for engaging with family and carers of deceased patients such as a single point of contact. A duty of candour was applied at first point of contact. Engagement with families was individualised and person-centred. Support offered to families included arranging signposting to advice about funerals, information about coroners, the complaints process was explained and how to access medical records. The family liaison team gave support for as long as the family needed up until inquest, then worked towards closure. Referrals could be made to independent advocacy, psychological services. The family liaison lead had an agreement with the trust's director of nursing that they could refer families into the trust's child and adolescent mental health systemic family therapy and access to psychological therapies where appropriate to identify early support.

Families received a specific version of investigation reports did not contain acronyms or clinical jargon so that they were easy to read. Families received invites to contribute to the investigation terms of reference and outline any specific questions they want answered about their relative's care and treatment. The serious investigation group and family liaison monitored that the family questions received answers. Families gave feedback on the care and treatment of their family member and the investigation process. The family liaison worker met with the family at the end of

the investigation process to explain the outcome of the investigation. There were clear processes in place for managing communications with families who did not wish to engage. Feedback from families about the support they had received from the family liaison team was overwhelmingly positive.

Staff involved in serious incident investigations, received support from line managers and occupational health if required. A psychologist supported the patient safety team, they reported having regular supervision and individual wellbeing plans.

The trust had processes to manage current and future performance which were regularly reviewed and improved. The trust had embarked upon four big improvement projects which involved 1189 staff, these were the learning disability community team, neighbourhood teams, urgent care pathway and electronic rostering. The trust had used methods such as 100 day rapid turnaround programmes created jointly with staff. Their purpose was to use the general principle of urgency. The governance of the plan was supported by electronic project software. Where services had gone through this type of programme staff shared their learning form the process. We observed the trust board approving a 100 day plan for the Radbourne unit and discussion about the wider influence on the urgent care pathway in the Sustainable Transformation Partnership. Evaluation of programmes occurred using a national tool. The emphasis was upon using the right coaching techniques with staff and involving service users and carers to bring about improvement.

The quality committee looked at emerging hotspots and common emergent themes by corroborating evidence through reports and dashboards and quality visits to find out if there were emerging issues and monitor improvement.

The trust had a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. There is an audit and risk committee which has oversight of audits and risks and reports to the board. The committee members had non-executive chairs and representative non-executives from other board committees. This meant there was good links between board committees. Local and national priorities were reflected in the audit programme. There was good involvement of medical staff in the audit programme. The trust took part in Prescribing Observatory for Mental Health audits and there was a ward and team level audit schedule for medicines management. Clinical pharmacy standards for ward based pharmacists and technicians were formalised approximately one year ago. The trust intends to audit against these.

There were good links to the research department. Both audit and research strengths were used in the recruitment of staff to the trust.

The board decided when and where to carry out deep dives to understand an issue better. Non-executives could request deep dives based on performance data.

Information Management

The board received holistic information on quality and sustainability. Leaders used meeting agendas to discuss quality and sustainability sufficiently at all levels across the trust. Staff said they had access to all necessary information and were encouraged to challenge its reliability. Staff in substance misuse reported good access to information. Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. The trust was aware of its performance using

key performance indicators and other metrics. This data fed into the board as assurance framework.

The information governance team published key performance indicators online daily as a dashboard via the intranet. Visual staffing levels were part of the key performance indicator data. However, there were instance we saw when further information would be helpful to managers for example in the hope and reliance hub which provided patient activities managers did not receive information on what the number of activities offered were and what the take up of activities was, nor did they receive data on the reasons for non-take up of activities.

The board and senior staff expressed confidence in the quality of data and welcomed challenge, however there was some confusion about the profile of some data. The data was checked using the data quality kitemark and audits undertaken in November 2017 and May 2018. Data was found to be 100% concordant. This was reported to the board, and meant that data presented to the board was good. Senior staff told us that supervision and appraisal data counted in staff on long term leave and distorted the data, the information team had developed a system in March 2018 which only included eligible staff to improve the data capture. Public Health England and clinical commissioning groups reported ongoing work on data quality was occurring. Data quality is now part of the mental health forum where best practices are shared.
Information was in an accessible format, prompt, correct and identified areas for improvement. The information governance team gave examples of how they informed the quality improvement agenda, for example carers had requested copies of patient discharge letter to aid care, this was actioned provided the patient had consent to this recorded on the system. They had also used data to help a patient challenge national insurance contribution payment. Systems were in place to collect data from wards and teams and this was not over burdensome for front line staff. The was good use of specialist team of clinically trained staff in information governance to free up ward based staff to deal with information requests under the 2018 General Data Protection Regulation.

IT systems worked slowly and this impacted on the quality of care. Staff told us that the log in and log out process for recording 15 minute observations was slow and effected the recording of real time observations, therefore due to time constraints they would stay logged in when not in front of a computer. We served an enforcement notice which the trust accepted about the recording of observations. The trust immediately put in mitigating actions such as more staff on wards that were carrying out 15 minute observations, and were working to implement a hand held electronic device that would record observations in real time by 3 August 2018. The during the inspection the trust showed us that they were using the IT systems in place to audit the recording of observations by ward and by staff member, this performance monitoring information supported wards to obtain 100% compliance in recording observations in accordance with trust policy.

Staff had access to IT equipment and systems needed to do their work. The trust had one electronic patient record for the community and hospital and reliance on paper records had reduced. The trust had an integration system in place between System One (a system used by GPs) and its electronic patient record. This meant that substance misuse services and children's services could generate an alert if either system had a patient record open. The trust was working on "known at the same address" process so that it would help with safeguarding, for example an alert could be generated there were child or adult concerns at the same address. Staff in

community teams had encrypted laptops to allow for flexible working and mobile phones. A few staff told us they did not have enough computers in their areas.

The trust had initiatives to support improvements in care involved plans to pilot technology to remotely monitor patients as they slept so that they were not disturbed by staff doing observations. An electrocardiogram trial was in place to have a digital solution to read the heart rhythm results on site. The trust had completed the information governance toolkit assessment and an independent team had audited it. The trust was the top mental health trust for information governance toolkit results. The trust had adopted the general data protection register toolkit.

Information governance systems were in place including confidentiality of patient records. The trust had information governance and management policies in place approved by the information governance committee and there was a dashboard in place to monitor policies. The trust had completed migration to NHS mail to improve data security. A secure portal was used for submitting data. The trust was compliant with the NHS guidelines about password management. Laptops not used for three months were removed from the system to prevent units becoming insecure.
The information risk register was reviewed monthly. There was live backup of information to a drive off site which was tested regularly to confirm accuracy. Old paper records were stored off site, the trust received 250 requests per month for these as they were not scanned in. There were systems in place to track all paper records within the trust. The information governance committee met monthly and was attended by the Caldicott guardian and the Senior Information Risk Owner.

The trust had embraced the General Data Protection Regulation with 96% of staff completing training. Tailored information governance training was available for staff with limited access to computers such as estates and domestic staff. The team worked closely with the patient experience team and met with patients, carers and families during complaint investigations to explain what information was held and reasons why certain information could not be given. The team worked with the legal team to provide access to patient records as required.
The trust learnt from data security breaches. The information governance team received notifications of data breaches through the electronic incident reporting system. No network breaches had occurred to date. We found robust decision processes used to inform patients of data breaches which always involved the Caldicott Guardian. An information bulletin went out to all staff providing information governance learning articles and giving practical real life examples to highlight how to address issues.

Engagement

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The trust has a structured and systematic approach to engaging with people who use services and those close to them and their representatives. The ward, team and division had access to feedback from patients, carers and staff and were using this to make improvements. The trust had started to use reverse commissioning which is an initiative supported by the NHS black minority ethnic network to use patient and public networks and needs assessment to identify gaps in the service provision and highlight culturally appropriate interventions. We found the trust to be very knowledgeable of the cultural and ethnic background of people within Derbyshire including hard to reach groups of people.

The chaplaincy service was working to increase inclusivity with the Muslim and Sikh community. Ramadan celebrations received supported on the forensic wards with activity timetables, medication times and staff rota adjusted to support observation of Ramadan. Vegan medication for vegans showed sensitivity to patients' needs.

The trust works in a catchment area in which there are over 70 languages spoken. There were issues with interpreting services because they could not always get the right language. Crisis services supported the needs of deaf service users by offering a specific clinic for deaf service users and linked into the local deaf services. The trust responded to patient feedback and used a specific agency approved by deaf community to provide interpreting with the right qualifications. Until recently there had been carer representation on the medicine management committee. Informal links continued and carer/patient concerns remained a standing item on the committee agenda to ensure the patient voice was heard. The trust's psychiatric teaching unit has won accolades for its programme of involving patients in the teaching and training of undergraduate medical students.

Communication systems such as the trust website, intranet and newsletter were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. Team briefings occurred monthly.

Learning, continuous improvement and innovation

In February 2018 a quality improvement strategy was produced, it was values led and based on staff responses. It outlined the aspirations for the use of various quality assurance tools and strategies. The trust was in the early stages of an implementation journey. A quality improvement committee and a quality improvement team had been established. Non-executive and executive directors and senior managers told us their ethos was to take a co-production bottom up approach with staff to quality improvement. Deputy directors were undertaking quality improvement projects linked to fellowships with the linked to fellowships with the Generation Q - The Health Foundation.. The electronic questionnaires obtained the views of clinical staff and external stakeholders before embarking on a quality improvement journey to gauge receptiveness and undertake temperature checks.

The trust was actively participating in clinical research studies. The trust has a research and development unit and a research and development strategy. Research funding has grown from £100k to £300k in three years. Reporting to the board occurred via the quality committee. Research examples undertaken related to self harm and suicide prevention, living well with dementia and dementia care, falls in early dementia. Research was shared nationally for example a psychotherapy research involvement in mood disorder study was presented at a conference in May 2018. 30 clinicians had been involved in various clinical trials.

The trust actively sought to participate in national improvement and innovation projects. For example, police triage vehicles with mental health staff support had reduced admissions to the health based place of safety. Staff made suggestions for improvement and gave examples of ideas implemented for example in substance misuse services staff worked with 147 people at significant risk of death with their GPs to meet their physical health needs. The community based services for older people team undertook a surgery in the GP practice for anti-psychotic

medication in a one stop shop which undertakes blood tests. The trust was in the early stages of using standardised improvement tools and methods, and were planning to train staff have the skills to use them. For example, the Lean model helped reduce the time taken to send out inpatient letters by working with medical secretaries to identify issues and solutions.

A director of business improvement and head of programme delivery were responsible for 38 programmes of delivery. For example the learning disability team had received a new contract specification, this resulted in the staff, service users and carers being involved in scoping what the new service specification would look like with support from the performance office. Each of the programmes was signed off by the medical and director of nursing.

Effective systems were in place to identify and learn from incidents. The trust issued a bi monthly electronic newsletter “practice matters” to all staff. This provided lessons learnt from deaths, adverse childhood experience suicide audits, learning from complaints using real examples, themes and learning from serious untoward incidents.

The trust consistently maintained financial stability. The performance and finance committee approved the annual accounts for 2017/18. It monitored and held to account the financial plan. The board received a financial report each month as part of the integrated performance reports. Leaders told us that the trust was not finance driven and quality was the priority. A zero-based budget approach was used. Investment decisions were linked to the strategic plan and discussions within the board.

The trust was financially sound and had to deliver a £4.8 million cost improvement programme that was devolved to divisions and services. The director of business improvement and transformations role was to manage the cost improvement programme and implement the quality improvement programme. Staff were aware of their contribution to cost improvement objectives and were encouraged to identify ideas that would save money via the planning cycle round. All proposals received a quality impact assessment make sure the patient expertise, care treatment and effectiveness was not compromised, examples of eight proposals being rejected were given. The medical and nursing directors were essential to challenging the plans prior to proposals going through to the executive leadership team. The quality committee had oversight of the quality impact assessments. Review of the plans occurred through the division structures. Cost improvement programmes were discussed in fortnightly monitoring meetings and risks were sited to the performance and finance committee.

The finance staff focus group told us they were encouraged to be innovative and felt self-empowered. The finance team ran clinics to communicate financial statements and budget reports to different departments. There was provision for different levels of budget training for aspiring, new, experienced budget holders. The finance team reported that they were very close to the clinical and operational teams and attended operational meetings. They received support to undertake shifts in the clinical areas to understand staff and patient needs. Budget holders received support to use budgets to respond to service and patient needs. A review of all budgets occurred between August and December 2017 and was revised in preparation for the new financial year. There is a pharmacy cost reduction programme in place.

Finances overview	Historical data		Projections	
Financial Metrics	Previous financial year (2 years ago)	Last financial year (2017)	This financial year	Next financial year (2019)
Income	£130.984m	£135.965m	£139.267m	£138.697m
Surplus	£1.129m	£2.841m	£3.351m	£2.331m
Full costs	£129.855m	£133.124m	£135.916m	£136.366m
Budget	£131.216m	£135.389m	£131.745m	£136.366m

At the time of the inspection the trust was operating in a budget of £140 million

There was a five-year estate strategy in place until 2022. The trust sat on the Sustainable Transformation Partnership estates group to support service pathway. Implementation of the principle of “one public estate” occurred with other public bodies such as Public Health England, police, fire and councils and other NHS providers. This worked well and had allowed the trust to expand its perinatal services in the north. One public estate enabled consideration of options at a good rate quickly.

The trust PLACE scores were good overall for 2017 achieving 100% for food. The PLACE scores were well above the national benchmark for trusts of its type. The prioritisation of capital spend was dependent on clinical need, there was an annual programme of capital spend.

Service level agreements were in place for estates in other trusts. However, delays in maintenance could occur due to the rebalance on another organisation and disputes could occur as to wheatear damage caused was by patients.

The trust was looking at its dormitory provision through its clinical service transformation programme, there was a concern that to lose dormitory provision would result in loss of beds. The trust had introduced gender neutral toilets for staff.

The estates team were involved in the suicide prevention strategy work in relation to ligature reduction and tools used to restrict windows or carry out observations. The team were looking at the use of electronic patient bracelets to lock doors. Following Grenfell there was a review undertaken of the estate.

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

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

Accreditation scheme	Service	Service accredited	Comments and Date of accreditation / review

Triangle of care – level 2	Not specified	Not specified	September 2017
Royal College of Psychiatrists, Quality Network for Perinatal MH Services	The Beeches	The Beeches	1 July 2017 to 1 July 2020

Community Perinatal Service received formal notification of achieving accreditation from The Royal College of Psychiatrists in July 2018.

The Royal College of Psychiatrists accredited the electroconvulsive therapy suite in September 2017.

Wards for older people with mental health problems

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group
Trust HQ	Cubley Court (Female)	18	Female
Trust HQ	Cubley Court (Male)	18	Male
London Road Community Hospital (LRCH)	LRCH Ward 1	16	Mixed
London Road Community Hospital (LRCH)	LRCH Ward 2 - Vacant	16	Mixed

Is the service safe?

Safe and clean care environments

Safety of the ward layout

Staff were not able to observe all parts of the ward from the nursing station. Staff used observations and positioned themselves in areas where they could see all parts of the ward to reduce these risks. Staff also completed individual risk assessments for patients who were at risk of self-harm to minimise these risks. At Cubley Court, seating areas were set up for night staff so the staff had full view of the bedroom areas.

Cubley Court had separate wards for men and women. Ward 1 was a mixed-sex ward with separate lounges for women. The layout of Ward 1 meant that patients did not have to pass bedrooms of patients of the opposite sex to reach the bathrooms or toilets. Staff were aware of and had considered the needs of transgender patients. For example, the ward manager explained how the allocation of the patient to either the male or female corridor would be determined based on the individual patient's preference, individual needs and risk assessment.

All bedrooms were en-suite with either a shower or a bath.

Staff carried personal alarms to summon help from other staff if needed.

Alarm call bells were not near to patients' beds in their bedrooms on Ward 1. If a patient needed to call staff from their beds, they used a bell to summon attention. Alarm call bells were positioned within arms length and easily accessible within the toilets and washing areas on Ward 1. At Cubley Court, the nurse call system was positioned on the wall in patients' bedrooms and behind the toilet or beyond arms length in the toilet areas. These alarms may not be obvious to a person with significant cognitive impairment. We saw that nurse call bells were available for patients to use in communal areas.

Staff at Cubley Court observed patients when they were in their bedrooms at intervals dependent on their level of risk. Some patients' bedroom doors were locked during the day to promote patient safety. Staff had risk assessed this for each patient.

Staff completed regular risk assessments of the care environment on all the wards. These were called 'environmental risk assessments'. We saw these detailed the most current risks on each of the wards and had appropriate actions to reduce these risks wherever possible. The trust had a fire safety policy available to all staff on the intranet and a regular fire risk assessment was completed by the health and safety officer. We saw exits were clearly marked across all wards and all patients had personal evacuation plans. Personal evacuation plans detailed what support each patient may need to mobilise and evacuate in the event of an emergency. There was evidence that these had been updated if a patient's needs changed. These plans were stored in the nursing office at Ward 1 and at Cubley Court they were on posters outside patients' bedrooms. Staff completed weekly fire alarm tests and monthly fire drills on each of the wards. The service had fire wardens across all shifts and kept firefighting equipment in the nursing office.

Staff completed ligature risk assessments on all the wards. A ligature if a fixture or fitting that a patient could use for tying or binding as a means of hanging her/himself. This was regularly

reviewed and detailed the list of potential ligatures within each separate room on the ward and any changes to the level of risk presented. For example, on Ward 1 we saw that the soap dispensers had recently been added to the risk assessment and the service had taken appropriate, immediate action to reduce this risk. This had improved since our last inspection. Individual patient risk assessments were used alongside these ligature risk assessments to assess and monitor patients' individual risk of harming themselves and to support staff to keep them safe.

Maintenance, cleanliness and infection control

All ward areas were clean, had good furnishings and were mostly well maintained. On Cubley male, there were very few decorative pictures or items around the ward and some minimal damage to the walls. This was due to the pictures being damaged by some patients and therefore the staff felt it was most appropriate to remove these pictures to promote patient and staff safety. There were plans in place to introduce some decorative objects that were more securely attached to the walls. On Cubley male, some of the chairs had damage to the fabric exposing the foam. New garden furniture had been purchased at Cubley court since our last inspection and we saw plans were in place to improve the quiet/sensory room.

For the most recent Patient-led Assessments of the Care Environment assessment (2017), London Road Community Hospital scored 100% for cleanliness, and 95.4% for condition, appearance and maintenance. Kingsway Hospital site scored 99.2% for cleanliness, and 97.1% condition, appearance and maintenance.

Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly. This had improved since our previous inspection. Cleaning equipment was safety checked twice daily. Records on Ward 1 demonstrated the morning checks were fully completed, but there were seven missing checks for the afternoon checks during the month of May 2018.

Staff adhered to infection control principles, including handwashing. There were clear protocols in place to manage an outbreak of infection on the ward, including the process for sending patients' clothes home with instructions on how to wash the clothing. Personal protective equipment was available on both wards and within the clinic rooms. We saw that clinical waste was handled and disposed of appropriately. Patients and staff were encouraged to have the Flu vaccination and we saw leaflets about this at both sites. Flu vaccination uptake on Ward 1 was 37% (13/35 patients), 37% (13/35 patients) for Cubley Court Female and 41% (17/41 patients) for Cubley Court male. The service participated in a biannual infection control audit. There were no seclusion facilities on any of the wards we visited. Ward 1 had a de-escalation room to support patients if they became extremely agitated and requested some time alone in a quiet environment. Ward staff told us this had not been used in several months.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. At Ward 1, we found the key to the oxygen cylinder was not attached to the cylinder which could result in a delay to access to oxygen in an emergency. This was immediately rectified by staff. Staff checked the temperatures of the rooms and fridges daily so that medicines were stored safely. There were two missing temperature recordings during the month of May 2018 in the Cubley male clinic room. This had also been identified by the ward pharmacy staff. We saw instances where some equipment was missing from the resuscitation

trolley and action had been taken by the staff member to acquire this from pharmacy. Supplements that were prescribed to individual patients were stored in the food store. However, the food store was not in the clinic room and the temperature of this food store was not monitored.

Staff maintained equipment well and kept it clean. 'Clean' stickers were not in use, but all equipment was clean and ready for use.

Safe staffing

Nursing staff

Ward managers used electronic rostering to make sure each shift had enough registered nurses to safely meet patients' needs and monitor communal areas of wards.

Managers set staffing levels at Cubley male were as follows; on the early and late shift, two registered nurses and five nursing assistants and on the night shift, two registered nurses and three nursing assistants. On the day of our inspection, the staffing had been adjusted due to patient observation levels so that there were nine staff on the early and late shift and eight during the night, with a minimum of two registered nurses on each shift. On Cubley female on the early and late shifts the set staffing levels were two registered nurses and four nursing assistants and at night, two registered nurses and three nursing assistants. Managers set staffing levels on Ward 1 were six staff on an early shift, five on a late shift and four on a night shift, with a minimum of two registered nurses on each shift. On days when multidisciplinary meetings were held one additional registered nurse was allocated to support the ward.

Staffing overview at a glance [1] (Internal use only - Remove before publication)

Definition

Substantive – All filled allocated and funded posts.

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

Substantive staff figures			Trust target
Total number of substantive staff	At 28 February 2018	108.3	N/A
Total number of substantive staff leavers	1 March 2017 – 28 February 2018	19.4	N/A
Average WTE* leavers over 12 months (%)	1 March 2017 – 28 February 2018	15%	10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 28 February 2018	15.7	N/A
Total vacancies overall (%)	At 28 February 2018	13%	10%
Total permanent staff sickness overall (%)	At 28 February 2018	12%	5%

[1] Turnover analysis

	1 March 2017 – 28 February 2018	7%	5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 28 February 2018	54.7	N/A
Establishment levels nursing assistants (WTE*)	At 28 February 2018	61.1	N/A
Number of vacancies, qualified nurses (WTE*)	At 28 February 2018	7.1	N/A
Number of vacancies nursing assistants (WTE*)	At 28 February 2018	7.6	N/A
Qualified nurse vacancy rate	At 28 February 2018	13%	10%
Nursing assistant vacancy rate	At 28 February 2018	12%	10%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 March 2017 – 28 February 2018	3 (<1%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 March 2017 – 28 February 2018	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 March 2017 – 28 February 2018	8 (<1%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	3762 (24%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	757 (5%)	N/A

*Whole-time Equivalent

When necessary, managers deployed bank nursing staff to maintain safe staffing levels. The electronic rostering system automatically sent shift requests to the nurse bank. The system allowed managers to request preferred staff. Ward managers tried to book bank and temporary staff that were known to the wards. This meant that staff understood ward procedures, were familiar with patients and their needs and could manage risk effectively. We saw the use of bank staff was highest on Cubley male (30.7% in March 2018) and lowest on Cubley female (4.7% in March 2018). The service did not use agency staff.

The service reported an overall vacancy rate of 13% for registered nurses at 28 February 2018. The service reported an overall vacancy rate of 12% for nursing assistants at 28 February 2018. The service has reported a vacancy rate for all staff of 13% as of 28 February 2018.

	Registered nurses			**Health care assistants**			**Overall staff figures**		
Ward/Team	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**

LRCH Ward 2	0.5	0.5	100%	0	0	0%	0.5	0.5	100%
Cubley Court (Female)	4.3	19.3	22%	3.3	20.9	16%	7.8	43.4	18%
Cubley Court (Male)	1.2	18	7%	4.1	23.8	17%	4.9	44.6	11%
LRCH Ward 1	1.2	16.9	7%	0.2	16.4	1%	2.6	36.3	7%
Service total	**7.1**	**54.7**	**13%**	**7.6**	**61.1**	**12%**	**15.7**	**124.8**	**13%**
Trust total	**116.2**	**970.5**	**12%**	**34.3**	**375.2**	**9%**	**310.3**	**2490.1**	**12%**

NB: All figures displayed are whole-time equivalents

Between 1 March 2017 and 28 February 2018, bank staff filled less than 1% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, no agency staff covered shifts for qualified nurses. Less than 1% of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Cubley Court (Female)	4544	1 (<1%)	0 (0%)	1 (<1%)
Cubley Court (Male)	4692	0 (0%)	0 (0%)	3 (<1%)
LRCH Ward 1	4440	2 (<1%)	0 (0%)	4 (<1%)
LRCH Ward 2	897	0 (0%)	0 (0%)	0 (0%)
Service total	14573	3 (<1%*)	0 (0%*)	8 (<1%*)
Trust Total	**248873**	**1416 (<1%)**	**5000 (2%)**	**293 (<1%)**

*****Percentage of total shifts

Between 1 March 2017 and 28 February 2018, 24% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, no agency staff covered nursing assistant shifts. 5% of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Cubley Court (Female)	5232	1197 (23%)	0 (0%)	229 (4%)

Cubley Court (Male)	5952	1679 (28%)	0 (0%)	394 (7%)
LRCH Ward 1	3641	886 (24%)	0 (0%)	134 (4%)
LRCH Ward 2	927	0 (0%)	0 (0%)	0 (0%)
Service total	15752	3762 (24%*)	0 (0%*)	757 (5%*)
Trust Total	**83457**	**15372 (18%)**	**0 (0%)**	**2497 (3%)**

***** Percentage of total shifts

This service had 19.4 (15%) staff leavers between 1 March 2017 and 28 February 2018.

Ward	Substantive staff (February 2018)	Substantive staff Leavers (1 March 2017 to 28 February 2018)	Average % staff leavers over the past year (1 March 2017 to 28 February 2018)
Cubley Court (Female)	35.1	7	19%
LRCH Ward 2	0	3	19%
LRCH Ward 1	33.0	5.8	18%
Cubley Court (Male)	38.6	3.6	9%
Service total	**106.7**	**19.4**	**15%**
Trust Total	**2167.7**	**219.3**	**10%**

The sickness rate for this service was 7% between 1 March 2017 and 28 March 2018. The most recent months data (February 2018) showed a sickness rate of 12%.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
LRCH Ward 2	-	23%
Cubley Court (Female)	8%	6%
Cubley Court (Male)	10%	6%
LRCH Ward 1	18%	6%
Service total	**12%**	**7%**
Trust Total	**7%**	**5%**

Staff reported that all the wards were regularly short staffed and that this impacted on patient activities, management of patient aggression, staff breaks and morale. Staff at Ward 1 reported there were not always enough staff to carry out physical interventions and that this was primarily due to the isolation of the unit from the other services. However, they reported that staff from the Kingsway Site supported as soon as possible. Staff at Cubley Court reported there had been times when there had not been enough staff to carry out physical interventions on the ward. In these circumstances, the team had utilised the trust's central control and restraint team to support. We saw evidence that staff rarely cancelled escorted leave or ward activities because there were too few staff. The in-reach team at London Road supported patient leave and the occupational therapy team at Cubley Court supported leave. Ward-based activities were primarily led by the occupational therapy team and were rarely cancelled.

Staff at Cubley Court reported there were not always enough staff to care for deteriorating patients. They cited examples of this including incidents where patients were transferred to the local acute hospital and due to a lack of nursing staff to accompany patients, the junior doctor had supported the patient.

The service was looking at ways to support nursing staff. This included rotating staff from other services across the trust and using other disciplines such as occupational therapists and physiotherapists to support with some of the nurse-led responsibilities. Some staff we spoke with told us that this took them away from their usual professional roles to complete tasks usually assigned to a nurse. In addition, the trust had developed other strategies to reduce its registered nurse vacancies. This included the introduction of the retire and return policy to allow staff who had recently retired to return to work part-time.

The service was piloting a night bleep holder role. This role was covered by a registered nurse who could support staff where there was a change in risk or increased observations on the ward. This role had helped to support staff where shifts had previously been unfilled. For night shifts, Cubley Court had a risk assessment that stated they needed a minimum of three registered nurses between the two Cubley wards, and aimed to have two qualified nurses on each ward. The night bleep holder role allowed the wards to assess where this role was most needed across the three wards. Managers told us the night bleep holder is primarily based at Cubley Court and is then included in staffing numbers. We reviewed the staffing rosters on Cubley female for the week prior to our inspection and saw there were six shifts that had been unfilled. During these shifts, we saw support had been accessed from the night bleep holder.

The ward manager could adjust staffing levels daily to take account of case mix. For example, if a patient required an increased level of observation, the first staff member required to support this was absorbed within the current staffing numbers. After this, managers requested additional staff. Managers used Hurst's staffing tool to measure patient acuity against staffing levels and adjusted this accordingly.

Staff told us a qualified nurse was always present in communal areas of the ward and this was supported by our observations. Staffing levels allowed patients to have regular one-to-one time with their named nurse.

The below table covers staff fill rates for registered nurses and care staff during December 2017, January 2018 and February 2018.

Cubley female ward had below 90% registered nurses for night shifts for all months reported (48% for night shifts in January 2018 and 45% for night shifts in February 2018).

Cubley male ward had over 125% care staff for night shifts for all months reported. Ward 1 had below 90% registered nurses for day shifts for all months reported.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses %	Care staff %	Nurses %	Care staff %	Nurses %	Care staff %	Nurses %	Care staff %	Nurses %	Care staff %	Nurses %	Care staff %
	December 2017				January 2018				February 2018			
Cubley Court Female	118.23	106.34	69.37	144.1	82.08	91.82	48.39	120.4	70.67	70.95	45.25	107.1
Cubley Court Male	90.82	112.66	85.49	179.6	76.85	126.32	91.95	181.7	77.26	146.1	94.65	182.1
LRCH Ward 1 OP	86.56	106.74	100.00	146.8	88.03	92.83	96.78	124.2	76.15	117.0	94.65	142.9

Medical staff

Some staff we spoke with raised concerns about the amount of medical cover for the wards and felt that there were not enough doctors to support care and treatment. Two consultant psychiatrists covered Ward 1 and split their caseload into Derby City patients and Derby County patients. A speciality doctor, a junior doctor and a trainee doctor also supported the ward. Three consultant psychiatrists covered Cubley Court; one full time consultant on Cubley male, one part-time (three days per week) consultant on Cubley female and one consultant to cover both Cubley male and female for two days per week. Each consultant covered the on-call rota every one out of seven days. The on-call rota covered the inpatient wards, the dementia rapid response teams, local care homes in the community and the GP service. In addition to this, a junior doctor covered the ward out of hours and could respond within twenty minutes.

Staff were aware of the procedures to follow during a medical emergency.

Mandatory training

The compliance for mandatory and statutory training courses at 28 February 2018 was 86% (for the current financial year) compared to 88% reported in the previous financial year.

Key:

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

Training Course	**Trust Target %**	**Training compliance % for this service**	**Trust Wide Training Compliance %**
Data Security Awareness (Previously IG) (Annual)	95%	97%	91%
Equality, Diversity and Human Rights - Level 1 (3 yearly)	85%	71%	78%
Fraud Awareness (3 yearly)	85%	99%	95%
Health, Safety & Welfare (3 Yearly)	85%	80%	81%
Moving & Handling Level 1 (3 yearly)	85%	91%	83%
Promoting Safer & Therapeutic Services Clinical Staff (3 yearly)	85%	97%	85%
Promoting Safer & Therapeutic Services Non-Clinical Staff (3 yearly)	85%	71%	86%
Safeguarding - Adults Level 1 (Non Clinical) (3 Yearly)	85%	71%	87%
Safeguarding - Children Level 1 (once only)	85%	99%	98%
Aseptic Non-Touch Technique (ANTT) - 2 yearly	85%	84%	79%
Autism (ASD) Awareness Level 1 (Once)	85%	74%	57%
Care Certificate (Once Only)	85%	84%	84%
Deprivation of Liberty Standards (Once)	85%	98%	83%
Dual Diagnosis Level 1 (Once)	85%	90%	70%
Dual Diagnosis Level 2 (Once)	85%	73%	57%
Fire Safety - Fire Warden (3 Yearly)	85%	90%	64%
First Aid at Work Certificate (3 Yearly)	85%	75%	84%
Food Hygiene Awareness Update (Annual)	85%	77%	64%
Food Hygiene Certificate (3 Yearly)	85%	50%	35%
General Risk Assessor Training (3 Yearly)	85%	38%	21%

Infection Control Level 1 (Identified Non Clinical) (2 yearly)	85%	50%	69%
Investigating Incidents, Complaints, Claims & Report Writing (Once only)	85%	0%	71%
Meds Mgmt - Admin & Documentation (3 yearly)	85%	76%	36%
Meds Mgmt - Controlled Drugs (3 yearly)	85%	64%	34%
Meds Mgmt - Use of Medication in the Management of Violence & Aggression v5 (3 yearly)	85%	88%	62%
Mental Capacity Act (Once)	85%	96%	84%
Mental Health Act 2007 (Once)	85%	92%	79%
Moving & Handling Level 2 - Inanimate Objects (2 Yearly)	85%	25%	75%
Moving & Handling Level 2 - People (2 yearly)	85%	89%	68%
Physical Health in Mental Health (3Yearly)	85%	45%	24%
Positive & Safe - PROACT SCIPr-UK - TACTICS (Older) inc PSTS (Annual)	85%	87%	81%
R Resuscitation - Basic Life Support & AED (annual)	85%	95%	64%
Resuscitation - Immediate Life Support - ILS - (annual)	85%	82%	73%
Safeguarding - Adults Level 3 (2 Yearly)	85%	57%	55%
Safeguarding - Children Level 2 (3 yearly)	85%	96%	90%
Safeguarding - Children Level 2 (once only)	85%	98%	93%
Safeguarding - Children Level 3 (3 yearly)	85%	83%	80%
Safeguarding - Children Level 3 (annual)	85%	0%	73%
Safeguarding - PREVENTing Radicalisation - Level 1 (3 yearly)	85%	57%	86%
Safeguarding - PREVENTing Radicalisation/WRAP Level 3 (3 yearly)	85%	100%	90%
Smoking Cessation Level 1 (Once Only)	85%	75%	33%

Staff Recruitment Training - All Recruiters (3 Yearly)	85%	83%	59%
Total		**86%**	**75%**

During our inspection visit, the average compulsory training compliance level across all three wards as at 24 May 2018 was 91.3%. However, medication competency was at 58%.

The average role specific training compliance figure was 79.1% for Cubley male, 83.2% for Cubley female and 77.9% as at 24 May 2018.

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 31 sets of care records. In all but two of the records reviewed, patients had a risk assessment, known as the safety assessment. Staff completed safety assessments with patients on admission and reviewed it regularly, including after every incident. In two of the risk assessments reviewed at Ward 1, the patients' risk assessment had not been updated to reflect an increase in risk following an incident. Staff reported that the safety assessment document was not fit for use with patients with dementia as it was unclear where to put information related to the symptoms associated with dementia.

Staff used safety plans (risk assessments), handover, multi-disciplinary team meetings and observations to assess and respond to changing risks to or posed by patients. However, on Ward 1, we noted that two of the patient files we reviewed did not show evidence that safety plans had been updated following an incident concerning safety. We raised this with the trust at our feedback who conducted an audit which illustrated that 50% of patient safety plans had not been updated following the reporting of an incident. The trust reported there were inconsistencies that require improvement, and these were to be highlighted in the qualified staff meeting. We saw a copy of an email that was circulated to all qualified staff to reaffirm the need to update the Safety Assessment following an incident. The trust were exploring if there was the possibility of an alert being added to the incident reporting system to prompt staff to update the safety assessment and care plans following a reportable incident.

However, on Ward 1, it was unclear whether staff had routinely reviewed risk assessments before patients detained under the Mental Health Act went off the ward on Section 17 leave. Section 17 leave is permission for patients to leave hospital. There was no document available for staff to record their risk assessment of the patient before they accessed Section 17 leave off the ward. This remained an issue from our previous inspection. However, we saw that safety plans were updated where a risk had changed prior to patients accessing leave. Section 17 leave care plans were also printed for patients to outline who to contact whilst on leave if they needed help.

Staff completed hip protection assessments on admission for all patients who had a history of falls. If the patient was deemed to be at risk of falls, staff completed a full falls assessment. We saw falls assessments were detailed, outlined the patients' requirement for supportive equipment, were developed by the multidisciplinary team, and were regularly reviewed. We saw that patients' risk of falls was directly related to their level of staff observation and care plans. Patients' risk of falls was reviewed weekly in the falls meeting which was chaired by the trust falls lead and was attended by senior members of the multidisciplinary team.

Staff at Cubley Court told us sharp items that could cause harm and plastic bags were banned on the ward. However, there was not a list of banned items shared with patients and/or their carers/relatives and patients were not searched upon entering the ward. It was therefore unclear how this was enforced on the ward. Ward 1 had clear protocols around the management of restricted items.

We saw clear processes in place to manage patient absconsions and managers could identify how this differed depending if the person was detained under the Mental Health Act. Patients at risk of absconsion had a care plan in place. At Cubley Court, patients at higher risk of absconsion were nursed in the side of the ward that was furthest away from the front doors of the ward to reduce the risk of them absconding.

Management of patient risk

Staff were aware of and dealt with any specific risk issues, such as falls or pressure ulcers.

Staff assessed patients on admission for their risk of falls, safe moving and handing or pressure ulcers. Staff liaised appropriately with tissue viability nurses and other professionals, such as previous care homes or the general hospital from which the patient had been admitted. Staff also spoke to families and carers of patients who were newly admitted to the ward to understand their needs and behaviours as best as possible.

However, information and lessons learned about risk issues was not always shared across the wards. For example, two level three pressure ulcers had been acquired after admission on Cubley female. Both were reported as serious incidents in line with reporting policy. We requested and reviewed documentation from these two incidents, including the initial service management review forms. Information leading up to and learning from the incidents was detailed. Staff we spoke with on Cubley male were unaware of these incidents or lessons learned as a result.

Both Cubley Court and Ward 1 had tissue viability link nurses. These staff members had received additional training around tissue viability from the local general acute hospital. Their role as a link nurse involved educating the staff and patients on issues to do with tissue viability and pressure sores as well as disseminating learning and knowledge from any incidents.

Managers told us that the tissue viability nurse from the Royal Derby Hospital visited the ward to offer to support for any pressure sore incidents and was also available over the phone to offer advice and support to staff on the ward.

Equipment, including airflow mattress, were available on site and able to be ordered into the ward if necessary. Staff told us this service was responsive and equipment would be delivered in good time. Staff completed body maps of patients on admission to the ward for any tissue viability issues to be addressed quickly.

Staff used the Waterlow Score to assess tissue viability. We assessed six sets of notes at Ward 1 and six at Cubley male. We saw Waterlow Scores completed at admission in all notes at Ward 1, and in five notes at Cubley male. We also saw evidence that staff updated these when needed.

A malnutrition screening tool was used to assess if patients were nutritionally at risk. We assessed six sets of notes at Ward 1 and six at Cubley male. We found malnutrition screening tools

completed at admission in five out of six notes on Ward 1 and four out of six notes at Cubley male. We saw evidence of these being updated during patients' stay on the ward. We also saw that where dietician intervention had been requested this had occurred in a timely manner.

The trust used the Derby Early Warning Score assessment tool. This uses a range of physiological observations to indicate if a patient may be physically deteriorating. Staff recorded these assessment observations on the trust's electronic patient record form. Where the scores were elevated the electronic recording system alerted staff to act in line with the Derby Early Warning Score escalation procedure. However, there was an occasion where a doctor had requested a patient's DEWS observations be increased to twice in 24 hours due to an increasing warning score. However, staff had not recorded any physiological observations for that patient during the specified 24 hour period. We reviewed another patient's records on Cubley female which indicated that the patient's blood pressure monitoring score was outside of her normal limits. We found the Derby Early Warning Score computer system advised staff to continue normal monitoring rather than repeat the observations, despite the recording being abnormal for this patient. This suggested that the computer system was not functioning as designed. We did not find any mention of this within nursing records.

The trust confirmed there was no sepsis policy in place. Training for sepsis was included in one of the scenario based practices for the intermediate life support training. However, this scenario included National Early Warning Score based scoring and not Derby Early Warning Score so there was limited assurance that staff would be able to apply this training in practice. Staff told us they had not received any training in sepsis awareness.

Staff did not always follow policies and procedures for the use of observation (including to minimise risk from potential ligature points). We reviewed five patient records on Cubley male and four records at Cubley female. We found there were several omissions in observations, particularly of patients who were being nursed on level three observations. Patients who were on 'level three' observations were to be observed every 15 minutes and staff were to record these observations in real time on the electronic system. The most notable omissions were recorded at 12:19 – 15:02 and 15:18 – 17:26. This showed that some patients had not been observed for over two hours. The Care Quality Commission had previously issued a Requirement Notice in relation to this issue following an unannounced inspection of Cubley male ward on 13 March 2018.

We saw and staff reported issues with this process and explained there was often a delay in recording of the observations, resulting in 'back-dating' of observations. The service had attempted to reduce this practice by introducing laptops on the ward for staff to input their patient observations. We observed staff inputting their observations in this manner but saw that the systems were slow and time-consuming. This resulted in staff spending less time engaging with and supporting the patients. We raised this with the trust at the post-inspection feedback session and they reported there was a scoping exercise underway looking at the possibility of having hand-held devices for recording observations across the trust.

Staff had imposed few blanket restrictions on patients and encouraged independence on all wards. At Cubley Court, we saw that not all patients could not access their bedrooms during the day. Staff completed individual risk assessments for patients that showed the reasons for this. We saw staff enabled patients to go into their bedrooms when they wanted to and staff made sure that the patient was safe. Staff did not search patients on any of the wards.

Staff adhered to best practice in implementing a smoke-free policy. Patients could smoke when using section 17 leave. section 17 leave is permission for patients to leave hospital.

On Ward 1, the ward doors were locked and staff, patients and visitors could only get off the ward using a coded keypad. Staff told us that they verbally told informal patients that they could leave the ward when they wanted to and we saw a sign on the door to remind informal patients of their right to leave at their will. On Ward 1, we saw this was also contained in the ward booklet.

Use of restrictive interventions

In the 12 months before the inspection, there were 110 episodes of restraint. These were highest on Cubley male (67 episodes). There were no episodes of prone restraint.

Staff were trained in Strategies for Crisis Intervention and Prevention to support patients safely as a last resort when de-escalation had failed. This had improved since our last inspection. We observed staff supporting patients in line with the training. Training instructors supported staff on the ward to recommend bespoke intervention plans for each patient. These plans were regularly reviewed and could be adapted if required. Where restrictive interventions were used, we saw these incidents were reported onto the electronic reporting system and reviewed for lessons learned. These incidents were reviewed by the multidisciplinary team and we saw examples where a patient's life history was obtained to inform the most appropriate engagement plan.

The wards in this service participated in the trust's restrictive interventions reduction programme. Staff on Cubley female were trainers for the Strategies for Crisis intervention and Prevention programme. To ensure there was always one training instructor on each ward at Cubley Court, the service had asked one staff member from Cubley male to do this training. The current Strategies for Crisis intervention and Prevention team had decided to meet with the national training team to explore alternative training around restraint to safely support patients of higher acuity. Staff reported this was because of the current restraint technique not being appropriate for patients with complex needs.

Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.

Staff followed National Institute for Care and Health Excellence guidance when using rapid tranquilisation. The use of rapid tranquilisation was reviewed in weekly multidisciplinary team meetings and there was a good process in place for monitoring and reviewing the use of rapid tranquilisation.

The below table focuses on the last 12 months of data: 1 March 2017 to 28 February 2018.

Ward name	Seclusions	Restraints	Of restraints, incidents of prone restraint	Rapid tranquilisations (number and % of restraint incidents)
Cubley Court (Male)	**0**	67	0 (0%)	7 (10%)

Cubley Court (Female)	**0**	30	0 (0%)	31 (103%)
LRCH – Ward 1	**0**	11	0 (0%)	9 (82%)
Cubley Court (shared area)	**0**	2	0 (0%)	0 (0%)
Service total	**0**	**110**	**0 (0%)**	**47**

The number of restraint incidents reported during this inspection was higher than the 81 reported for the previous 12 months.

There were no seclusion rooms on any of the wards. Staff told us they did not use other rooms of bedrooms to seclude or segregate patients.

Safeguarding

The trust had a safeguarding policy which explained clear processes for staff to follow when reporting safeguarding. There was also a safeguarding 'app' for staff to use for easy access to information about different types of abuse, what to do if they had a concern about an adult at risk and a range of referral pathways.

All staff were trained in safeguarding adults level 1 and 2, 99% of staff were trained in safeguarding children level 1 and 81.2% were trained in safeguarding children level 3. All staff we spoke with knew how to make a safeguarding alert, and did so when appropriate. This had improved since our last inspection. Staff told us nursing assistants would report their concerns to qualified nurses rather than make a referral themselves.

On Ward 1, all patients had a safeguarding plan in place due to a history of thefts of patient belongings on the ward. Staff reviewed safeguarding concerns and referrals in multidisciplinary team meetings and sought further advice from the trust's safeguarding lead when they needed it.

Staff reported a good response from the local safeguarding authority when they submitted safeguarding referrals.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff had a good understanding of the need to put immediate actions in place to safeguard patients when making a safeguarding referral. This included moving patients to different areas of the ward to reduce interactions with patients where there had been an incident of patient to patient verbal or physical aggression.

Staff followed safe procedures for children visiting the ward. At Cubley Court and on Ward 1, there was a family room for children to visit and this was off the ward. Staff could be flexible to suit the needs to the patients regarding visits to the ward.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has its own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust reported that there had been 100 safeguarding referrals made within this core service during the period 1 May 2017 to 23 May 2018. 75% of these referrals were made from Cubley male ward. The trust has stated that there is the potential for safeguarding referrals to have been made without an incident report having been completed. Both Safeguarding Adult Boards maintain data of referrals received into the local authorities but, currently, "health" referrals are not currently represented by organisation.

The ward manager on Cubley male reported they are looking to develop a safeguarding log as information about safeguarding referrals regularly gets lost.

Staff access to essential information

All records were stored electronically. Mental Health Act and Deprivation of Liberty Safeguards paperwork was uploaded electronically so all information was stored in the same place.

Information needed to deliver patient care was available to all relevant staff, including bank staff, when they needed it and was in an accessible form. This included when patients moved between teams. For example, staff on Ward 1 reported the ease of communication exchange with the in-reach team.

Medicines management

Staff followed good practice in medicines management, including transport, storage, dispensing, administration, medicines reconciliation, recording, disposal and use of covert medication and did this in line with national guidance. The pharmacist attended the ward every weekday and liaised closely with the patients' GPs. Patients on covert medication had received a best interest meeting by the multidisciplinary team and a pharmacy support form was attached to the medication card to tell staff exactly how to administer the medication in line with the patient's care plan. Staff completed medication audits regularly and these audits had clear action plans in place and actions were followed up in a timely manner. Lessons were learned from medication incidents and errors and there was clear evidence of change in practice as a result.

There were robust and effective processes in place for self-medication.

The pharmacy team worked well within the multi-disciplinary team and attended weekly meetings with the rest of the team to ensure they were kept up to date with changes in patients' presentation and medication requirements.

We observed a medication round with a nurse on Cubley male. We saw the nurses followed the medication administration procedures correctly.

Staff reviewed the effects of medication on patients' physical health regularly and in line with NICE guidance, especially when the patient was prescribed a high dose of antipsychotic medication.

We found that at Cubley Court, the self-harm risk assessment section of the treatment cards was not completed. This meant that staff administering medication were not always aware of the patients' risk of self-harm.

Track record on safety

Between 1 March 2017 and 28 February 2018 there were five incidents reported by this service. Two of the incidents related to abuse/alleged abuse of adult patient by staff and two of the incidents related to pressure ulcers.

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

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

Staff were aware of how to protect patients from harm. Following historical issues around theft of patient belongings on Ward 1, the staff had clear processes in place for investigating incidents of this nature. Further incidents of this nature had been reported and had been fully investigated by the police. In addition, safeguarding strategy meetings were held and actions were taken to safeguard all patients on this ward. The service was undertaking regular security audits to help identify how to reduce the risk of further incidents taking place and initial findings showed evidence of improvement. The trust was due to commence a new investigation into the incidents of items going missing. Staff at Ward 1 had implemented changes because of incidents of theft on the ward. The service had started to log the contents of the safe with its current contents being communicated to staff members on each shift change. The service was also considering the possibility of installing closed circuit television into the corridors that patient's bedrooms are positioned off to enable staff to track movements in this area if needed.

Staff received feedback of incidents and learning was shared both within the service and with relevant bodies outside of the service, including the in-reach team and the local safeguarding team, where appropriate. Actions identified to support staff to protect patients from harm included an audit of the ward keys to ensure all were logged and signed for by staff, guidance for staff on the correct recording of valuables and other actions for all services across the Kingsway site including a review of the recording of items in ward safes.

	Number of incidents reported		
Type of incident reported	**Cubley Court (Female)**	**LRCH - Ward 1**	**Service Total**
Abuse/alleged abuse of adult patient by staff	1	1	2
Medication incident	1	0	1

Pressure ulcer	2	0	2
Total	**4**	**1**	**5**

Reporting incidents and learning from when things go wrong

All staff we spoke with knew what incidents to report and how to report them through the electronic reporting system.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. The trust sent out briefings on incidents via email to managers and 'blue light' reports were sent to all staff via email if something unexpected happened. This was also discussed and reviewed in team meetings.

There was evidence that changes had been made because of feedback. For example, a staff member who had been involved in a serious incident at Cubley Court had been given additional staff support. Lessons were shared across the multidisciplinary team and this had been discussed with staff during handover and team meetings. On Ward 1, we heard how the staff team had completed some work around reducing patient falls and had recently purchased some new bed sensors and chair sensors. The team had seen a reduction in falls because of this.

Staff received a debrief following incidents, and managers and other staff offered them support. The newly appointed clinical psychologist was planning to become heavily involved in this debriefing process and supporting staff to think about how patients' behaviours may be influenced by a range of factors.

Patients were offered a debrief following an incident. Staff used their clinical judgment and knowledge of the individual patient to determine the best method for offering a debrief. Staff told us some patients were seen on a one to one basis, some were seen with their named nurse and others were supported by their family during the debrief.

Is the service effective?

Assessment of needs and planning of care

We reviewed 16 care records. All contained a comprehensive mental health assessment that staff had completed within 24 hours of the patient's admission.

We reviewed 15 patient records for evidence of a physical health assessment on admission. This had always been completed on Cubley male and female wards and in four out of six records at Ward 1. Patients had access to specialist assessments on admission including venous thromboembolism assessments, constipation and urinary tract infection assessments and osteoporosis screening.

Staff developed care plans that met the needs identified in the assessment. Care plans were detailed, personalised and covered the full range of each patient's needs. Staff included the patient and/or their relative/carer's views in care plans wherever possible. Staff kept care plans up to date in all but three of the records we reviewed, where there were no clear discharge plans in place.

Best practice in treatment and care

We looked at all medication care records for patients. Records showed that staff had followed the National Institute for Health and Care Excellence guidelines when prescribing medication.

Staff provided a range of care and treatment interventions suitable for the patient group. The service had recently appointed a clinical psychologist who worked one day per week on each ward. The Royal College of Psychiatrists accreditation standards for older people's inpatient services currently recommend a minimum of 0.5 whole time equivalent dedicated clinical psychology time for each ward. The clinical psychologist was in the process of completing initial assessments with the patients at the time of our inspection. However, plans were in place to begin working with patients and staff using techniques from cognitive behavioural therapy, cognitive analytical therapy and compassion focused therapy approaches. The clinical psychologist told us they were keen to work closely with the community teams to make sure that any therapeutic input that began during a patient's admission to hospital could be continued in the community.

Occupational therapists used the Model of Human Occupation Screening Tool in line with national guidance. This is an assessment tool that allows the therapist to get an overview of the patient's occupational functioning. The occupational therapy team offered a range of activities and supported patients to engage in recovery focused assessments both on and off the ward. Nursing and occupational therapy staff developed a therapeutic timetable for patients on each of the wards that included cognitive stimulation therapy, baking and gardening groups, tea parties, as well as external-led activities such as the monthly 'singing for the brain' session, led by the Alzheimer's Society. The timetable of activities was clearly displayed on the wards. This had improved since our last inspection.

Staff ensured that patients had good access to physical healthcare. This had improved since our last inspection. Patients' needs were assessed, monitored and reviewed regularly and information was stored within the patients' care notes. Staff told us that they would work with patients and their families to enable patients to attend external GP appointments and any regular screening programmes if required. We saw examples where staff from the ward had liaised with a patient's GP to attain further information about their health and medication on admission.

Patients had access to specialists when needed. For example, a specialist mental health physiotherapist could provide urgent assessment of a patient within 48 hours of referral and had close links with the specialist neurology service. We saw staff worked closely with dieticians to make sure those patients with conditions such as diabetes had a suitable diet plan. Staff on the wards told us how a specialist diabetic nurse visited from the acute hospital site to provide ongoing support and monitoring of diabetic patients. However, there was limited evidence of ongoing personalised physical health interventions within patients care plans.

Staff had access to the equipment necessary to complete comprehensive physical healthcare assessments and treatment, including pressure relieving mattresses and cushions to prevent pressure ulcers. The clinical equipment included a bladder scanner which registered staff had been trained to use. However, we did not see any evidence of the Lester cardio-metabolic health resource or similar being used to monitor ongoing screening and interventions of patient's physical health conditions.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. Members of the multidisciplinary team, including dieticians, speech and language therapists and occupational therapists, had assessed patients' needs for food and drink and for specialist nutrition and hydration. For example, we saw specialist feeding aids that were individually prescribed by the occupational therapy team. Patients' records showed that nursing staff had followed guidelines where appropriate.

Staff supported patients to live healthier lives by supporting patients with weight management and encouraging patients to engage in exercise. For patients who were able, staff encouraged and escorted them to perform two daily 15 minute walks to increase their level of physical activity.

Occupational therapy groups were based on the seven dimensions of wellness to promote health active ageing. Cubley Court had recently introduced E-burners to promote physical healthcare and smoking cessation. We saw that health promotion information was displayed on walls on the wards. However, some of this information was in small font which may be difficult for service users or their visitors to read.

Staff used recognised Health of the Nation Outcome Scales to assess and record severity and outcomes for each patient on their admission and discharge. These scales measure behaviour, self-injury, cognitive problems and activities of daily living and are designed to help build up a picture of a patient's responses to nursing and medical interventions.
Clinical staff actively participated in clinical audits. This included medicine records, storage and administration, care records, physical health monitoring, self-harm, capacity to consent to admission and treatment and the Mental Health Act. Audits we looked at showed staff had improved their practice as a result of the findings. The service also received regular quality visits from the trust to identify areas for improvement and good practice and monitor performance with current standards.

Skilled staff to deliver care

Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. The multidisciplinary team consisted of psychiatrists, speciality doctors, junior doctors, a clinical psychologist, occupational therapists, occupational therapy assistants, pharmacists, nurses (including link nurses and specialist nurses such as tissue viability nurses), nursing assistants, speech and language therapists, physiotherapists and domestic and housekeeping staff. The service had recently developed a new recreational worker role on each of the Cubley wards. The purpose of this role was to promote engagement and recreation during evenings and weekends as well as day times.

Managers provided new staff with an appropriate induction, using the care certificate standards as the benchmark for healthcare assistants. This had improved since our last inspection. We reviewed five staff induction files and saw that four out of five were fully complete. However, in one

staff member's file, we saw they had not completed several training courses during the induction process, including information governance, observation, resuscitation and infection control.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
LRCH Ward 2	0	0	-
LRCH Ward 1	36	32	89%
Kingsway Cubley Court Female	39	37	95%
Kingsway Cubley Court Male	41	41	100%
Service total	**116**	**110**	**95%**
Trust wide	**2406**	**1858**	**77%**

- The trust's target rate for appraisal compliance is 90%. As at 28 February 2018, the overall appraisal rates for non-medical staff (undertaken between 1 March 2017 and 28 February 2018) within this service was 95% and 100% for medical staff.
- The wards failing to achieve the trust's appraisal target were Ward 1 with an appraisal rate of 89%.
- The rate of appraisal compliance for non-medical staff reported during this inspection was the same as the 95% reported for the last year

Managers provided staff with supervision and an annual appraisal of their work performance. This had improved since our last inspection. Supervision consists of meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development. We reviewed five staff supervision files and saw evidence of reflective practice and support from supervisors.

- The trust's measure of clinical supervision data is the number of sessions delivered.
- Between 1 March 2017 and 28 February 2018, the average rate for the non-medical staff in this service was 50%.
- **Caveat:** there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
LRCH Ward 1	369	159	43%
Cubley Court (Female)	454	230	51%
Cubley Court (Male)	499	263	53%
LRCH Ward 2	52	30	58%
Service total	**1374**	**682**	**50%**
Trust Total	**19680**	**12660**	**64%**

During our inspection, we reviewed supervision figures and found that the average clinical supervision compliance for this service was 79.1% (79.4% for Ward 1, 89.4% for Cubley male and 68.4% for Cubley female) as at the date of our inspection. Average managerial supervision compliance was 79.9% (72.2% for Ward 1, 90.2% for Cubley male and 77.5% for Cubley female).

Staff had access to regular team meetings on all the wards we visited. Weekly team meetings took place on the wards, as well as weekly multidisciplinary ward round meetings. In addition, individual professional groups attended meetings with their peers monthly. An operational meeting was held fortnightly at Cubley Court for the senior team members to discuss patients risks and needs across the two wards.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. All staff groups had regular practice development days. These days allowed staff to talk about issues or good practice specific to their role, latest research and up to date practice. For example, occupational therapy staff told us they had regular continued professional development meetings every 12 weeks.

Although managers had ensured staff completed the trust's compulsory/mandatory training courses, not all staff across the three wards had completed the service's role specific training courses. These courses include topics such as infection prevention and control, physical health in mental health and autism awareness.

Managers dealt with poor staff performance promptly and effectively.

Multi-disciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings. On Ward 1, daily Purposeful Inpatient Assessment meetings took place to discuss patient progress and suitability for discharge with the in-reach team. Discharge meetings were held regularly on Cubley Court. Twice weekly multidisciplinary ward rounds were held on Cubley Court and Ward 1. Several other meetings took place as and when required including Care Programme Approach meetings and best interest meetings.

We observed staff handovers between shifts. These were detailed and effective in providing staff with the information they needed about patients' needs, including a range of information about

patients' physical health, personal care, do not attempt resuscitation status, medication and diet and fluids.

Staff in community mental health teams including the in-reach team attended multidisciplinary team meetings on the wards. This meant that they knew the needs of the patients before the hospital discharged the patient into the community and helped to plan for this. Staff from the dementia rapid response teams visited the wards at Cubley Court and attended multidisciplinary meetings there. Staff on all the wards reported excellent relationships with the community based teams and were confident in their ability to request information form these teams and share information appropriately to better patient care.

Patient records we looked at showed that staff worked with patients' GP and care homes when needed.

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

As of 28 February 2018, 92% of the workforce in this service had received training in the Mental Health Act. The trust stated that this training is mandatory for all inpatient and community staff and is only completed once. The training compliance reported during this inspection was higher than the 89% reported for the last year.

Doctors and registered nurses we spoke with showed that they had knowledge of the Mental Health Act, the code of practice and the guiding principles.

On admission, a competent member of staff examined patients' accompanying Mental Health Act papers. This was to ensure patients were legally detained under the Act.

Staff on all wards knew who the trust Mental Health Act administrators were and how to contact them. The Mental Health Act administrators offered support to staff on the wards to make sure staff followed the Act.

The service had a range of policies covering Mental Health Act. We reviewed the policies regarding section 17 leave, manager's hearings and section 132 rights. All the policies were in date and contained information related to the Code of Practice (2015). These policies were stored on the trust intranet page and were accessible to all staff. Staff told us and we saw it was not clear whether there was an overarching Mental Health Act policy.

Information about access to independent mental health advocacy was displayed around the wards and communal/reception areas. None of the patients we spoke with were aware of the role of the advocate.

Staff ensured that patients could take section 17 leave when this had been granted by the responsible clinician. section 17 leave is permission for patients to leave hospital. Patients told us they were always able to take their leave as planned. On Ward 1, the in-reach team supported ward staff with escorted leave. Occupational therapists supported patients with section 17 leave wherever possible on both the Cubley wards and on Ward 1.

Staff on the wards kept clear records of leave granted to patients. Patients, staff and, where applicable, carers were aware of what leave was granted and where the patient could go on leave.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. We saw this had taken place in all the records we reviewed both on patients' admission to the ward and routinely thereafter. This had improved since our last inspection.

Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff stored copies of patients' detention papers and associated records (for example, section 17 leave forms) correctly and so that they were available to all staff that needed access to them.

Consent to treatment forms were in place and staff attached these to medication charts where applicable. This meant that nurses could administer the medication under the correct legal framework.

The service displayed a notice on all three wards to tell informal patients that they could leave the ward freely.

None of the care plans we looked at on Ward 1 or at Cubley Court referred to section 117 aftercare services for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment. Staff we spoke with were familiar with the section 117 aftercare process.

Nursing staff and Mental Health Act administration staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was strong evidence of learning from these audits. Audits identified clear areas for improvement and actions had been taken to address any concerns/omissions in a timely way. This had improved since our last inspection.

Good practice in applying the Mental Capacity Act

As of 28 February 2018, 96% of the workforce in this service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all inpatient and community staff and is only completed once.

The training compliance reported during this inspection was the same as the 96% reported in the previous year.

Staff had a good understanding of the Mental Capacity Act and considered capacity in their everyday practice.

The trust reported that 65 Deprivations of Liberty Safeguards applications were made to the Local Authority for this service between 1 March 2017 and 28 February 2018. We received two direct notifications from the trust to notify of application authorisation. There is a national backlog of Deprivations of Liberty Safeguard applications and staff told us several patients were discharged from hospital before their application authorisation was processed. Staff we spoke with had a good understanding of Deprivations of Liberty Safeguards.

The trust had a policy on the Mental Capacity Act and a separate policy around deprivation of liberty safeguards. The deprivation of liberty policy was out of date at the time of our inspection and had been due for review in April 2018. Staff told us that they knew where this policy was kept and could refer to it when needed.

Staff knew where to get advice from within the trust regarding the Mental Capacity Act, including Deprivation of Liberty Safeguards.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it. We saw examples of staff maximising patients' capacity to support them to make decisions for themselves, including the use of cue cards.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. We reviewed several capacity assessments and saw overall, these were detailed, decision-specific and considered the patient's views as much as possible. Capacity assessments were easy to find. This had improved significantly since our previous inspection.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person and their relative/carer(s) wishes, feelings, culture and history. This had improved since our last inspection. Staff held best interest meetings to review patients' discharge where a patient lacked capacity to make decisions for themselves around their discharge. We saw that these meetings involved patients' families, patients and a range of other professionals involved in patients' care. Staff clearly explained the aim of the care packages to patients and their families.

Staff enabled patients to make advance decisions when appropriate. We reviewed six Do Not Attempt Cardio Pulmonary Resuscitation plans at Cubley Court and these were correctly completed with an appropriate review date and evidence of discussion of options and involvement of relevant persons.

Staff knew where to get advice regarding the Mental Capacity Act within the trust. The trust lead for the Mental Capacity Act visited the wards and provided advice and training for staff.

The service had arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act weekly and acted on any learning that resulted from it.

Number of DoLS applications made by month

	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 17	Feb 17	Total
Applications made	9	5	4	5	10	13	4	2	2	3	5	3	65
Applications approved	**4**	**0**	**1**	**0**	**1**	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**8**

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients gave examples of how staff were respectful towards them and how they supported them to understand their care and treatment. Staff provided emotional support to patients to minimise their distress. Staff attitudes and behaviours when interacting with patients

showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it.

We observed a lunch time at both Ward 1 and on Cubley male ward using the short observational framework for inspection. We observed many positive interactions between patients and staff. Staff gave patients a choice of dining areas wherever possible to allow patients to make a choice about whether they wished to eat alone, in a smaller group or with a group of patients. Patients were encouraged to eat as much as possible and offered alternative options if needed. Staff assisted patients to get their walking aids to leave the dining area when they had finished eating. Staff at Cubley Court helped patients to orientate themselves within the ward environment by explaining clearly where they were and gently guiding patients to where they wanted to get to.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. For example, we saw staff patients supported patients during their treatment at the local general hospital.

Staff were sensitive to the individual needs and preferences of each patient, for example around personal care, spiritual and religious needs.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Staff maintained the confidentiality of information about patients. We saw examples of this throughout our inspection, including locking computer screens when patients or their carers or relatives could see the screens. Patients also told us they did not hear staff discussing other patients around them. We observed clinicians moving into private areas to discuss individual patients or test results.

Staff respected patients' privacy and dignity. All but one of the patients we spoke with told us that staff always knock on their door before entering their bedroom. The 2017 Patient-Led Assessments of the Care Environment score for privacy, dignity and wellbeing at London Road Community Hospital was 91.3% and at Kingsway site was 92.9%. This is higher than the England average for mental health and learning disability services (90.6%).

Involvement in care

Involvement of patients

Staff used the admission process to inform and orient patients to the ward and to the service. On Ward 1, staff met with the patient and their relative or carer in the quiet room before showing the patient around the ward, including their bedroom. An information pack was developed and kept in the patient's bedroom with further information about the ward, including meal times. Staff explained how they gradually introduced patients to staff and other patients soon after the patient's admission. At Cubley Court, patients were oriented to the ward and supported with an increased level of observation where there was a high risk of falls or other risk-related behaviours. If patients did not have support from relatives or carers, social workers supported patients with the admission process.

Staff involved patients in care planning and risk assessment as much as possible. Where patients were unable to be involved in their care planning and risk assessment, this was documented by staff. For example, we saw that very few patients on Cubley Court had a copy of their care plan and this was documented. However, in one patient's care plan on Cubley female, staff had documented that the patient had capacity but had not been given a copy of her care plan and no reason for this was documented.

Where patients were under the Care Programme Approach, regular meetings were held and patients were involved in decisions made about their care. Staff encouraged patients to participate fully in meetings about their care and treatment and summaries of the discussion were shared with patients at the end of the meeting to ensure they understood what decisions had been made.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. For example, staff checked that patients had the appropriate communication equipment, such as hearing aids and glasses and could request an assessment by the audiology, speech and language and optometry team. Staff at Cubley court also used cue cards to support patients with word-finding difficulties.

On Ward 1, patients were given the opportunity to feedback on services via weekly community meetings. Nursing assistants chaired these meetings. We reviewed the minutes of the previous community meetings. We saw that these minutes had been hand written by staff for the past two years and there were no actions allocated to individuals or records of actions being followed up. Staff told us actions were followed up each week but this was not documented. Community meetings were not held on Cubley Court. Patients we spoke with on Cubley Court were unsure on how to give feedback on the service they received, but all patients said they could speak with nursing staff if they had any concerns.

Staff enabled patients to make advance decisions when appropriate. We reviewed six Do Not Attempt Cardio Pulmonary Resuscitation plans at Cubley Court and these were correctly completed with an appropriate review date and evidence of discussion of options and involvement of relevant persons. We also reviewed documentation packs that patients took with them when receiving treatment off site and saw that Do Not Attempt Cardio Pulmonary Resuscitation forms were prominent in these folders for patients who had these plans in place. We did not see any other evidence of advance decisions being made. Staff told us advance decisions are prompted by the patients and support from solicitors is provided wherever required.

The service had access to an advocacy service. All patients at Cubley Court were referred to the advocacy service on admission. However, none of the patients we spoke with were aware of the advocacy service or the role of an advocate. There were leaflets and posters about advocacy services on the ward for patients and in the reception area for relatives or friends of the patients at both Ward 1 and Cubley Court.

Involvement of families and carers

There were appropriate visiting areas for carers and relatives to visit patients on the wards. At Cubley Court, staff told us the service planned to put a sofa bed in the family room for carers or

relatives to stay at the hospital if the patient was very unwell or receiving end of life care. Staff and patients and their relatives/carers could access support from the trust's palliative care team.

Staff involved patients and those close to them in decisions about their care and treatment. All the patients and their relatives or carers we spoke with confirmed this. We saw that family members could make appointments to attend ward rounds with consultants if they wished to be informed about their relative's condition and care.

Carers were actively involved in activities on the ward. For example, at Cubley Court, the team were planning a 'day at the seaside' day to be held in the communal area between the wards. Staff had informed carers about this and invited them to the event. The communal area at Cubley Court had a range of information on display including other local services that may be able to support carers/families, events that were coming up on the ward and information about treatments and therapies available to patients.

Staff enabled families and carers to give feedback on the service they received. Cubley Court held carers sessions on the first Sunday of every month. We saw the minutes of a recent carers meeting. These meetings were chaired by the link nurse from both Cubley male and female wards. Meetings involved discussions around topics raised by the carers, such as the admission process and what this entails. A suggestion box was pointed out to attendees of the meeting to encourage carers to feedback and make suggestions about areas to discuss in future meetings. The minutes detailed that information leaflets were handed out to carers about local carers groups and advice from national organisations such as the Alzheimer's Society. Relatives and carers were encouraged to give feedback through other means including; friends and family test, online feedback surveys, discharge meetings and through the in-reach team who met with carers and relatives at home.

Staff worked closely with each patient's community team and social worker to identify the needs of the carers. At Cubley Court, carers champions had been developed on both wards and these carers were supported by nursing assistants in their roles.

Is the service responsive?

Access and discharge

Bed management

- The trust provided information regarding average monthly bed occupancies for three wards in this service between 1 March 2017 and 28 February 2018.
- Three of the wards within this service reported average bed occupancies ranging above the trust benchmark of 85% over this period.
- The trust reported that the average bed occupancy for this service was 85% over the year.
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Ward name	Average monthly bed occupancy range (1 March 2017 – 28 February 2018) (current inspection)
Cubley Court (female)	36% to 97%

Cubley Court (male)	43% to 91%
LRCH Ward 1	85% to 108%

At the time of our inspection, there were 17 patients on Ward 1, eight patients on Cubley female and 14 patients on Cubley male. Ward 2 remained closed. Staff told us the community older people's rapid response team and the in-reach team worked hard to prevent hospital admissions.

- At the time of our inspection, there were no patients placed out of area because of bed shortages. This service reported one out area placement between 1 March 2017 and 28 February 2018 which lasted 60 days.

Beds were available when needed for patients living in the 'catchment area'.

The average length of stay for patients on older people's inpatient mental health wards for the period 1 March 2017 to 28 February 2018 was 66 days; Cubley female 95 days; 75 days on Cubley male and 67 days on Ward 1. The average length of stay had increased on Cubley female and Ward 1 and had decreased on Cubley male.

There was always a bed available when patients returned from leave.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. When patients were moved or discharged, this happened at an appropriate time of day.

Patients had access to an enhanced care bed if required. Staff contacted the bleep holder to discuss this with the relevant personnel before moving a patient to the local enhanced care ward at Radbourne Unit, which was sufficiently close for the person to maintain contact with family and friends.

- This service reported five readmissions within 28 days between 1 March 2017 and 28 February 2018. Four of the readmissions (80%) were readmissions to the same ward as discharge.
- The average of days between discharge and readmission was three days. There were no instances whereby patients were readmitted on the same day as being discharged but there was one instance where a patient was readmitted the day after being discharged.
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Ward name	Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
Cubley Court (female)	2	1	50%	2 - 3	2.5
Cubley Court (male)	1	1	100%	1	1
LRCH Ward 1	2	2	100%	2 – 7	4.5

-

Discharge and transfers of care

During the period 1 June 2017 to 31 May 2018, there were 210 discharges from the service. The highest number of discharges were from Ward 1 (91).

Staff planned for patient discharges, including good liaison with care managers/co-ordinators.

On Ward 1, daily Purposeful Inpatient Assessment meetings were held to discuss the arrangements for each patient's discharge. Members of the multi-disciplinary team attended these meetings, including the in-reach team, and therefore discussions were holistic and reviewed each patient's needs in detail. The trust informed us this was due to become a seven-day service from June 2018.

At Cubley Court, the team had recently moved to the 'red to green' method of monitoring and reviewing patient discharges. This allowed staff to colour code patients' discharge plans and identify discharge care packages at the most appropriate time.

All patients had a general care plan, which sometimes mentioned their plans around discharge. However, there was a section on the electronic recording system entitled 'discharge care plan' and we found three of the 16 patient care records we reviewed did not have a specific discharge care plan. This meant it was difficult for staff to navigate their way around the electronic system to find patients' most up to date discharge plans. One of the patients who was missing this specific discharge care plan was close to discharge and although we saw evidence of positive discharge planning through CPA meetings, discharge planning meetings and multi-disciplinary ward round meeting, this was not recorded in the patient's discharge care plan. This had improved since our last inspection, but further work was required to rectify the issue.

A patient flow co-ordinator worked in the in-reach team to actively follow up actions from the Purposeful Inpatient Assessment meetings. The service was looking to introduce a discharge coordinator role for registered nurses. The aim of this role was to facilitate smooth discharge for patients and reduce any delays in discharge.

Staff supported patients during referrals and transfers between services. For example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit.

between 1 March 2017 and 28 February 2018, there were 25 delayed discharges from older people's inpatient wards. The wards with the highest number of delayed discharges was ward 1 at London Road Community Hospital (23).

Facilities that promote comfort, dignity and privacy

At Cubley Court, patients had their own bedrooms, rather than bed bays or dormitories. On Ward 1, two of the female bedrooms were shared, meaning that two female patients would share a bedroom, with a privacy curtain between the two sleeping areas. On Ward 1, the privacy film that covered the windows on the patient bedroom doors did not cover the entire window. This meant that other patients and staff could see into their bedroom at any time.

There were provisional plans in place for Ward 1 to be moved to another ward on the Kingsway site. This process was in the option appraisal phase during our visit but staff, patients and their carers/relatives had been informed of this.

Patients could personalise bedrooms. However, staff and patients told us that generally, due to patients' short stay in hospital, they did not personalise their bedrooms very much. For example, at Cubley Court we saw patients had some small personalised items such as photos and duvet covers from home. At Cubley Court, staff had developed a poster/thumbnail sketch that was kept in patient bedrooms that contained information about the patient's life for staff to get to know them and talk to them about their life. Staff worked with the patient and their relatives to add information

that was meaningful for them. This meant that staff could engage with the patient and talk with them about their life and the things they liked to do. Staff told us this helped when new or bank staff came on the ward as it was a quick way to familiarise themselves with the patient.

Patients had somewhere secure to store their possessions. On Ward 1, we saw that cabinets were locked with patients' possessions. At Cubley Court, staff encouraged patients and their families to take the patient's possessions home, but the ward could store small amounts of valuables securely.

There were rooms available on all wards for therapeutic activity and patients had access to well-maintained outdoor spaces including gardens. The trust provided adapted kitchens on the wards. The occupational therapists assessed patients in these kitchens to plan their discharge home from hospital. There was a physiotherapy treatment room at Cubley Court which contained a range of equipment suitable to the needs of the patients and the therapeutic activities. There was a relaxation room on both wards and an arts/activities room at Cubley Court. Staff told us there were plans to enhance the relaxation room at Ward 1, which appeared tired and bare.

There were quiet areas on the ward and a room where patients could meet visitors. On Ward 1, there was one communal quiet lounge. Patients could meet visitors in the quiet rooms and the lounge and dining areas. Visitors were not allowed in patients' bedrooms.

At Cubley Court, there were quiet lounges and rest areas on the circular corridors of the ward. Visiting times were set as 2pm – 4pm and 6pm – 8pm but if patients/relatives let staff know in advance they required a visit outside of these hours, staff could accommodate this. We observed visits taking place outside of these hours during our inspection.

Patients could make a phone call in private on all wards by using a cordless phone. During our inspection, patients on Ward 1 were unaware of this and told us they were unable to make a phone call in private. In response to this the trust has said they will add posters to the ward display to make patients aware of the availability of this phone.

Patients had access to outside space. On Ward 1, patients had access to a central courtyard which was kept unlocked. There were benches to rest on and leafy sheltered areas from the sun. The pathway was non-slip and free from trip hazards. The pipe work and guttering was fully encased to be anti-ligature. At Cubley Court, there was a central garden area that patients could access.

Patients told us that the food was good and they always had a choice. Patients were offered a choice of sandwiches as an alternative to a hot meal. Patients could not make hot drinks or snacks for themselves at all times due to the kitchen being locked at night to reduce risk. However, patients told us and we saw that patients were offered a choice of hot drinks and snacks during the day. A cold drinks machine was available for patients to use on Ward 1 and at Cubley Court, jugs of juice were available in the lounges. Staff were observed to top these up during the day and to encourage patients to have a drink. Patients could request a hot drink or snack at any point during the day.

The 2017 Patient-Led Assessments of the Care Environment score for ward food at the locations scored higher than similar trusts.

Site name	Ward food
Trust HQ[2]	99.4%
London Road Community Hospital	91.9%
Trust overall	**94.7%**
England average (mental health and learning disabilities)	**91.5%**

Patients' engagement with the wider community

Staff supported patients to maintain contact with their families and carers. Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

Patients with mobility difficulties could access all wards. The multidisciplinary team completed comprehensive assessments of each patient to ensure the appropriate supportive equipment was made available to them. All the wards we visited were on the ground level and each ward had assisted bathing areas and support for patients with mobility difficulties. However, on Ward 1, there was only one assisted bathroom which is in the female sleeping area. Staff told us the male patients must use the shower and are not given the choice as to whether they want to use the bath.

The trust provided aids and adaptations for patients who needed assistance with eating and drinking. We saw patients using these where appropriate.

The service displayed information on treatments, local services and we saw lesbian, gay, bisexual, transgender+ posters on display around the service.

Overall, the service provided information in an accessible form for the patient group. For example, pictorial signage was clear and at the appropriate height. However, some of the noticeboards on Ward 1 contained small text that was difficult to read. At Cubley Court, assisted toilets were clearly marked using the recommended bright yellow colour. However, this did not work well in one of the areas as the walls were also yellow, so it was difficult to identify where the toilet was. Toilet seats and assistance rails were a strong contrasting colour to help patients to identify them.

Information leaflets on site were available in a range of different languages upon request. Managers ensured staff and patients had easy access to interpreters and/or signers. We were told that it could be arranged for interpreters to attend ward rounds or best interest meetings for patients whose first language was not English. Patients had a choice of foods to meet the dietary requirements of religious and ethnic groups. Staff ensured that patients had access to appropriate spiritual support. Patients told us this was available on all the wards and we saw leaflets with information about how to access spiritual support.

[2] This site provides services other than inpatient services for older people. The PLACE scores noted were received from all inpatients admitted to this site.

Listening to and learning from concerns and complaints

From 1 March 2017 to 28 February 2018, there had been two complaints made about Cubley female ward, one complaint made about Cubley male ward and two complaints made about Ward 1.

None of the patients we spoke with knew how to make a complaint. However, all said they would feel comfortable raising a concern with staff. Staff supported patients to make complaints where appropriate. Staff told us that when patients or their relatives/carers complained or raised concerns, staff tried to manage these immediately. If this was not possible, the concern was escalated through the complaints and concerns policy. If relatives/carers raised a complaint, they received feedback via the family liaison workers.

All staff we spoke with knew how to handle complaints appropriately and saw them as a way of making improvements. For example, we heard that there had been concerns raised about the visiting times and the service had responded by being more flexible with visiting times wherever possible. Relatives had raised concerns about not knowing who their relative's named nurse was. Processes had been put in place for the named nurse to contact relatives/carers to introduce themselves.

Staff received feedback from managers on the outcome of complaints investigations and acted on these findings. The trust had a blue light learning system where learning from incidents and complaints was shared. Staff we spoke with referenced this as a place to find any learning from complaints and incidents.

The trust also recorded compliments. From 1 March 2017 to 28 February 2018, this service received 28 compliments.

Is the service well led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles. All the ward managers and several lead nurses we spoke with had a good understanding of the service they supported and could explain clearly how the team were working to provide high quality care. Stable leadership had been put in place on each of the wards we visited. This was an improvement from our last inspection. Managers had a good knowledge of the patients in their care as well as the needs of the staff group they supported.

The service lead and ward managers were visible in the service and approachable for patients and staff. Ward managers reported they were well supported by the service lead and other members of the senior leadership team. Staff told us the trust chief executive had set up open sessions where staff were invited to meet with them and raise any concerns or issues. Managers reported the services received occasional visits from the senior leadership team.

Vision and strategy

Staff we spoke with knew and understood the trust's vision and values and how they were applied in their work. Most of the staff we spoke with talked about putting patients first, respecting people and being open and honest.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing.

For example; the trust had updated its vison and values and its vision following feedback from staff. The feedback provided explained that staff wanted a simpler, clearer vision of what the trust aimed to achieve in the future.

Culture

Staff felt respected, supported and valued. Managers reported having enough authority to complete their roles effectively and knew how to access further support if they needed it. One of the managers we spoke with was new to the role and described being supported in their new position.

Staff felt positive and proud about working within this service and being part of the trust. Most staff spoken with said morale and job satisfaction was good on the wards. This had improved significantly at Cubley Court since our last inspection. Some staff on Ward 1 were still adjusting to the closure of Ward 2 and the merge of the two wards staff groups, but reported things were improving.

There were no bullying or harassment cases in any of the teams we visited.

Not all staff were clear about the role of the Freedom to Speak Up Guardian, but most people knew who this person was and how to contact them. Staff we spoke with reported they would raise concerns without fear of victimisation and knew how to use the whistleblowing process.

Managers dealt with poor staff performance promptly when required. We heard examples from managers of how they supported staff where there were concerns about a staff member's competency and the process for following this through if concerns were not rectified.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

We reviewed the staff appraisal process and saw this included conversation about career development and how this could be supported. The process had been simplified from previous years and encouraged staff to reflect on their yearly performance and development and identify personal and professional needs and goals for the future.

Staff reported that the trust promoted equality and diversity in its day to day work and in providing opportunities for career progression.

The service's staff sickness and absence (6%) were slightly higher than the average for the trust (5%). Managers explained this was due to several staff members requiring long term sickness support.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Managers were also able to refer staff for this service where appropriate.

The trust recognised staff success within the service – for example, through staff awards. Sixteen staff had been nominated for the staff 'DEED' awards during the period 25 May 2017 to 19 May 2018. These nominations highlighted how the staff members had delivered high quality care in line with the trust's values. As part of the NHS's 70th birthday celebrations, patients, staff and public were asked to nominate Health and Care's Top 70 Stars– people who have made an exceptional contribution to patient care, services and local communities. The Top 70 Stars campaign was run by the NHS Confederation, with NHS England and NHS Improvement. A staff member from Cubley Court male was given this award.

From 1 March 2017 to 28 February 2018 there were four cases where staff had been either suspended, placed under supervision or were redeployed. One member of staff was suspended, two were placed under supervision and one was redeployed to days.

Governance

There were vacancies on all of the wards we visited, but the service and its staff mitigated these vacancies as best as possible by using regular, familiar bank staff and developing innovative roles for other members of the multidisciplinary team to support these gaps.

We observed three multidisciplinary team meetings, including a ward round meeting, a best interest meeting and a Care Programme Approach meeting, as well as two handovers between shifts. We saw that agendas were clear, comprehensive and tailored to the needs of the patient group. Operational meetings were held fortnightly where all ward managers and lead nurses came together to discuss learning across wards as well as issues related to the day to day running of the wards, such as staffing, safeguarding and environmental concerns.

Meetings took place as frequently as planned and were well attended by the relevant staff groups.

We saw that staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

The trust provided mandatory/compulsory training to staff but did not ensure compliance with role specific training. Staff were regularly supervised and appraised and received formal and informal support from managers and their peers. This had improved significantly since our previous inspection.

The trust had a named senior level accountable person for physical health care, the interim Assistant Director of Public and Physical Healthcare. The trust had a Physical Healthcare Strategy document in place outlining the strategic priorities in relation to CQUIN and Physical Health care over the next three years. There was also a trust wide physical health care team in place to provide further training and support to staff at ward level.

Staff participated in a range of clinical audits to assure good practice was taking place and we saw clear evidence of learning from these audits.

Staff within the service worked closely with both the in-reach team and the dementia rapid response team. The introduction of these teams had had a large impact on the level of acuity and behaviours that challenge presented by the patients admitted to the three wards. For example both these teams were supporting more patients to remain in the community and therefore the

level of risk and complex needs presented by those patients who were admitted to the wards was becoming increasingly higher.

The trust provided their board assurance framework, which details any risk scoring 15 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The four strategic ambitions outlined by the trust relating to this service are as follows:

1 - We will deliver **quality** in everything we do providing safe, effective and service user centred care
2 - We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time
3 - We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.
4 - We will **transform** services to achieve long-term financial sustainability.

The trust provided a document detailing their 10 highest profile risks. Each of these has a current risk score of 15 or higher. However, none related to this service.

Management of risk, issues and performance

Staff were aware of the trust risk register and how to submit concerns that would be fed into a directorate wide register. The electronic incident reporting system sent incident reports to managers and the trust risk team. The trust risk team identified themes from these, which they fed back to the managers. Managers discussed these with staff in team meetings and supervision to reduce the risk of them happening again. We saw that staff concerns matched those on the risk register.

The service had plans for emergencies, such as adverse weather or flu outbreak. Staff within the service were trained in ‘silver command’ level training to respond to a major incident. For example, staff gave an example of when the electronic recording system went down and mitigations meant that staff knew how to respond.

Most staff we spoke with told us they felt their feedback was listened to. However, one staff member raised concerns that the trust board had taken too long to listen to feedback from staff about the complex nature and acuity of patients at Cubley Court.

Information management

Staff reported and we observed issues with the information technology equipment used to do their work. Computers used on the wards and in the nursing offices to input patient information, including observations, was slow and burdensome for staff to use and resulted in staff spending less time engaging with patients.

Information governance systems included confidentiality of patient records.

Managers had access to electronic dashboards to review their key performance indicators and ensure good care and treatment was offered to patients. Managers could review their incident reporting system for all incidents reported on their ward and view and follow up any outstanding actions. Service managers could access all wards’ dashboards to view this information across the service. Staff made notifications to external bodies as needed.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the trust and the services they used, through the intranet, bulletins and staff and carers' meetings.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

There were provisional plans in place for Ward 1 to be moved to one of the Kingsway sites to reduce the isolation of the ward. However, it was unclear how staff, patients and their relatives/carers had been engaged in this decision-making process. Staff reported they were kept updated on progress with regards to this possible move, but had not been consulted on around this.

Staff and patients reported that senior members of the leadership team were approachable and they could give feedback on the services. Members of the public could meet with the trust's senior leadership team at monthly board of directors' meetings. The trust's website published details of where and when these meetings happened.

Directorate leaders engaged with external stakeholders including commissioners and regulatory bodies where required.

Learning, continuous improvement and innovation

We saw a 'you said, we did' board displayed at Cubley Court that showed how the service had responded to feedback from patients and their carers/relatives.

Nursing and occupational therapy staff had been involved in a project where they had identified other hospitals providing care for older people with mental health problems and behaviours that challenge to try and share best practice and learn ideas from these services.

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. For example, on Cubley female, staff had developed end of life packs and equipment in response to a clear need for improvement in this area. Staff were supported to develop and promote this.

The service had introduced intentional 'rounding' to all three wards. This meant that the nurse in charge reviewed the ward approximately every two hours and recorded the outcome of this. This had been piloted at London Road Hospital and rolled out to Cubley Court. Feedback from staff and the service managers about this process was that it had improved the patient experience and had allowed patients to access early help.

At Cubley Court, we saw a banner in communal lounge to encourage patients and carers to participate in dementia research. The trust website detailed the activities of the research and development centre.

NHS Trusts can participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain

standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

This service has not been awarded an accreditation.

The trust participated in the Commissioning for Quality and Innovation framework which supports improvements in the quality of services and the creation of new, improved patterns of care. The trust had formulated working groups for frameworks 3a, 3b and 9 with action plans in place.

Forensic inpatient/secure wards

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Trust HQ	Kedleston Low Secure Unit – Curzon Ward	8	Male
Trust HQ	Kedleston Low Secure Unit – Scarsdale Ward	12	Male

Is the service safe?

Safe and clean care environments

Safety of the ward layout

The service had suitable premises and equipment and looked after them well. Since our last inspection in June 2016, the trust had refurbished the unit. On Scarsdale Ward, this meant that staff could observe safely all parts of the ward. The trust had created a new staff base and reconfigured bedrooms so that staff could see the bedroom corridors from the staff base. Staff on Curzon Ward observed patients when they were in their bedrooms at intervals dependent on their level of risk. The refurbishment had enabled patients on Scarsdale Ward safe access to the kitchen to make drinks and snacks. The reception area had also been extended and secured.

Staff completed regular risk assessments of the care environment on all the wards. These were called 'environmental risk assessments'. We saw these detailed the most current risks on each wards and staff had taken appropriate actions to reduce these risks wherever possible. 100% of staff had completed fire warden training which meant that there was a fire warden on each shift. The trust had a fire safety policy available to all staff on the intranet and the health and safety officer completed a regular fire risk assessment. Staff completed weekly fire alarm tests and monthly fire drills on each of the wards. We saw exits were clearly marked across both wards and all patients had personal evacuation plans. Personal evacuation plans detailed what support each patient may need to mobilise and evacuate in the event of an emergency. There was evidence that these had been updated if a patient needs changed.

Staff carried personal alarms to summon help from other staff if needed. On arrival reception staff gave each member of the inspection team a personal alarm so they could summon help from staff if needed during the day.

Ligature risks

Staff completed ligature risk assessments. A ligature is a fixture or fitting that a patient could use for tying or binding as a means of hanging her/himself. The trust had acknowledged in the risk assessment that the patients in the unit presented a high risk due to their individual risk assessment. Staff regularly reviewed the patient and ligature risk assessments. They detailed the list of potential ligatures within each separate room on the wards and any changes to the level of risk presented. As part of the refurbishment works, the trust had installed anti ligature fittings in the shower rooms and bathrooms. They had removed ventilation grills in bedrooms, which removed the ligature risks. They fitted new blinds on both wards which were anti ligature. The trust had purchased privacy screens for bedroom to ensuite areas on Scarsdale Ward, which folded if a person tried to use them as a ligature. These were available in beach or mountain scenes to provide choice and comfort. The trust had fitted collapsible shower rails in all en suites. Staff increased the level of observations for each patient when needed to reduce the risks. Ligature cutters were available in each clinic room. Staff knew where these were kept and how to use them.

Maintenance, cleanliness and infection control

All ward areas were clean. The trust had purchased new furniture for all communal areas and bedroom areas. This included new furniture on Curzon Ward following our last inspection. Furniture provided was easy to wipe clean. Patients told us that the ward was always clean and cleaning staff worked hard to do this. Patients were also involved in the cleaning of their bedrooms on Scarsdale Ward, as part of their rehabilitation. At our last inspection the flooring in the shower room on Curzon Ward was stained with adhesive. This was outstanding at this inspection and made the floor look dirty although the cleaner had just mopped it.

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. Staff adhered to infection control principles, including handwashing. Personal protective equipment was available on both wards and within the clinic rooms. We saw that clinical waste was handled and disposed of appropriately.

PLACE assessments

For the most recent Patient-led Assessments of the Care Environment assessment (2017), Kingsway Hospital where the service was based, scored 99.16% in cleanliness and 97.1% on condition, appearance and maintenance.

Seclusion room

At our last inspection, the seclusion room did not meet the Mental Health Act Code of Practice. The trust had rebuilt the seclusion suite as part of the refurbishment works to meet the Code of Practice. There were two seclusion rooms, both of which had an en-suite shower, wash hand basin and toilet. The fittings were of anti-ligature type to reduce this risk. Each room had access to outdoor space. A clock was visible from inside each room to orient the patient to time. Staff had identified a blind spot in the en-suite areas. They were able to reduce this risk by changing the controls on the windows from film to clear so that all parts of the room could be viewed from outside. There were two - way communication facilities so that staff could speak to the patient when in each room and vice versa.

Clinic room and equipment

The trust had refurbished the clinic room on each ward since our previous inspection. Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs. Staff checked these regularly to ensure they were safe to use and replaced when needed. Clinic rooms were generally clean, however we noticed there was high level dust in the clinic room on Curzon Ward.

Safe staffing

Nursing staff

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and abuse and to provide the right care and treatment. The trust had estimated the number and grade of nurses needed to ensure that patients were safe and there were enough staff to keep patients safe from avoidable harm. We looked at a month of rotas

before our inspection and these showed safe staffing levels were maintained. The current staffing levels were six staff on each shift. There were two shifts: early and late during the day and one at night. There were three staff on each ward with one or two registered nurses and unregistered nurses. There were also two staff each day working a flexi shift, one 8.30am to 4.30pm and another 12pm to 8pm. The ward manager and clinical lead were both registered nurses and covered where needed during the day, which helped to cover when staff supported patients to take their section 17 leave. There was also a registered nurse who covered the site as the bleep holder who could assist in an emergency. An extra staff member was on duty on ward round days so other staff could spend time with patients. There were enough staff to safely carry out physical interventions.

The trust used bank staff to cover where needed but not agency staff. Between 1 March 2017 and 28 February 2018, bank staff filled 1% of shifts to cover sickness, absence or vacancy for registered nurses. In the same period, no agency staff covered shifts for qualified nurses. Less than 1% of shifts were unable to be filled by either bank or agency staff. Staff told us that bank staff used were familiar with the ward and knew the needs of the patients.

The ward manager was able to adjust staffing numbers daily to take account of case mix and patient need. On the day before and during our inspection, extra staff were used to meet the needs of a patient who was admitted. All staff said that staffing numbers could be increased when needed and were confident that as patient occupancy levels increased, staffing would be increased to match.

Five patients said that sometimes their leave was postponed because of too few staff, however one patient said their leave was never postponed.

Staffing overview at a glance

Definition

Substantive – All filled allocated and funded posts.

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

Substantive staff figures			**Trust target**
Total number of substantive staff	At 28 February 2018	42.8	N/A
Total number of substantive staff leavers	1 March 2017 – 28 February 2018	4	N/A
Average WTE* leavers over 12 months (%)	1 March 2017 – 28 February 2018	10%	10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 28 February 2018	10.4	N/A
Total vacancies overall (%)	At 28 February 2018	19%	10%
Total permanent staff sickness overall (%)	At 28 February 2018	11%	5%

	1 March 2017 – 28 February 2018	7%	5%
Establishment and vacancy (qualified nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 28 February 2018	25.5	N/A
Establishment levels nursing assistants (WTE*)	At 28 February 2018	20.4	N/A
Number of vacancies, qualified nurses (WTE*)	At 28 February 2018	10.2	N/A
Number of vacancies nursing assistants (WTE*)	At 28 February 2018	0.2	N/A
Qualified nurse vacancy rate	At 28 February 2018	40%	10%
Nursing assistant vacancy rate	At 28 February 2018	1%	10%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 March 2017 – 28 February 2018	89 (1%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 March 2017 – 28 February 2018	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 March 2017 – 28 February 2018	3 (<1%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	336 (7%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	80 (2%)	N/A

*Whole-time Equivalent

This service reported an overall vacancy rate of 40% for registered nurses at 28 February 2018. The ward manager said that the establishment level at the time of our inspection, was 17 and 13 full time and one part time were in post. Another part time registered nurse was starting in June 2018. Two full time registered nurses had been recruited, one was due to start in September 2018 and another was due to finish their nurse training and would start in April 2019. This would leave one vacancy.

This service reported an overall vacancy rate of 1% for nursing assistants at 28 February 2018. The ward manager said that another nursing assistant had been recruited and was due to start in June 2018.

This service has reported a vacancy rate for all staff of 19% as of 28 February 2018. There was one band 5 and one part time band 3 assistant occupational therapist and one full time band 4 technical instructor. The trust had recruited a band 6 occupational therapist but they withdrew so the post was re- advertised.

Registered nurses	Health care assistants	Overall staff figu

Ward/ Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishme
Kedleston Low Secure Unit	10.2	25.5	40%	0.2	20.4	1%	10.6	51
Dist Forensic Medical	0	0	0%	0	0	0%	-0.2	2.4
Service total	**10.2**	**25.5**	**40%**	**0.2**	**20.4**	**1%**	**10.4**	**53.4**
Trust total	**116.2**	**970.5**	**12%**	**34.3**	**375.2**	**9%**	**310.3**	**2490.1**

NB: All figures displayed are whole-time equivalents

Establishment, Vacancy, Levels of Bank & Agency Usage

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Kedleston Low Secure Unit	6678	89 (1%)	0 (0%)	3 (<1%)
Service total	**6678**	**89 (1%)**	**0 (0%)**	**3 (<1%)**
Trust Total	**248873**	**1416 (<1%)**	**5000 (2%)**	**293 (<1%)**

*****Percentage of total shifts

Between 1 March 2017 and 28 February 2018, 7% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, no agency staff covered nursing assistant shifts and 2% of nursing assistant shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Kedleston Low Secure Unit	4896	336 (7%)	0 (0%)	80 (2%)
Service total	**4896**	**336 (7%)**	**0 (0%)**	**80 (2%)**
Trust Total	**83457**	**15372 (18%)**	**0 (0%)**	**2497 (3%)**

***** Percentage of total shifts

Sickness, turnover and vacancies

This service had four (10%) staff leavers between 1 March 2017 and 28 February 2018.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Dist Forensic Medical	1.6	0	0%
Kedleston Low Secure Unit	41.2	4	10%
Service total	**42.8**	**4**	**10%**
Trust Total	**2167.7**	**219.3**	**10%**

The average sickness rate for this service was 7% between 1 March 2017 and 28 February 2018. The most recent month's data (February 2018) showed a sickness rate of 11%. Sickness rates increased over the second half of the year. The highest sickness rate was in September 2017 and October 2017 with 13% and 12% respectively. The ward manager told us that the figures had increased due to staff being on long term sick leave for surgery and they had now returned.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Dist Forensic Medical	0%	3%
Kedleston Low Secure Unit	11%	7%
Service total	**11%**	**7%**
Trust Total	**7%**	**5%**

Staff fill rates

The below table covers staff fill rates for registered nurses and care staff during December 2017, January 2018 and February 2018.

Kedleston Unit had below 90% care staff for all shifts in December 2017, January 2018 and February 2018. The unit also had below 90% registered nurses for night shifts in December 2017, January 2018 and February 2018. The patient occupancy levels were low during this period due to the refurbishment works.

Key:

> 125%	< 90%

Day		Night		Day		Night		Day		Night	
Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff

	December 2017				January 2018				February 2018			
Kedlest on Low Secure Unit	92%	68%	87%	79%	91%	60%	89%	81%	93%	66%	91%	87%

Medical staff

There was adequate medical cover day and night and a doctor could attend the ward in an emergency. Staff told us that at night one junior doctor and one consultant were on call and would be available within 20 minutes.

Between 1 March 2017 and 28 February 2018, there were 623 medical locum shifts in total of which none were filled by bank or agency staff to cover sickness, absence or vacancy.

Training data summary

Mandatory training

The trust training department had merged with Derbyshire Community NHS Trust and this had affected the figures for this trust. The trust gave us figures that showed that staff had received the necessary training since they submitted the data request at the end of February 2018. The compliance for mandatory and statutory training courses at 28 February 2018 (for the current financial year) was 85%. Of the training courses listed 20 failed to achieve the trust target and of those, 12 failed to score above 75%. The training compliance reported for this service was lower than the 83% reported in the previous year (1 April 2016 - 31 March 2017). At the time of our inspection, we saw that staff had completed or were booked to attend the necessary training courses. The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Key:

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

Training Course	**Trust Target %**	**Training compliance % for this core service**	**Trust Wide Training Compliance %**
Data Security Awareness (Previously IG) (Annual)	95%	95%	91%
Equality, Diversity and Human Rights - Level 1 (3 yearly)	85%	82%	78%
Fraud Awareness (3 yearly)	85%	100%	95%
Health, Safety & Welfare (3 Yearly)	85%	70%	81%
Moving & Handling Level 1 (3 yearly)	85%	95%	83%

Promoting Safer & Therapeutic Services Clinical Staff (3 yearly)	85%	95%	85%
Promoting Safer & Therapeutic Services Non-Clinical Staff (3 yearly)	85%	67%	86%
Safeguarding - Adults Level 1 (Non Clinical) (3 Yearly)	85%	100%	87%
Safeguarding - Children Level 1 (once only)	85%	98%	98%
Aseptic Non-Touch Technique (ANTT) - 2 yearly	85%	100%	79%
Autism (ASD) Awareness Level 1 (Once)	85%	70%	57%
Care Certificate (Once Only)	85%	86%	84%
Deprivation of Liberty Standards (Once)	85%	89%	83%
Dual Diagnosis Level 1 (Once)	85%	98%	70%
Dual Diagnosis Level 2 (Once)	85%	63%	57%
Fire Safety - Fire Warden (3 Yearly)	85%	100%	64%
First Aid at Work Certificate (3 Yearly)	85%	67%	84%
Food Hygiene Awareness Update (Annual)	85%	81%	64%
Food Hygiene Certificate (3 Yearly)	85%	100%	35%
General Risk Assessor Training (3 Yearly)	85%	100%	21%
Medic - Section 12 Approval (EXTERNAL 5 Yearly)	85%	0%	63%
Meds Management - Admin & Documentation (3 yearly)	85%	69%	36%
Meds Management - Controlled Drugs (3 yearly)	85%	44%	34%
Meds Management - Use of Medication in the Management of Violence & Aggression v5 (3 yearly)	85%	83%	62%
Mental Capacity Act (Once)	85%	90%	84%
Mental Health Act 2007 (Once)	85%	89%	79%
Moving & Handling Level 2 - People (2 yearly)	85%	83%	68%
Physical Health in Mental Health (3Yearly)	85%	56%	24%
Positive & Safe - Teamwork - inc PSTS (Annual)	85%	80%	67%
R Resuscitation - Basic Life Support & AED (annual)	85%	95%	64%
Resuscitation - Immediate Life Support - ILS - (annual)	85%	84%	73%
Safeguarding - Adults Level 3 (2 Yearly)	85%	50%	55%
Safeguarding - Children Level 2 (3 yearly)	85%	86%	90%
Safeguarding - Children Level 2 (once only)	85%	95%	93%

Safeguarding - Children Level 3 (3 yearly)	85%	80%	80%
Safeguarding - PREVENTing Radicalisation - Level 1 (3 yearly)	85%	67%	86%
Safeguarding - PREVENTing Radicalisation/WRAP Level 3 (3 yearly)	85%	95%	90%
Smoking Cessation Level 1 (Once Only)	85%	72%	33%
Staff Recruitment Training - All Recruiters (3 Yearly)	85%	75%	59%
Total		**85%**	**75%**

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff reviewed each patient's risks in their multi-disciplinary team meeting. All staff were aware of each patient's risks. Staff completed a safety risk assessment when a patient was admitted. Within 12 weeks of the patient's admission staff completed the 20 item historical clinical risk version 3 (HCR20). Staff updated the risk assessments as patients risks changed and reviewed them at the patient's fortnightly ward round.

Management of patient risk

Staff had not always recorded the rationale for blanket restrictions. A blanket restriction is a restriction imposed on all patients by staff that is not based on the patients' individual need or risk. The ward manager told us that visiting other units as part of the Forensic Quality Network had challenged their views on blanket restrictions. For example, at previous inspections patients had no leave from the ward after dark, which was very restrictive in winter months. Patients now had this if their individual risk assessment supported that it was safe to do so. All patients had their own mobile phones but could only use them on leave. The ward manager was reviewing how this could be tailored to individual need and risk. However, we saw that not all restrictions were blanket. For example, patients said that no caffeine was allowed on the ward but tea bags contained caffeine, patients had caffeinated soft drinks and one patient had their own coffee machine. Also, staff had to supervise all visits but the newly appointed clinical lead was reviewing if this was needed for all patients and all visitors. We observed that restrictions were discussed in each patient's multi-disciplinary team meeting.

Staff followed the trust's policy for the use of observation. This was dependent on individual risk and need.

Staff were aware of the trust's security policy which included relational security. All staff wore a bag and belt. This meant that their keys, issued to them on entering reception, were attached to the staff member. The unit staff induction included all aspects of security and had been developed since our previous inspection to improve staff awareness of the importance of security. Staff searched all patients on return from unescorted leave. There were always two staff present to do this and staff said that as much as possible this was two male staff.

Use of restrictive interventions

The trust trained staff in positive and proactive management. This included techniques to deescalate the patient so reducing the need for restraint. The training was mandatory for all permanent staff, which included occupational therapists. Following the training all staff had a yearly update. This service had two incidents of restraint between 1 March 2017 and 28 February 2018. All staff said that restraint was rarely used. Records we looked at showed that staff used techniques of reducing the need for restraint by their relationship with each patient in a positive way which deescalated the patients' agitation and aggression. The trust had a 'Positive and Safe group' which discussed reducing restrictive practice. The ward manager said they aimed to involve an Expert by Experience in this so to get the patients view of what was needed to further reduce the need for restraint.

Restraint

The below table focuses on the last 12 months' worth of data: 1 March 2017 and 28 February 2018. There were no instances of mechanical restraint over the reporting period. The two restraint incidents reported over the year, was lower than the nine reported in the previous year.

Ward name	Seclusions	Restraints	Of restraints, incidents of prone restraint	Rapid tranquilisations
Kedleston Low Secure Unit – Curzon Ward	**1**	1	1 (100%)	0 (0%)
Kedleston Low Secure Unit – Scarsdale Ward	**0**	1	1 (100%)	0 (0%)
Service total	**1**	**2**	**2 (100%)**	0 (0%)

Seclusion

- Over the 12 months reporting period from 1 March 2017 to 28 February 2018, there was one incident of seclusion in February 2018. The number of seclusion incidents reported during this inspection was lower than the 11 reported during the previous 12 months. Records for this seclusion showed there was an appropriate rationale for seclusion. Staff had reviewed the patient at the required intervals. Following the period of seclusion, managers ensured that the patient and all staff involved had a debrief.

Segregation

There have been no instances of long term segregation over the 12 month reporting period.
The number of segregation incidents reported during this inspection was the same as the number reported during the previous 12 months.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. All staff were aware of safeguarding procedures. Patients told us they felt safe at the unit. Where staff had identified that patients were at risk of radicalisation, the patient was under the

PREVENT programme. This meant that they were seen by an independent person to ensure that the risks were reduced and any information needed was given to staff on how to safely support the patient.

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

The trust had stated that there was the potential for safeguarding referrals to have been made without an incident report having been completed. Both Safeguarding Adult Boards maintain data of referrals received into the local authorities but, currently, "health" referrals are not currently represented by organisation. A request has been made of the performance department in Derby City Council to provide a breakdown of referrals made by each separate provider service.

The ward manager told us that they had made two safeguarding referrals in the last six months. One related to a patient who was at risk of financial exploitation and the other related to an allegation made by a patient. Staff acted quickly on these allegations and put actions in place to safeguard the patient from abuse and harm.

Staff access to essential information

The trust stored all records electronically. Staff uploaded Mental Health Act paperwork electronically so all information was stored in the same place.

Information needed to deliver patient care was available to all relevant staff (including bank staff) when they needed it and was in an accessible form. This included when patients moved between teams. For example, information about the patient was passed on to the patient's community team or next placement at the pre- discharge meeting.

Medicines management

The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time. Staff checked the temperatures of the room and fridges where medicines were stored. These were within the recommended ranges to store medicines safely. All medicines stored were in date. There were no patients prescribed controlled drugs on Scarsdale Ward at the time of inspection. There was a controlled drugs book available so this would be used if patients were to be prescribed these. On Curzon Ward, the controlled drugs stored cross referenced with the entries in the controlled drug book. Staff locked all medicines required in the controlled drugs cabinet, which they securely bolted.

Staff followed the trust's medicines self-administration policy for patients who were assessed as able to take part in administering their own medicines. On Scarsdale Ward, storage was available in a locked cabinet in each patient's bedroom. Staff gave patients information about the medicines prescribed to them. Staff recorded any allergies each patient had in their individual prescription chart.

Track record on safety

The trust reported and dealt with incidents in an appropriate way.

Serious incidents requiring investigation

Trusts must report all serious incidents to the Strategic Information Executive System within two working days of an incident being identified.

Between 1 March 2017 and 28 February 2018 this service reported two Strategic Information Executive System incidents. The number of serious incidents reported during this inspection was lower than the eight reported at the last inspection.

We looked at both Strategic Information Executive System incidents, which both related to unauthorised absence. Staff took appropriate action in both incidents and the patient returned to the ward.

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

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with Strategic Information Executive System.

	Number of incidents reported	
Type of incident reported on Strategic Information Executive System	Kedleston Low Secure Unit - Scarsdale Ward	Service Total
Apparent/actual/suspected self-inflicted harm	1	1
Unauthorised absence	1	1
Total		

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. 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.

All staff had access to the electronic incident reporting system. All staff said that managers gave them a debrief after incidents. Staff discussed incidents in team meetings and all minutes were available for all staff on the trust's shared drive. This included feedback from incidents and learning lessons. Staff received feedback from investigation of incidents, both internal and external to the service. The trust sent out briefings on incidents via email to managers and 'blue light' reports to all staff by email if something unexpected happened. This was also discussed and reviewed in team meetings.

Staff understood the duty of candour. There were no incidents where duty of candour was used. However, staff discussed incidents with patients and looked at ways to reduce the likelihood of them happening again.

No nurses had been injured in the past three months.

Is the service effective?

Assessment of need and planning care

Care plans were up to date, personalised and holistic. All patients told us they had a copy of their care plan and knew what was in it. We looked at eight patient care records. These showed that a doctor had examined the physical health of each patient on admission. Records showed that staff monitored the patients' physical health needs during their admission. Patients said staff took their physical observations weekly. They said if they were unwell, they saw a doctor straight away.

Occupational therapists developed a care plan with the patient soon after their admission. Each patient also had a 'Wellness self-management programme plan.' The patient set their own goals for each area and their progress for each of these was evaluated fortnightly during their meeting with their multi-disciplinary team.

Best practice in treatment and care

Patient care records we looked at showed that staff followed National Institute for Health and Care Excellence guidance in the management of violence and aggression and on schizophrenia.

Psychology staff offered a wide range of individual and group psychology sessions to individual patients based on their assessed needs and which followed National Institute for Health and Care Excellence guidance. Records showed that patients were involved in their assessment. Therapies included recovery from substance misuse, Sex Offenders Treatment Programmes, compassion focussed therapy, dialectal behaviour therapy, trauma therapy, Schema therapy and anger management, depression and anxiety groups. Psychologists also offered family therapy sessions where appropriate.

Staff at the unit facilitated a men's health group for patients. This included all areas of men's health including self-testing for testicular cancer and sexual health. They showcased this as best practice at the national low secure group.

Records we looked at showed that staff had consistently used the LESTER physical health tool to monitor the patients physical health needs. This is a tool that helps to give people with mental illness better care for their physical health.

National and local audits

Clinical staff actively participated in clinical audits. This service participated in 11 clinical audits as part of their clinical audit programme 2017 – 2018. These included medicine prescribing and monitoring, National Institute of Health and Care Excellence guidance in treating psychosis and schizophrenia, nutritional screening, seclusion reviews, records and treatment under the Mental

Health Act 1983. Audits we looked at showed that staff had improved their practice as a result of the findings. The trust also undertook regular quality visits of the service to identify areas for improvement, good practice and monitor performance with current standards. Band 6 registered nurses did monthly care plan audits to review their effectiveness in meeting the needs of the patient.

Skilled staff to deliver care

The service made sure staff were competent for their roles. Staff received mandatory training. Staff told us they had also had training in Cognitive Behavioural Therapy and caring for patients with psychosis in forensic services.

The trust made sure that all staff received an induction when they first started working there. This included bank staff who always had an induction to the unit on their first shift there. The induction programme included equality, diversity and inclusion, information governance training, safeguarding children and adults, computer fraud training, fire and health and safety training. During the trust formal induction there were 'market place display stands' that inductees could visit. These included mandatory stands that the staff member had to visit. The lead staff member on the stand ticked the relevant part of the induction booklet when assured the staff member had received the information they needed for their role.

Psychologists provided training for all staff in the use of the 20 item historical clinical risk version 3 (HCR20 v3) tool which was good practice and increased the effectiveness of this tool. Psychologists also facilitated monthly reflective practice sessions for all staff.

Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. All staff said these were monthly supervision sessions.

Appraisals for permanent non-medical staff

The trust made sure that they appraised the performance of all staff. The trust's target rate for appraisal compliance is 90%. As at 28 February 2018, the overall appraisal rate for non-medical staff within this service was 79%. The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 83% reported in the previous year. The ward manager reported that issues with the recording of appraisals in January and February 2018 had now been resolved and the rates had increased to meet the target. There were also five new staff members who started working there in this period who did not require an annual appraisal.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Kedleston Low Secure Unit	43	34	79%
Service total	**43**	**34**	**79%**
Trust wide	**1858**	**2406**	**77%**

Appraisals for permanent medical staff

The trust's target rate for appraisal compliance is 90%. As at 28 February 2018, the overall appraisal rates for medical staff within this service was 100%.

The rate of appraisal compliance for medical staff reported during this inspection was higher than the 50% reported in the previous year.

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
Dist Forensic Medical	2	2	100%
Service total	**2**	**2**	**100%**
Trust wide	**114**	**77**	**68%**

Clinical supervision

The trust's measure of clinical supervision data is sessions delivered, hours of supervision delivered.

Between 1 March 2017 and 28 February 2018 the average rate for the non-medical staff in this service was 69%.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Kingsway Campus	459	315	69%
Service total	**459**	**315**	**69%**
Trust Total	**19680**	**12660**	**64%**

Multi-disciplinary and interagency team work

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. All patients had a fortnightly meeting with their multi-disciplinary team where their care plan was reviewed. We observed good working in the team and meetings were well structured. Nurses said their voice was heard in the meetings as they were the ones who worked closely with patients on a daily basis.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

Staff from the unit had links with the trust substance misuse team. The trust had identified that a substance misuse worker was needed on the Kingsway site, where the unit is sited. The ward manager had assisted in creating the job description for this role.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983. They knew how to support patients experiencing mental ill health. Records we looked at showed that staff kept clear records of leave granted to patients. Patients, staff and carers (where applicable) were aware of the parameters of leave granted, including risks and contingency/crisis measures. Patients told us they were always given a copy of their leave form.

Mental Health Act training figures

As of 28 February 2018, 89% of staff in this service had received training in the Mental Health Act. The trust stated that this training was mandatory for all inpatient and community staff and renewed every year. The training compliance reported during this inspection was higher than the 74% reported in the previous year.

The trust had a central Mental Health Act team who provided administrative support and legal advice on implementation of the Mental Health Act and its code of practice. All staff we spoke with were aware of how to contact this team. In the records we looked at, staff had filled in correctly the detention paperwork and made sure that it was up to date and stored appropriately. Records showed that staff adhered to consent to treatment and capacity requirements. Staff attached copies of consent to treatment forms to medication charts where applicable. Records showed that staff told patients about their rights under the Mental Health Act on admission. Since our previous inspection, the trust had created a tick box on the rights form where staff could record if the patient had understood or not. This prompted staff to record when they needed to explain again to the patient their rights. The administrator from the trust Mental Health Act office also prompted staff when patients' rights were due. All staff were aware of the role of the Independent Mental Health Advocate and made sure they referred patients on admission. Staff also displayed information about the Independent Mental Health Advocate on the patient notice board and in the visitors' room.

There were monthly audits to ensure that the Mental Health Act was being applied correctly and the registered nurses on the unit completed these.

Good practice in applying the Mental Capacity Act

Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care.

Since our last inspection staff recording of decisions about assessment of capacity had improved. We saw a section in the electronic patient record system where staff had recorded if the patient

had the mental capacity to make a decision and if they were unable to give consent to a decision. All records we looked at showed that staff had assessed the patient's capacity and there was evidence of informed consent. For example, when a patient was admitted, staff completed the record as to whether the patient had the capacity to consent to admission. One record showed that staff had assessed the patient as not having the capacity to consent to admission. The multi-disciplinary team responsible for the patient's care had discussed and recorded that the admission was in the patient's best interests.

Mental Capacity Act training figures

As of 28 February 2018, 90% of the workforce in this service had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all inpatient staff and was renewed every year. The training compliance reported during this inspection was lower than the 100% reported in the previous year. Staff told us that training in the Mental Capacity Act was face to face as well as e-learning and from podcasts. They had attended some bite size training that involved using scenarios to help their understanding of the Mental Capacity Act.

Deprivation of Liberty Safeguards

- The trust reported that no Deprivation of Liberty Safeguard applications were made to the Local Authority for this service between 1 March 2017 and 28 February 2018. All patients at the unit were detained there until the Mental Health Act 1983.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients said that they felt that staff genuinely cared about their wellbeing. Throughout our inspection, we observed that staff respected each patient and supported them with kindness, dignity and compassion.

PLACE - data in relation to privacy, dignity and wellbeing

The 2017 Patient-Led Assessments of the Care Environment score for privacy, dignity and wellbeing at this service location scored higher than similar organisations.

Site name[3]	Privacy, dignity and wellbeing
Trust HQ	92.3%
Trust overall	**93.6%**
England average (mental health and learning disabilities)	**90.6%**

The involvement of people in the care they receive

Involvement of patients

Staff involved patients and those close to them in decisions about their care and treatment. Staff told us that planning for a patient's admission started at the time when they assessed the patient before they were admitted. The admission process included how staff were to orient patients to the ward. Staff said they adapted this to individuals depending on how much the patient was able to engage. Patients told us that staff gave them a welcome pack when they were admitted that told them all about the ward, staff and their care plan.

Patients told us they knew what was in their care plan and this was reviewed at the meeting with their multi-disciplinary team fortnightly. We observed that each patient was supported in the meeting in a way that met their needs and wishes. For example, one patient read a prepared summary at the beginning and another patient asked a staff member to read out their summary and ask them questions. We observed that staff spent time to make sure that the patient understood what was being said in meetings about their care and treatment. Records showed that care plans were patient centred, included information about the patient's life story and set goals for the patient to achieve. A person who had previously used the services in the trust had designed a 'doodle pad.' This was a pad of blank paper that all patients received on admission. This was to relieve patients anxieties in meetings and each patient could use as they wish to doodle or write things down that they wanted to discuss with staff to help them focus. They did not have to show this to anyone else.

Staff gave each patient an information leaflet about the risk assessment. This told the patient in an easier to read way what the aims of this were, what was meant by risk and why they needed to talk about it.

All patients said they were aware of advocacy and had been referred to this service. Staff had provided information about advocacy on the patient information board on each ward and in the visitors' room. Staff told us that an advocate had challenged why patients needed to attend a morning ward meeting at weekends. Staff had discussed with the advocate the need for routine as part of rehabilitation on Scarsdale Ward. However, they had changed the time from 9.30 to 10.30am at weekends which patients had agreed to. Each morning there was a meeting on the ward where patients planned what they were going to do that day and which staff were to support them. Monthly community meetings were held on each ward. On the patient information board, we saw minutes of these and also information about, "You said; we did". This showed that staff had listened to what patients said and made changes as a result. Patients told us they had recently given feedback on the service through filling in surveys. They thought their views would be listened to.

Patients on Scarsdale Ward had keys to their bedrooms and we saw patients using these to lock their bedroom and access their bedrooms when they wanted to. Patients on Scarsdale Ward had access to the kitchen when they wanted to make snacks and drinks. Patients could also adjust the privacy screens in their bedroom doors to aid privacy. Patients on both wards were able to personalise their bedrooms.

Staff had worked with patients to help them to think about their health and wishes around their current and future care. Each patient had a document called 'My Shared Pathway'. This helped

the patient to focus on what things helped to keep them well and prevent a relapse in their mental health. Care plans included patients' preferences about what they wanted staff to do if they needed to be secluded and what helped them to calm down when they were agitated or distressed. For example, some patients had worked on their soothing playlist for staff to play when they became distressed.

Involvement of families and carers

Relatives said that staff were supportive and they were involved in their relatives care as much as they wanted them to be. They told us they were invited to meetings about their relative as they had agreed to this. There was a visitors' room which the trust had recently refurbished. This made it more comfortable for patients to meet with their visitors. Relatives requested that tea making facilities be provided in the visitors' room and these were provided. Staff supervised all visits; however, this was being reviewed to tailor to individual need. One relative told us that they were able to visit daily. Relatives told us they could visit at varied times.

The unit relaunched the carers' forum in February 2018 which meant that carers met together and with staff to discuss ideas for service improvement and to listen to their views. Some staff had attended the Royal College of Psychiatrists Quality Network Conference in March this year. This included the launch of a carer's toolkit that staff used to improve their work with carers.

Is the service responsive?

Access and discharge

Bed occupancy

- The unit had undergone refurbishment over the last two years and had remained open throughout. This had reduced the occupancy levels as patients had been moved to Curzon Ward during the refurbishment of Scarsdale Ward and then to Scarsdale Ward while work was ongoing on Curzon Ward. At the time of our inspection, the works programme had been completed and both wards reopened.
- The trust provided information regarding average monthly bed occupancies for both wards in this service between 1 March 2017 and 28 February 2018.
- Curzon Ward reported average bed occupancies ranging above the trust benchmark of 85% over this period. This was because all the patients were moved to Curzon Ward while Scarsdale Ward was refurbished. The trust reported that the average bed occupancy for this service was 48%.

Ward name	**Average monthly bed occupancy range (**1 March 2017 – 28 February 2018**)**
Kedleston Low Secure Unit - Curzon Ward	62.5% to 101.3%
Kedleston Low Secure Unit – Scarsdale Ward	57.5% to 75%

Average length of stay data

- The trust provided information for average length of stay for the period 1 March 2017 to 28 February 2018. The trust reported that the average length of stay for this service was 227 days. Curzon Ward is for admission and assessment so we would expect as reported that the average length of stay was shorter than on Scarsdale Ward, which is for rehabilitation.
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Ward name	**Average length of stay range (**1 March 2017 – 28 February 2018**)**
Kedleston Low Secure Unit - Curzon Ward	12 - 183
Kedleston Low Secure Unit – Scarsdale Ward	27 - 748

Out of area placements

- This service reported no out area placements between 1 March 2017 and 28 February 2018.

Readmissions

- This service reported no readmissions within 28 days between 1 March 2017 and 28 February 2018.

Discharge and transfers of care

Delayed discharges

- Between 1 March 2017 and 28 February 2018 there were seven patients who were discharged from this service. None of these discharges were delayed due to there not being another place where the patient could move to. Records showed that staff started planning for discharge within the first few weeks of admission and this was consistently planned for during the patients stay.

Referral to assessment and treatment times

Records showed that patients were moved from one ward to another during their stay. This was because of the refurbishment works. Staff made sure that the impact of this on patients care was minimised and did not affect their care and treatment.

Facilities that promote comfort, dignity and privacy

Since our previous inspection the trust had refurbished the unit to create a range of rooms and equipment. They had created a kitchen that patients could use to cook their own meals and patients told us they liked to cook there and had themed ‘Come dine with me’ nights. The kitchen had adjustable height worktops to meet the needs of people who use a wheelchair.

The trust had refurbished both clinic rooms which provided an examination couch for staff to monitor patients’ physical health. A new multi-function multi-disciplinary meeting room with screen had been provided. There was a well-equipped gym and the trust was training staff to be able to safely support patients using the gym. The trust had refurbished the visitors’ room and we saw relatives often used this. An additional quiet lounge had been created on each ward; these were comfortably furnished with soft chairs and bean bags. There was a laundry which patients used to do their own washing and we observed patients doing this. There was a pool table in the conservatory in Scarsdale Ward.

All bedrooms on Scarsdale Ward now had en suite shower room, toilet and wash hand basin. The trust had not replaced the flooring in the shower room in Curzon Ward. We saw this was stained with adhesive at our inspection in June 2016. Since our previous inspection, the trust had fitted new curtains throughout both wards.

Patients had access to a payphone on each ward and they said they could make their phone calls in private. Patients could use their own mobile phones when they were on leave but not on the ward. The ward manager told us they were looking at options of providing basic mobile phones without the Internet that patients could use on the ward. The report following the Royal College of Psychiatrists Quality Network visit in September 2017 had recommended this.

The trust had refurbished the seclusion suite so it met the Mental Health Act Code of Practice 2015. This included a facility where patients could listen to music and the colour of lighting in the room could be changed to help reduce the patients’ anxiety and agitation.

Patients had access to outdoor secure gardens which included seating areas, football goal and basketball hoop. Before the refurbishment works, there was a horticultural garden used by the occupational therapists to work with patients. Since the refurbishment works, this had not been landscaped but still looked like a building site and was not safe for patients to use. Staff told us that this reduced the opportunities patients had on the ward to take part in horticultural activities as they had to go to other areas on the hospital site. The ward manager told us that contractors were due to landscape this garden the week after our inspection.

Six patients said that the food was good and there was enough choice to meet individual needs and tastes. Five patients said the portion sizes were adequate but one patient said portions were sometimes small. The trust offered culturally appropriate foods which included Halal, vegan and vegetarian. Staff had sought vegan medication to meet one patient's dietary needs. Patients told us about themed cooking nights which had included foods from India and a variety of pizza.

PLACE assessments

The 2017 Patient-led Assessments of the Care Environment score for ward food at the location scored higher than similar trusts.

Site name[4]	Ward food
Trust HQ	99.4%
Trust overall	**94.7%**
England average (mental health and learning disabilities)	**91.5%**

Patients cooked their own food with support from staff in the evenings and at weekends and this was also a social event. Patients on Scarsdale Ward had open access to the kitchen to make their own snacks and drinks. On Curzon Ward, staff supported patients to access the kitchen when they wanted to depending on individual risk assessment.

Patients' engagement with the wider community

Staff encouraged patients to use their section 17 leave to access the wider community. Some patients attended college courses in the community, which included Maths and English. There was also their own Recovery College in the unit. Patients were involved in delivering the courses and received certificates for the courses they completed. These included 'Hip hop for health', angling and work on conservation projects. Patients also attended therapy groups in the community provided by local mental health charities. Staff had assisted patients to form links with the local professional football club and patients told us they enjoyed this.

Meeting the needs of all people who use the service

The service took account of patients' individual needs. Some patients were observing Ramadan. Staff had adjusted these patients' times for medication where possible and reduced activities they took part in during the day. One member of staff who was observing Ramadan was working night shifts to accommodate their needs and to support patients during the time they could break their fast. Staff also supported patients to go to the mosque.

The hospital chaplaincy service was available to patients depending on their individual religious needs. Information was available on notice boards in the wards about the service offered. Chaplains visited patients on the ward if they did not have section 17 leave. Chaplains led multi faith services at the Ashbourne Centre, which was on the hospital site. Staff told us they were developing a 'spiritual box' for the unit to include materials for patients to use to meet their spiritual needs on the ward.

The men's health group provided patients with information on sexual health and the needs of patients from the gay, bisexual and transgender communities. The trust held a Lesbian, Gay, Bisexual, Transgender conference for staff in the week before our inspection. Psychologists worked with patients on exploring their identity as an individual and how this impacted on their wellbeing.

The trust produced information leaflets in a range of languages. Staff said that further languages could be obtained on request. Staff knew how to access interpreters. They said they always requested interpreters and did not use families to translate so to get an impartial voice for the patient. Staff were planning for the cultural needs of a patient before their admission so the patient could access the foods they enjoy and have links with their community. Staff had recently introduced a feedback sheet from patients' multi-disciplinary meetings in an easy to read format.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. Staff displayed the trust's complaints information on ward notice boards and in the visitors' room. All patients, relatives and staff we spoke with were aware of the complaints process. Patients and their relatives were confident that staff would take action to improve the service as a result of complaints. Cards were available for patients to write their complaints on. We observed that the doctor emphasised the complaints process during patients' multi-disciplinary meetings.

Formal complaints

This service received one complaint between 1 March 2017 and 28 February 2018, which was due to care planning.

Ward name	Reason	Date received	Date closed
Kedleston Unit - Curzon Ward	Care Planning	19/04/2017	05/05/2017

Compliments

The ward manager said they had identified that they needed to improve recording of compliments as they had received several but did not always record these. This service received five compliments during the last 12 months from 1 March 2017 to 28 February 2018. This accounted for less than 1% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

The ward manager provided stability and consistency for the team. The trust had appointed the manager shortly before our previous inspection. Staff told us that the ward manager had brought positive changes to the unit. Staff spoke highly of the ward manager and felt well supported by them. The ward manager had a good knowledge of the patients in their care as well as the needs

of the staff group they supported. The trust had recently appointed a clinical lead who started working there the day before this inspection. The aim was to enable the ward manager to focus on the day to day operational management.

Staff said that trust senior managers were visible and had recently visited the unit. The ward manager felt well supported by senior managers. The Chair of the trust had also visited. Some staff attended the trust board meeting to present the proposed changes in January 2017 and to feedback on developments in January 2018. One of the non-executive directors had also recently visited the unit.

Vision and strategy

Staff we spoke with knew and understood the trust's vision and values and how they were applied in the work of their team. All staff we spoke with talked about putting the patient first, respecting people and being open and honest. Staff had the opportunity to contribute to discussions about the strategy for the service.

Culture

Staff felt respected, supported and valued. The ward manager said they had enough authority to complete their role effectively and knew how to access further support if they needed it. Staff felt positive and proud about working within this service and being part of the trust. Staff spoken with said morale and job satisfaction was good on the wards and this had improved significantly since our previous inspection.

There were no bullying or harassment cases in this service. All staff we spoke with were clear about the role of the Freedom to Speak Up Guardian, who they were and how to contact them. Information about their role was displayed on the staff information board. Staff we spoke with reported they would raise concerns without fear of victimisation and knew how to use the whistleblowing process.

Managers dealt with poor staff performance promptly when required. Staff thought that relationships within the multi-disciplinary team had improved. Psychologists thought that managers now supported the need for psychology and the psychologists within the team. Staff now had monthly business staff meetings and monthly forensic clinical supervision, which they said they found helpful. Staff said they more sensitive to each other as a team and respected each other.

We reviewed the staff appraisal process and saw this included conversation about career development and how this could be supported. The process had been simplified from previous years and encouraged staff to reflect on their yearly performance and development and identify personal and professional needs and goals for the future.

Staff reported that the trust promoted equality and diversity in its day to day work and in providing opportunities for career progression.

The sickness rate for this service was 7% between 1 March 2017 and 28 February 2018. The most recent month's data (February 2018) showed a sickness rate of 11%. This was higher than the average for the trust (5%). The ward manager told us that the figures had increased due to staff being on long term sick leave for surgery and they had now returned. Staff had access to support for their own physical and emotional health needs through an occupational health service. The ward manager was also able to refer staff for this service where appropriate.

Suspension and supervised practice

From 1 March 2017 to 28 February 2018 there were two cases where staff were redeployed.

Ward name	Suspended	Under supervision	Ward move	Redeployed	Total
Kedleston Low Secure Unit	0	0	0	1	1
Dist Forensic Medical	0	0	0	1	1
Service total	**0**	**0**	**0**	**2**	**2**

Governance

We found that the trust had made a number of improvements since our previous inspection. They had continued to identify risks to patient safety and had responded to these appropriately.

There were vacancies on the wards however these had reduced significantly since our previous inspection. Staff reduced the risks of these vacancies as best as possible by using regular, familiar bank staff.

We observed two multidisciplinary team (patients ward rounds) meetings and the handover between shifts. Agendas were clear, comprehensive and tailored to the needs of the patient group. Operational meetings were held fortnightly where all ward managers and lead nurses came together to discuss learning across wards as well as issues related to the day to day running of the wards, such as staffing, safeguarding and environmental concerns.

Meetings took place as frequently as planned and were well attended by the relevant staff groups.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

The trust provided mandatory (compulsory) training to staff. Managers regularly supervised and appraised staff who also received informal support from managers and their peers. This had improved significantly since our previous inspection.

Staff participated in a range of clinical audits to assure good practice was taking place and we saw clear evidence of learning from these audits.

Board assurance framework

The trust have provided their board assurance framework, which details any risk scoring four or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The four strategic ambitions outlined by the trust relating to this service are as follows:

1 - We will deliver quality in everything we do providing safe, effective and service user centred care.
2 - We will develop strong, effective, credible and sustainable partnerships with key stakeholders to deliver care in the right place at the right time.
3 - We will develop our people to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.
4 - We will transform services to achieve long-term financial sustainability.

Management of risk, issues and performance

Staff were aware of the trust risk register and how to submit concerns that would be fed into a directorate wide register. The electronic incident reporting system sent incident reports to managers and the trust risk team. The trust risk team identified themes from these, which they fed back to the managers. The ward manager discussed these with staff in team meetings and supervision to reduce the risk of them happening again.

The service had plans for emergencies, such as adverse weather or flu break.

Corporate risk register

The trust had provided a document detailing their 10 highest profile risks. Each of these has a current risk score of 15 or higher. However, none of these related to this service.

Information management

Staff used the electronic patient records system and we saw that this included the information staff needed to deliver patient care. Information governance systems included confidentiality of patient records. The ward manager had access to electronic dashboards to review their key performance indicators and ensure good care and treatment was offered to patients. The ward manager could also review their incident reporting system for all incidents reported on the unit and view and follow up any outstanding actions. Service managers could access all wards' dashboards to view this information across the service.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the trust and the services they used, through the intranet, bulletins and staff and carers' meetings. Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Staff had access to the feedback from patients, carers and staff and used it to make improvements.

Staff and patients reported that senior members of the leadership team were approachable and they could give feedback on the service.

Directorate leaders engaged with external stakeholders including commissioners and regulatory bodies where required.

Learning, continuous improvement and innovation

Staff had opportunities for leadership development, opportunities to feedback on services and input into service development. The ward manager said they had an opportunity to be involved in the refurbishment and felt the views of clinicians were valued and respected.

We saw a 'you said, we did' board displayed on each ward that showed how staff had responded to feedback from patients.

Accreditation of services

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

This service has not been awarded an accreditation. However, they were a member of the Royal College of Psychiatrists Forensic Quality Network for forensic mental health services. They purchased a peer review of the unit. The ward manager showed us a copy of the report of the Quality Network visit in September 2017. The ward manager had taken action to meet some of the recommendations from this visit. This included a space for staff to take time off the wards, developing a 'spiritual box' which carries religious material for patients and staff to use, looking at the use of basic mobile phones on the ward and developing the carers forum. Staff had accessed Quality Network conferences and had done peer reviews of other services, which had helped them to develop the service they provide.

Community-based mental health services for older people

Facts and data about this service

Location site name	Team name	Patient group (male, female, mixed)
Trust HQ	Dementia Rapid Response Team (DRRT) - North	Mixed
Trust HQ	Dementia Rapid Response Team (DRRT)- South	Mixed
Trust HQ	Dovedale Day Hospital	Mixed
Trust HQ	Erewash Neighbourhood	Mixed
Trust HQ	In-Reach Home Treatment Team - Older Adults	Mixed
Trust HQ	Midway Day Hospital	Mixed
Trust HQ	Resource Centre Outpatients	Mixed
Trust HQ	Trust-wide Discharge & Liaison Team	Mixed
Trust HQ	Trust-wide Memory Assessment Service	Mixed

Is the service safe?

Safe and clean environment

The trust did not own all the buildings where teams were based and some buildings were shared with other teams and organisations. Cleaning arrangements differed across the team bases visited and cleaning records were not available for us to view during the inspection. However, all areas were visibly clean.

Patients were not seen at dementia rapid response team bases and neighbourhood staff members reported that patients were rarely seen at team bases.

Managers reported the trust completed regular risk assessments of the care environment and these were available for staff to view on the trust's electronic incident reporting and risk management system. Managers reported that environmental risk assessments included fire and ligature risks.

Alarm systems were in place at all sites where patients attended. Some sites had alarm trigger points within interview rooms while at other sites staff carried personal alarms. Staff did not work alone at sites where patients attended; additional staff were always on site to respond in the event of an alarm.

All neighbourhood team bases had a clinic room shared by all services located there. Clinics had facilities to store medication securely and equipment necessary to carry out physical health examinations. Staff also had access to portable physical health equipment to use with patients in the community. Teams shared responsibility for clinic room checks including daily room and fridge temperatures. Records at the Bolsover and Claycross neighbourhood team base did not demonstrate that staff completed daily clinic room checks. For example the record for March 2018 had a total of 13 completed checks.

All neighbourhood team bases had access to emergency equipment that included oxygen, ligature cutter and automated external defibrillator. Teams shared responsibility for daily checks of emergency equipment. Records at two locations did not demonstrate staff completed daily emergency equipment checks.

The neighbourhood team bases visited had a good standard of furnishings and appeared well-maintained. Parking was limited at some locations and staff reported this sometimes caused delays on return to the base from community visits. Staff at the Amber Valley neighbourhood team accessed a small and poorly maintained office space. Staff reported it impacted negatively on morale.

Staff adhered to infection control principles, including handwashing. There were hand-sanitising stations at each location and posters advising staff and patients of correct hand washing techniques. Community staff carried hand-sanitising gels and we saw staff using these during community visits.

Fire extinguishers and portable electronic equipment had visible and up to date safety stickers attached. Teams did not routinely use 'clean' stickers to demonstrate regular cleaning of equipment.

Safe staffing

When they were establishing the neighbourhood model, the trust had used external consultants to review staffing levels across teams using a 'Safer Staffing' tool. The teams we visited had sufficient staff to respond to the needs of patients using the service and staff said they were rarely short staffed.

The North Dales and High Peak dementia rapid response team had commenced in November 2017 and planned to be fully operational by the end of 2018. The trust was recruiting towards a target of 20.7 whole time equivalent staff from a variety of disciplines and grades. The South Derbyshire dementia rapid response team was fully staffed to a compliment of 29 whole time equivalents from a variety of disciplines and grades.

In community mental health teams, the number, profession and grade of staff in post matched the trust's staffing plan. Managers reported they could make changes to vacancies and recruitment in response to the demands of patients from the local community. For example; the Bolsover and Clay Cross team had changed a nurse vacancy to an occupational therapist position.

The North Dales and High Peak dementia rapid response team reported difficulties recruiting nurses. The team manager reported two band 6 and one band 5 nurse vacancies outstanding in its current phase of recruitment.

Staff caseloads were between 20 and 32 patients. This varied according to role, grade and the number of hours worked. One manager reported guidance around maximum and minimum caseloads was not clearly documented for staff to follow. Managers assessed the size of caseloads at allocation and multidisciplinary meetings. Managers also reviewed and supported staff to manage individual caseloads during supervision. However, the structure of supervision practice at Amber Valley and Erewash meant that the manager did not have direct oversight of individual staff caseloads.

Dementia rapid response teams reviewed the caseload of the team at daily handovers. The manager of the North Dales and High Peak reported the maximum number of patients the team could support had not been agreed. When we visited, the team was supporting seven patients.

Teams had cover arrangements for sickness, leave and vacant posts that ensured patient safety.

Team managers reported there was no use of bank or agency staff. There was one locum psychiatrist working in the south of the county. They were block booked for three month periods and had been in post for two and a half years because of difficulties in recruiting a consultant.

Staff reported they could quickly access a psychiatrist when required. Staff reported this was usually by telephone or email. The consultant psychiatrist attached to a team attended weekly for the multidisciplinary team meeting. Psychiatrists contributed to an on-call rota covering out of hours and dementia rapid response teams.

Definition

Substantive – All filled allocated and funded posts.

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

Substantive staff figures	Trust target

Total number of substantive staff	At 28 February 2018	178.7	N/A
Total number of substantive staff leavers	1 March 2017 – 28 February 2018	11.3	N/A
Average WTE* leavers over 12 months (%)	1 March 2017 – 28 February 2018	6%	10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 28 February 2018	19.4	N/A
Total vacancies overall (%)	At 28 February 2018	10%	10%
Total permanent staff sickness overall (%)	Most recent month (At 28 February 2018)	5%	5%
	1 March 2017 – 28 February 2018	5%	5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 28 February 2018	109.7	N/A
Establishment levels nursing assistants (WTE*)	At 28 February 2018	38.0	N/A
Number of vacancies, qualified nurses (WTE*)	At 28 February 2018	10.6	N/A
Number of vacancies nursing assistants (WTE*)	At 28 February 2018	1.3	N/A
Qualified nurse vacancy rate	At 28 February 2018	10%	10%
Nursing assistant vacancy rate	At 28 February 2018	3%	10%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 March 2017 – 28 February 2018	60 (<1%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 March 2017 – 28 February 2018	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 March 2017 – 28 February 2018	43 (<1%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	24 (<1%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	0 (0%)	N/A

*Whole time Equivalent

This service reported an overall vacancy rate of 10% for registered nurses at 28 February 2018.

This service reported an overall vacancy rate of 3% for nursing assistants at 28 February 2018.

This service has reported a vacancy rate for all staff of 10% as of 28 February 2018.

	Registered nurses	Health care assistants	Overall staff figures

Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
County Elderly Serv Medical	0	0	0%	0	0	0%	1.3	1.9	68%
County S OP Day Services	3.4	5.6	61%	0.8	2.5	31%	5.1	11.4	44%
Memory Assess Service	0.6	7.2	8%	0	0	0%	3.7	15.6	24%
Dovedale OP Day Hospital	0.6	4.4	14%	0.3	2.8	9%	1.5	10.4	14%
South Derbyshire+Derbyshire Dales Nhood Older Adult (OA)	2.1	9.1	23%	0	2	0%	2.1	16.5	13%
Dementia Rapid Response	0.4	12.2	3%	0.9	11.7	8%	3.2	29.6	11%
Chesterfield Central Nhood OA	0.8	7.2	11%	0	2	0%	1.0	11.6	9%
Erewash Nhood OA	0	10.2	0%	0.8	1.8	44%	1.1	14.8	8%
Derby City Nhood OA	1.4	13.9	10%	0	4.2	0%	1.2	23.8	5%
Amber Valley Nhood OA	0	11.9	0%	0	2	0%	0.6	17.4	3%
Bolsover+Clay Cross Nhood OA	0.2	8.2	2%	0	1.6	0%	0.2	11.9	2%
Trust-wide Discharge & Liaison Team OP	-0.1	2.7	-3%	0	0	0%	0.1	3.6	1%
High Peaks+ North Dales DRRT	0	2.5	0%	0	2.8	0%	0	5.3	0%
Killamarsh+ North Chesterfield Nhood OA	0	7	0%	0	2	0%	0	10.5	0%
High Peaks + North Dales Nhood OA	1.2	7.6	16%	-1.4	2.7	-52%	-1.2	12.4	-10%
City Elderly Serv Medical	0	0	0%	0	0	0%	-0.4	1.7	-21%
Service total	**10.6**	**109.7**	**10%**	**1.3**	**38**	**3%**	**19.4**	**198.3**	**10%**
Trust total	**116.2**	**970.5**	**12%**	**34.3**	**375.2**	**9%**	**310.3**	**2490.1**	**12%**

NB: All figures displayed are whole-time equivalents

Between 1 March 2017 and 28 February 2018, bank staff filled less than 1% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 2% of shifts for qualified nurses. Less than 1% of shifts were unable to be filled by either bank or agency staff.

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
High Peaks + North Dales Nhood OA	1155	39 (3%)	0 (0%)	0 (0%)

South Derbyshire+Derbyshire Dales Nhood OA	1353	21 (2%)	0 (0%)	43 (3%)
Amber Valley Nhood OA	1842	0 (0%)	0 (0%)	0 (0%)
Bolsover+Clay Cross Nhood OA	1246	0 (0%)	0 (0%)	0 (0%)
Chesterfield Central Nhood OA	1080	0 (0%)	0 (0%)	0 (0%)
County South OP Day Services	1464	0 (0%)	0 (0%)	0 (0%)
Dementia Rapid Response	3180	0 (0%)	0 (0%)	0 (0%)
Derby City Nhood OA	2069	0 (0%)	0 (0%)	0 (0%)
Dovedale OP Day Hospital	1239	0 (0%)	0 (0%)	0 (0%)
Erewash Nhood OA	1545	0 (0%)	0 (0%)	0 (0%)
HU OP Memory Clinic	44	0 (0%)	0 (0%)	0 (0%)
Killamarsh+ North Chesterfield Nhood OA	1064	0 (0%)	0 (0%)	0 (0%)
Memory Assess Service	1694	0 (0%)	0 (0%)	0 (0%)
Memory Assess Service Erewash	17	0 (0%)	0 (0%)	0 (0%)
Memory Assess Service North	54	0 (0%)	0 (0%)	0 (0%)
Memory Assess Service South	89	0 (0%)	0 (0%)	0 (0%)
Trust-wide Discharge & Liaison Team OP	708	0 (0%)	0 (0%)	0 (0%)
Service total	**19843**	**60 (<1%*)**	**0 (0%*)**	**43 (<1%*)**
Trust Total	**248873**	**1416 (<1%)**	**5000 (2%)**	**293 (<1%)**

*****Percentage of total shifts

Between 1 March 2017 and 28 February 2018, bank staff filled less than 1% of shifts to cover sickness, absence or vacancy for nursing assistants.

In the same period, agency staff were not used to cover shifts for sickness, absence or vacancy for nursing assistants. No shifts were unable to be filled by either bank or agency staff.

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
South Derbyshire+Derbyshire Dales Nhood OA	346	24 (7%)	0 (0%)	0 (0%)

Amber Valley Nhood OA	301	0 (0%)	0 (0%)	0 (0%)
Bolsover+Clay Cross Nhood OA	245	0 (0%)	0 (0%)	0 (0%)
Chesterfield Central Nhood OA	340	0 (0%)	0 (0%)	0 (0%)
County South OP Day Services	648	0 (0%)	0 (0%)	0 (0%)
Dementia Rapid Response	2784	0 (0%)	0 (0%)	0 (0%)
Derby City Nhood OA	637	0 (0%)	0 (0%)	0 (0%)
Dovedale OP Day Hospital	732	0 (0%)	0 (0%)	0 (0%)
Erewash Nhood OA	273	0 (0%)	0 (0%)	0 (0%)
High Peaks + North Dales Nhood OA	406	0 (0%)	0 (0%)	0 (0%)
Killamarsh+ North Chesterfield Nhood OA	301	0 (0%)	0 (0%)	0 (0%)
Service total	**7013**	**24 (<1%*)**	**0 (0%*)**	**0 (0%*)**
Trust Total	**83457**	**15372 (18%)**	**0 (0%)**	**2497 (3%)**

***** Percentage of total shifts

This service had 11.3 (6%) staff leavers between 1 March 2017 and 28 February 2018.

Team	Substantive staff (February 2018)	Substantive staff Leavers (1 March 2017 to 28 February 2018)	Average % staff leavers (1 March 2017 to 28 February 2018)
County South Older People Day Hospital	5.8	2.0	27%
Memory Assess Service	12.0	1.8	13%
Derby City Neighbourhood - Older Adult	23.6	2.6	11%
Erewash Neighbourhood - Older Adult	13.2	1.4	10%
Killamarsh+ North Chesterfield Nhood OA	9.5	0.8	10%
Amber Valley Neighbourhood - Older Adult	17.3	1.0	6%
Chesterfield Central Nhood OA	11.5	0.5	5%
Dementia Rapid Response	26.4	0.8	3%

High Peaks + North Dales Nhood OA	13.5	0.4	3%
Bolsover+Clay Cross Nhood OA	11.1	0	0%
Dovedale Older People Day Hospital	8.5	0	0%
MASH Health Advisors	1.8	0	0%
High Peaks+ North Dales DRRT	4.8	0	0%
South Derbyshire+Derbyshire Dales Nhood OA	14.4	0	0%
Trust Wide Discharge Liaison Team OP	3.6	0	0%
City Elderly Service Medical	1.6	0	0%
Service total	**178.7**	**11.3**	**6%**
Trust Total	**2167.7**	**219.3**	**10%**

The sickness rate for this service was 5% between 1 March 2017 and 28 February 2018. The most recent month's data (February 2018) showed a sickness rate of 5%.

Team	**Total % staff sickness (at latest month)**	**Ave % permanent staff sickness (over the past year)**
County South Older People Day Hospital	5%	9%
High Peaks + North Dales Nhood OA	10%	8%
Dovedale Older People Day Hospital	11%	8%
Bolsover+Clay Cross Nhood OA	1%	7%
Erewash Neighbourhood - Older Adult	5%	7%
South Derbyshire+Derbyshire Dales Nhood OA	5%	7%
Dementia Rapid Response	5%	6%
Derby City Dementia Liaison Service	-	6%
Memory Assessment Service North	-	5%
Chesterfield Central Nhood OA	3%	4%
Derby City Neighbourhood – OA	9%	3%

Hartington Unit Older People Memory Clinic	-	3%
Memory Assessment Service	2%	3%
Amber Valley Neighbourhood - OA	1%	3%
Killamarsh+ North Chesterfield Nhood OA	0%	2%
Trust Wide Discharge Liaison Team OP	4y	2%
City Elderly Service Medical	0%	1%
Memory Assessment Service Erewash	-	1%
Memory Assessment Service South	-	1%
Service total	**5%**	**5%**
Trust Total	**7%**	**5%**

Medical staff

Between 1 March 2017 and 28 February 2018, there were no medical locum shifts that were filled by bank staff to cover sickness, absence or vacancy.

In the same time period, agency staff covered 43% of shifts. There were no medical locum shifts that were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
City Elderly Serv Medical	1096	0 (0%)	644 (59%)	0 (0%)
County Elderly Serv Medical	156	0 (0%)	0 (0%)	0 (0%)
Dementia Rapid Response	18	0 (0%)	0 (0%)	0 (0%)
Memory Assessment Service	221	0 (0%)	0 (0%)	0 (0%)
Memory Assessment Service Erewash	3	0 (0%)	0 (0%)	0 (0%)
Memory Assessment Service South	16	0 (0%)	0 (0%)	0 (0%)
Service total	**1510**	**(0%*)**	**644 (43%*)**	**0 (0%*)**
Trust Total	**41564**	**0 (0%)**	**4944 (12%)**	**0 (0%)**

***** Percentage of total shifts

Mandatory training

The compliance for mandatory and statutory training courses at 28 February 2018 was 79% (for the current financial year) compared to 89% reported in the previous financial year.

Team managers reported their staff were up to date with mandatory training requirements and team compliance met trust targets. Managers received information on staff training as part of key performance indicators. All staff had a 'training passport', this identified training specific to their roles. Staff reported that there could sometimes be technical difficulties accessing e-learning, but the trust had identified this and was working to resolve it. The trust did provide classroom training for some courses in both the north and south of the county, but staff reported these were not frequently available in the north and quickly became fully subscribed to.

The trust reported it had an online dementia awareness training course as part of mandatory training requirements for all staff.

The North Dales and High Peak dementia rapid response team was a new restricted and partial service. The team's mandatory training was 17%. This was a team with emerging compliance. The manager explained this was because of on-going recruitment within the team and staff were booked to access training.

Key:

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

Training Course	**Trust Target %**	**Training compliance % for this service**	**Trust Wide Training Compliance %**
Data Security Awareness (Previously IG) (Annual)	95%	93%	91%
Equality, Diversity and Human Rights - Level 1 (3 yearly)	85%	87%	78%
Fraud Awareness (3 yearly)	85%	98%	95%
Health, Safety & Welfare (3 Yearly)	85%	78%	81%
Moving & Handling Level 1 (3 yearly)	85%	91%	83%
Promoting Safer & Therapeutic Services Clinical Staff (3 yearly)	85%	93%	85%
Promoting Safer & Therapeutic Services Non-Clinical Staff (3 yearly)	85%	86%	86%
Safeguarding - Adults Level 1 (Non Clinical) (3 Yearly)	85%	86%	87%
Safeguarding - Children Level 1 (once only)	85%	96%	98%
Autism (ASD) Awareness Level 1 (Once)	85%	74%	57%
Care Certificate (Once Only)	85%	83%	84%
Deprivation of Liberty Standards (Once)	85%	90%	83%
Dual Diagnosis Level 1 (Once)	85%	74%	70%
Dual Diagnosis Level 2 (Once)	85%	70%	57%
Fire Safety - Fire Warden (3 Yearly)	85%	64%	64%
First Aid at Work Certificate (3 Yearly)	85%	88%	84%
Food Hygiene Awareness Update (Annual)	85%	30%	64%
Food Hygiene Certificate (3 Yearly)	85%	11%	35%
General Risk Assessor Training (3 Yearly)	85%	25%	21%

Investigating Incidents, Complaints, Claims & Report Writing (Once only)	85%	86%	71%
Medic - Section 12 Approval (EXTERNAL 5 Yearly)	85%	50%	63%
Meds Mgmt - Use of Medication in the Management of Violence & Aggression v5 (3 yearly)	85%	50%	62%
Mental Capacity Act (Once)	85%	94%	84%
Mental Health Act 2007 (Once)	85%	84%	79%
Moving & Handling Level 2 - MEDICAL EXEMPTION (See individual risk assessment) 1 Year	85%	67%	75%
Moving & Handling Level 2 - People (2 yearly)	85%	69%	68%
Physical Health in Mental Health (3Yearly)	85%	49%	24%
Positive & Safe - Breakaway (Annual)	85%	0%	36%
Positive & Safe - PROACT SCIPr-UK - TACTICS (Older) inc PSTS (Annual)	85%	52%	81%
R Resuscitation - Basic Life Support & AED (annual)	85%	67%	64%
Resuscitation - Basic Life Support MEDICAL EXEMPTION (See individual risk assessment) (Annual)	85%	100%	100%
Resuscitation - Immediate Life Support - ILS - (annual)	85%	50%	73%
Safeguarding - Adults Level 3 (2 Yearly)	85%	58%	55%
Safeguarding - Children Level 2 (3 yearly)	85%	82%	90%
Safeguarding - Children Level 2 (once only)	85%	94%	93%
Safeguarding - Children Level 3 (3 yearly)	85%	91%	80%
Safeguarding - Children Level 3 (annual)	85%	0%	73%
Safeguarding - PREVENTing Radicalisation - Level 1 (3 yearly)	85%	82%	86%
Safeguarding - PREVENTing Radicalisation/WRAP Level 3 (3 yearly)	85%	93%	90%
Smoking Cessation Level 1 (Once Only)	85%	22%	33%
Staff Recruitment Training - All Recruiters (3 Yearly)	85%	74%	59%
Total		**79%**	**75%**

Assessing and managing risk to patients and staff

Assessment of patient risk

The trust had developed a safety plan that acted as the risk assessment tool for all patients. Safety plans were present in all the 41 patient records we looked at. We saw staff had completed 35 of these comprehensively and they provided detailed information to develop plans from. Staff reported they updated safety plans every six months, following incidents or after any identified changes to risk. Forty of the records looked at contained an up to date safety plan.

The safety plan was built into the electronic patient record and accessible to all clinical staff in the trust. The plan included assessments of violence, substance misuse, exploitation, and was used across all locations including inpatient settings. Staff reported it was structured to meet the needs of working age adults and not specific to older adult risk presentations. However, the trust's

comprehensive mental health assessment tool also prompted staff to consider issues commonly associated to older age including mobility, falls, and disability.

There was evidence in patient records that staff created crisis plans when patients needed them. This included identifying which professionals to contact and how to contact them in the event of crisis. Staff were aware of advance decisions, but they were not aware of any of their patients' having one in place. An advanced decision is a statement about what care and treatment you want to refuse if you are unable to make that decision in the future. An advance decision must be clear and follow procedures set out in the Mental Capacity Act. One manager explained that there was a plan to start trialling advance care planning for patients with an organic presentation and some functional presentations.

Management of patient risk

Staff could respond promptly to sudden deterioration in a patient's health. In the absence of a patient's care coordinator, each team had a duty worker who could respond to, or liaise with other professionals about concerns of deterioration in a patient's health. Staff reported concerns could be raised during visits, or calls from patients, carers, and other professionals.

The trust provided staff with policy guidance on the management of waiting times. Dementia rapid response teams did not operate waiting lists. Waiting lists varied across the teams visited and some reported they had no waiting lists. For those with waiting lists, no team reported waiting times greater than 13 weeks for routine referrals. Staff reported they informed patients and carers when they were on a waiting list and provided details of how to contact the team. Staff reported they relied on patients, carers and other professionals to make contact if there was deterioration in a patient's health or an increase in the level of risk. This was in line with the trust's policy guidance which stated that staff should make telephone contact with a waiting patient after 16 weeks. Staff discussed patients on the waiting list at allocation and multidisciplinary meetings, prioritising those patients were concerns had been received.

The trust provided staff with policy guidance on lone working. All teams visited were consistent in the personal safety protocols used when visiting patients in the community. This included the completion of a 'flight plan' detailing planned visits for the day, safe and well checks at the end of the day, and an established trigger word that staff telephoned with to indicate immediate risk and the need for assistance.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will

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

The trust provided staff with safeguarding training of both adults and children. Completion of level one and level two training was mandatory for all staff. Safeguarding policy guidance was available to staff on the trust intranet and staff knew how to raise a safeguarding alert. Staff also reported advice and support was available from local and trust safeguarding leads. The way teams recorded a raised safeguarding alert varied. Some teams reported that all safeguarding alerts raised with the local authority triggered an incident report, while others reported some would not also trigger an incident report. For example; a safeguarding alert raised for a patient residing in a care home. The trust untoward incident reporting and investigation policy and procedure stated that all abuse of service users must be reported as an incident.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff were aware of the types of harm experienced by their patient group, including neglect, financial abuse, and risks to children where grandparents were contributing to care giving. Staff worked in partnership with local safeguarding teams. They provided examples of attending safeguarding link meetings and safeguarding colleagues attending team meetings.

The trust was unable to provide safeguarding details at service or trust level. This did not mean that staff were not raising safeguarding concerns.

The trust has stated that there is the potential for safeguarding referrals to have been made without a datix incident report having been completed. Both Safeguarding Adult Boards maintain data of referrals received into the local authorities but, currently, "health" referrals are not currently represented by organisation. A request has made of the performance department in Derby City Council to provide a breakdown of referrals made by each separate provider service.

Staff described how they would protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. This included applying knowledge and skills learned from safeguarding training, guidance from trust polices, and discussion with local safeguarding services and leads.

Staff access to essential information

Staff used an electronic patient record. All paper documentation was uploaded to the electronic record and then shredded. Staff accessed the electronic patient record securely using individual passwords and smartcards.

All staff in the trust, including inpatient teams, could access the electronic patient record. This meant staff could share all information about patients and their care between teams. Laptop computers were available to community staff and provided access to the electronic patient record when they had an internet connection away from trust locations.

Medicines management

The trust provided policies on good practice medicines management. This included guidance for community based practitioners. Staff stored medication securely at team bases and lockable cases were available for transporting medication in the community. There was one incidence of

non-compliant practice with the medicines code in a community team and the local manager took appropriate action to redress this practice issue raised on inspection and escalated it within the trust as an incident.

Staff reported how they worked with patients to regularly review the effects of medication on patients' physical health. This included patients who were prescribed anti- dementia medication, injectable antipsychotic medication and lithium. Staff described several interventions at regular intervals that were in accordance with guidance from the National Institute for Health and Care Excellence. This included blood pressure checks, blood tests and electrocardiograms. Patients at Derby City had access to a physical health clinic where staff monitored physical health.

Track record on safety

Trusts must report all serious incidents to the Strategic Information Executive System within two working days of an incident being identified.

Between 1 March 2017 and 28 February 2018 there was one Strategic Information Executive System incidents reported by this service.

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

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with Strategic Information Executive System.

Team managers reported that unexpected deaths of patients using the service were the most common serious incidents within this core service. Staff reported these deaths as incidents; they were reviewed by the trust's safety team but often did not proceed to a full investigation if the cause of death was from an existing chronic illness or complications following surgery.

Type of incident reported	Team name	Number of incidents reported
Apparent/actual/suspected homicide	Resource Centre - Outpatient Dept.	1
Total	**1**	**1**

Reporting incidents and learning from when things go wrong

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

In the last two years, there has been one 'prevention of future death' report sent to Derbyshire Healthcare NHS Foundation Trust, however it does not relate to this service.

Staff knew what incidents to report and gave examples of the types of incidents to be reported. This included unexpected deaths, accidents and compliments received from patients or carers. Staff recorded incidents on an electronic reporting system. Managers could access the trust's serious incident team for advice and support around incidents and investigations.

Over a 13 month period between March 2017 and March 2018 neighbourhood teams for older adults reported 110 incidents. The categories of incident reported included accidents, falls, financial abuse, neglect in care, and incidents of abuse or aggression. One manager reported that following a piece of work to refresh staff practice around incidents, staff were now reporting more.

Staff were aware of duty of candour. The duty of candour is a regulatory duty related to openness and transparency. It requires providers to notify people who have used services (or other relevant persons) of certain safety incidents and then provide reasonable support. Team managers gave examples of speaking to patients and carers when things went wrong, and providing debrief following incidents.

Staff received feedback from investigations of local incidents. The trust circulated ‘blue light’ emails that included information and lessons learned from incidents across the trust.

Staff met to discuss feedback at team meetings, multidisciplinary meetings and supervision.

Staff reported changes they had made because of feedback from incidents. Examples were given of team learning around bi-polar illness and changes in the way crisis services worked with patients aged over 65 years and diagnosed with a functional illness.

Staff were offered debrief and support following serious incidents. The trust provided a post incident peer support service to assist staff to recover from serious incidents.

Is the service effective?

Assessment of needs and planning of care

During the inspection we looked at 41 patient records. Staff completed a comprehensive mental health assessment with patients entering the service. Staff worked to a format provided by the trust that included mental health presentation and history, children and caring responsibilities, accommodation, finances and physical factors. The dementia rapid response service used the Newcastle Model for behaviours that challenge to guide the assessment of patients referred to the service.

The trust had a physical health monitoring policy for patients in the community. The policy identified primary care as the lead organisation for providing treatment and monitoring physical health in the community. Trust staff were required to complete a physical health questionnaire with patients as part of the assessment process. The questionnaire relied on interview and reports from a patient's GP or care home. Staff reported they did not routinely take physical observations of all patients entering the services. However, they did take baseline physical observations and monitored these for patients prescribed medicine by the service. We found physical health assessments completed in 29 of the records reviewed. At Derby City none of the six records reviewed identified an assessment or ongoing monitoring of patients' physical health.

Care plans were present in 40 of the records we reviewed. Staff completed plans to a good standard. This included identifying a range of needs, being personal to, and focussing on the recovery of the patient. Staff made changes to plans when necessary and 39 records contained up to date care plans. However, care planning practices varied. Staff completed a list summarising planned actions or interventions for patients without complex needs and not part of the Care Programme Approach. For patients with more complex needs or included under the Care Programme Approach, staff developed more detailed care plans that demonstrated established care planning principles. Managers identified a forthcoming trust project to implement a consistent approach to care planning for older adults in the community.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for older people in the community. This included support for housing, benefits, and supporting patients to remain in their own homes. Staff interventions were guided by National Institute for Health and Care Excellence recommendations. For example; in the management of personality disorders, and anxiety presentations. Although multidisciplinary teams included psychologists and occupational therapists many teams had waiting lists for patients to access these services. When we inspected in 2016 we found 118 patients waiting for psychology services and the longest average waiting had been 45 weeks. The trust had been told it must ensure they are able to provide psychology services in a timely manner to those patients that need this intervention. During this inspection, we found across all teams there were a total of 72 patients waiting for psychology services and 138 patients waiting for occupational therapy services. The longest average wait for psychology was up to 21 weeks for patients accessing the High Peaks and North Dales team. The longest average wait for occupational therapy was up to 12 weeks for patients accessing the Chesterfield Central team.

Staff were aware of the need to ensure that patients' physical healthcare needs were being met. We found evidence staff monitored patient's physical health in 26 of the records reviewed. Staff were aware of the need for patients with a severe and enduring mental illness to have an annual health check. The trust's initial assessment document prompted staff to ask about annual health checks and staff worked with general practitioners to ensure these were completed.

The trust reported it was in the process of updating the physical health monitoring policy for patients in the community. The new policy was planned to account for changes to national guidance about older adults' physical care needs and delirium, and the inception of dementia rapid response teams.

Staff supported patients to live healthier lives. This included stop smoking interventions, information on healthy eating, alcohol screening, and referral to community wellness and healthy living groups.

Teams used Health of the Nation Outcomes Scales to monitor patient progress. Staff also provided examples of using a range of tools to rate severity of symptoms and monitor outcomes for a range of patient needs. This included geriatric depressions scales, Addenbrooke's Cognitive Examination-III, Abbey Pain Scale, Adult Carer Quality of Life Questionnaire, and antecedent, behaviour, consequence charts. Staff also noted using alcohol rating scales more frequently in response to an increase in the number of referrals where alcohol concerns were identified.

The trust provided staff with technology to support patient care. The electronic record system allowed information sharing and referrals between teams across the trust. Staff reported the trust provided information technology systems that allowed them to access patient physical health results. This included blood test, x-rays and computer tomography scan results.

This service participated in two clinical audits as part of their clinical audit programme 2017 – 2018.

Audit name	Audit scope	Date completed	Key actions following the audit
POMH-UK Topic 11c: Prescribing anti-psychotic medication for people with Dementia	* Cubley Court (Male/Female) * Derby City * Amber Valley * Chesterfield * Dales North * County South & South Dales * Linacre Ward * Melbourne Ward * Riverside * County North East * Erewash	25 May 2017	* To design an e-form based on the paper based antipsychotic prescribing form devised by Rachel Walsh (Senior Clinical Pharmacist) * To engage with the South Inpatient Nurses to see whether they can prepare the antipsychotic prescribing forms for completion prior to ward rounds * To discuss the audit results regarding inpatient prevalence for the North at the North Derbyshire Older Adults Peers Group * To discuss the audit results at the South Peer Group Meeting
Documentation of capacity and consent for CTO patients	* Community Team	18 November 2016	* Implement a system that can promptly notify community consultants of patients being discharged on a CTO, so a review appointment can be arranged as a matter of priority * Create a template, similar to that used on wards, to support comprehensive collection of data * To re audit in order to establish recommendations have been implemented and are established and embedded into practice

In addition to the trust's clinical audit programme, staff participated in local clinical audit activity. The trust required that staff participated in twice yearly audits of patient records. Some teams also provided examples or infection control audits and medicine chart audits.

Skilled staff to deliver care

Teams included or had access to a range of specialists required to meet the needs of older people in the community. In addition to doctors, nurses and support workers, we found occupational therapists and psychologists were part of neighbourhood teams. Psychologists within community teams were not line managed by neighbourhood team managers. Physiotherapy was provided by the trust and available for teams to make referrals to. The Derby City team had one whole time equivalent speech and language therapist, other teams made referrals to externals providers for this service. All teams accessed dietician input by referrals to external providers. Administration and domestic staff provided additional support to each of the teams.

The trust offered staff training specific to dementia. This was in accordance with the National Institute of Health and Care Excellence 'Dementia: support in health and social care' quality standard one and Health Education England standards. Tier one training was dementia awareness and mandatory for all staff. Tier two training was available to all staff involved in looking after patients with dementia. This covered many areas including delirium and dementia, communication in dementia and, end of life care. The trust also reported it had supported staff to obtain university accredited qualifications specific to dementia care.

The trust provided a programme of physical health training to staff in community teams covering a range of topics that included delirium, blood pressure monitoring, and blood sugar monitoring. This training was included on staffs' 'training passport'. The trust reported that a 'Delirium in Dementia' training package was soon to be launched throughout the county and would be accessible to staff in the trust.

Teams had staff that were experienced and qualified. Staff gave us examples of additional training they had completed including dementia specific training and non-medical prescribing.

Managers provided new staff with induction opportunities as part of a probation period to ensure staff had the right skills and knowledge to meet the needs of the patient group. All staff attended a trust induction and a local induction to the team they were working in. Mandatory training and shadowing other staff was provided during induction. Managers regularly reviewed staff progress during probation periods.

Managers ensured staff had access to regular team meetings. Some teams used the Care Quality Commission inspection domains of safe, effective, caring, responsive and well led to organise agenda items. Staff meetings were recorded and included discussions about safeguarding, lone working, audit, complaints and waiting lists.

Team managers discussed learning needs with staff during supervision, appraisals, and team meetings and ensured staff received necessary specialist training for their roles.

Team managers initially addressed poor staff performance during supervision. This included developing plans to improve performance and support staff. Team managers demonstrated when and how to escalate concerns higher in the organisation; for example, to human resources or occupational health.

The trust had details about volunteering opportunities and a volunteer coordinator on its website. Managers reported there were no volunteers in the teams we visited.

Managers provided staff with appraisals of their work performance. This was part of professional supervision that also included reviewing progress towards revalidation for registered staff. Appraisals were annual, but staff met to review progress and goals every six months. Team managers received monitoring and feedback on appraisals as part of key performance indicators.

The trust's target rate for appraisal compliance is 90%. As at 28 February 2018, the overall appraisal rates for non-medical staff within this service was 86%.

The teams failing to achieve the trust's appraisal target were High Peaks and North Dales Neighbourhood - Older Adult team with an appraisal rate of 50%, Dementia Rapid Response team with an appraisal rate of 83%, South Derbyshire and Derbyshire Dales Neighbourhood - Older Adult team with an appraisal rate of 82%. The North Dementia Rapid Response team had an appraisal rate of 0% because it was a new team in its early formation.

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 87% reported for the previous year.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
High Peaks+ North Dales DRRT	5	0	0%
High Peaks + North Dales Nhood OA	18	9	50%
Memory Assessment Service	15	12	80%
South Derbyshire+Derbyshire Dales Nhood OA	17	14	82%
Dementia Rapid Response	29	24	83%
Dovedale Older People Day Hospital 'DH'	10	9	90%
Chesterfield Central Nhood OA	14	13	93%
Amber Valley Neighbourhood - OA	20	19	95%
Derby City Neighbourhood - Older Adult	27	26	96%
Bolsover+Clay Cross Nhood OA	15	15	100%
County South Older People Day Hospital 'DH'	6	6	100%
Erewash Neighbourhood - OA	15	15	100%
Killamarsh+ North Chesterfield Nhood OA	11	11	100%
Trust Wide Discharge Liaison Team OP	4	4	100%
Service total	**206**	**177**	**86%**
Trust wide	**2406**	**1858**	**77%**

The trust's target rate for appraisal compliance is 90%. As at 28 February 2018, the overall appraisal rates for medical staff within this service was 67%.

The team failing to achieve the trust's appraisal target was City Elderly Service Medical with an appraisal rate of 50%.

The rate of appraisal compliance for medical staff reported during this inspection was lower than the 100% reported for the previous year. The trust informed us that a 100% compliance with NHS England targets was achieved at year end and reported to the board.

Team name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
City Elderly Service Medical	2	1	50%
Memory Assessment Service	1	1	100%
Service total	**3**	**2**	**67%**
Trust wide	**114**	**77**	**68%**

Managers, at most of the teams visited, provided all staff with supervision. Supervision is a meeting to discuss case management, to reflect on and learn from practice, personal support and professional development. Staff reported supervision took place every four to six weeks. Meetings followed an agenda, were recorded and signed on completion. Arrangements for supervision varied at Amber Valley and Erewash. The manager had introduced a structure of supervision where individuals were supervised by a member of staff at the clinical grade above them. For example; Band 6 nurses supervised band 5 nurses. Managers also provided staff with opportunities for clinical supervision and staff were responsible for organising this themselves. Some teams had processes in place to identify and record unplanned peer discussions between team members that contributed to supervision practices.

The trust's measure of clinical supervision data is sessions delivered.

Between 1 March 2017 and 28 February 2018, the average rate across all 16 teams in this service was 78%.

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

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
High Peaks + North Dales Nhood OA	120	55	46%
Killamarsh+ North Chesterfield Nhood OA	55	32	58%
County South Older People Day Hospital DH	57	34	60%
Memory Assessment Service Erewash	5	3	60%
Memory Assessment Service North	12	8	67%
Chesterfield Central Nhood OA	79	55	70%
Dementia Rapid Response Team	319	240	75%

Derby City Nhood OA	143	115	80%
Memory Assessment ServiceAS (L4) - MAS	109	91	83%
Dovedale Older People Day Hospital DH	86	73	85%
Amber Valley Neighbourhood - OA	126	112	89%
Bolsover+Clay Cross Nhood OA	98	92	94%
Erewash Neighbourhood - Older Adult	100	95	95%
South Derbyshire+Derbyshire Dales Nhood OA	99	94	95%
Hartington Unit Older People Memory Clinic	3	3	100%
Memory Assessment Service South	19	19	100%
Service total	**1430**	**1121**	**78%**
Trust Total	**19680**	**12660**	**64%**

Multidisciplinary and interagency team work

Each team had regular multidisciplinary team meetings. Some teams combined their weekly multidisciplinary team meeting and referral meetings, while others occurred separately. Meetings were attended by all staff members and relevant professionals external to the team were also invited. Staff reported meetings were recorded and provided an opportunity to review patient care and treatment.

Staff reported they shared information with each other informally throughout the day. Duty workers shared information received about patients directly with care coordinators and updated patient's electronic record. Dementia rapid response team held daily morning handovers to discuss patient presentation, review risk and allocate visits.

Teams reported effective working relationships with other teams within the organisation. Staff reported they worked with adult colleagues within neighbourhood teams to identify the best service to meet the needs of patients referred. This included discussing referrals and joint visits to assess patients. Staff believed being located together and accessing the same patient electronic record helped teams to work together. Neighbourhood teams received referrals for and acted as gatekeepers to the memory assessment service and dementia rapid response teams. The team manager of Chesterfield team also attended inpatient meetings where obstacles and delays to patients' discharge was discussed.

Community teams had good working links with primary care, social services, and other teams external to the organisation. We saw examples of how staff worked with an allocated general practitioner practice or care home. This included attending practice meetings and supporting care home staff to meet the needs of patients. The Derby City team base was shared with social care. Staff worked closely with social care colleagues particularly when patients had dementia. Staff reported there was no shared patient electronic record with social care and this sometimes caused a delay in sharing information.

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

The trust provided training in the Mental Health Act as part of mandatory training requirements. Figures for February 2018 indicated that 84% of eligible staff had completed training in the Mental Health Act. The training compliance reported during this inspection was higher than the 80% reported for the previous year, but still below the trust's mandatory training target of 85%.

Staff we spoke with demonstrated a satisfactory understanding of the Mental Health Act, the Code of Practice and the guiding principles. One staff member reported they had not received training specific to Community Treatment Orders.

Staff accessed administrative support and legal advice on the implementation of the Mental Health Act from the trust's centrally located lead team.

Staff had access to local Mental Health Act policies and procedures, and to the Code of Practice. Managers had told staff only access online policies and procedures, this ensured practice followed most recent guidance and the trust emailed staff when policies were updated. Copies of the Code of Practice were available at team bases we visited and trust posters displayed guided staff specifically on Community Treatment Orders.

Staff we spoke with were aware of the requirement to explain rights under the Mental Health Act or Community Treatment Orders to those patient's subject to them. Staff reported this was included in trust Mental Health Act policy guidance and detailed that staff should record when they have given rights to patients.

For those patients' subject to the Mental Health Act or Community Treatment Orders, staff ensured they had access to information about independent mental health advocacy. We saw this was included in information leaflets that staff gave to patients.

Team managers reported they rarely had patients subject to a Community Treatment Order and at the time of the inspection there were none at the teams visited. This meant we were not able to see if staff completed Community Treatment Order paperwork correctly and kept it up to date. Doctors reported they met with social workers to review completed Mental Health Act detention papers and ensure it was completed correctly. Staff told us all Mental Health Act paperwork was uploaded and stored securely on the electronic patient record system.

The teams we visited did not provide us with the opportunity to see how staff prepared care plans that referred to identified section 117 aftercare services provided for patients who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment.

Staff were not aware of regular audits by the trust to ensure the Mental Health Act was being applied correctly. Staff did not identify learning from local or trust wide audits.

Good practice in applying the Mental Capacity Act

The trust provided training in the Mental Capacity Act as part of mandatory training requirements. Figures for February 2018 indicated that 94% of eligible staff had completed training in the Mental Health Act. This was above the trust's mandatory training target of 85%. The training compliance reported during this inspection was lower than the 96% reported for the previous year. Managers at some teams had provided staff with additional development sessions to support learning around the Mental Capacity Act.

Staff we spoke with demonstrated a satisfactory understanding of the Mental Capacity Act, including the five statutory principles. Staff reported multidisciplinary team meetings and supervision sessions included discussions about the Mental Capacity Act.

The trust provided staff with policy guidance on the Mental Capacity Act. Staff were aware of the policy and knew how to access it.

Staff knew where to get advice from within the trust regarding the Mental Capacity Act. This included policy guidance, senior colleagues and the trust's identified lead.

Staff could describe how they gave patients assistance to make a specific decision for themselves before they assumed the patient lacked the mental capacity to make it themselves. This included providing information in different formats, providing information at different times, ensuring patients had access to and were using communication aids correctly, and involving advocacy or carers to provide information.

We saw staff assessed and recorded capacity to consent appropriately in 38 of the 41 records reviewed. Staff reported following the 2016 Care Quality Commission inspection the trust had incorporated mental capacity assessments into the electronic patient record, providing prompts for staff to consider mental capacity regularly and a process for staff to follow.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. Staff could provide examples of when they had organised meetings involving families, carers and other professionals to inform decisions about patient care.

Staff did not routinely know what was in place to monitor adherence to and audit the application of the Mental Capacity Act. Some staff reported they were not aware of any arrangements. Others identified local audits of patient records and some were aware of a community audit focussing on capacity to consent. Staff said this had been audited at neighbourhood team level and did not provide results specific to either working age adult or older adult teams within the neighbourhood. They reported the trust had acted on staff feedback and planned to provide results specific to teams at the next audit.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We saw staff interactions provided patients with advice, help and support. These were professionally delivered with warmth and respect, and included checking understanding with patients and providing feedback following assessments. We saw that staff followed up concerns identified during appointments, acting quickly to protect patients and resolve the concern.

Staff supported patients to understand and manage their care, treatment or condition. Patients and carers reported that staff explained and discussed things with them, particularly around medication. They also said staff provided information leaflets on a range of subjects including mental health conditions, physical health and other local support organisations.

Staff identified other services that were available locally to support carers and patients. This included health, social care, voluntary, and charitable organisations. Patients and carers provided examples of staff offering practical support to access these services.

We spoke with 14 patients and 18 carers, all said staff treated them well and behaved appropriately towards them. They told us staff listened to them and were kind, caring, polite, and respectful.

Staff understood the individual needs of patients, including personal, cultural, social and religious needs. Staff demonstrated this by providing information in ways patients could understand and worked with patients to identify and access social support. The trust also provided a spirituality and well-being service that was available to patients and carers.

The trust provided opportunities for staff to raise concerns about disrespectful, discriminatory or abusive behaviours towards patients without fear of consequences. This included a Freedom to Speak Up Guardian to help staff raise concerns in a confidential, supportive and anonymised manner.

Staff maintained the confidentiality of information about patients. We saw information sharing documentation in patient records where staff had recorded who patients wanted information shared with. Staff also used password protection to access patient electronic records and conducted appointments in areas that were private.

Involvement in care

Involvement of patients

Patients and carers we spoke with felt that staff had involved them when developing care plans. This included being offered choice to accept or decline treatments suggested by staff. Although 29 records identified that staff had shared copies of plans this differed considerably to the experience of patients we spoke with. Only four of the fifteen patients we spoke with could clearly recall being offered or having a copy of their care plan.

Staff communicated with patients so that they understood their care and treatment. We saw examples of staff speaking at an appropriate pace for the patient they were speaking with and checking understanding with patients. When patients had communication difficulties, staff accessed information or worked with other professionals to find effective ways to communicate. This included providing large print information, working with speech and language therapists and checking patients were using existing communication aids.

The trust provided opportunities for patients to be involved in decisions about the service. Details of neighbourhood involvement meetings for patients and carers were detailed on the trust's website. However, team managers in the north of the county reported these had been poorly attended by older people using mental health services. Teams were developing links with Healthwatch to improve on patient engagement. Healthwatch is an independent organisation that aims to understand the needs, experiences and concerns of people using health and social care services and to speak up on their behalf.

Staff enabled patients to give feedback on the service they received. We saw feedback cards and boxes in waiting areas of team bases and the trust's website feedback section included the Friends and Family Test and details of how to contact the patient experience team. The Friends and Family Test is a quick and anonymous way for patients to give feedback after receiving care or treatment. It helps providers and commissioners understand if patients are happy with services, or where improvements are needed.

Staff were aware of advance decisions and details about them were included in the trust's information booklet given to patients. Staff reported practices to assist patients in making advance decisions were not yet embedded. However, we did see evidence of advance decisions included in some crisis planning and conversations between staff and patients.

The trust displayed information about advocacy in neighbourhood team bases and included it in trust care and treatment publications for patients and carers. Staff reported they ensured these leaflets were provided to people accessing a service.

Involvement of families and carers

Staff involved families and carers appropriately in the care provided to patients. This was confirmed in our conversations with carers who felt staff kept them informed and involved them. Carers also reported that staff provided them with support. This included listening to them, respecting them, and putting them in touch with local carer organisations. The trust provided mental health carer forums offering support to anyone caring for someone with a mental health problem. The trust website provided access to a carers' newsletter.

The trust provided opportunities for families and carers to give feedback on the service they received. The trust's website included the Friends and Family Test. Details of how to contact the patient experience team was also on the website and included in the carer and family handbook produced by the trust. The handbook was available at neighbourhood team bases and was included as part of the carers pack given out by staff. Staff also facilitated community meetings

and engagement activities. Carers felt able to provide verbal feedback on the service they received to staff they regularly met with. However, they did not feel that more formal processes of providing feedback were made available to them.

Information about how to access a carer's assessment was included in the carer and family handbook produced by the trust. Carers reported staff offered carers assessments and assisted them to contact local carer organisations.

Is the service responsive?

Access and waiting times

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

The Service met the referral to assessment target in nine of the targets listed.

Name of hospital site or location	Name of team	Service Type	Days from referral to initial assessment		Days from assessment to treatment	
			Target	Actual (mean)	Target	Actual (mean)
Trust HQ	Dementia Rapid Response	Derby City	126	0	n/a	0
Trust HQ	Dovedale Day Hospital	Derby City	126	70	n/a	7
Trust HQ	In-Reach Home Treatment Team - Older Adults	Derby City	126	0	n/a	1
Trust HQ	Midway Day Hospital	Derby City	126	158	n/a	7
Trust HQ	Trust-wide Discharge & Liaison Team	Derby City	126	7	n/a	7
Trust HQ	High Peaks+ North Dales DRRT	North Derbyshire	126	4	n/a	12
Trust HQ	Memory Assessment Service North - MAS	North Derbyshire	126	73	n/a	21
Trust HQ	Memory Assessment Service North - Memory Clinic	North Derbyshire	126	127	n/a	160.5
Trust HQ	MASH Health Advisor	Not Known	126	0	n/a	27.5
Trust HQ	Older Adults Rehab Wards	Not Known	126	5	n/a	1
Trust HQ	Memory Assessment Service South - MAS	South Derbyshire	126	55	n/a	61

The operating policy for neighbourhood teams had criteria for which patients would be offered a service. Following an assessment, staff signposted patients that did not meet criteria to other services. The trust's waiting times policy detailed concerns that would prompt staff to consider a referral unsuitable for a waiting list and consider immediate allocation. Concerns included chronic physical health conditions, and risks related to drug or alcohol misuse.

The operating policy for neighbourhood teams specified a target time from referral to assessment. For urgent referrals this was within two working days, and for routine assessments this was within twenty working days. Team managers reported that unless waiting for care co-ordinator, there was no waiting time from assessment to treatment. Dementia rapid response team managers reported they aimed to assess patients referred to the service within four hours. Again, there was no waiting time from assessment to treatment for those patients meeting the team's criteria for which patients would be offered a service.

Teams could see urgent referrals quickly. Duty workers triaged all referrals and could see urgent referrals within two working days. Duty workers directed urgent referrals for patients with dementia to dementia rapid response teams to be seen quickly.

Dementia rapid response teams were not 24 hour services. The south team operated between 8am and 8pm Monday to Friday, and between 9am and 5pm Saturday to Sunday. There were plans for the north team to keep the same hours once the service was fully staffed. At the time of the inspection the north operated between 9am and 5pm seven days a week. The trust's crisis service did not offer a service to patients with dementia, but would support older adult patients with a functional illness who were already on a neighbourhood team's caseload.

Patients could telephone teams and, if they were available, speak to their care coordinator. All teams had a duty worker who could respond promptly and adequately when care coordinators were not available.

Staff described how they tried to engage with people who found it difficult or were reluctant to engage with mental health services. This included attempting contact by telephone and working alongside professionals already engaged with the patient. Dementia rapid response teams were able to work with hard to engage dementia patients. This was demonstrated during a community visit where we observed a staff member communicating skilfully to maintain and develop a relationship with a hard to engage patient.

Teams had processes in place to re-engage with patients who did not attend their appointments. Staff described actions they would take, including contact by letter, telephone, and liaison with identified carers or other professionals.

Within the teams' hours of operation, staff offered patients flexibility in the times of appointments. Staff reported they would also consider the needs of family and carers supporting patients to attend appointments or wishing to attend appointments them self.

Staff reported appointments were rarely cancelled and only because of unexpected circumstances such as staff sickness or absence. Patients and carers we spoke with confirmed this. Staff offered an explanation, apology and assistance to re-arrange an appointment as soon as possible.

Staff reported appointments usually ran on time. Administration staff and duty workers supported staff working in the community to keep patients informed when appointments were not running on time.

Staff we spoke with did not comment on any use of technology to support timely access to care and treatment.

Staff supported patients during referrals and transfers between services. This included handovers, joint visits and maintaining contact with patients during inpatient admissions.

The facilities promote comfort, dignity and privacy

Patients were not seen at dementia rapid response team bases and neighbourhood staff members reported that patients were rarely seen at team bases. However, staff at neighbourhood team bases had access to a range of rooms and equipment to support treatment and care. This included interview rooms and clinics.

Interview rooms had adequate soundproofing to prevent the content of conversations being heard from outside of them. Where rooms were located at street level or directly in front of car parks, frosted plastic to windows maintained privacy of patients visiting the service.

Patient engagement with the wider community

When appropriate, staff could assist patients to access education and work opportunities. Staff worked with local organisations to identify opportunities and supported patients to access them.

Staff supported patients to maintain contact with their families and carers. Where possible teams assisted patients to remain in their own homes by assessing independent living skills, referring to social care when needed, and supporting carers.

Staff encouraged patients and carers to develop and maintain relationships with people that mattered to them. Groups were available to patients that assisted them to better manage symptoms of anxiety and depression, and build confidence to maintain social links. Staff could also refer patients to access day hospital facilities and dementia specific groups. We also saw staff making befriending services available to patients. One carer described how they had benefitted from staff encouragement to socialise and maintain friendships.

Meeting the needs of all people who use the service

Staff in neighbourhood and dementia rapid response teams prioritised seeing patients in their own home. However, we saw that adjustments to neighbourhood team bases ensured disabled people had access to premises and met patients' communication needs.

Staff ensured patients had access to a range of information leaflets including treatments, advocacy and local services. Staff also provided a families and carers pack that included information about being a carer, support services and local resources

Staff reported information could be provided in accessible formats for older adults. This included large print, easy read and braille. Information leaflets provided by the trust included contact details for obtaining that information in other formats.

Information leaflets were primarily available in English. Information leaflets provided by the trust included contact details for obtaining information in seven different languages. Staff reported they could obtain information in languages other than English on request or in response to individual needs.

Managers ensured staff and patients had access to interpreters and/or signers where needed. Derby City had a higher proportion of people from ethnic backgrounds whose first language may not be English. Staff from this neighbourhood team reported that memory assessments could be made available in a patients first language and described links with Asian and Afro Caribbean communities.

Listening to and learning from concerns and complaints

This service received 135 complaints between 1 March 2017 and 28 February 2018.

The highest volume of complaints was for availability of services, activities, or therapies.

The South Derbyshire and Derbyshire Dales neighbourhood team had the most complaints (29).

This service received 118 compliments during the last 12 months from 1 March 2017 to 28 February 2018 which accounted for 10% of all compliments received by the trust as a whole.

Ward name	Total Complaints
Neighbourhood - South Derbyshire and Derbyshire Dales	29
Neighbourhood - Bolsover & Clay Cross Locality	21
Neighbourhood - Killamarsh & Chesterfield North	21
Neighbourhood - Chesterfield Central	18
Neighbourhood - Amber Valley	13
Neighbourhood - Derby City (B)	10
Neighbourhood - Erewash	8
Neighbourhood - High Peak & North Dales	6
Neighbourhood - Derby City (C)	4
Neighbourhood - Derby City (A)	3
Neighbourhood Services - Management Team	1
Neighbourhood Services - Medical Secretaries	1

Patients and carers reported they knew how to complain or raise concerns. Some had received written information about making a complaint and others reported they would speak with a staff member. No patients or carers told us they wanted to make a complaint.

Patients received feedback when they complained or raised concerns. One patient described how a complaint had been resolved and the feedback they had received.

Staff reported complaints or concerns were treated confidentiality and the identity of the complainant was protected. Staff reported that trust policies provided additional guidance on protecting patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to respond to complaints or concerns raised with them. Firstly, staff tried to address and resolve complaints locally. If this failed staff assisted patients to make written complaints, or referred to the trust patient experience team. Area service managers or team managers were required to investigate concerns escalated to the patient experience team. The trust had a policy in place to guide staff in dealing with complaints or concerns.

Staff received feedback on the outcome of the investigation of complaints through emails, team meetings or during individual supervision. One team manager described how local practice had changed because of feedback from the investigation of a complaint.

Is the service well led?

Leadership

Team managers were registered nurses employed at Band 7. This reflected the skills, knowledge and experience needed to perform their role.

Managers demonstrated a good understanding of the teams they managed. They could explain how their teams worked with other professionals and carers to provide safe and effective services for patients. Managers were also able to identify obstacles to care delivery and describe how they were working to address these.

Staff knew who their senior managers were and could provide examples of them visiting team bases. Staff felt that where concerns had been identified with senior managers during visits, these had been listened to and acted upon. The trusts chief executive visited locations as part of an 'on the road' initiative that provided the opportunity to meet with staff and patients.

Managers reported leadership opportunities were available including courses on managing people. However, some felt that although courses were available they were often oversubscribed and difficult to book on to. Managers also reported participating in leadership meetings and peer support groups for new managers.

Vision and strategy

Staff were aware of the trusts vision and values but could not always describe details of them when asked. However, the trust had updated its vision and values at the end of 2017 and staff were still familiarising themselves with them. Managers could explain how the visions and values were applied in the work of their team including having a recovery focus and treating people at home to prevent admissions to care homes or hospital.

The trusts vision, values and strategic objectives were available to staff and patients online. We saw theses displayed on posters and computer screen savers at the team bases we visited.

Staff felt they had the opportunity to contribute to discussions about the strategy for their service. For example; the trust had updated its vison and values and its vision following feedback from staff. The feedback provided explained how staff wanted a simpler, clearer vision of what the trust aimed to achieve in the future. However, some staff still felt they had not had enough opportunity to contribute to discussions about the implementation of the neighbourhood model when it was first proposed.

The trust first moved towards the neighbourhood model of community mental health provision in 2016. It was envisioned it would be an ageless service combining adult and older people's community mental health teams. In 2017 the trust undertook a review of the neighbourhood structure to develop an alternative model of service delivery. This followed concerns the neighbourhoods were not delivering desired improvements in clinical effectiveness or patient care, and several challenges had emerged. The review identified that adult and older peoples' teams all teams were now based in the same building and could work together to meet the needs of patients. However, teams continued to work separately operationally and in day to day management. The review also identified several areas that experienced difficulties. This included effective estate provision, pathways and strategy for psychological therapies and developing a

robust training strategy. The trust reports it is continuing to work with neighbourhood services to address these issues.

Staff we spoke with reported a commitment to deliver safe and high quality care within the budgets available to them. This included working in partnership with other teams and community providers.

Culture

Staff felt respected, supported and valued in their roles, particularly by their immediate team managers. This included feeling positive and proud of working in their team and for the trust. Comments from staff included that they felt involved, listened to, and morale in teams was good.

Staff knew how to use the trust's whistle-blowing process and knew about the role of the Speak Up Guardian. Most staff felt able to raise concerns without fear of retribution. However, some staff commented they would have concerns about anonymity if they were required to use the processes available to them.

Managers dealt with poor staff performance when needed. The trust provided managers with support and structures to address poor staff performance. Managers could provide examples of how staff performance concerns had been managed and the support they had received from human resources departments while doing so.

Staff reported teams worked well together. Where there had been difficulties within teams' managers were able to describe how they had been dealt with appropriately.

Staff reported appraisals included conversations about career development and how it could be supported.

The trust published its approach to developing and delivering equality, diversity and inclusion on its website. It also included its workforce demographic report that provided detailed analysis of the trust's workforce by race, ethnicity, gender, age, religion, disability and sexual orientation. Our conversations with staff did not include how the trust promoted equality and diversity in its day to day work and in providing opportunities for career progression. However, the trusts website provided details of a black and minority ethnic support network, a lesbian, gay, bisexual, transgender and queer/questioning staff network, and disability staff support.

The sickness rate for this service was 5 per cent between 1 March 2017 and 28 February 2018. This was the same as the average for the trust as a whole.

The trust had an occupational health department that staff accessed to support for their own physical and emotional health.

The trust ran delivering excellence awards that recognised team and staff success in the trust. In 2017 the neighbourhood teams from Chesterfield Central, and High Peak and North Dales were finalists in the trust's delivering excellence quality awards.

From 1 March 2017 to 28 February 2018 there were no cases where staff have been either suspended, placed under supervision or were moved to a different team.

Governance

The trust has provided their board assurance framework, which details any risk scoring 15 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The four strategic ambitions outlined by the trust relating to this service are as follows:

1 - We will deliver **quality** in everything we do providing safe, effective and service user centred care
2 - We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time
3 - We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.
4 - We will **transform** services to achieve long-term financial sustainability.

Teams did not have a standardised approach to what must be discussed in team meetings. We saw teams used different formats to organise agenda items and share information. This did not ensure all essential information, such as learning from incidents and complaints, was consistently shared and discussed by all staff.

Staff could describe changes to clinical practice and procedures that had been implemented as recommendations from reviews of incidents, complaints and safeguarding alerts. The trust provided plans to demonstrate it was acting to implement recommendations identified in the 2016 Care Quality Commission inspection.

We saw staff primarily participated in audits of patient records and the trust provided resulting action plans for 2018. The action plan identified objectives to be achieved, actions, completion dates and evidence required to demonstrate that staff acted upon the plan. The trust also demonstrated evidence of action plans resulting from their clinical audit programme.

Guidance was not always available for staff on arrangements for working with other teams within the trust. Operational policy and procedures were still in draft form for the memory assessment service and the dementia rapid response teams. These draft formats were not routinely available to staff. Staff demonstrated a good understanding of arrangements for working with teams outside of the trust. This included providers of 24 hour care facilities, social care and general practitioner practices.

Management of risk, issues and performance

Team managers had access to local risk registers that were personal to the services they managed. Staff raised concerns with team managers who could add items to local risk registers or, if required, escalate the concern to their immediate line manager. The trust also held a trust wide risk register identifying concerns at divisional levels.

The trust wide risk register identified two risks related to neighbourhood services. These included insufficient care coordinator capacity resulting in higher waits for patients, and waiting times for psychological assessment and intervention. The trust risk register described the risk, and controls in place to manage the risk. Staff concerns in relation to waiting times for psychological services match the risk register.

The trust had a developed a number of policies to prepare for and manage emergencies. This included adverse weather and bomb threats.

We received one concern from staff as an example of where they believed cost improvements had compromised patient care. This concerned funding for a venue from which to run a patient group. Staff had not been able to use a centrally located and accessible venue because of cost restrictions.

Information management

The trust used an electronic incident reporting system and used systems to collect data about team performance, including care clustering, mandatory training and appraisals. These were not over-burdensome for frontline staff to use.

Staff used patient electronic records that were accessible trust wide and an electronic staff record that included access to online learning courses. Staff opinion of the trusts information technology systems varied. Some staff found the patient electronic record slow and difficult to navigate, and some had experienced difficulties accessing online learning. The trust provided staff working in the community with a smart phone and laptop that allowed staff to access information technology systems remotely. Staff believed they had the right equipment for their jobs. We also saw an example of the trust using speech recognition software to assist a staff member with communication difficulties.

Information governance systems included confidentiality of patient records. Staff accessed electronic records privately and with the use of passwords.

Team managers believed they had access to information to support them with their management role. This included access to online policies and procedures, and key performance indicators.

Team managers reported the trust presented key performance indicators in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed. This included notifying the Care Quality Commission and informing NHS England of serious incidents requiring investigation through the Strategic Executive Information System

Engagement

The trust had a presence on several social media platforms to communicate its latest news stories, events and keep involved with the community it served. This was managed by a dedicated communications and involvement team. Staff, patients and carers also had up to date information about the work of the trust through its ‘Connections’ magazine which was available online. The trust informed us that they send out information via a trust membership communication tool on a regular basis**.**

Patients and carers had the opportunity to give feedback on the service that they received. The trust’s website included an area to leave feedback, view the feedback of others, and link to the friends and family test, a nation-wide patient experience survey. We also saw patient feedback cards and comments boxes in team reception areas.

The trust reported it used feedback from patients, carers and staff to make improvements. This included creating ‘you said we did reports’ and planning conferences for people with protected characteristics.

The trust organised neighbourhood involvement meetings to involve patients and carers in decision-making about the service.

Members of the public could meet with the trusts senior leadership team at monthly board of directors' meetings. The trust's website published details of where and when these meetings happened. The trust also ran neighbourhood involvement meetings for staff, patients and carers to provide feedback and discuss proposed changes to services.

The trust provided details of how it had engaged with external stakeholders and was working in partnership to provide services to patients.

Learning, continuous improvement and innovation

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

This service has not been awarded an accreditation.

Staff reported they met as a team to discuss opportunities for improvements and innovations that led to change. Examples of this included establishing treatment groups and providing staff training to meet the needs of patients being referred to teams.

The trust website detailed the activities of the research and development centre. Staff did not identify participation in any research opportunities specific to older adults in the community. One manager provided an example of a staff member being seconded to the research and development centre.

We saw evidence of innovation within older people's neighbourhood teams. The trust was implementing a 24 hour care strategy to better manage high numbers of referrals from providers of 24 hour care facilities. The strategy proposed an approach from all teams that required one identified nurse working with a 24 hour care facility to provide consistent advice and education to the patients and staff at that location. The approach included the development of a resource file for each location detailing dementia information and advice, and reference points to further learning and information. Managers we spoke with were aware of the strategy and could explain how they were working to implement it.

Team managers reported how quality improvement initiatives were discussed at leadership meetings. The trust had an established practice of 'quality visits' during which teams had to demonstrate their compliance with trust quality standards.

Staff did not identify if they participated in national audits relevant to their service. However, information from the trust identified participation in one national audit with a focus on prescribing anti-psychotic medication for people with dementia

Mental health crisis services and health-based places of safety

We did not inspect the liaison and diversion services (Criminal Justice) as part of this inspection. We met with a group of staff from the RAID liaison teams.

Facts and data about this service

Location site name	Team name	Number of clinics per month	Patient group (male, female, mixed)
Hartington Unit	RAID Liaison Team - North	1.43	Mixed
Hartington Unit	Crisis & Home Treatment Team North & High Peak	-	Mixed
Radbourne Unit	RDH Hope And Resilience Hub	-	Mixed
Radbourne Unit	Crisis Services	-	Mixed
Trust HQ	RAID Liaison Team - South	-	Mixed
Trust HQ	Liaison & Diversion Services (Criminal Justice)	-	Mixed
Trust HQ	Mental Health Advice Assessment Hub	-	Mixed

Is the service safe?

Safe and clean environment

Mental health crisis services

The offices of the crisis resolution and home treatment teams were clean, tidy and well maintained. Staff rarely saw the people who used the service at their bases but all teams could access clinic rooms on their sites, if required. The Chesterfield and Derby City and County South crisis resolution and home treatment teams had offices based within hospital settings. The High Peak and Dales team had an office in a local community health centre. All three offices had reception areas that received all visitors.

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. Staff followed infection control principles, including handwashing, and anti-bacterial hand gel was provided throughout the offices.

Health based places of safety

We visited the health based places of safety (also known as the section 136 suite) at the Radbourne Unit at Royal Derby Hospital and at the Hartington Unit at Chesterfield Royal Hospital.

There were some risks to the safety of people who used the service. At the suite at the Hartington Unit, there was a blind spot under the window between the office and main sitting area. However, this was reduced by the use of closed circuit television cameras. There was a large viewing window between the nursing office and the area where the person using the service would be. Staff said that when sitting at the desk, the computer monitor obscured the window view, which reduced visibility of the person using the suite. There were also some blind spots in the bathroom behind the toilet under the window. There was not a mirror to reduce these blind spots which were also evident at our previous inspection in June 2016. Staff could adjust the privacy panel on the door to the bathroom but despite this, staff were not able to see the patient if they were in the blind spot.

The trust had removed the ligature points at the Hartington Unit that we identified at our previous inspection in June 2016. A ligature is a fixture or fitting that a patient could use for tying or binding as a means of hanging themselves. The two doors into the bathroom were now ligature free. However, the soap dispenser, towel rail and alarm system were not ligature free but could be used to anchor a ligature. Since our previous inspection, the trust had made available ligature cutters for staff to use. The bins in the suite could be removed and used as weapons if a person using the suite was behaving in an aggressive way. There was no bed in the suite. Staff told us they would move in a mattress and bedding if the person wanted to lie down. The call bell system in the suite did not work. Staff told us it was no longer in use, which meant that the person in the suite would not be able to summon help if needed.

Staff carried personal alarms. The ‘bleep holder’ (staff who were called to work in the suite) at the Hartington Unit had a key ring which had over 30 keys on it and staff had difficulty finding the key they needed. There were at least six keys to access paper files. However, staff now used electronic patient records systems so no longer needed to access these but the keys had not been removed. Staff remedied this at the time of our inspection. They also removed the keys to the

bathroom door and placed them with the key to the viewing panel. They kept this set of keys in the 136 suite which meant staff working there would be able to access them quickly.

The suite at the Hartington Unit was clean and records showed that staff cleaned it twice daily even if it had not been used.

The suite at the Radbourne Unit was based in a discreet and quiet area and was clearly signposted for easy access by the police and ambulance services. The suite was purpose built and well designed with anti – ligature fittings. There was a large observation screen between the area where staff would be based and the area where the person using the service would be. However, there was a blind spot that obscured the view of the person when they were in the shower room. The trust had rated this as a high risk on their ligature risk assessment and had agreed funding to improve this by providing a mirror and viewing screens in the wall. They also planned to install two way intercoms so it was easier for staff and the person using the service to communicate which could reduce the risks of the person harming themselves. The suite was suitably furnished with a weighted bed and mattress, a small table and two chairs which were attached to the floor.

The shower drain at the Radbourne Unit suite was dirty and did not look like it had been cleaned for several days. Staff said that the suite was cleaned daily however, there were no cleaning records available to show this was done.

Staff tested the emergency equipment in both suites. At the Radbourne Unit, staff told us that emergency drugs were not kept in the suite but on Ward 35. If a person needed staff to administer the drugs, staff used their swipe card to go through two doors to Ward 35 and back again to the suite. Staff said this could be done quickly but any risks of this had not been assessed.

Staff flushed the water outlets each month to prevent the spread of legionella. However, staff at the Hartington Unit did not record this in March 2018.

Safe staffing

Mental health crisis services

The staffing arrangements varied between the crisis resolution and home treatment teams. The High Peak and Dales team was a small satellite service closely linked to the Chesterfield team. Each team had dedicated staff but shared team management and clinical leadership. There was enough staff in these teams to provide the right care and treatment.

The service did not have enough staff in the City and County South teams to provide the right care and treatment. Staff told us the staffing levels were safe as the two teams operated as one to reduce the risks. However, they could not offer the care needed to reintegrate people into the community and provide consistency of care. On average, most people who used the service were cared for by four different staff. The trust had reviewed their staffing and identified the amount of staff needed to rectify this. They had received funding from the commissioners and had started to recruit more staff. This included a band 7 operational manager who would manage both teams with a clinical lead band 7 in each team. They had also advertised for five band 6 posts, four band 4 support workers; one of which will be specialist in substance misuse and another in housing issues. They were also recruiting for one staff grade psychiatrist. The area service manager would decide when the staffing levels were stable enough to split the teams.

In the South and City team, the trust had estimated that there should be at least 13 staff on shift from Monday to Friday and 12 at weekends. This included one staff member who worked from 3pm to midnight, a staff member on the late shift from 1pm to 10pm, and another from 9.30pm to 8.30am. This staff member was supported by on call medical staff, bleep holder and the North staff to support them, should they need it. This person worked alone from midnight to 8.30pm. There were only 12 staff on 13 June 2018, as three were on mandatory training that week and others were on annual leave. There were two staff members off sick and one staff member left during our inspection to go on maternity leave. Managers told us that they could use agency staff but only for three month contracts and had to apply to the trust for an extension every three months. There was a pool of experienced staff who could be called on to do bank shifts where needed. Staff who worked in the teams and the local neighbourhood community mental health teams also did bank shifts, which provided more consistency.

Staff in all teams and people who used the service we spoke with said a psychiatrist was always available. Individual staff did not have a caseload but people were allocated to the team. Managers regularly reviewed caseloads.

Health based places of safety

There was no dedicated staffing in either of the health based places of safety. The 'bleep holder' (identified supernumerary manager for the site) was responsible for the 136 suite at the Hartington Unit until 9pm. After 9pm, staff from the Chesterfield crisis resolution and home treatment team staffed the 136 suite.

At the Radbourne Unit, the 'bleep holder' for the site staffed the136 suite when needed. The role of the 'bleep holder' included dealing with clinical emergencies, absent without leave incidents and managerial issues for the whole unit. Staff said staffing the 136 suite prevented them from doing their other duties and could affect the running of the wards if the person in the suite had to wait for their mental health assessment.

Substantive – All filled allocated and funded posts.

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

Substantive staff figures			**Trust target**
Total number of substantive staff	At 28 February 2018	161.1	N/A
Total number of substantive staff leavers	1 March 2017 – 28 February 2018	14.6	N/A
Average WTE* leavers over 12 months (%)	1 March 2017 – 28 February 2018	9%	10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 28 February 2018	30.2	N/A
Total vacancies overall (%)	At 28 February 2018	16%	10%
Total permanent staff sickness overall (%)	At 28 February 2018	6%	5%
	1 March 2017 – 28 February 2018	7%	5%

Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 28 February 2018	119.9	N/A
Establishment levels nursing assistants (WTE*)	At 28 February 2018	30.4	N/A
Number of vacancies, qualified nurses (WTE*)	At 28 February 2018	18.0	N/A
Number of vacancies nursing assistants (WTE*)	At 28 February 2018	4.7	N/A
Qualified nurse vacancy rate	At 28 February 2018	15%	10%
Nursing assistant vacancy rate	At 28 February 2018	15%	10%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (Qualified Nurses)	1 March 2017 – 28 February 2018	17 (<1%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 March 2017 – 28 February 2018	743 (2%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 March 2017 – 28 February 2018	99 (<1%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	1105 (17%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	1 (<1%)	N/A

*Whole Time Equivalent

This service reported an overall vacancy rate of 15% for registered nurses and 15% for nursing assistants at 28 February 2018.

This service has reported a vacancy rate for all staff of 16% as of 28 February 2018.

	Registered nurses			**Health care assistants**			**Overall staff figures**		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
MH Advice + Assessment Hub	1.7	3.9	43%	0	0	0%	1.9	4.1	46%
Criminal Justice Liaison	2.7	13.6	20%	4.8	11.8	41%	8.8	27.9	32%
Chesterfield CRHT	5.8	22.9	25%	0	3.0	0%	5.9	27.6	21%
City + County South CRHT	4.3	27.2	16%	0	3.0	0%	5.7	36.4	16%
Liaison Team South	2.5	20.0	12%	0	0	0%	4.3	29.1	15%
Liaison Team North	0.3	17.5	2%	0	0	0%	2.3	22.4	10%
County Crisis Medical	0	0	0%	0	0	0%	0.1	2.1	5%

High Peak and Dales CRHT	0.2	5.8	3%	0	0.8	0%	0.2	7.6	3%
City Crisis Medical	0	0	0%	0	0	0%	0	3.0	0%
Inreach + Home Treatment OP	-0.5	5.0	-10%	-1	3.0	-33%	-0.6	10.6	-6%
Hope and Resilience Hub	1.0	3.8	26%	1.0	8.8	11%	1.9	20.8	9%
Service total	**18.0**	**119.7**	**15%**	**4.7**	**30.4**	**15%**	**30.2**	**191.5**	**16%**
Trust total	**116.2**	**970.5**	**12%**	**34.3**	**375.2**	**9%**	**310.3**	**2490.1**	**12%**

NB: All figures displayed are whole-time equivalents

Between 1 March 2017 and 28 February 2018, bank staff filled less than 1% of shifts to cover sickness, absence or vacancy for registered nurses.

In the same period, agency staff covered 2% of shifts for qualified nurses. Less than 1% of shifts were unable to be filled by either bank or agency staff.

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Chesterfield CRHT	5964	5 (<1%)	86 (1%)	51 (1%)
City + County South CRHT	7092	12 (<1%)	650 (9%)	48 (1%)
Criminal Justice Liaison	3444	0 (0%)	0 (0%)	0 (0%)
High Peak and Dales CRHT	1512	0 (0%)	7 (<1%)	0 (0%)
Inreach + Home Treatment OP	1100	0 (0%)	0 (0%)	0 (0%)
Liaison Team North	4170	0 (0%)	0 (0%)	0 (0%)
Liaison Team South	5220	0 (0%)	0 (0%)	0 (0%)
MH Advice + Assessment Hub	1028	0 (0%)	0 (0%)	0 (0%)
Hope and Resilience Hub	812	0 (0%)	0 (0%)	0 (0%)
Service total	30342	**17 (<1%*)**	**743 (2%*)**	**99 (<1%*)**
Trust Total	**248873**	**1416 (<1%)**	**5000 (2%)**	**293 (<1%)**

***Percentage of total shifts

Between 1 March 2017 and 28 February 2018, 17% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, no agency staff covered nursing assistant shifts. Less than 1% of shifts were unable to be filled by either bank or agency staff.

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Chesterfield CRHT	780	1105 (142%)	0 (0%*)	0 (0%*)
City + County South CRHT	780	0 (0%*)	0 (0%*)	1 (<1%)
Criminal Justice Liaison	2836	0 (0%*)	0 (0%*)	0 (0%*)
High Peak and Dales CRHT	204	0 (0%*)	0 (0%*)	0 (0%*)
Inreach + Home Treatment OP	673	0 (0%*)	0 (0%*)	0 (0%*)
Hope and Resilience Hub	1309	0 (0%)	0 (0%)	0 (0%)
Service total	**6582**	**1105 (17%*)**	**0 (0%*)**	**1 (<1%)**
Trust Total	**83457**	**15372 (18%)**	**0 (0%)**	**2497 (3%)**

***** Percentage of total shifts

Turnover

This service had 12.8 (9%) staff leavers between 1 March 2017 and 28 February 2018.

Team	Substantive staff- (February 2018)	Substantive staff Leavers (1 March 2017 to 28 February 2018)	Average % staff leavers (1 March 2017 to 28 February 2018)
Liaison Team North	19.5	3.4	18%
High Peak and Dales CRHT	7.4	1.0	14%
Chesterfield CRHT	21.7	3.2	13%
Criminal Justice Liaison Team	19.3	2.5	13%
Hope & Resilience Hub	19.4	1.8	10%
Liaison Team South	25.4	1.7	6%
City & County South CRHT	30.7	1.0	3%
City Crisis Medical	3.0	0	0%
County Crisis Medical	2.0	0	0%
In Reach + Home Treatment OP	10.5	0	0%
MH Advice + Assessment Hub	2.2	0	0%
Service total	**161.1**	**14.6**	**9%**

Trust Total	**2167.7**	**219.3**	**10%**

Sickness

The sickness rate for this service was 7% between 1 March 2017 and 28 March 2018. The most recent month's data (February 2018) showed a sickness rate of 6%. Managers showed us the sickness rates for the City and County South crisis resolution and home treatment team which was 6.5% in February 2018 against a target of 5% but in March 2018, this reduced to zero. In the Chesterfield team, the actual sickness rate in February 2018 was 11% but this had reduced to 3.8% in March 2018 against the target of 5%.

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Criminal Justice Liaison Team	7%	12%
Chesterfield CRHT	6%	10%
Hope & Resilience Hub	10%	10%
City & County South CRHT	6%	9%
Liaison Team South	4%	6%
MH Advice + Assessment Hub	0%	6%
High Peak and Dales CRHT	0%	4%
In Reach + Home Treatment OP	0%	2%
Liaison Team North	7%	2%
City Crisis Medical	0%	1%
County Crisis Medical	0%	0%
Service total	**6%**	**7%**
Trust Total	**7%**	**5%**

Medical staff

Between 1 March 2017 and 28 February 2018, no shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same time period, agency staff covered 12% of shifts. No shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
City Crisis Medical	780	0 (0%)	0 (0%)	0 (0%)
County Crisis Medical	686	0 (0%)	295 (43%)	0 (0%)
Inreach + Home Treatment OP	24	0 (0%)	0 (0%)	0 (0%)
Liaison Team North	460	0 (0%)	21 (5%)	0 (0%)
Liaison Team South	716	0 (0%)	0 (0%)	0 (0%)
Service total	**2666**	**0 (0%)**	**316 (12%)**	**0 (0%)**
Trust Total	**41564**	**0 (0%)**	**4944 (12%)**	**0 (0%)**

***** Percentage of total shifts

Mandatory training

The service provided mandatory training in key skills to all staff. The trust trained staff in a block week of mandatory training. This helped to make sure that all staff would complete the training they needed to know how to safely meet the needs of people who use the service. The trust had trained all staff in the Chesterfield crisis resolution and home treatment team in mandatory training. Staff said they could access further training specific to their role. In March 2018, staff in the City and County South team met the trust target of 85% of completion of mandatory training. Managers had blocked book other staff to attend the training so all staff will have completed this by January 2019.

The compliance for mandatory and statutory training courses at 28 February 2018 was 75% for the current financial year. The training compliance reported for this service was lower than the 83% reported for the previous financial year. However, since then this had improved due to the block booking of staff on to mandatory training.

Key:

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

Training Course	Trust Target %	Training compliance % for this service	Trust Wide Training Compliance %
Data Security Awareness (Previously IG) (Annual)	95%	92%	91%
Equality, Diversity and Human Rights - Level 1 (3 yearly)	85%	77%	78%
Fraud Awareness (3 yearly)	85%	97%	95%
Health, Safety & Welfare (3 Yearly)	85%	74%	81%
Moving & Handling Level 1 (3 yearly)	85%	81%	83%
Promoting Safer & Therapeutic Services Clinical Staff (3 yearly)	85%	87%	85%

Promoting Safer & Therapeutic Services Non-Clinical Staff (3 yearly)	85%	100%	86%
Safeguarding - Adults Level 1 (Non Clinical) (3 Yearly)	85%	93%	87%
Safeguarding - Children Level 1 (once only)	85%	97%	98%
Aseptic Non-Touch Technique (ANTT) - 2 yearly	85%	38%	79%
Autism (ASD) Awareness Level 1 (Once)	85%	58%	57%
Care Certificate (Once Only)	85%	91%	84%
Deprivation of Liberty Standards (Once)	85%	87%	83%
Dual Diagnosis Level 1 (Once)	85%	69%	70%
Dual Diagnosis Level 2 (Once)	85%	71%	57%
Fire Safety - Fire Warden (3 Yearly)	85%	20%	64%
First Aid at Work Certificate (3 Yearly)	85%	100%	84%
Food Hygiene Awareness Update (Annual)	85%	55%	64%
Food Hygiene Certificate (3 Yearly)	85%	55%	35%
General Risk Assessor Training (3 Yearly)	85%	13%	21%
Medic - Approved Clinician (EXTERNAL COURSE 5 Yearly)	85%	60%	86%
Medic - Section 12 Approval (EXTERNAL 5 Yearly)	85%	43%	63%
Meds Mgmt - Admin & Documentation (3 yearly)	85%	20%	36%
Meds Mgmt - Controlled Drugs (3 yearly)	85%	26%	34%
Meds Mgmt - Use of Medication in the Management of Violence & Aggression v5 (3 yearly)	85%	19%	62%
Mental Capacity Act (Once)	85%	88%	84%
Mental Health Act 2007 (Once)	85%	84%	79%
383|LOCAL|R Moving & Handling Level 2 - Inanimate Objects (2 Yearly)|	85%	100%	
Moving & Handling Level 2 - People (2 yearly)	85%	59%	68%
Physical Health in Mental Health (3Yearly)	85%	8%	24%
Positive & Safe - Breakaway (Annual)	85%	34%	36%
Positive & Safe - PROACT SCIPr-UK - TACTICS (Older) inc PSTS (Annual)	85%	100%	81%
R Resuscitation - Basic Life Support & AED (annual)	85%	54%	64%
Resuscitation - Basic Life Support MEDICAL EXEMPTION (See individual risk assessment) (Annual)	85%	100%	75%
Resuscitation - Immediate Life Support - ILS - (annual)	85%	60%	73%
Safeguarding - Adults Level 3 (2 Yearly)	85%	56%	55%
Safeguarding - Children Level 2 (3 yearly)	85%	96%	90%
Safeguarding - Children Level 2 (once only)	85%	94%	93%
Safeguarding - Children Level 3 (3 yearly)	85%	85%	80%

Safeguarding - PREVENTing Radicalisation - Level 1 (3 yearly)	85%	92%	86%
Safeguarding - PREVENTing Radicalisation/WRAP Level 3 (3 yearly)	85%	88%	90%
Smoking Cessation Level 1 (Once Only)	85%	26%	33%
Staff Recruitment Training - All Recruiters (3 Yearly)	85%	48%	59%
This service	85%	70%	**75%**

Assessing and managing risk to patients and staff

Assessment of patient risk

Mental health crisis services

Staff completed timely comprehensive assessments within 24 hours of the person being referred to the crisis resolution and home treatment teams. In the teams, staff followed the trust's policy and used a red, amber, and green rating to assess the risks of people who used the service. Staff assessed each person referred and if the person needed an immediate assessment, staff aimed to do it that same day or evening. Staff phoned the person within four hours of receiving their referral to make sure the person could keep themselves and others safe and gave them the team contact numbers.

Staff assessed the person's risk during their first contact using the 'safety plan' and reviewed it every time they had contact with the person. The 'safety plan' was for staff to assess and manage the immediate and long term risks of the person using the service. They assessed the person's reasons for living, distress triggers, safe environment, activities to lift their mood, calming activities, distracting activities, contact for general support, specific suicide prevention support, professional support, emergency contact details and the person's commitment to implement their safety plan.

The lone working practices varied in each team. The trust had a lone working policy that was robust. In all crisis resolution and home treatment teams, two staff members visited people who were not known to the team to complete their initial assessment. The patient electronic record system highlighted any risks to staff, for example, dangerous dogs or previous violence to staff.

There were robust lone working practices in the High Peak and Dales team. The area the team worked in was rural and at times remote but staff told us they felt safe during the day. However, not all staff felt safe working alone in the building between 5 to 10pm. Staff at the Chesterfield and High Peak and Dales teams used a tracker (known as the 'flight recorder') to note staff's scheduled visits, which the duty worker checked regularly and all staff had access to this. In the City and County South team, the allocated co-coordinator for each shift knew where all staff were from the white board that staff signed in and out on. It was their responsibility to contact the staff member if they had not returned at the expected time. It was the responsibility of each staff member to ring the office to say they were home if going straight from a visit. However, the white board did not reflect which staff member was in or out at the time of our inspection. Staff said that the system was not consistent to monitor or track staff when out on visits. They said that the trust had given all staff a work mobile phone but not all staff used these.

Health-based places of safety

Staff did not robustly assess the risks of people using the health based places of safety. For example, in the 136 suite at the Hartington Unit, we saw that staff had not updated one person's risk assessment since 2014 when the person was last there. Staff said there was not a process to update the safety plan for a person using the 136 suite. The patient electronic record system did not identify if the person had been to the 136 suite before until staff scanned the paper copy of the current safety plan into it. This meant that there was a lack of information about the person, their risks and changes in their mental state which could affect their safety and wellbeing.

One staff member from the Chesterfield crisis resolution and home treatment team was responsible for staffing the 136 suite at the Hartington Unit overnight from 9pm. Staff told us they would take an alarm if they thought the person might pose a risk but did not routinely lock the door to the suite. They said they were often alone at night with the person while waiting for a mental health act assessment if they thought it was safe for the police to leave. Not all staff working there felt safe when working alone at night.

Staff used the red, amber, and green system to manage people's ongoing risks. Staff assessed as red, people who had significant safety needs, for example, if they had active suicide plans and staff would visit the person at least once a day. People moved to amber or green as they made progress, but could move back to red if their risks increased.

Staff used the safety plan to manage the risks of the person using the service. The trust had trained all staff to use this. However, this was not available on the patient electronic record system. Staff had to hand write the plan and scan into the electronic system. Records showed that staff updated the safety plan at each home visit.

There was variation between the teams in how staff managed the risks of people using the service. Staff who completed people's initial assessments fed back to the daily team clinical discussion meeting and discussed the ongoing plan to safely support the person. Staff discussed people's risks at their daily meetings and we observed this. Staff discussed the risks of each person they had rated red in the daily meeting led by the clinical lead. In all teams staff had a handover between each shift. Staff in the Chesterfield and High Peak and Dales teams gave the next shift detail of people's risks. However, in the handover we observed at the City and County South team staff did not discuss when the person's safety plan needed updating. There was nothing on the white board to indicate the review date. The handover was not structured or recorded and there was limited discussion as to why staff had assessed the person as red, amber or green.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. All staff were aware of the trust's safeguarding policy and who the trust safeguarding leads for children and adults were.

Staff discussed any issues of safeguarding children and adults at risk in the multidisciplinary team meetings we observed. Staff recorded this discussion and made referrals to local safeguarding teams where needed.

Staff assessed the level of vulnerability of each person using the service through their assessment and took into account the person's mental capacity to make decisions. We observed the multidisciplinary team discuss a safeguarding issue. Staff followed the safeguarding procedures, assessed the person's mental capacity and the person's preferred outcome was sought and recorded.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Both Safeguarding Adult Boards maintain data of referrals received into the local authorities but, currently, "health" referrals are not currently represented by organisation. A request has made of the performance department in Derby City Council to provide a breakdown of referrals made by each separate provider service.

- Derbyshire Healthcare NHS Foundation Trust has submitted details of one serious case review commenced or published in the last 12 months (1 March 2017 to 28 February 2018), however it did not relate to this service.

Staff access to essential information

The trust had a patient electronic records system. Staff told us that this made it difficult to give the person using the service a copy of their care plan or write with them electronically. The safety plan was not available electronically but staff had to complete on paper and scan into the system.

Medicines management

Mental health crisis services

The service prescribed, gave, recorded and stored medicines well. Since our previous inspection in June 2016, the trust had updated the medicine card. This included all the information about the patients' medicine including any allergies so that staff would have all the details in one place. Staff could order and administer the patient's medicines and record on the card.

Staff stored medicines safely in locked cabinets and fridges in the clinic rooms and tested the room temperatures daily to ensure that the medicines would be effective. The 'clinic room' at the High Peak and Dales crisis resolution and home treatment team was a cupboard in the small staff office. The trust had begun installing an air conditioning system to cool the room.

People who used the service told us that staff gave them the information they needed about their medicines, which included the side effects. Staff also explained to them the different medicines to treat their condition and the options available to them.

The trust were recruiting a pharmacy technician in both the North and the South of the county to work in the teams following a pharmacist vacancy. Pharmacists offered phone advice to staff in the teams.

Staff did not always complete medicine reconciliation (accurately recording what medicines the person is using that include any over the counter and complementary medicines). For example, in the City and County South team, one record showed that staff had not completed this until four days after the initial contact they had with the person using the service. One staff spoken with was unable to describe how they would do this. Staff at the Chesterfield team told us that doctors and pharmacists did the medicines reconciliation. This could lead to delays in assessing what medicines the person was taking and how safe it was for the person to have medicines that they could use to overdose.

Health based places of safety

Medicines were not stored within the 136 suites. Doctors could prescribe medicines and staff could access medicines from neighbouring wards when required.

Track record on safety

Staff learnt from incidents and made changes to improve the service. Managers told us that the crisis review which identified the need for several additional staff in City and County South crisis resolution and home treatment team was as a result of the suicide of a person using the service in 2014.

The trust told us about a serious untoward incident in one of the teams that happened in May 2018. We saw that managers and staff responded appropriately to this incident.

There was a serious untoward incident that occurred on the day before our inspection. The trust did not inform us of this which meant that we could not respond sensitively to the needs of staff during our inspection. However, the trust did report the incident to the Strategic Information Executive within the two working day target.

Between 1 March 2017 and 28 February 2018 there were five Strategic Information Executive System incidents reported by this service. The most common type of incident was apparent or actual or suspected self-inflicted harm with four. We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with Strategic Information Executive System.

The number of serious incidents reported during this inspection was lower than the eight reported at the previous inspection.

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

	Number of incidents reported

Type of incident reported	Crisis Resolution & Home Treatment Team - Chesterfield	Crisis Resolution & Home Treatment Team - City & County South	RAID Liaison Team - South	Service Total
Apparent/actual/suspected self-inflicted harm	2	1	1	4
Treatment delay	0	0	1	1
Total				

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. All staff had access to the electronic incident reporting system.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff at the Chesterfield team said they had received good debrief following incidents and managers shared learning from lessons well. Staff discussed incidents in their monthly team meetings and the trust had a lesson learned space on their intranet. Staff at the High Peak and Dales team felt they were not offered sufficient debrief when an incident happened there, due to the limited management cover there, but they supported each other well. Some staff told us that they discussed learning from incidents in team meetings but thought that sometimes there was a delay in how lessons learned were embedded into their daily work with people who used the service.

When things went wrong, staff apologised and gave patients honest information and suitable support. Following a recent serious untoward incident we saw that supported the family of the person using the service and identified a family liaison worker to provide ongoing support. Managers also offered staff who had worked with the person one to one support and support from the trust psychology team. The area service manager had also identified what lessons could be learned. Staff in all the crisis resolution and home treatment teams had started using immediate safety plans as result of this incident. The trust was to train all staff again in suicide awareness.

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

In the last two years, there has been one 'prevention of future death' report sent to Derbyshire Healthcare NHS Foundation Trust, however it doesn't relate to this service.

Is the service effective?

Assessment of need and planning of care

Staff did not always keep appropriate records of the care and treatment they provided to people who used the service. Records were not always clear, up-to-date and available to all staff providing care. We looked at 18 completed care plans for people who used the service. Six of

these from the teams in Chesterfield and High Peaks and Dales included a detailed care plan that showed staff how to support the person to meet all of their needs.

We observed multidisciplinary clinical meetings where the teams discussed all the needs of the person. They had a lot of information about each person who used the service which they used to plan the ongoing care and treatment. This information was in the person's electronic record. However, staff showed us how difficult it was to access all this information in one document as they had to open up each contact with the person.

Best practice in treatment and care

Staff in the crisis resolution and home treatment teams followed National Institute for Health and Care Excellence guidance relevant to their practice. For example, staff followed guidance on the management of anxiety and depression and prescribing to people who have psychosis. Staff in the teams used the 'Becks suicide intent scale' to assess the risks to people who used the service. They also used health of the nation outcome scales. These measured the health and social functioning of people who used the service as part of their assessment.

Staff offered psychological education to people who used the service. For example, they offered people techniques on how they could manage their anxiety or their low mood. As staff in the teams only worked with people for a short time (usually maximum of six to eight weeks) they did not offer psychological therapies. Several staff in the teams were trained in compassion focused, dialectal behaviour and systemic skills therapy. They used techniques from these therapies to engage with people who used the service. Staff referred people for longer term support from psychologists. However, staff told us that the trust had a waiting list of 18 months for a person to be seen by a psychologist.

In five of the 18 care plans we looked at, there was no record that staff had assessed the physical health of the person using the service. In one person's record, staff had noted that the person had high blood pressure. However, staff had not recorded the person's blood pressure or how this was managed. In another person's record, staff had noted that the person had arthritis but not how this was managed or if it affected their mental health. In another person's care plan staff recorded that the person had diabetes but there was no record of how the person was managing their diabetes. However, in another three people's care plans staff had detailed how to support the person to manage their physical health needs. In one person's record, staff had explored the person's physical health needs and put a plan in place to work with the person's GP to follow up on the results of tests.

In the City and County South team, there were two nurses who trained other staff in how to support people with physical health needs. Staff had requested that the trust purchase an electro cardiogram machine for the team. The trust offered staff training in taking blood samples so this could be done by staff within the teams. We observed that doctors requested that people go to their local health centre or hospital for blood tests and electro cardiogram tests.

In each crisis resolution and home treatment team there was a dedicated support worker who offered advice on housing and welfare issues. This reduced the impact that these issues had on people's mental health.

The teams worked in line with the Department of Health's mental health crisis care concordant, which aimed to ensure people experiencing mental health crisis can get timely help when they

need it. The concordant is a national agreement between services and agencies involved in the care and support of people in crisis. Staff attended quarterly crisis concordant meetings and feedback the information to all staff in the teams.

Clinical staff actively participated in clinical audits. This service participated in six clinical audits as part of their clinical audit programme 2017 – 2018. These included two about the recording the mental capacity of people when undertaking medical reviews in the crisis teams, medicines reconciliation in the crisis teams, communication by letter to people who were seen by the team for confusion, the referral criteria to crisis resolution and home treatment teams and prescribing benzodiazepines when discharging a person from the Radbourne Unit. Audits we looked at showed that staff had improved their practice as a result of the findings. Where further improvement was needed, the trust made arrangements to repeat the audits and monitor performance with current standards.

Skilled staff to deliver care

Mental health crisis services

The crisis resolution and home treatment teams consisted of nurses, doctors, occupational therapists and some social workers. The band 6 posts were for mental health practitioners and not just restricted to nursing staff. The trust had identified the need for pharmacist input into the teams and was recruiting pharmacy technicians. Staff said they used their own clinical skills to benefit the people using the service and complemented each other in the team. As a result of the crisis review, managers hoped to improve the skill mix in the recruitment of staff. They had advertised for band 4 support workers who were specialist in substance misuse and housing issues.

Since our previous inspection in June 2016, the trust had improved the staff induction process. When a new staff member started working in the crisis resolution and home treatment team they were supernumerary for the first two weeks. They had an opportunity to get to know the area and the team they worked in, learnt how to use the patient electronic record system and did some of the mandatory training. Each staff member had to work through a ‘one stop shop’ on the trust intranet to be aware of all the trust’s policies. In the first month of employment, the staff member identified their goals with their manager and reviewed these again after three months and then six months. They had supervision with their manager at least every six weeks. Before the staff member did the duty cover they had to shadow a duty worker for at least three times.

The trust had trained staff in the teams in the mandatory training they needed for their role, since our previous inspection in June 2016. Staff also told us they had received training in equality and diversity, how to meet the needs of people with autism and psychological therapies. This meant they had the skills needed to support people who used the service.

Health based places of safety

Staff who were the ‘bleep holders’ covered the health based places of safety. The trust had trained them in the responsibilities of the ‘bleep holder’. However, they had not received any specific training to work in the health based place of safety.

Mental health crisis services

Managers did not always appraise staff work performance in a timely way. The trust’s target rate for annual appraisal compliance was 90%. However, at March 2018 the rate for the Chesterfield

team was 79% and at City and County South team was 63%. At the time of our inspection, there were six staff members in the City and County South team who had not had an annual appraisal. Managers had booked these to be completed in the next few weeks.

As at 28 February 2018, the overall appraisal rates for non-medical staff within this service was 81%. The teams failing to achieve the trust's appraisal target were the following crisis resolution and home treatment teams: High Peak and Dales with an appraisal rate of 56%, City & County South at 63%, Chesterfield at 79% and the Mental Health Advice and Assessment Hub team at 67%, and Liaison Team North at 81%.

The rate of appraisal compliance for non-medical staff reported was (as of 28 February 2018) lower than the 85% reported for the previous financial year.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
High Peak and Dales CRHT	9	5	56%
City & County South CRHT	32	20	63%
MH Advice + Assessment Hub	3	2	67%
Chesterfield CRHT	24	19	79%
Liaison Team North	21	17	81%
Criminal Justice Liaison Team	20	18	90%
Liaison Team South	24	23	96%
In Reach + Home Treatment OP	11	11	100%
Hope & Resilience Hub	23	20	87%
Service total	**167**	**135**	**81%**
Trust wide	**2406**	**1858**	**77%**

The trust's target rate for appraisal compliance is 90%. As at 28 February 2018, the overall appraisal rates for medical staff within this service was 78%.

County Crisis Medical team failed to achieve the trust's appraisal target with an appraisal rate of 0%. The rate of appraisal compliance for medical staff reported was (as of 28 February 2018) lower than the 91% reported in the previous financial year. However, the trust informed us that they achieved 100% compliance at the end of year with the NHS England target.

Team name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
County Crisis Medical	2	0	0%
City Crisis Medical	3	3	100%
Liaison Team North	1	1	100%
Liaison Team South	3	3	100%

Service total	**9**	**7**	**78%**
Trust wide	**114**	**77**	**68%**

All staff told us that managers regularly supervised them. At the time of our inspection, the rate of management supervision in the City and County South crisis resolution and home treatment team was 91%. This had increased from 72% in April 2018.

Staff told us the amount of clinical supervision they had varied depending on their clinical background, for example, occupational therapists had regular clinical supervision. Staff said that they found the multidisciplinary meetings useful in discussing their clinical skills and were a form of clinical supervision but this was often not recorded as such. Band 6 staff met together regularly for group development supervisions. At the time of our inspection the rate of recorded clinical supervision in the City and County South team was 59%. This had increased from 47% in April 2018.

The trust's measure of clinical supervision data is sessions delivered. Between 1 March 2017 and 28 February 2018 the average rate across all nine teams in this service was 71%.

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

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
City & County South CRHT	352	174	49%
MH Advice + Assessment Hub	50	27	54%
Criminal Justice Liaison Team	225	123	55%
Liaison Team South	276	241	87%
Chesterfield CRHT	290	270	93%
Liaison Team North	201	187	93%
High Peak and Dales CRHT	94	94	100%
Radbourne Campus - Hope & Resilience Hub	230	94	41%
Service total	**1718**	**1214**	**71%**
Trust Total	**19680**	**12660**	**64%**

Multidisciplinary and interagency team work

Mental health crisis services

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and occupational therapists supported each other to provide good care. In the City and County South team, the multidisciplinary team met to discuss the care of each person who used the service fortnightly. They aimed to do this weekly when the two teams split. We observed four

multidisciplinary team meetings across the crisis resolution and home treatment teams. These were thorough and effective, staff showed respect for each other's professional opinion and shared the tasks to support people who used the service.

The Chesterfield and High Peak and Dales teams worked effectively with other teams in the trust. Staff in the City and County South teams told us they worked well with some Neighbourhood teams but other relationships were at times strained. They said that staff in the Neighbourhood teams did not always understand their role and thought they were no longer responsible for the person once referred to crisis resolution and home treatment teams. The clinical lead met with managers in the Neighbourhood teams regularly to help them work together more effectively and attended their weekly allocation meetings.

The police and local clinical commissioning group had funded a new team called the Joint Engagement Team. This consisted of a mental health practitioner and a specially trained police officer who worked full time within the mental health community teams. The team worked with people who had several section136 detentions, who often called ambulances, had multiple attendances at emergency departments or excessive admissions to a mental health hospital. Staff at crisis resolution and home treatment teams worked with and could refer people to this team.

Staff in the teams liaised with social services, housing services, food banks, refugee associations, women's and men's centres, domestic violence services and services for people who are homeless. There was a crisis house in Derby and staff from the teams referred people there when needed.

The crisis resolution and home treatment teams had a handover between each shift. Staff did not record the handover in the City and County South team so those staff unable to attend would not know what the risks and needs of people who use the service were that day.

Health based places of safety

The trust participated in the multi-agency group with other organisations involved in the operation of the section 136 of the Mental Health Act. These included the police, ambulance services and the local authority. In the Chesterfield crisis resolution and home treatment team, we saw that good partnership working between the staff in the trust, police and ambulance services had led to a significant reduction in the use of the 136 suite. Delays in assessing people under the Mental Health Act were rare. All teams reported that they had good working relationships with the approved mental health act practitioners' teams.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983. They knew how to support patients experiencing mental ill health.

Staff were aware of who the trust Mental Health Act administrators were and worked with them to make sure they followed the Mental Health Act.

All staff we spoke with told us they had received training in the Mental Health Act and the Code of Practice. This had included updated information about changes to section 136 and all staff were aware of the trust's updated policy. As of 28 February 2018, the trust had trained 84% of staff in this service in the Mental Health Act. The trust stated that this training was mandatory for all

services for inpatient and community staff and was completed once. The training compliance reported during this inspection was lower than the 91% reported for the previous year.

The trust general manager chaired a quarterly meeting on the implementation of the Mental Health Act 1983. Minutes of these showed that those present discussed outcomes and future learning so that staff implementation of the Mental Health Act could be improved.

Health based places of safety

Records in both of the health based places of safety showed that staff had explained to the person using the service their rights under section 132 of the Mental Health Act 1983. All staff were able to describe how they would refer patients to an Independent Mental Health Advocate and did this where appropriate.

Staff told us they sent the section 136 paperwork to the Mental Health Act office and this was scanned into the person's record on the electronic patient records system. In the 136 suite at the Hartington Unit, we found some inconsistencies in recording on the patient electronic records system. Some section 12 doctors had entered their contact with the person in the clinical notes section of the assessment document but others did not do this. This could mean that all the information about the person is not available.

Good practice in applying the Mental Capacity Act

Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care.

Since our previous inspection in June 2016, staff understanding of the Mental Capacity Act 2005 had improved. The trust had trained all staff in the Mental Capacity Act and staff were able to undertake decision specific capacity assessments. Staff had to complete on the electronic patient record system their rationale as to how they had assessed if the person had the mental capacity to make the decision. They also had to record how they had concluded that the person did not have capacity. The trust had issued staff with prompts on the back of their identity badges as a reminder to consider the person's mental capacity in all decisions about their care and treatment. Staff had recorded if the patient had the mental capacity to make a decision or if they were unable to give consent to a decision. Staff always sought people's consent to care and treatment.

All records we looked at showed that staff had assessed the patient's capacity and there was evidence of informed consent. We observed that staff discussed whether or not people who used the service had the mental capacity to consent to decisions in the meetings they held about them. Staff also assessed the person's insight into their distress and understanding of the care and treatment offered to them. Records included examples of where staff had discussed the appropriate care and treatment for people that was in their best interests.

Band 7 staff completed regular audits of how staff were applying the Mental Capacity Act 2005. In the Chesterfield and High Peaks crisis resolution and home treatment teams' staff recording of people's capacity had improved significantly from 20% of records audited to over 80%. Managers also recorded that the quality of recording had improved and staff had improved their understanding of why capacity assessments were essential in meeting people's needs.

The trust trained staff in the Mental Capacity Act. As of 28 February 2018, 88% of the workforce had received training. The trust stated that this training is mandatory for all services for inpatient

and community staff and is completed once. The training compliance reported during this inspection was lower than the 95% reported for the previous year however; staff were booked to receive this training.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff cared for people who used the service with compassion. Feedback from patients confirmed that staff treated them well and with kindness. People who used the service said that staff were kind, caring, respectful, polite, always there for them and genuinely interested in their wellbeing.

We observed that staff offered people who used the service choices about the times they would visit and were flexible. People who used the service told us that staff never cancelled their appointments and always arrived on time. People said that staff always returned their calls promptly.

Staff gave people the telephone numbers to contact the crisis resolution and home treatment team. One person said they could always contact the team at all times of the day and night. However, one person said they had a problem contacting the team at night but never during the day.

People who used the service said that the doctor had discussed their medication with them and offered them choices about these. They also said that staff gave them advice on smoking cessation, healthy eating and sleep patterns. One person said that staff had made sure they understood the treatment options offered and had not rushed them to make choices about these. Staff gave people information leaflets to help them to understand their mental health and what they could do to improve it. People told us they had found the information helpful.

Staff tried to reduce the amount of different staff who had contact with the person to provide consistency of care. People told us they appreciated this. One person said that only three staff had visited them which helped them to feel less anxious about meeting new staff.

We observed that staff knew patients well. Staff spoke about people who used the service with empathy and respect.

Staff provided emotional support to people who used the service to minimise their distress. One person said that they would not be here without staff as staff had visited them straightaway and discussed coping strategies which helped them. We observed staff worked with people and their relatives to help them cope emotionally, encourage independence and take responsibility for their safety. Staff discussed in detail in the multidisciplinary team meeting how they could support the person to reduce their dependence on the crisis resolution and home treatment team.

We met with some people who used the service in the Hope and Resilience Hub at the Radbourne Unit. People told us that staff had offered them consistent support and they visited the Hub daily. They said activities at the Hub helped to distract their thinking and had prevented them from becoming a danger to themselves.

Involvement in care

Involvement of patients

People who used the service told us that staff involved them and those close to them in decisions about their care and treatment. They said staff involved them in writing their care plan and staff always asked for their views and listened to them. The crisis, relapse and contingency care plan was written in a way that asked for the person's views. For example, looking after myself when I become unwell and recognising when I am becoming unwell. However, we looked at 18 people's care plans. Staff had recorded on only one person's record that they had offered a copy of the care plan to the person. Staff told us that they involved people but did not always record this on the electronic patient record system. We observed in meetings about people who used the service that staff always considered the person's views. People did not attend the meetings but managers spoke of plans to use Skype in the future so they could be involved. People who used the Hub at the Radbourne Unit were invited to attend meetings there about their care.

Staff at the City and County South team had drafted a sample leaflet with written information about the team which they had sent to the trust's communication team for printing. However, this had not been produced. The managers agreed to follow this up. People who used the service were not involved in the recruitment of staff but managers had recognised that this was needed.

Staff referred people to advocacy services and people said that advocates were readily available. We saw in the patient information folder that described what an advance statement was and asked the person if they wanted information about them shared with their family or carer. Records showed and people who used the service told us that staff respected their wishes, for example, staff did not visit the person while their relative was there.

In the City and County South crisis resolution and home treatment team, the band 8 nurse consultant showed us how they were developing advance decision plans for people who use the service to complete. This included asking the person what staff should do if the person needed to come into hospital or go to the crisis house and how they would want their relatives, including their children, to be involved. Staff recognised that this work needed to be done with people who used the service once they had developed a relationship with the person. We observed in staff handover sessions that staff discussed whether the person had any advance statements or decision plans in place.

Involvement of families and carers

Carers told us that staff were always concerned about how they were and they felt included in the care of their relative. Carers said that staff were always available for them, returned their telephone calls promptly and never cancelled any appointments.

The trust had produced an information booklet for carers and families and a contact card for quick reference to numbers of organisations in the area who could help them. Carers told us that staff had given them a copy of this and had found it useful. We observed that a carer was involved in a meeting about their relative and staff listened to their views.

Within each crisis resolution and home treatment team, there was a staff member who was a carer's champion. In the High Peak and Dales team the champion had developed support for carers in their local area.

Is the service responsive?

Access and waiting times

Mental health crisis services

People could access the service when they needed it. The crisis resolution and home treatment teams operated 24 hours a day, seven days a week and were commissioned to provide services to adults aged 18 to 64 years. The teams had no clinical exclusion criteria. However, if a person had used drugs or alcohol the assessment might be delayed to make sure staff and the person were safe.

Staff contacted the person using the service within four hours of them being referred. At this contact staff ensured the person could maintain their safety and gave them contact numbers. The teams aimed to assess people within 24 hours of the referral. We saw that staff assessed people in the evenings as well as during the day. Staff said this had improved due to the addition of twilight shifts from 1 to 10pm. The average duration of a home treatment episode was for six to eight weeks for all teams.

There was no waiting list for the crisis resolution and home treatment teams. Each team worked from the 'assessment board' in the office which listed people waiting for an assessment. Staff assessed the urgency of these in discussion with the referrer to the team. On each shift, there were band 6 clinicians who could complete assessments. People who used the service of the City and County South team could be referred to the Hope and Resilience Hub at the Radbourne Unit as part of their treatment. There was a two week waiting list for this.

At the time of our inspection, there were 72 people using the service of the City and County South crisis resolution and home treatment team. There were 20 people in the City on home treatment and 22 people in the County South. The area service manager said they did not monitor access and waiting times to the teams. However, they had recently reviewed the service specification with the commissioners and this had highlighted the need to look at response times. The service specification was for four to 24 hours and was with the commissioners to formally agree this.

The crisis resolution and home treatment teams held gate keeping responsibilities for all acute mental health inpatient beds at the Hartington Unit, Radbourne Unit and the Stepping Hill hospital in Stockport (for Derbyshire patients only). If staff from the neighbourhood teams requested that a person needed to be admitted to hospital staff from the teams would visit the person to complete an assessment.

The crisis resolution and home treatment teams worked with the in-reach teams. They supported people with discharge from wards and aimed to discharge them earlier where home treatment was more appropriate to meet their needs. The crisis resolution and home treatment teams also worked with the psychiatric liaison teams who were based at the acute hospital emergency departments. Staff from the teams assessed people with staff from the psychiatric liaison teams at night where needed.

Staff said that there were delays in the community mental health neighbourhood teams for people waiting to be allocated to a care coordinator. This sometimes impacted on how long a person was treated by the crisis resolution and home treatment teams. Staff visited people who had been allocated a care coordinator with the care coordinator.

Health based places of safety

Staff recorded delays in accessing Approved Mental Health Professionals for assessments under section 136 of the Mental Health Act on the trust electronic incident report system. They worked with the Approved Mental Health Professionals lead to see how they could reduce these. Managers attended quarterly meetings with the police, ambulance service and social services where they also discussed any delays in people using the health based places of safety. There had been no breaches of people accessing the 136 suite within the set timescale at the Hartington Unit.

There were improvements made in reducing the impact of people's mental health crisis. In the North of the County, a street triage team had been set up with the input of the crisis concordant and local commissioners. The team worked on the streets with those in distress due to their mental illness. This service was available seven days a week from 4pm to midnight on Monday to Friday and 9pm to midnight on Saturday and Sunday. The county council employed the staff in the team but the trust managers managed the team. The team consisted of three nurses and two social workers with one of each profession per shift. The number of people who used the 136 suite at the Hartington Unit had reduced as a result of this service.

In the three months from January to March 2018, 78% of assessments of people using the 136 suite took between four to eight hours to complete. One assessment had taken between 8 to 16 hours. There had been no assessments at police stations.

The trust provided information on 'referral to initial assessment' and 'assessment to treatment' times for the below services. All six services met the referral to assessment targets.

Name of hospital site or location	Name of team	Service Type	Days from referral to initial assessment		Days from assessment to treatment	
			Target	Actual (median)	Target	Actual (median)
Hartington Unit	Crisis & Home Treatment Team North & High Peak	Campus Assessment Services	126	1	n/a	0
Trust HQ	Liaison & Diversion Services (Criminal Justice)	Forensic & Rehabilitation Services	126	0	n/a	3
Trust HQ	Forensic Psychiatry	Forensic & Rehabilitation Services	126	54	n/a	32.5
Hartington Unit	Chesterfield CRHT	Hartington Campus	126	1	n/a	0
Hartington Unit	County South & City CRHT	Hartington Campus	126	1	n/a	0

Hartington Unit	Hartington In-Reach Team	Hartington Campus	126	0	n/a	1

The facilities promote comfort, dignity and privacy

Mental health crisis services

Staff from the crisis resolution and home treatment teams visited most people in their own homes. Staff worked flexibly and occasionally saw people in their local health centre or at the Hub at the Radbourne Unit if the person requested this. Staff from the in-reach teams visited people on the hospital wards. Staff worked with the people who used the service to agree the type and frequency of visits and contact with them.

Staff gave people advice about other services they may benefit from, for example, housing, welfare rights, advocacy, debt advice, drug and alcohol services and domestic violence support agencies. In the Chesterfield, City and County South teams the trust had employed band 4 support workers who could offer advice to people who used the service on housing and welfare benefits. Staff said this input had reduced admissions to hospital, earlier discharges from hospitals and reduced the length of time the person used the team.

Health based places of safety

At the Hartington Unit people who used the service did not have free access to outside space. There was not a bed although staff could bring a mattress and bedding from a storeroom. Most people only stayed in the suite for a few hours however, they could stay for up to 24 hours. The use of service was one of the lowest in the country in NHS benchmarking data. The entrance to the health based place of safety was up a concrete ramp beside the main entrance to the Hartington Unit. This was not discreet if the person was in a disturbed state.

In both health based places of safety there was a clock that the person using the suite would be able to see to orient them to time. A shower, toilet and sink were available. Staff ensured the person had access to snacks, meals and drinks, toiletries and a telephone, as required.

Patients' engagement with the wider community

Staff in the City and County South team could refer people to the Hope and Resilience Hub at the Radbourne Unit. People told us this helped them to become less isolated and they had an opportunity to engage with the wider community. Staff offered people who used the teams support with their employment and liaised with their employers in how they could make reasonable adjustments to keep the person employed.

Staff from the teams offered training in suicide prevention to police and the Red Cross who worked with refugees and asylum seekers in the local area. They also planned to offer this to employers in the area.

Meeting the needs of all people who use the service

Mental health crisis services

The service took account of patients' individual needs. People who used the service told us that continuity of care was important. The teams tried to make sure that people were seen by the same group of staff.

The teams had access to language interpreting services. We observed staff discussed if there was a need for this service when assessing the person's needs in the clinical discussion meetings. The trust produced information about the service and about medicines in a range of languages.

Staff gave us examples of how they had supported people with visual and hearing impairments so there were no barriers to the person receiving care from the teams. Staff could access British Sign Language interpreters and also used text talk facilities. Information was available for staff in the offices on how to support people with autism.

Staff responded quickly to people's complex needs, for example, they referred people to specialists where needed. In the City and County South teams, the trust employed a band 8 nurse consultant. They worked with people who had complex needs, who were often admitted to mental health hospitals, attended hospital emergency departments or regularly used the health based place of safety. They responded to these people's needs to assess if staff could work with them in a different way to support the person in the community.

Health based places of safety

There was level access to both places of health based places of safety so that people with a physical disability could access these. However, due to ligature risks there were no rails in the shower room and toilet.

Staff had access to language interpreting services. However, information about the rights of people using the 136 suite was not available in an easy read format.

Listening to and learning from concerns and complaints

Staff knew how to handle and report complaints. They logged them on the trust's electronic system and followed the trust's policy for investigating and responding to complaints. Managers discussed any themes of complaints and how they could respond to these to improve the service.

The trust produced information about how to make a complaint in a way that was clear to people who used the service. People who used the service and their relatives told us they knew how to make a complaint if they needed to. People were confident that staff would try and resolve their concerns or complaints.

This service received 21 complaints between 1 March 2017 and 28 February 2018. There were nine complaints about staff abruptness, rudeness and unprofessionalism. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Ward name	Total Complaints

Crisis Resolution & Home Treatment Team - Chesterfield	8
RAID Liaison Team - South	6
Crisis Resolution & Home Treatment Team - City & County South	5
RAID Liaison Team – North	2

Staff also knew how to respond to compliments and recorded these on the trust's electronic system.

This service received 139 compliments during the last 12 months from 1 March 2017 to 28 February 2018 which accounted for 12% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Staff in all teams we visited told us that their managers were supportive. In the High Peak crisis and resolution home treatment team, there was an operational manager there for only one day a week. They worked in the Chesterfield team but managed both teams. A clinical manager also supported the team one day a week. Staff said that the High Peak team would benefit from more management support.

In the City and County South team there were two band 7 clinical leads. The crisis review recommended that there be an operational manager at band 8 and the trust had advertised to recruit to this post. The operational manager would manage both teams when they split in the future. We found that there was a lack of operational management and oversight in the team.

Most staff said that senior trust managers were more visible than at our previous inspection in June 2016. Senior managers and board members had visited the teams. Some staff had attended the trust board meeting which had included a focus on the work of the crisis resolution and home treatment teams. The board members had emailed the teams to thank them for their presentation. Staff said they could meet with the Chief Executive if they wanted to and they and the trust Chief Operating Officer were approachable.

Vision and strategy

Staff knew and agreed with the trust's vision and values. The trust had updated their vision and values. Staff said this was changed following consultation with them and that senior managers had listened to their ideas. All staff we spoke with said they put the person at the centre of everything they did and worked better together. They said these values were embedded within the work of their team.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. All staff we spoke with told us that the culture of the trust had improved since our previous inspection and most said it was now a nice place to work. Staff said they thought their views were listened to by senior managers and the board.

We specifically asked 17 staff members if they would be confident to raise concerns without fear of victimisation and 16 replied that they would. One staff member said they would raise concerns but they would do this anonymously. Staff told us there was not a blame culture within the teams.

All staff were aware of who the trust Freedom to Speak Up Guardian was and how they could contact them. We saw posters displayed with this information in all the offices and health based places of safety we visited.

We reviewed the staff appraisal process and saw this included conversation about career development and how this could be supported. The process had been simplified since our previous inspection. It encouraged staff to reflect on their yearly performance and development and identify personal and professional needs and goals for the future.

Staff at higher band levels reported that the trust promoted equality and diversity in its day to day work and in providing opportunities for career progression. However, support workers and administrative staff in band 4 and below posts said it was difficult to develop and progress to higher band posts as there was limited career progression within the trust.

Governance

The trust provided mandatory training to staff. Managers regularly supervised and appraised staff who also received informal support from managers and their peers. The regularity of supervision had improved significantly since our previous inspection.

In the City and County South crisis resolution and home treatment teams there were two band 7 clinical lead but no operational manager. However, the trust had advertised to recruit to this post. We found that there was no clear governance structure in the team. None of the staff we spoke with could articulate how the team worked together and if there were any structures in place. We looked at the minutes of six team meetings. There were no issues arising from the previous minutes or any follow up to discussions. In the minutes of the meeting on 10 October 2017 staff discussed a recent care plan audit carried out by the clinical lead. There was no evidence that staff had taken out care plans to people who used the service and agreed by them and their carers. All staff were asked to note this. The minutes of the meeting on 6 February 2018 discussed another care plan audit and all staff were asked again to note to give a copy to the person. We found at this inspection that there were several records that did not evidence that staff had given a copy of the care plan to the person and had not recorded that the person was involved. This meant that although managers had identified improvements were needed through audits there was no structure to ensure these improvements were made and embedded into the work of the staff team. We also looked at four staff supervision records. There was no indication of the dates of the previous supervision or what was discussed. Only one of the four records was detailed and had a follow up date for the next supervision. Staff were not able to provide further supervision records requested so we could track if this was a systemic issue.

The trust has provided their board assurance framework, which details any risk scoring 15 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The four strategic ambitions outlined by the trust relating to this service are as follows:

1 - We will deliver **quality** in everything we do providing safe, effective and service user centred care
2 - We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time
3 - We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.
4 - We will **transform** services to achieve long-term financial sustainability.

Management of risk, issues and performance

All staff said they could submit items to the trusts risk register and found this a useful tool. For example, staff in the City and County South crisis resolution and home treatment team had identified a connectivity issue with the Wi-Fi in the office so put this on the risk register. Staff from the trust's information technology team visited the office and found that the Wi-Fi did not work so they replaced the hub.

Staff from the City and County South team told us that the two teams were put together as part of a cost improvement programme. The crisis review had found that this compromised care and had recommended that the team split again. Managers were currently recruiting staff to work in the teams and the teams would split when safe staffing levels were reached. Managers said that the trust board and senior managers regularly monitored the use of agency staff but did not stop using them if needed to care for people who used the service.

Managers discussed safeguarding concerns raised in their fortnightly operational meeting.

The levels of staff supervision and appraisals had increased since our previous inspection in June 2016. All staff had an identified supervisor. The rates of mandatory training had also improved. The trust had improved the staff induction process and this was formalised and robust. Staff also had group peer development supervision. The trust held Schwartz rounds which helped improved practice, all staff were informed of these by email and the outcomes to make improvements across the service.

There was one grievance process ongoing. Managers said this process had been delayed due to the trust human resources department merging with a neighbouring trust. However, they said they now had an allocated human resources lead to each team who met with the team managers every six weeks to look at performance issues.

Information management

Some staff told us that the electronic patient record had improved. All staff had laptops so they could access the patient record system remotely, respond to their emails and use Skype. However, most staff in all the teams showed us examples of difficulties they had in using the patient electronic records system. For example, staff said that if a person using the service had taken an overdose they would not know this by looking at the person's name on the system. They

would have to open all the documents of contact with the person. We found that staff could not open one document which would show all of the person's current assessment, needs and risks.

Managers had put a business case together so staff could access other patient record systems, for example, to the Improving Access to Psychological Therapies service. They recognised this would be a significant cost but staff would find this useful when assessing people who used the service.

Managers told us the trust's information team were able to access information from the electronic systems and put into report formats which they found helpful.

The trust was changing all staff emails to the nhs.net system which would allow them to communicate more effectively across the NHS.

Engagement

Staff, people who used the service and their carers had access to up-to-date information about the work of the trust and the services they used, through the staff intranet, bulletins and staff and carer's meetings. People who used the service and their carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Staff had access to the feedback from people who used the service, their carers and staff and used it to make improvements.

Staff reported that senior members of the leadership team were approachable and they could give feedback on the service.

Area service managers engaged with external stakeholders including commissioners, police, ambulance services, social services and other regulatory bodies where required.

Learning, continuous improvement and innovation

Staff who were band 6 and above told us they had opportunities for leadership development, opportunities to feedback on services and input into service development. Staff said they had attended a trust listening event where they felt able to express their views about service development. Staff had attended leadership training through the East Midlands Leadership Academy, NHS leadership academy and through the trust.

The area service manager said the crisis review was research based and was an ongoing process to develop the City and County South team through recruitment and splitting the team into two. Staff said that this would improve the quality of care offered to people who use service.

In the City and County South team the trust had employed a band 8 nurse consultant. They had a caseload of people who used the services in the trust as well as the emergency department at the acute hospital, ambulance service and social care service. The trust had audited their role and the amount of services these people used. They found that through this specific work, people had reduced the amount of services used.

Since our previous inspection, the trust had worked with staff to improve how they assessed the mental capacity of people who used the service to make specific decisions about their care and treatment. Audits had shown and we found that these had improved significantly.

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

The trust had prioritised over recruitment and staff training over accreditation this year. This was to reduce staff pressure.

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

Facts and data about this service

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

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Hartington Unit	Hartington Unit Morton Ward	24	Mixed
Hartington Unit	Hartington Unit Tansley Ward	24	Mixed
Hartington Unit	Hartington Unit Pleasley Ward	20	Mixed
Radbourne Unit	RDH Enhanced Care Ward	10	Mixed
Radbourne Unit	RDH Ward 33 Adult Acute Inpatient	20	Female
Radbourne Unit	RDH Ward 34 Adult Acute Inpatient	20	Male
Radbourne Unit	RDH Ward 35 Adult Acute Inpatient	20	Mixed
Radbourne Unit	RDH Ward 36 Adult Acute Inpatient	20	Mixed

Is the service safe?

Safe and clean care environments

Safety of the ward layout

The trust completed annual risk assessments of the ward environment and staff completed updates when new risks emerged or following incidents and lessons learned.

Hartington Unit had three wards with two wards located on the first floor and one ward located on the ground floor. Radbourne Unit had five wards. Wards 33, 34 and 36 were located on the first floor, and wards 35 and the enhanced care ward were located on the ground floor.

All the wards had similar layouts. On entry to a ward, there was a long corridor that had staff offices, meeting rooms and storerooms. The end of the corridor held the nursing station and opened out into a communal area, which had bedroom corridors to the left and right of it. The bedroom corridors held dormitory bedrooms, some single rooms, and patients' bathrooms and toilets.

The nursing station allowed observation of most areas of the wards although there were some blind spots around corners along the bedroom corridors on all the wards. The wards did not have parabolic mirrors installed to help manage the risks. Staff managed risk through individual risk assessments and observations. However, the new observations process made this more difficult.

During our inspection, we found additional risks on the units. The single rooms on ward 33 and some rooms on the enhanced care ward had viewing window panels positioned too high for most staff to see through easily. The ensuite bathroom on Tansley ward had a wall that separated the toilet and shower areas. However, this limited the space in the bathroom, especially the access to the shower area. In addition, the narrow corridor to the shower contained a large radiator, which created a hazard and narrowed access to the shower area for the patient, and to staff should they need to assist the patient. The ward manager had reported the issue and awaited a resolution.

Each ward had received a full ligature risk assessment in the last 12 months. All wards had ligature anchor points that staff knew about and dealt with appropriately to reduce the risks to patients. For example, staff designated toilets that had door handles that could act as ligature anchor points for staff and visitors only, and locked them when not in use. Other rooms that had ligature anchor points (such as the laundry, some bath and shower rooms, the gardens, the recreation room on ward 33) had supervised access for patients. The furnishings and fittings on the wards were anti-ligature, for example, showers, taps and curtain rails. Since our last inspection, the trust had removed doors from wardrobes in the dormitory bedrooms as they had presented ligature risks.

The trust reported no mixed sex accommodation breaches in the 12 months to 28 February 2018. The layout of the wards complied with the Department of Health gender separation requirements. Radbourne Unit had two single sex wards. The other six wards were mixed-gender wards, which had separate male and female bedroom corridors, separate bathroom facilities, and female-only lounges. However, on Pleasley ward, we saw a male patient sat in the female-only lounge in the presence of female patients. Staff did not intervene to redirect the patient. Staff informed us that male patients went to the lounge because it was located in the centre of the ward next to the communal dining room.

All staff had personal safety alarms issued at the start of each shift. Wards at Hartington Unit had nurse call systems fitted in above each bed in the dormitories and in the bathrooms and toilets. The dining rooms and communal lounges did not have nurse call alarms fitted but these rooms were clearly visible from the nursing stations.

Wards at Radbourne Unit had nurse call alarms fitted in bathrooms and toilets. Some of the nurse call alarms in the assisted bathrooms on ward 34 in the Radbourne Unit were located at a height that made them difficult to reach for some people, for example, frail patients, patients with mobility issues and wheelchair users. Staff on ward 35 offered patients mobile alarms.

Maintenance, cleanliness and infection control

All the wards were visibly clean, well maintained and had furnishings that were in good condition. Each unit had domestic staff allocated to each ward who cleaned the wards regularly to a high standard. We saw completed and up-to-date cleaning charts for all areas of the units. However, on Hartington Unit, domestic staff had trolleys that were in poor condition with broken doors and locks that no longer worked. This presented a risk to patients as the trolleys held hazardous items such as chemical-based cleaners. Ward staff asked the domestic staff not to use the trolleys when they had patients with high risks. At other times, when domestic staff used the trolleys on the wards, they left them unattended in order to complete their duties. We raised our concerns with the cleaning supervisor who assured us that he had ordered new trolleys.

Staff experienced challenges with maintenance and repair. The trust had contractual arrangements with two other neighbouring trusts for the provision of estates services, which did not cover damage caused by patients. As such, staff reported faults and damage immediately but experienced delays to repairs as trusts negotiated responsibility. During the week of our inspection, we saw broken cleaning trolleys, broken doors on quiet rooms on two wards at Hartington Unit, and an out of order bathroom in a seclusion room at Radbourne Unit. Staff had reported the issues some weeks earlier.

Staff followed infection control principles such as handwashing. We saw that hand sanitiser, anti-bacterial wipes and protective gloves were available throughout the units. The soap dispensers had information and reminders about handwashing displayed on them. The trust completed annual infection prevention and control audits, and wards completed infection control audits on a six-

monthly basis. However, at Hartington Unit, staff used the storerooms on the wards for mixed storage that included patients' possessions, contraband items, clinical waste, dirty laundry, and medical supplies. This did not promote good infection control practice or patient safety. Some storerooms had staff access only, however, some had supervised access for patients, which presented additional risks. For example, on Morton ward, the laundry held a large clinical waste bin, patients' lockers and staff lockers. The dirty utility room was untidy and held bags of dirty laundry (collected twice a day), trays for patients' toiletry items, reusable shopping bags, and two small clinical waste boxes for sharps. Patients had supervised access to these rooms. On Tansley ward, the dirty utility room, which had staff only access, had a locked cupboard that held clinical supplies and patients' property such as phone chargers. On Pleasley ward, the dirty utility room held the laundry, the sluice, spare toiletries, clinical supplies and patients' belongings such as phone chargers. Patients had supervised access to the room.

In the 2017 patient-led assessments of the care environment at Hartington Unit and Radbourne Unit scored the same or higher than similar trusts in England for the three areas noted below.

Site name	Cleanliness	Condition appearance and maintenance	Disability
Hartington Unit	98.0%	95.3%	94.7%
Radbourne Unit	99.7%	96.5%	90.7%
Trust overall	**99.1%**	**96.3%**	**92.5%**
England average (mental health and learning disabilities)	**98.0%**	**95.2%**	**86.3%**

However, some of the patients we spoke with on wards 33, 34, and 35 complained about the poor standard of cleanliness of the toilets on their wards.

Seclusion room

- The trust had a purpose-built seclusion suite on the enhanced care ward at Radbourne Unit that contained two separate seclusion rooms. The layout, design and contents of the seclusion rooms complied with the Mental Health Act Code of Practice. The seclusion rooms had anti-ligature fixtures and fittings. The rooms had two-way intercoms, temperature control units, toilet facilities (with automatic taps) and clocks. One of the rooms had adaptations that met the needs of people with limited mobility. Staff had the opportunity to offer sensory-based interventions to secluded patients such as music and aromatherapy that helped them relax in one of the rooms. However, at the time of our inspection, one of the seclusion rooms had a toilet area that was out of use because of severe damage to the flooring. Staff said they had reported the issue "some weeks ago" and were still awaiting repair. In the meantime, staff continued to use the seclusion room if needed but locked the toilet door. Staff provided the patient with a receptacle for urgent toilet needs, and during their reviews and observations, they opened the toilet door for the patient, if it was safe to do so.
-
- The Hartington Unit did not have any designated seclusion rooms. Staff rarely used seclusion but when they did, they followed the principles set out in the trust's seclusion and long-term segregation policy.

Clinic room and equipment

Most wards had fully equipped clinic rooms that were secure, clean and tidy. The clinic rooms in Hartington Unit did not have examination couches but these were available in a nearby doctor's examination room. The clinic rooms held clinical equipment such as blood pressure monitors, electrocardiogram machines, pulse oximeters and blood glucometers as well as emergency equipment such as oxygen cylinders, resuscitation equipment and emergency drugs that staff checked weekly. However, we found that not all clinical equipment was clean, well maintained and safe to use. For example, on Tansley ward, the oxygen cylinder had the incorrect mask attached, which was covered in dust. On ward 33, the oxygen cylinder did not have tubing or a mask, and the nebuliser and the contents of the first aid box were out of date. On the enhanced care ward, the oxygen cylinder did not have tubing, and the sharps bin was not labelled.

Electrical items had received the appropriate safety tests. Pleasley ward had a mobile hoist that had been tested and maintained earlier in the year.

Safe staffing

Nursing staff

The tables below show that as of 28 February 2018, the core service did not have enough staff with the right skills to match its staffing establishments for each ward. The service had a total staffing establishment of 235 staff that included 164 whole time equivalent qualified nurses and 68 whole time equivalent healthcare assistants. Ward 33, 34, 35, and 36 each had a staffing establishment of 21 nurses and eight healthcare assistants. The enhanced care ward had an allocation of 18 nurses and 15 healthcare assistants. Each of the wards at Hartington Unit had around 20 nurses and seven healthcare assistants. As of 28 February 2018, this core service reported an overall staff vacancy rate of 18%. At that time, the wards had 53 vacancies for qualified nurses (32%) but no vacancies for healthcare assistants. All wards had vacancies for qualified nurses but Radbourne Unit wards had the highest levels. Ward 34 had 10 vacancies, and ward 33 and 36 each had eight vacancies.

Definition

Substantive – All filled allocated and funded posts.

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

Vacancies and sickness		
Total vacancies overall (excluding seconded staff)	At 28 February 2018	47.2
Total vacancies overall (%)	At 28 February 2018	18%
Total permanent staff sickness overall (%)	Most recent month (At 28 February 2018)	10%

	1 March 2017 – 28 February 2018	8%

Establishment and vacancy (nurses and care assistants)

Establishment levels qualified nurses (WTE*)	At 28 February 2018	164.4
Establishment levels nursing assistants (WTE*)	At 28 February 2018	67.6
Number of vacancies, qualified nurses (WTE*)	At 28 February 2018	52.6
Number of WTE vacancies nursing assistants	At 28 February 2018	-1.3
Qualified nurse vacancy rate	At 28 February 2018	32%
Nursing assistant vacancy rate	At 28 February 2018	-2%

	Registered nurses			Healthcare assistants			Overall staff figures	
Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment
City Adult Acute Medical	0	0	0	0	0	0	3.0	9.0
Ward 34	10.4	21.4	49%	-0.4	7.6	-5%	8.0	30.0
Cnty Adult Acute Medical	0	0	0	0	0	0	1.1	4.0
HU Tansley Ward Adult	5.6	20.3	28%	0.3	7.0	5%	6.4	29.4
RDH Wd 36 Adult Acute IP	8.2	21.4	38%	-1.8	7.6	-24%	6.6	30.0
HU Pleasley Ward Adult	6.3	20.5	30%	0.6	7.1	8%	5.8	28.6
Enhanced Care Ward	5.0	18.2	28%	0.6	15.2	4%	5.6	34.4
HU Morton Ward Adult	4.0	19.8	20%	0.7	7.9	9%	3.7	28.7
Ward 33	7.9	21.4	37%	-1.4	7.6	-18%	3.5	30.0
RDH Wd 35 Adult Acute IP	5.2	21.4	24%	0.1	7.6	1%	3.3	30.0
Enhanced Care Ward Medics	0	0	0	0	0	0	0.2	2.0
Psychology UC South	0	0	0	0	0	0	0	1.4

Service total	**52.6**	**164.4**	**32%**	**-1.3**	**67.6**	**-2%**	**47.2**	**257.5**	
Trust total	**116.2**	**970.5**	**12%**	**34.3**	**375.2**	**9%**	**310.3**	**2490.1**	

*Whole time equivalent

NB: All figures displayed are whole time equivalents

At the time of our inspection, Morton and Tansley wards had recruited staff to all vacancies although not all staff had started work yet. Pleasley ward still had five vacancies for qualified nurses but managed to fill shifts with bank staff. However, all the wards at Radbourne Unit continued to experience staffing shortages caused by vacancies, staff sickness, and high turnover. The staff and managers expressed concern about the staffing issues they experienced daily and said that wards did not always have safe staffing levels.

The core service had a higher average sickness rate than the trust's average. The table below shows that for the year to 28 February 2018, the average staff sickness rate for this core service was 8%, above the trust's average of 5%. The most recent month's data (February 2018) showed a sickness rate of 10% for the service, above the trust's average of 8% for the same month. The enhanced care ward based at Radbourne Unit and Tansley ward at Hartington Unit showed the highest staff sickness rates with 14% and 13% respectively. The sickness rate for the staff on the other wards ranged from 5% to 7%.

Ward/Team	**Total % staff sickness (at February 2018)**	**Ave % permanent staff sickness (1 March 2017 to 28 February 2018)**
Enhanced Care Ward	20%	14%
Hartington Unit Tansley Ward Adult	15%	13%
RDH Ward 36 Adult Acute Inpatient	4%	7%
RDH Ward 35 Adult Acute Inpatient	14%	7%
RDH Ward 33 Adult Acute Inpatient	3%	6%
Hartington Unit Morton Ward Adult	5%	5%
Hartington Unit Pleasley Ward Adult	7%	5%
RDH Ward 34 Adult Acute	13%	5%
Enhanced Care Ward Medics	5%	2%
City Adult Acute Medical	0%	1%

County Adult Acute Medical	0%	1%
Psychology UC South	0%	0%
Service total	**10%**	**8%**
Trust Total	**7%**	**5%**

The core service had a staff turnover rate that matched the trust's average turnover rate. The table below shows that in the year to 28 February 2018, 21 staff had left the service, which equated to an overall staff turnover rate of 10% based on the total substantive staff allocation for each ward. On this basis, Hartington Unit wards showed the highest number of staff leavers during this period. Tansley ward had six staff leave (24%) and Pleasley ward had five staff leave (19%). For the other wards, the ward staff turnover rate ranged between 1% and 12%. However, wards at Radbourne Unit did not have a full establishment of substantive staff and had carried vacancies for some time.

Ward/Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Enhanced Care Ward Medics	2.0	1.0	50%
Hartington Unit Tansley Ward Adult	22.0	5.8	24%
Hartington Unit Pleasley Ward Adult	22.3	4.5	19%
City Adult Acute Medical	6.0	1.0	15%
RDH Ward 34 Adult Acute	20.0	3.0	12%
RDH Ward 35 Adult Acute Inpatient	27.32	3.0	11%
Hartington Unit Morton Ward Adult	26	1.4	6%
RDH Ward 33 Adult Acute Inpatient	27.5	0.8	3%
Enhanced Care Ward	28.8	0.4	1%
County Adult Acute Medical	3.0	0	0%
RDH Ward 36 Adult Acute Inpatient	23.4	0	0%
Psychology UC South	1.0	0	0%
Service total	**209.3**	**20.9**	**10%**
Trust Total	**2167.7**	**219.3**	**10%**

Each ward had a minimum staff allocation based on the number of patients and their needs. However, the ward managers at Radbourne Unit struggled to fill shifts with minimum staffing

requirements due to staffing shortages (substantive staff, bank and agency staff). Some of the ward managers and staff we spoke with said that it felt unsafe on the wards at times because of the low staffing levels when compared to their patients' needs.

Ward managers could adjust their staffing levels easily as long as they provided reasonable justification, for example, to meet enhanced observations or support patients with complex presentations. For example, managers received additional staff to support staff and patients during the refurbishment of the wards at Hartington Unit.

The wards had two daytime shifts and a night-time shift. Most daytime shifts had a minimum of three registered nurses and two healthcare assistants. Most night-time shifts had a minimum of two registered nurses and one healthcare assistant. We found that Hartington Unit wards met the minimum staffing numbers for each shift. Occasionally, managers deployed additional healthcare assistants on night shifts if they had only one registered nurse available. At Radbourne Unit, the wards did not always have the full complement of staff they needed to meet minimum staffing levels. Most wards relied on student nurses. Managers met daily ('huddles') to discuss the staffing issues, identify gaps and propose solutions. Staff moved between wards frequently to help other wards, which reduced the staffing levels on the wards that staff left. One staff member described a situation where three of the four staff allocated to the ward left the ward to meet their patients' needs (for example, a medical appointment), and the staff member was left alone with 18 patients. The staff member had to raise the alarm at one point but reported a delayed response.

The table below shows the shift fill rates for qualified nurses and healthcare assistants for December 2017, January 2018 and February 2018. The data showed that all eight wards had gaps in nursing cover during night shifts throughout this period. However, the data also showed there were over the usual number of healthcare assistants on all of these shifts. The data showed gaps in meeting the minimum staffing levels for some day shifts. Again, ward managers deployed additional healthcare assistants to support the wards.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses %	Care staff %	Nurses %	Care staff %	Nurses %	Care staff %	Nurses %	Care staff %	Nurses %	Care staff %	Nurses %	Care staff %
	December 2017				January 2018				February 2018			
Morton Ward	98.7	144.7	66.1	203.2	112.0	121.9	61.3	254.8	111.2	104.5	57.1	250.0

Pleasley Ward	83.4	107.2	37.1	200.0	103.3	116.7	54.8	203.2	85.6	131.6	46.4	185.7
Tansley Ward	72.0	129.7	51.6	222.6	70.1	145.3	59.7	177.4	78.6	138.9	60.7	189.3
RDH Ward 33	96.6	129.7	70.97	274.2	87.7	135.8	79.0	235.5	83.7	129.6	78.6	250.0
RDH Ward 34	74.6	111.7	61.3	225.8	67.5	125.2	62.9	245.2	75.4	122.8	75.0	182.1
RDH Ward 35	74.01	135.4	64.5	132.3	81.1	121.1	66.1	129.0	81.0	132.1	51.8	135.7
RDH Ward 36	83.1	134.5	50.0	264.5	93.4	125.7	50.0	235.5	91.0	134.8	50.0	260.7
Enhanced Care Ward	75.73%	125.14 %	48.39 %	217.74%	77.10 %	122.32 %	51.61 %	208.06%	80.67 %	126.94%	60.71 %	205.36%

Ward managers rarely used agency staff to cover shifts but tried to use bank staff who were familiar with the wards. The tables below show that in the 12 months to 28 February 2018, this core service used bank staff to cover gaps for healthcare assistants (sickness, absence or vacancy) in 52% of all shifts and 9% of shifts were left unfilled. In the same period, only 1% (432 out of 43209) of shifts required cover for qualified nurses. Agency or bank staff covered the gaps except for 118 shifts that were left unfilled.

Ward/Team	Available shifts (qualified nurses)	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Enhanced Care Ward	4752	2 (<1%)	9 (<1%)	11 (<1%)
HU Morton Ward Adult	5208	14 (<1%)	0 (0%)	11 (<1%)
HU Pleasley Ward Adult	5391	14 (<1%)	90 (2%)	24 (<1%)
HU Tansley Ward Adult	5406	1 (<1%)	0 (0%)	44 (1%)
RDH Wd 35 Adult Acute IP	5712	18 (<1%)	22 (<1%)	11 (<1%)
RDH Wd 36 Adult Acute IP	5580	0 (0%)	4 (<1%)	2 (<1%)
Ward 33	5580	8 (<1%)	149 (3%)	12 (<1%)
Ward 34	5580	96 (2%)	5 (<1%)	3 (<1%)
Service total	**43209**	**153 (<1%*)**	**279 (1%*)**	**118 (<1%*)**

Trust Total	**248873**	**1416 (<1%)**	**5000 (2%)**	**293 (<1%)**

*****Percentage of total shifts

Ward/Team	Available shifts (healthcare assistants)	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Enhanced Care Ward	3960	1864 (47%)	0 (0%)	222 (6%)
HU Morton Ward Adult	2064	1154 (56%)	0 (0%)	121 (6%)
HU Pleasley Ward Adult	1836	624 (34%)	0 (0%)	231 (13%)
HU Tansley Ward Adult	1836	1354 (74%)	0 (0%)	312 (17%)
RDH Wd 35 Adult Acute IP	1980	1228 (62%)	0 (0%)	218 (11%)
RDH Wd 36 Adult Acute IP	1980	1195 (60%)	0 (0%)	108 (5%)
Ward 33	1980	961 (49%)	0 (0%)	171 (9%)
Ward 34	1980	808 (41%)	0 (0%)	122 (6%)
Service total	**17616**	**9188 (52%*)**	**0 (0%*)**	**1505 (9%*)**
Trust Total	**83457**	**15372 (18%)**	**0 (0%)**	**2497 (3%)**

***** Percentage of total shifts

Staff were always present in the communal areas of the wards at Hartington Unit but not at Radbourne Unit. The nursing stations on the wards were centrally located, which helped ensure staff presence. Staffing levels on the wards at Hartington Unit allowed patients to have regular one-to-one time with their named nurses. Staff rarely cancelled patients' escorted leave or activities because of staffing shortages. At Radbourne Unit, patients reported that staff were around but very busy. Most of the wards at Radbourne Unit cancelled activities and occasionally patients' leave because of staffing shortages. Some of the patients we spoke with on ward 36 reported delays to receiving their medication because of staffing shortages. One patient recalled a time when a staff member had asked a patient to find staff to help the staff member.

There were enough staff on the wards in Hartington Unit to carry out physical interventions safely but staff did not think this was always the case on the wards at Radbourne Unit. Most of the staff

on duty on the wards at Radbourne Unit could carry out physical interventions, however, staffing shortages placed pressure on staff at these times.

All staff had received training in physical intervention. The trust had recently changed its physical intervention training programme from the management of violence and aggression to promoting safer and therapeutic services, which had a stronger focus on least restrictive interventions such as de-escalation. Not all staff had received training in the new approach. However, those who had liked the focus on minimal interventions.

Bank staff did not routinely receive training in physical interventions. However, managers ensured that regular bank staff and those booked for long periods received the appropriate training. This helped ensure that there were sufficient staff on the wards who could respond to incidents.

Medical staff

Medical staff worked on a specific unit and had responsibility for a specific ward. Hartington Unit had medical staffing establishment of three psychiatrists and Radbourne Unit had six psychiatrists. Each ward had access to a consultant psychiatrist, a junior doctor, and a specialist registrar or staff grade doctor. In addition, some wards had access to trainee doctors.

Most of the wards had access to adequate medical cover during the day and night, and staff could contact a doctor quickly in an emergency. Junior doctors provided out-of-hours cover supported by the on-call consultant psychiatrist. However, staff on ward 34 reported difficulties in accessing medical staff during the night.

The core service occasionally required temporary medical cover, for example, agency medical staff covered 13% of shifts (410 out of 3127 shifts) in the 12 months to 28 February 2018.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
City Adult Acute Medical	1928	0 (0%)	253 (13%)	0 (0%)
County Adult Acute Medical	750	0 (0%)	157 (21%)	0 (0%)
Enhanced Care Ward Medics	449	0 (0%)	0 (0%)	0 (0%)
Service total	**3127**	**0 (0%*)**	**410 (13%*)**	**0 (0%*)**
Trust Total	**41564**	**0 (0%)**	**4944 (12%)**	**0 (0%)**

***** Percentage of total shifts

Mandatory training

Staff received mandatory training but were they were not all up-to-date with it. The table below shows that as of 28 February 2018, the average mandatory training rate for this core service was 72%, lower than the 76% reported for the previous year (1 April 2016 to 31 March 2017). Compliance rates were lower than 75% for a large number of training courses such as:

- resuscitation (basic life support and defibrillator), 65%
- physical health in mental health, 20%.
- Mental Health Act, 67%
- autism awareness level 1, 56%
- smoking cessation level 1, 67%.

Compliance rates were low for annual refreshers and advanced levels in courses such as:

- positive and safe teamwork (including promoting safer and therapeutic services), 67%
- dual diagnosis (level 2), 51%
- food hygiene awareness update, 56%.

Trust data showed that the core service had poor training compliance in a number of medicines management courses that included use of medication in the management of violence and aggression (68%); administration and documentation (37%); and controlled drugs (36%).

Key:

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

Training course	This service %	Trust target %	Trust wide mandatory/ statutory training total %
Positive & Safe - Teamwork (C&R) MEDICAL EXEMPTION (See individual risk assessment) (Annual)	100%	85%	100%
Resuscitation - Basic Life Support MEDICAL EXEMPTION (See individual risk assessment) (Annual)	100%	85%	100%
Safeguarding - Children Level 1 (once only)	98%	85%	98%
Fraud Awareness (3 yearly)	94%	85%	95%
Data Security Awareness (Previously IG) (Annual)	93%	95%	91%
Fire Safety - Fire Warden (3 Yearly)	91%	85%	64%
Safeguarding - Children Level 2 (once only)	89%	85%	93%

Promoting Safer & Therapeutic Services Non-Clinical Staff (3 yearly)	88%	85%	86%
Promoting Safer & Therapeutic Services Clinical Staff (3 yearly)	87%	85%	85%
Deprivation of Liberty Standards (Once)	87%	85%	85%
Mental Capacity Act (Once)	86%	85%	84%
Medic - Section 12 Approval (EXTERNAL 5 Yearly)	86%	85%	63%
Moving & Handling Level 1 (3 yearly)	85%	85%	83%
Safeguarding - PREVENTing Radicalisation/WRAP Level 3 (3 yearly)	85%	85%	90%
R Safeguarding - Children Level 2 (3 yearly)	83%	85%	90%
Health, Safety & Welfare (3 Yearly)	80%	85%	81%
Aseptic Non-Touch Technique (ANTT) - 2 yearly	80%	85%	79%
Medic - Approved Clinician (EXTERNAL COURSE 5 Yearly)	80%	85%	86%
Safeguarding - PREVENTing Radicalisation - Level 1 (3 yearly)	80%	85%	86%
Care Certificate (Once Only)	77%	85%	84%
Safeguarding - Adults Level 1 (Non Clinical) (3 Yearly)	75%	85%	87%
First Aid at Work Certificate (3 Yearly)	75%	85%	84%
Resuscitation - Immediate Life Support - ILS - (annual)	73%	85%	73%
Moving & Handling Level 2 - People (2 yearly)	71%	85%	68%
Equality, Diversity and Human Rights - Level 1 (3 yearly)	70%	85%	78%
Dual Diagnosis Level 1 (Once)	70%	85%	71%
Meds Mgmt - Use of Medication in the Management of Violence & Aggression v5 (3 yearly)	68%	85%	62%
Mental Health Act 2007 (Once)	67%	85%	79%
Positive & Safe - Teamwork - inc PSTS (Annual)	67%	85%	67%
Smoking Cessation Level 1 (Once Only)	67%	85%	33%
Staff Recruitment Training - All Recruiters (3 Yearly)	66%	85%	59%

R Resuscitation - Basic Life Support & AED (annual)	65%	85%	64%
Safeguarding - Children Level 3 (3 yearly)	65%	85%	80%
Food Hygiene Awareness Update (Annual)	56%	85%	64%
Autism (ASD) Awareness Level 1 (Once)	56%	85%	57%
Dual Diagnosis Level 2 (Once)	51%	85%	57%
R Safeguarding - Adults Level 3 (2 Yearly)	45%	85%	55%
Food Hygiene Certificate (3 Yearly)	40%	85%	35%
Meds Mgmt - Admin & Documentation (3 yearly)	37%	85%	36%
Meds Mgmt - Controlled Drugs (3 yearly)	36%	85%	34%
Physical Health in Mental Health (3Yearly)	20%	85%	24%
General Risk Assessor Training (3 Yearly)	12%	85%	21%
Investigating Incidents, Complaints, Claims & Report Writing (Once only)	0%	85%	71%
Total	**72%**	**85%**	75%

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed the risk assessments of 46 patients that showed that staff completed standard risk assessments with patients on admission but did not always update them regularly or after each incident. Staff used a risk assessment tool known as the safety assessment to assess and record the risks patients presented. Some staff said they felt that the new safety assessments and plans that had replaced the functional analysis of care environments risk tools used in the past did not help them to identify risks and develop risk management plans.

Management of patient risk

Staff were aware of and dealt with any specific risk issues such as falls. Staff completed specific risk plans for patients at risk of falls. Records showed that staff reported any falls as incidents and took appropriate action to support patients after falls. In addition, occupational therapists offered specialist input to wards around falls. For example, on Pleasley ward, an occupational therapist had suggested improvements to the ward environment and arranged the purchase of some specialist equipment.

Staff identified and responded to changing risks to, or posed by, patients. However, staff did not always update patients' care records such as risk assessments and safety plans. Most staff relied

on information shared at handovers and patients' ward reviews. We found that information from different sources did not always match up, which potentially compromised patients' care and safety. For example, on Tansley ward, we found inconsistencies in information discussed at the staff handover meeting, the red to green meeting, a patient's care review meeting and recorded in their electronic records.

We found that the observations policy process was potentially unsafe and not fit for purpose. We observed the observations process as staff raised it as a concern. Staff completed observations based on each individual patient's risks and assessed observation levels, for example, hourly (level 4), 15 minutes (level 3), arm's length (level 2) and eyesight (level 1). There was no formal manual (paper) recording system in use for staff to note where patients were although some staff took their own notes. Staff on observations had to remember where patients were and what they were doing and then record them onto the electronic records system directly after completing them. This meant that observations did not take place as required because the staff member left patients' observations to find a computer to record the observation. We observed the recording process, which took several minutes to complete due to the need to locate a computer, log on, open the application, find the list of ward patients, filter to a list of patients on specific observations, enter the relevant patient's notes, and then add the notes. During this process, the system generated a number of errors that staff had to deal with that created further delays. Although each ward had computers located on the nursing stations, staff had to search for laptops when these were in use. Staff on Morton and Tansley wards reported a shortage of computers on some wards and difficulties finding a workstation. The small laptops converted to hand held tablets. However, these were not fit for the purpose of timely completion and recording of observations.

Staff did not routinely search patients. However, when staff needed to conduct a personal search, they ensured it was done by a staff member of the same gender as the patient. Most wards searched patients' belongings on admission for items not permitted on the wards (known as contraband) and other risky items although ward 33 could not apply a consistent approach to searches because of staffing issues. Most staff had received training in managing violence and aggression training, which included searching patients but not their belongings or bedrooms. However, the trust had replaced this with promoting safer and therapeutic services training, which included training on searching possessions and rooms. As of 28 February 2018, 86% of staff had received the new training and training sessions were ongoing. However, during our inspection, we came across staff who searched patients' possessions even though they had not yet received the appropriate training. Staff did not have any specific equipment to support their searches. Staff did not always complete searches of patients' possessions in private rooms. Some patients we spoke with at Radbourne Unit complained that searches of their possessions took place in communal areas such as the dining room.

We found that most staff and managers were unable to identify a policy or other guidance on what items counted as risky or contraband. The staff and managers we spoke with said they knew what to look for and shared information by 'word of mouth'. We found inconsistencies between staff on what items they classed as risky or contraband, and practice varied across the wards. For example, on some wards, staff held all phone chargers but on other wards staff allowed short

phone chargers. The staff we spoke with could not tell us what information patients received about searches and risky items although we found some patient information booklets that had a list of contraband items.

Staff applied blanket restrictions on patients' freedom only when justified. For example, the ward doors remained unlocked unless the need to ensure patients' safety required greater restriction. However, ward 35 had unlocked doors at times even though they opened onto non-secure hospital grounds. This increased the environmental risks to patients and the risk of absconsion.

We reviewed trust data on incidents associated with absconsion for all wards for the year to 31 March 2018. This showed that the eight wards had reported 290 incidents of absconsion made up of 167 incidents of absconsion and 123 incidents of attempted absconsion for detained and informal patients. Tansley ward had the highest number of incidents with 71 followed by ward 34 with 70. Pleasley ward had the lowest number of incidents with two. The highest number of actual absconsions occurred on Tansley ward (51) and ward 34 (36). The most attempted absconsions (98 out of 123) occurred at Radbourne Unit.

Staff did not adhere to the trust's smoke-free policy although they had tried to implement a tobacco-free environment. They advised patients on admission that they could not smoke tobacco and offered them nicotine replacement therapy or electronic burners. Patients had access to smoking cessation support. As of 28 February 2018, 67% of staff in this core service had completed training on smoking cessation.

During our inspection, we found that illicit tobacco smoking happened on most wards. We smelled tobacco smoking on Tansley ward and ward 33. On ward 33, we heard staff encourage a patient to take a cigarette break. Staff and patients told us that smoking took place in the bedrooms, toilets, courtyards and in other outdoor areas on the hospital sites. This meant that patients had access to contraband and risky items on the ward, such as lighters or matches, which posed a risk to others and a risk of fire. At Radbourne Unit, staff tolerated tobacco smoking to avoid incidents. Staff had experienced aggression from patients when they tried to stop tobacco smoking and felt anxious about the consequences if they strictly enforced tobacco-free practice. We saw a copy of an email to staff with a flow chart that advised staff to restrain patients to remove lighters if they did not hand them in. Some of the staff we spoke with said they did not agree with this approach and so did not comply. Following the inspection, the trust told us that this was not trust policy and not endorsed practice from the trust.

At the time of our inspection, most wards had informal patients who were fully aware of their rights, for example, to leave the ward. The informal patients did not have the same restrictions as the detained patients. Most ward exit doors had notices that stated that informal patients could leave at will. At the time of our inspection, staff had temporarily removed the notices on some of the ward exit doors at Hartington Unit that were being replaced.

Use of restrictive interventions

The trust's data showed the regular use of restrictive interventions such as seclusion and restraint on all the wards. Between 1 March 2017 and 28 February 2018, the trust reported 200 incidents of seclusion for this core service. This had increased from 173 in the previous year. All but two of the 200 episodes of seclusion took place in the wards at Radbourne Unit, which had two seclusion rooms. Hartington Unit did not have a dedicated seclusion facility but had a seclusion pathway. Tansley ward reported two episodes of seclusion in the 12 months to 28 February 2018. The enhanced care ward showed the highest use of seclusion with 84 episodes, followed by ward 34 with 43 episodes. The core service had no instances of long-term segregation in the 12 months to 28 February 2018.

Between 1 March 2017 and 28 February 2018, there were 464 incidents of restraint, of which 152 (33%) were incidents of prone restraint. Overall, the trust's data showed an increase in restraints with 422 incidents of restraint reported in the previous year. Ward 33 and the enhanced care ward at Radbourne Unit had the highest number of restraints with 119 and 106 respectively. These wards also had the highest numbers of prone restraints, with 45 and 37 respectively.

We asked ward staff and managers about their use of restrictive interventions. The staff we spoke with said they did not use restraint very often. We reviewed the trust's data on restraints, which showed that staff reported all types of restraint including low-level interventions such as 'touch'. We asked some of the ward managers about the high use of prone restraint. The ward managers explained that when they laid a person on a bed in a seclusion room, they reported this as an incident of prone restraint. However, this did not explain the incidents of prone restraint at Hartington Unit, which did not have seclusion rooms. The ward managers also told us that the trust's previous physical intervention training had not focused much on alternatives strategies such as de-escalation and redirection whereas the new training did. The managers said they could see the change in practice by staff and said that the use of restraint had started to reduce. We reviewed the data for the months of March to May 2018 and found that that on average the number of incidents of restraint, prone restraint and seclusion had increased compared to the quarterly average for the previous year. The use of seclusion and restrictive practice had reduced significantly over a three year period. The trust used benchmarking data confirm this.

The trust's 'Guidelines for the Use of Medication in the Management of Violence and Aggression' followed the appropriate National Institute of Health and Care Excellence guidance (NG10) when using intramuscular rapid tranquillisation or administering oral medication for agitation. For example, staff recorded the use of rapid tranquillisation and completed the appropriate physical health observations. Staff used a manual process to complete observations instead of direct recording on the electronic care records system because it was more efficient and safer for the purpose of monitoring patients' physical health. However, we could not locate records of the observations required following the use of oral medication for agitation.

Hartington Unit did not have a dedicated seclusion facility but occasionally used seclusion in line with the trust's seclusion pathway. For example, Tansley ward reported two incidents of seclusion in the 12 months to 28 February 2018. We reviewed the electronic seclusion records for

incidences of seclusion that had occurred in the past three months at both units. We found that the records lacked detail, for example, they did not show in which room the seclusions took place on Tansley ward. In one case of a patient who received rapid tranquillisation, we did not find evidence of any physical health observations. In addition, the records showed not all observations and reviews took place as required in order to comply with the Mental Health Act Code of Practice. On the enhanced care ward, we found notes that explained that some medical and nursing reviews did not take place because of clinical pressures elsewhere in the unit. On ward 35, seclusion records showed gaps for the reviews required. On the enhanced care ward, we saw seclusion records that had gaps for reviews and poor rationale for continuing seclusion. On ward 35, we found an incident of an informal patient secluded who did not receive the necessary Mental Health Act assessment in line with the trust's policy and the Mental Health Act Code of Practice.

The table below table shows data from 1 March 2017 to 28 February 2018.

Ward name	Seclusions	Restraints	Of restraints, incidents of prone restraint	Rapid tranquilisations
Hartington Unit - Morton Ward	0	32	17 (53%)	26
Hartington Unit - Pleasley Ward	0	32	5 (16%)	30
Hartington Unit - Tansley Ward	2	26	5 (19%)	13
Radbourne Unit - Enhanced Care Ward	84	106	45 (42%)	18
Radbourne Unit - Ward 33 Adult	29	119	37 (31%)	105
Radbourne Unit - Ward 34 Adult	43	57	18 (32%)	14
Radbourne Unit - Ward 35 Adult	26	57	15 (26%)	5
Radbourne Unit - Ward 36 Adult	16	35	10 (29%)	12
Service total	**200**	**464**	**152 (33%)**	**223**

Safeguarding

During our inspection, we found that most staff knew how to recognise safeguarding concerns but did not always report them. Some staff showed a good knowledge of safeguarding, especially on the wards at Radbourne Unit, and gave examples of issues they had reported. Ward 35 had a

safeguarding lead on the ward who had trained to level 3. However, at Hartington Unit, the staff we spoke with struggled to give us examples of safeguarding concerns they had dealt with. We identified safeguarding risks in four patients' records that staff had not followed up. At a handover meeting we attended on Tansley ward, we found that staff showed a lack of awareness of safeguarding issues and did not always follow up issues raised by patients. On Pleasley ward, we found that staff had chosen not to report a patient's allegations about an assault because they had not witnessed the alleged incident.

We reviewed the trust's training data for safeguarding adults and children. Staff received training in safeguarding adults and safeguarding children as part of their mandatory training. As of 28 February 2018, 98% of staff in this core service had received training in safeguarding children level 1 and 89% of staff had received training and 89% in safeguarding children level 2. Seventy-five per cent of staff had received training in safeguarding adults level 1 and 45% in safeguarding adults level 3.

The trust provided data on the number and type of safeguarding concerns raised and reported to the local safeguarding team. During our inspection, staff and managers on the wards were unable to access data on the number of safeguarding incidents reported and referred to the local safeguarding team. Trust data for the period January to May 2018 showed that the eight wards had made 52 referrals to their local adult safeguarding teams. Tansley ward made the most referrals with 23, ward 34 made nine referrals, Morton ward and wards 33 and 36 made five referrals, and the enhanced care ward made two referrals. Pleasley ward did not make any safeguarding adults referrals during this period.

The trust had safe procedures for children and families who visited the hospital. Staff assessed the risks of visits from children that took into account any child protection issues. The trust did not allow children to go on the wards. Each unit had a designated visitors' room. At times, patients met their visitors on the wards. However, some patients on wards 34 and 35 complained about using the dining room for such visits because of the lack of private rooms available.

Staff access to essential information

Staff reported delays in accessing essential information in a timely manner. In the past year, the trust had implemented an electronic records system to store all patients' records such as risk assessments, care plans and daily nursing notes. The system held scanned copies of Mental Health Act documents while the Mental Health Act office held original copies. As part of a paper-free initiative, the trust encouraged the use of the electronic system for all records and documents. All staff on the wards had access to the electronic system. However, staff found the system cumbersome and experienced regular issues with it, for example, delays in opening the application, slow functioning, and system errors and failures. Staff found that information was not consistently stored, which made it difficult to locate. For example, a patient's record showed an alert to flag up an allergy warning, however, the details of the allergy were difficult to find. In another patient's records, we found contradictory information about a patient's allergies to drugs.

In particular, staff struggled to access the system in a timely way when recording observations. Our review of electronic care notes showed that patients' records were incomplete or difficult to

locate. In general, there were gaps and inconsistencies in record-keeping, for example, we found gaps in records for observations, an absence of follow up notes for safeguarding issues, inconsistent use of section 17 leave plans, risks assessments that were not up-to-date, and poor evidence of patients' involvement in their care planning. Some ward managers we spoke with admitted that staff did not always document their interventions with patients because of the difficulties they experienced with the electronic system.

The trust had made some changes such as improving the broadband connection, and identifying 'super users' to support the wards. The trust also had working groups to address some of the known issues.

All nurses' offices had a white board and an electronic screen that held a summary of key information about patients, for example, bed number, Mental Health Act status. Staff relied on the whiteboard for key information about patients at a glance, and kept it up-to-date.

Medicines management

We found a number of issues with medicines management practices across all the wards following our review of medicines management practices on all eight wards and check of 101 prescription charts. Staff stored all medicines in locked cabinets in locked clinic rooms. Staff carried regular out stock checks on controlled drugs and other medicines. The wards had good access to the pharmacy team and Tansley ward had its own medicines optimisation worker. The clinic rooms contained a copy of the British National Formulary and a folder of relevant policies and guidelines for reference. However, we found gaps in the prescription charts that staff completed when they gave patients their medicine. We found gaps in 12 records on Pleasley ward where staff had not completed the self-harm history. On most wards, staff had not signed for the controlled drugs stocks they received. We found some gaps when checks on room and fridge temperatures did not occur. We found some medicines in use that did not have their open dates noted, for example, a bottle of lactulose on Pleasley ward.

Staff did the appropriate physical health monitoring for patients prescribed lithium and clozapine. The trust had a policy and forms to support the monitoring of patients on high doses of antipsychotic medication. However, on Morton ward, staff had not completed this process for a patient prescribed anti-psychotic medication above the recommended limits.

Track record on safety

Trusts must report all serious incidents to the national Strategic Executive Information System within two working days. Between 1 March 2017 and 28 February 2018, the trust reported 16 serious incidents. Six incidents involved possible self-inflicted harm, three involved allegations of abuse against staff members. Ward 35 reported the most incidents with four.

Number of incidents reported

Type of incident reported	Hartington Unit - Morton Ward	Hartington Unit - Pleasley Ward	Hartington Unit - Tansley Ward	Radbourne Unit - Enhanced Care Ward	Radbourne Unit - General	Radbourne Unit - Ward 34 Adult	Radbourne Unit - Ward 35 Adult	Radbourne Unit - Ward 36 Adult	Service Total
Apparent/actual/suspected self-inflicted harm	1	0	1	1	0	0	2	1	**6**
Abuse/alleged abuse of adult patient by staff	0	0	0	0	1	0	2	0	**3**
Admission of under 18s to adult mental health ward	1	0	0	0	0	1	0	0	**2**
Commissioning incident	0	0	0	0	1	0	0	0	**1**
Serious Incident by Outpatient (in receipt)	0	0	0	0	0	0	0	1	**1**
Suicide	0	1	0	0	0	0	0	0	**1**
Disruptive/aggressive/violent behaviour	0	0	0	1	0	0	0	0	**1**
Abuse/Aggression (Actual or Alleged) - Staff to Patient Inappropriate Sexual Behaviour	0	0	1	0	0	0	0	0	**1**
Total	**2**	**1**	**2**	**2**	**2**	**1**	**4**	**2**	**16**

Reporting incidents and learning from when things go wrong

Although staff knew how to report incidents on the trust's online incident reporting system, staff did not always recognise and report all incidents. During our inspection, we reviewed six incident reports and found that staff had completed them accurately. However, we found examples of incidents in patients' care notes that staff had not reported that included serious issues such as abuse of staff and infection control issues.

Staff understood the duty of candour and complied with the trust's policy. They were open and transparent with patients and their relatives and explained when things went wrong. Staff gave an example of a patient accidentally given a high dose of medication. Staff informed the patient and

their relatives. Staff investigated the incident and made changes to practice to prevent recurrence of the error.

The trust and managers had systems to share feedback from investigations. For example, the trust had a newsletter that it distributed to all staff. The trust sent alerts to all staff to inform them of critical safety incidents. The trust communicated lessons learned in emails Most staff said they received feedback but many staff we spoke with at Radbourne Unit said they did not have the time to look at the various communications.

There was some evidence of improvements made following incidents. For example, one of the wards in Hartington Unit had improved the storage process for patients' personal items following reports of missing items. All the wards had replaced their fixed weight-bearing paper towel holders with safer alternatives following a serious incident. At Radbourne Unit, managers had reviewed and changed lone working practices for staff when they supported patients in the hub's gym.

At Hartington Unit, staff and managers confirmed that they received debriefs after incidents. Staff spoke highly of their ward managers and the support they gave them. Staff at Radbourne Unit confirmed that they received debriefs after incidents but said they were not always timely (straight after the incident), and staff found that ongoing support was not always available to them.

Is the service effective?

Assessment of need and planning of care

We reviewed the care records of 46 patients, which showed that patients received comprehensive and timely mental health assessments soon after admission. In addition, they received initial physical health assessments that identified their specific healthcare conditions and any associated risks and needs. However, the records contained gaps that indicated that staff did not complete the physical health checks fully or record the information consistently in patients' records.

Staff developed care plans that covered patients' identified needs. We saw examples of good physical healthcare plans on Pleasley ward but not all patients who had physical health conditions identified upon admission had care plans to address their needs. Where patients did have physical health care plans, staff did not always follow them as patients' needs changed. Most of the care plans we reviewed contained basic information about patients' needs. The care plans were personalised and holistic but did not show a recovery-oriented approach.

Staff did not always update care plans in a timely manner. We found that staff relied heavily on information shared at handovers to remain up-to-date on patients' needs and risks rather than patients' care plans. This was partly because they frequently experienced issues with the

electronic care records system. Some staff reported that where they knew patients from previous admissions, they did not need to consult their care records. In general, we found that information from different sources did not match up, which had the potential to affect the effectiveness of patients' care. For example, on Tansley ward, we found inconsistencies in information between the handover meeting, the red to green meeting, a patient's care review and their electronic records.

Best practice in treatment and care

The service did not provide the full range of care and treatment interventions suitable for the patients group. The primary treatment model of care on the acute wards was psychiatry and nursing. The main treatment offered to the patient group was medication, which staff delivered in line with the relevant National Institute for Health and Care Excellence guidance and the recommended prescribing limits set out in the British National Formulary. Doctors requested a second opinion from an appointed doctor (known as SOADs) in cases where prescribing limits exceeded British National Formulary limits. However, we found one case where there was no evidence of the follow up of a patient prescribed high dose antipsychotic medication. Staff did the appropriate physical health monitoring for patients prescribed lithium and clozapine.

Patients in both units had little or no access to psychological therapies, which was not in line with good practice on acute mental health wards and National Institute for Health and Care Excellence guidance. Some staff and ward managers said that the service took a view that psychological therapy was not appropriate for patients on acute wards. The trust employed 2.4 whole time equivalent psychologists to cover the eight wards (up to 158 patients). The psychologists had additional duties that reduced the time they spent supporting patients on the wards. The psychologist team lacked the capacity to offer one-to-one psychological assessments and interventions. The psychologists ran a small number of groups in each unit, for example, the Hartington Unit had one group that looked at accepting and changing emotions based on dialectical behaviour therapy principles. Psychologists relied on occupational therapists to run other groups that offered psychological interventions to patients such as mindfulness, anxiety management and coping strategies.

There was no clear pathway for psychological input with patients. Patients did not receive psychology assessments on admission only following a referral from a psychiatrist. Psychologists did not routinely attend wards reviews. Psychologists rarely completed formulations although during our inspection, we found one example of a completed formulation on ward 33. The service's predominantly medical model of care meant that psychological therapies had a low profile and the psychologists received few referrals.

Although patients received psychiatric and nursing care, there was little evidence of a structured recovery-based approach underpinning the model of care on the wards. Recovery-based support such as activities and therapies was limited on the wards. Patients on all wards had poor access to ward-based activities although some patients had access to a range of activities at the recovery

hubs in each unit. Most wards had developed ward-based activity programmes but only ran them if there were enough staff. For example, Morton ward had a regular hair salon that had proved popular. Tansley ward offered pet therapy, karaoke and quizzes on an adhoc basis. However, there was no structured timetable of activities on Pleasley ward. Pleasley ward held a 'distraction box' that contained only wool. Ward 34 no ward-based activities due to staffing issues. Ward 35 had an activities timetable but staff and patients reported that they did not happen. The enhanced care ward had no activities. Patients commented on the lack of therapeutic activities on the wards and said they often felt bored.

Patients had good access to physical healthcare appropriate to their needs. Staff admitted older people and those with high levels of frailty to Pleasley ward at Hartington Unit. Staff tended to admit people with significant physical healthcare needs to the enhanced care ward at Radbourne Unit where they received an increased level of support. During our inspection, we observed a ward round on ward 36 attended by two psychiatrists and a nurse. The meetings had a holistic, patient-centred approach. Each patient's review lasted approximately 30 minutes. Staff sought the patient's views on their treatment and progress. Staff discussed the patient's quality of sleep, mood, diet and exercise with them during the meeting.

Staff referred patients to specialists as needed. Staff had good local working relationships with the local acute hospital and other healthcare providers such as dentists. We found that patients with physical health conditions had access to specialists such as stoma nurses, dieticians, diabetic nurses, physiotherapists, and speech and language therapists.

The trust did not have a sepsis policy. However, staff received training on sepsis in one of the scenario-based exercises in their immediate life support training although the scenario applied the national early warning score and not the local Derby early warning score. Staff we spoke with had little knowledge of the trust's stance on sepsis and gave different accounts of the training they had received. A doctor told us that they would transfer any patient at risk of sepsis to the local emergency department. They confirmed that nurses monitored changes in patients' physical health and requested medical reviews when needed.

Staff had access to a number of tools to help them monitor patients' physical health but they did not always use them correctly. Staff used the malnutrition universal screening tool to assess and monitor patients' risk of malnutrition. Staff used fluid charts to monitor patients' hydration status. Staff used the Waterlow scale to assess the risk and severity of pressure sores. The trust had developed a local early warning score assessment tool, which used a range of physiological observations to assess if a patient was deteriorating physically. Staff recorded the early warning score in the patient's electronic care record. We reviewed 13 early warning score records and found gaps in 12 of them. Staff did not always complete the early warning score assessment charts fully, which meant that calculations did not include all the key indicators. This meant that staff did not always accurately identify and treat deteriorating patients in a timely manner. In 11 of the records, we found that staff did not always follow the escalation procedure for those patients whose early warning assessment scores indicated the need for further action. For example, one patient whose score indicated a doctor's review did not have one for at least 27 hours.

Staff promoted healthy lifestyles to patients. The trust had planned a health day on 4 July for patients. All the units and wards had a range of health promotion information displayed on the wards, for example, ward 34 had information on the causes and prevention of cardiovascular disease, and information on diabetes, cholesterol and cancer. Hartington Unit had a physical health self-help guide for patients. Patients had access to a gym on site following a physiotherapy assessment. A patient had section 17 leave authorised to enable them to attend a local sports club. Staff offered patients on all wards flu vaccinations; Radbourne Unit wards showed an uptake of 48% on ward 33, 61% on ward 34, 41% on ward 35 and 71% on ward 36 and 60% on the enhanced care ward. We saw smoking cessation information and leaflets on the wards. Patients' care notes showed that staff offered patients smoking cessation and made referrals, where appropriate. Patients discharged from Radbourne Unit wards had access to physical health clinics as outpatients. The clinics used the Lester tool to assess and monitor patients' physical health status.

We found variable us of recognised tools and outcome measures throughout the service. The wards used the mental health clustering tool to assess and rate the severity of patients' needs. Staff and doctors were unable to confirm if they used the health of the nation outcome score or show us any examples. Staff on ward 35 developed wellness recovery action plans with patients. Occupational therapists used a range of tools and outcome measures to support their roles, for example, the model of human occupation screening tool, the occupational self-assessment, the occupational case history intervention, assessment of motor and process skills, the model of creative ability and the interest checklist.

Staff used technology to support patients. Staff had access to physical health monitoring equipment to offer patients tests onsite, for example, electrocardiograms. A doctor described using an easy to follow tool downloaded from the internet to help patients make choices about their treatment. Staff emailed (securely) patients' discharge summaries to their GPs within 24 hours of discharge. Staff used online resources to find information in response to patients' questions. The electronic care records system allowed the sharing of patients' records across the trust. However, the electronic care records system did not interface with, or give access to systems at other trusts, for example, to retrieve pathology results.

Staff participated in clinical audits and quality improvement initiatives. The service contributed to a number of the prescribing observatory for mental health audits such as those for prescribing for substance misuse: alcohol detoxification; rapid tranquillisation, and prescribing for bipolar disorder. During 2017/18, the trust completed a range of audits that included physical health handover, patients' awareness of the trust's smoke-free status, locked doors on wards and seclusion. The units received an annual health and safety audit, and an annual infection control audit. Ward staff conducted additional audits such as six-monthly infection control audits, monthly care notes reviews, and monthly fire safety checks. Pharmacist and pharmacy technicians attended the wards and completed audits on prescription charts, medicines stocks and controlled drugs management.

Skilled staff to deliver care

The core staff teams on the wards comprised psychiatrists, nurses and healthcare assistants but wards also had access to pharmacists, occupational therapists, social workers and psychologists. Ward managers had sufficient flexibility to consider the specific staffing needs on their wards. For example, most wards had employed ward-based occupational therapists out of their core staff budgets. However, ward managers included these staff in the shift rotas for nurses and healthcare assistants. This significantly limited the time they spent on ward-based occupational therapy activities. At Radbourne Unit, managers had reviewed the effectiveness of having ward-based occupational therapists counted in shift allocations and agreed to change this to make them supernumerary. Tansley ward had employed a medicines optimisation worker who took the lead for medicines management on the ward and liaised with the pharmacy team. Radbourne Unit wards had regular access to a dietician, and Pleasley ward had access to a physical health nurse and a fluid and diets nurse. Radbourne Unit managers planned to employ specialist learning disability nurses to support the wards.

Ward staff were suitably qualified and experienced for their roles. The wards had registered mental health nurses and healthcare assistants who had the appropriate training for their roles, for example, the care certificate.
Some staff had completed specialist training that helped them meet the needs of specific patents groups. For example, the core service had an overall training rate of 70% for dual diagnosis and 56% for autism. Staff also had access to additional training on an adhoc basis that helped them in their roles, for example, managing continence, dementia awareness, suicide awareness and response, epilepsy, and phlebotomy. Staff on the wards at Radbourne Unit said they struggled to access training because of staffing issues. Ward managers confirmed that they struggled to release staff due to shortages.

All new staff received the appropriate induction for their roles. Newly qualified staff worked alongside experienced nurses. Domestic staff allocated to the wards did not routinely receive training in physical intervention. However, the trust had arranged for domestic staff to receive breakaway training later in the year.

Our review of the trust's data (see the table below), staff records and our interviews with staff confirmed that not all staff received supervision regularly. The service had a supervision programme that comprised three elements – clinical, professional and management. There were a set number of sessions required for each element, which determined compliance, and contributed to the overall supervision rate for the ward. We reviewed the supervision data carefully, and spoke to a number of staff and managers about the quality and quantity of supervision they received. At Hartington Unit, although the data showed that the wards had a compliance rate of 40% as of 28 February 2018, we found that staff received supervision regularly. We spoke to the lead nurse for the supervision programme implemented on the three wards. Each ward had a matrix that showed each staff member's supervision requirements and compliance. We found that a large number of staff had received supervision regularly (on average at least once a month) throughout the past year. Staff we spoke with said they received regular supervision, with increased frequency if they needed additional support. At Radbourne Unit, the trust's data showed that the wards had an average compliance rate of 15%, and we found that staff did not receive supervision regularly. Staff had poor access to supervision and reported that it rarely happened. This was mainly due to the staffing pressures on these wards. The ward and unit managers recognised that supervision

levels were low and had plans to improve them that included allocation of a lead nurse to support their plans.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Radbourne Campus - Psychology UC South	7	0	0%
Radbourne Campus - RDH Ward 36 Adult Acute Inpatient	305	22	7%
Radbourne Campus - Enhanced Care Ward	334	37	11%
Radbourne Campus - RDH Ward 34 Adult Acute	293	45	15%
Radbourne Campus - RDH Ward 35 Adult Acute Inpatient	332	55	17%
Hartington Campus - Hartington Unit Pleasley Ward Adult	270	62	23%
Radbourne Campus - RDH Ward 33 Adult Acute Inpatient	301	71	24%
Hartington Campus - Hartington Unit Morton Ward Adult	281	122	43%
Hartington Campus - Hartington Unit Tansley Ward Adult	302	158	52%
Hartington Campus - Psychology AC County North	12	12	100%
Service total	**2437**	**684**	**28%**
Trust Total	**19680**	**12660**	**64%**

Not all staff had access to regular team meetings. Staff at Hartington Unit attended team meetings for their ward. At Radbourne Unit, staff meetings did not always occur or were cancelled because of staffing shortages and other pressures. Ward 34 held monthly meetings by holding them at handover times.

Some wards at Hartington Unit and all the wards at Radbourne had arranged weekly reflective practice sessions with a psychologist. The psychologist at Radbourne Unit also offered a monthly drop-in session for staff. Staff gave positive feedback about these sessions although staff at Radbourne Unit worried that they could not attend them regularly due to clinical activities and pressures. The service held monthly Schwartz rounds at alternate sites. These provided an opportunity for staff to discuss an issue or event they had experienced, and invite reflection.

As of 28 February 2018, the overall appraisal rate was 69% for clinical staff and 64% for medical staff, which were below the trust's target of 90%, lower than the trust's average of 77%, and lower

than the rates reported in the previous year. None of the wards achieved the trust's target of 90% although ward 34, Morton ward and Tansley ward reported appraisal rates between 81% and 89% for their staff. The enhanced care ward and wards 36 and 35 had the lowest rates of 43%, 50% and 63% respectively.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Enhanced Care Ward	30	13	43%
RDH Ward 36 Adult Acute Inpatient	26	13	50%
RDH Ward 35 Adult Acute Inpatient	30	19	63%
Hartington Unit Pleasley Ward Adult	23	16	70%
RDH Ward 33 Adult Acute Inpatient	29	22	76%
RDH Ward 34 Adult Acute	21	17	81%
Hartington Unit Tansley Ward Adult	25	21	84%
Hartington Unit Morton Ward Adult	28	25	89%
Service total	**212**	**146**	**69%**
Trust wide	**2406**	**1858**	**77%**

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
Enhanced Care Ward Medics	2	1	50%
City Adult Acute Medical	6	4	67%
County Adult Acute Medical	3	2	67%
Service total	**11**	**7**	**64%**
Trust wide	**114**	**77**	**68%**

Staff had access to development opportunities. Two healthcare assistants we spoke with were due to start a nurse associate course. Student nurses, especially those based at Hartington Unit, had access to lots of different opportunities and experiences to support their training.

Managers identified and dealt with performance issues. Some staff felt that the process was lengthy.

Multidisciplinary and interagency team work

Each ward held regular meetings (known as ward reviews) that mainly comprised the ward's psychiatrist and junior doctors, a nurse and the patient. The meetings were medically-led in line with the predominant model of care evident on the units. The trust's pharmacists and social worker attended when required. Occupational therapists, psychologists and other disciplines rarely attended. Healthcare assistants did not routinely attend these meetings unless the patient requested their support or the patient needed additional supervision. Staff invited relatives and community-based workers, as appropriate. Ward staff requested specialist assessments where required for specific patients' needs, for example, mobility issues, and reported the outcomes and interventions at the patient's review. We observed and attended five ward review meetings. Although the meetings were effective, they did not have a multidisciplinary approach.

All wards had effective handover meetings. We observed and attended handovers on most of the wards. We found that staff relied heavily on these meetings for quick, timely and effective information sharing about patients and other ward matters. We found that this was partly because of issues with the electronic records system. The meetings lasted up to 45 minutes and staff recorded information discussed on handover sheets. Some wards at Radbourne Unit found that handovers gave a good opportunity for team meetings. The enhanced care ward had 'super handovers' once a week that a psychologist attended.

The wards in both units worked well with each other, and with the activities hub based in each unit. The wards had good working relationships and shared information with other teams such as the community mental health teams and the crisis and home treatment team.

The wards at Hartington Unit liaised with patients' GPs and shared information appropriately. Staff had good working relationships with other local health services and hospitals. The complex case manager and doctors endeavoured to maintain contact with external providers of acute and intensive care beds for their patients. Although we found little evidence of regular contact with local authority social services and safeguarding teams, we came across an example of a multi-agency planning meeting for a patient on Pleasley ward.

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

The trust's data showed that as of 28 February 2018, 67% of staff in this core service had received training in the Mental Health Act, which was lower than the 70% reported for the previous year. Staff completed this once as part of their mandatory training requirements.

There was small but effective Mental Health Act administration team of 6.8 whole time equivelant staff based at Hartington Unit and Albany House. The Mental Health Act administrative staff and ensured that all Mental Health Act documentation met legal requirements. The Mental Health Act office retained all original copies of Mental Health Act documentation scanned all section papers onto the electronic patient record.

Staff had easy access to local Mental Health Act policies and procedures and wards held copies of the Code of Practice. Ward staff showed a reasonably good understanding of the Act and the Code of Practice although practice did not always meet requirements. Staff knew who their Mental Health Act administrators were and knew how to access them when they needed support.

Patients had easy access to information about independent mental health advocacy. The advocate visited the wards regularly so that patients knew who she was and could meet her.

Staff explained to patients their rights at regular intervals, and when a patient's circumstances changed. Staff explained the rights in a way that patients understood them and repeated them, if necessary. Mental Health Act administrators reminded ward staff when patients were due their rights, and requested signed forms of compliance.

Most patients took their section 17 leave (permission for patients to leave the hospital) as granted. Occasionally, patients on wards at Radbourne Unit had their leave cancelled due to staff shortages. Some patients we spoke with complained that they had to wait a week until their next review for approval of any changes to their leave although some doctors authorised changes sooner, that is, during the same week. During our inspection, we asked to look at some section 17 leave forms. Staff found it difficult to locate them, and we came across one case in which a patient was on leave without the correct authorisation.

Records showed that staff consulted a second opinion appointed doctor when necessary.

Most ward exit doors had notices that stated that informal patients could leave at will. At the time of our inspection, staff had temporarily removed the notices on some of the ward exit doors at Hartington Unit that were being replaced.

Care plans included reference to services for patients eligible for aftercare. In most cases, this meant aftercare and support from the home treatment or the community mental health teams. Many of the patients on the wards were already known to services.

Mental Health Act administrators completed audits on the Mental Health Act documentation they held. During 2017/18, the trust completed local audits on section 117 meetings, compliance with section 5(2) of the Mental Health Act, compliance with section 58 of the Mental Health Act, and record-keeping of the capacity to consent to or refuse treatment documentation.

Good practice in applying the Mental Capacity Act

Staff on all wards had a good understanding of the Act and the five statutory principles, in particular, the presumption of capacity. As of 28 February 2018, 86% of staff in this core service had received training in the Mental Capacity Act and the Deprivation of Liberty Safeguards.

The trust made one Deprivation of Liberty Safeguard application to the local authority for a patient on Pleasley ward between 1 March 2017 and 28 February 2018. Staff monitored the progress of these applications.

The trust had a policy on the Mental Capacity Act that included the Deprivation of Liberty Safeguards. Staff were aware of the policy and had access to it. Staff knew where to seek advice on any issues related to the Mental Capacity Act.

Staff helped patients make their own decisions. When a patient lacked capacity for a specific decision, staff discussed the issue and made a decision in the patient's best interests that took into account the importance of the patient's wishes, feelings, culture and history. Staff assessed and recorded capacity issues and decisions in patients' care notes.

The core service had local and trust-wide arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act every three months and addressed any issues identified.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We observed kind and caring interactions between staff and patients most of the time. At patients' care review meeting we attended, we saw that staff treated patients with dignity and respect. Staff responded to patients promptly and gave patients the support they needed. At Radbourne Unit, we saw that even though the wards were short-staffed, staff prioritised patient care. All staff showed commitment and motivation in their work.

Staff supported patients to understand and manage their condition, both mental and physical health. Doctors discussed treatment options with patients at their reviews. For example, on Morton ward, the doctor used online resources and tools to help patients make choices based on treatment types and side effects. Staff printed up-to-date information for patients and gave them leaflets about their medication.

Staff referred patients to other services, where required, and supported them to access them. This included physical health services, community mental health services, and social and leisure services. For example, staff escorted a patient to a local gym. We saw posters on ward 36 that offered patients access to chaperones to support them with activities.

Most patients said that staff treated them well and behaved professionally towards them. For example, a patient on ward 34 said, "it is the best acute ward I have been on." He felt supported

by staff and saw that they were interested in helping him get well. Another patient on ward 34 said “this is the most beneficial admission I have ever had.” A patient on Morton ward said, “the nurses do a good job.” A patient described the staff on ward 33 as “absolutely brilliant.” Patients on ward 36 described the staff as responsive, and one patient described the night staff as “amazing”. On the enhanced care ward, patients said that staff cared about them. However, on Pleasley ward, one patient complained about a member of staff’s attitude towards them.

Staff understood the individual needs of their patients. In many cases, long-serving staff knew their patients well from previous admissions. Staff helped meet patients’ individual needs, for example, food preferences for religious reasons.

Staff on the wards said they felt able to raise concerns about any inappropriate behaviour towards patients that they observed without fear of the consequences. We saw reports of incidents that concerned inappropriate behaviour related to patients, staff and other parties.

Staff ensured they kept information about patients confidential. Staff used the secure electronic care records system to store information about patients. Nurses’ offices had a white board and an electronic screen that held a summary of key information about patients, for example, bed number, Mental Health Act status. These boards were not visible from outside the office. However, on ward 36, staff reported that patients occasionally entered the office and saw confidential information about patients. Staff maintained confidentiality when meeting with patients, for example, they took patients to private areas for one-to-one sessions.

In the 2017 patient-led assessments of the care environment Hartington Unit and Radbourne Unit scored higher than similar trusts for privacy, dignity and wellbeing (see table below).

Site name	Privacy, dignity and wellbeing
Hartington Unit	92.4%
Radbourne Unit	95.6%
Trust overall	**93.6%**
England average (mental health and learning disabilities)	**90.6%**

Involvement in care

Involvement of patients

Staff used the admission process to inform and orient patients to the ward and unit. Each ward had patient information booklets that provided useful information to patients about the ward and units. Patients spoke positively of their welcome to the wards on admission. Healthcare assistants welcomed new patients with a drink and snack, and then gave them a tour of the ward.

Staff involved patients in assessments and care planning. Staff encouraged and supported patients to attend and participate in their care and treatment reviews. We attended seven ward reviews and observed that staff made patients feel comfortable, showed them respect and gave them a chance to speak. However, most of the patients we spoke with did not have copies of their care plans. Entries in patients' electronic records did not show if staff offered patients copies of care plans.

Staff helped patients understood their care and treatment in ways they understood.

Staff involved patients when appropriate in decisions about the service. All wards held patients' community meetings weekly, fortnightly or monthly, which gave patients an opportunity to speak up about any issues they had or changes they would like to see, and gave staff the opportunity to consult patients and invite feedback. However, records of community meetings on ward 35 showed a gap of six months before a meeting was held in early June 2018. All ward had patients' notice boards that had 'you said, we did' information.

Staff did not routinely ask patients for their views on their care preferences during a mental health crisis, and staff did not routinely complete advanced care planning for patients on any of the wards. During our inspection, we found only one example of an advanced care plan for a patient on ward 34.

Patients had good access to advocacy services and there was information about advocacy displayed on the wards. The independent mental health advocate visited the wards regularly so that patients knew who she was and could meet her.

Involvement of families and carers

Family members felt involved in their relative's care and said that staff invited them to care review meetings and kept them informed. All relatives received a carers' pack that included information about the service, support networks, and carers' assessments. Staff encouraged carers to visit their relatives within 72 hours of their admission.

Some wards had carers' lead nurses, for example, Tansley ward had a lead nurse who oversaw carers' information boards, information packs and acted as a link for carers'

The trust had a strong carers' engagement forum that met monthly. We attended a carers' day during our inspection. The carers' volunteers present described good working relationships with the trust. The trust supported the triangle of care initiative, which is a working collaboration between the patient, professional and carer that promotes safety, supports recovery and sustains wellbeing.

Is the service responsive?

Access and discharge

Bed management

- The trust experienced bed pressures in this core service due to bed capacity compared to demand, with additional impact caused by a lack of psychiatric intensive care beds and the re-admission rate. The trust's data for the 12 months to 28 February 2018 (see table below) showed that all eight wards reported average bed occupancy rates above the nationally recommended minimum threshold of 85%. The average bed occupancy rate for the core service was 98%. However, all wards with the exception of the enhanced care ward reached average monthly bed occupancy rates over 100%. Pleasley ward had the highest average monthly occupancy rate of 125% for working age adult admissions in some months.
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Ward name	Average bed occupancy range (1 March 2017 – 28 February 2018)
RDH Enhanced Care Ward	88% - 98%
Hartington Unit Morton Ward	89% - 101%
Hartington Unit Pleasley Ward Adult	58% - 125%
Hartington Unit Pleasley Ward (Older Adult)	78% - 121%
Hartington Unit Tansley Ward Adult	87% - 100%
RDH Ward 33 Adult Acute Inpatient	95% - 105%
RDH Ward 34 Adult Acute Inpatient	87% - 105%
RDH Ward 35 Adult Acute Inpatient	96% - 107%
RDH Ward 36 Adult Acute Inpatient	97% - 104%

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- The table below shows that the average length of stay for the period 1 March 2017 and 28 February 2018 for the acute wards ranged from 16 days to 125 days. The average length of stay was 38 days. Pleasley ward showed the longest average length of stay, however, the ward mainly supported older and/or frail patients.
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Ward name	Average length of stay range (1 March 2017 – 28 February 2018)
RDH Enhanced Care Ward	17.3 - 41.7
Hartington Unit Morton Ward	22.6 – 77.2
Hartington Unit Pleasley Ward Adult	15.9 – 105.3
Hartington Unit Pleasley Ward Older Adult	20.2 – 124.8
Hartington Unit Tansley Ward Adult	24.5 – 56.3
RDH Ward 33 Adult Acute Inpatient	20.7 – 70.6
RDH Ward 34 Adult Acute Inpatient	21.3 – 68.3
RDH Ward 35 Adult Acute Inpatient	18.3 – 70.9

RDH Ward 36 Adult Acute Inpatient	24.6 – 66.8

- The number of readmissions partly contributed to bed pressures. The table below shows that the acute wards had 131 readmissions within 28 days in the 12 months to 28 February 2018. Of these, 57 patients returned to the same ward. The average number of days between discharge and readmission was 13 days. Four patients were readmitted on the same day they were discharged, and five patients were readmitted the day after discharge.
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Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
131	57	44%	0 – 28	13

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Whenever possible, the trust admitted patients in the Derbyshire region to the hospital in their local area, and only used out of area placements when all of its acute beds were full. Patients who lived in the north of the county went to Hartington Unit in Chesterfield and patients from the south of the county went to Radbourne Unit in Derby. This was based partly on patients' GP practices, as well as patients' preferences to stay close to their homes. However, Radbourne Unit regularly had insufficient beds to meet the higher demand in the south of the county and so patients had to go to Hartington Unit. For example, at the time of our inspection, Hartington Unit had 19 patients from the Derby area. Staff admitted patients to the acute admission wards or the enhanced care ward. The enhanced care ward offered a higher staff to patient ratio and admitted patients with more complex needs than those who met the criteria for acute wards. The enhanced care ward assessed and treated patients that staff could not safely manage on the general acute wards. The enhanced care ward also provided a 72-hour assessment to patients in need of an intensive care bed.

Beds were not always available locally when needed, and the trust did not have any psychiatric intensive care wards. However, the trust remained in discussion with local commissioners regarding the need for a psychiatric intensive care unit locally. This meant that when the need for an intensive care bed arose, the trust consulted commissioners and arranged admissions to out of area hospitals. The service had a total of 166 out area placements in the 12 months to 28 February 2018. The placements lasted between one and 247 days. At the time of our inspection, the trust had 16 patients placed in psychiatric intensive care placements out of the local area. During the same week, the trust had placed a further six patients in out of area acute beds. The trust relied on private hospitals outside the local region, for example, Bradford, Weston Super-mare. The trust tried to repatriate patients when beds became available locally or when patients' mental health improved. In one example, staff described a patient who had been admitted to four different wards or units (a local ward, then two out of area private hospitals and back to a different local ward) in a six-to-eight week period. Medical staff struggled to maintain oversight of the care and treatment of those patients placed out of area.

The trust had a policy that allowed staff to admit patients to beds of patients who were on leave. The trust's guidance allowed admission to up to 50% of beds vacated by patients on leave for 72

hours or more. At times of extreme pressure, the trust increased the proportion of leave beds available for admission to approximately 66%. The trust had full capacity escalation plan that set out the actions and checks required by staff at such times.

Staff transferred patients between wards for clinical reasons only. Staff discharged patients at appropriate times of the day.

Discharge and transfers of care

Discharge was rarely delayed other than for clinical reasons. Between 1 March 2017 and 28 February 2018, there were 1142 discharges within this service, of which 68 (1.6%) discharges were delayed.

Each ward held 'red to green' meetings each day to look at bed management and patient flow. We attended two red to green meetings during our inspection. The meeting reviewed all the patients on the ward and identified any actual or potential barriers to a patient's recovery and discharge. Staff then prioritised actions to address any issues. The meeting had a particular focus on patients who had been in hospital for 40 days or more.

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- Discharge planning involved the patients and their relatives, as appropriate. Discharge planning also included the patients' commissioners and care coordinators to help plan aftercare services. Medical staff completed a discharge summary that administrative staff sent to the patient's GP within 24 hours, followed by a formal discharge letter.

Staff supported patients during transfers between wards and other services. The trust had contracted a private escorted transport service to help with transfers into and out of the hospital, for example, to or from intensive care beds.

The trust complied with NHS England's transfer of care standards. For example, staff sent discharge summaries to GPs by email within 24 hours of discharge. The acute wards arranged follow up visits for discharged patients. The crisis response and home treatment teams and the community mental health teams completed the follow up visits within either two or seven days of a patient's discharge. The trust checked that patients received their follow up visits.

Facilities that promote comfort, dignity and privacy

Most patients slept in dormitory-style bedrooms. Each ward had up to four dormitories and up to three single bedrooms. Each of the mixed-gender wards had separate corridors for female and male patients that contained dormitories, single rooms and bathroom facilities. One single bedroom on each ward had ensuite facilities. Each ward had a communal dining room and lounge. Pleasley ward had a female-only lounge in a central location. The female-only lounge had access from the ward corridor and from the dining room. The lounge had signs on and above the doors stating it was female only, however, these did not prevent male patients from entering the room. Staff did not always redirect male patients when they entered the lounge.

The dormitories at Hartington Unit had curtains that separated the beds, and gave patients a degree of privacy. The dormitories at Radbourne Unit had a mixture of solid partitions made up of bedroom furniture and curtains that separated the beds. These provided a degree of privacy to patients.

The trust had reviewed the numbers of beds on each ward and considered the feasibility of replacing its dormitory-style accommodation with single ensuite bedrooms. Some wards had reduced their bed capacity (for example, from 24 to 20 beds on some of the wards at Radbourne Unit). The trust identified risks to making such changes that included a lack of capital, and reduced bed capacity overall with a consequential increase in out of area placements. In early 2017, the trust submitted this information and following financial planning, confirmed that the trust in 2017 to 2018 would have enough capital to invest in increased bed capacity. The trust supplied outline drawings and the impact on bed numbers of moving to single rooms.

Many of the patients we spoke with on Pleasley ward and ward 33, 34 and 36 complained about a lack of safe storage for their belongings in the dormitories and said that some of their personal items had gone missing. The wardrobes did not have doors as they had ligature anchor points. This meant that patients' belongings were on view when the curtains were open. Each wardrobe had a small key-coded safe. However, the coded lock mechanisms on each safe did not always work or staff did not know how to use them. In addition, patients had items that were considered a risk or too valuable to hold in the wardrobe safes. Where necessary, staff offered patients alternative storage, for example, on Pleasley and Tansley wards, staff offered patients lockers to store any valuable items. On ward 33, each patient had a plastic box that staff kept in a storeroom. Staff on the enhanced care ward and ward 35 stored patients' valuable items in locked storerooms. Not all the wards had robust logging in and out systems for patients' possessions that staff stored.

Patients personalise their bedroom areas if they wished to. We saw patients had photos and other personal items in their bedroom areas.

Each ward had a range of rooms that supported treatment and care that included private examination rooms, quiet rooms, fully furnished lounges and dining rooms, and equipment such as televisions, music systems, arts and crafts, books and jigsaws.

Each unit had an activities hub on site but away from the wards. Patients required referral to access the hubs. Each hub had a dedicated team to run it made up of an occupational therapist and recreational assistants. This meant that ward staff did not have to leave the wards to support the patient who attended the hubs. The hubs provided a communal space for recreation and a programme of activities. Patients liked the hubs because they offered pleasant and relaxed environments away from the wards where they engaged in a range of recreational and therapeutic activities. The hubs had cafes and access to pleasant outdoor spaces and facilities. The hubs had a range of equipment such as pool tables, table tennis tables, book libraries, and arts and crafts

materials. The hubs had a programme of activities that included karaoke, bingo, and arts and crafts as well as therapeutic groups such as anxiety management, coping skills, and managing conflict.

All the wards had quiet areas that patients had access to. Each ward a large, comfortable lounge and spacious dining room as well as female-only lounges, and a number of smaller multi-function rooms.

Each ward had a mobile or fixed payphone for patients' use. As these did not always allow privacy, each ward had a mobile ward phone that patients could use.

Some wards had direct access to outside space such as gardens and courtyards. Pleasley ward was located on the ground floor and had a courtyard that patients accessed with staff supervision due to environmental risks. However, the entrance to the courtyard was located on the female corridor. Ward 35 and the enhanced care ward were located on the ground floor and had direct access to a courtyard or garden. The outside area attached to ward 35 was not secure and so staff kept the doors locked, and the garden attached to the enhanced care ward overlooked a car park, which did not give patients privacy.

Morton and Tansley wards, and wards 33, 34 and 36 were located on the first floor of their units and so did not have direct access to outdoor space. However, patients who accessed the activities hub on the ground floor also had access to outdoor space. Otherwise, patients required authorised leave to go outdoors.

During our inspection, which took place in a long period of hot weather, we found that most of the wards were very warm with little climate control available. Some communal lounges and dining rooms had air conditioning units in them, however, the rest of the ward remained very warm. Patients and staff complained about the temperature on the wards, especially in the bedrooms.

Patients had access to drinks and snacks throughout the day and night. Each ward had a well-equipped patients' kitchen and a patients' fridge fully stocked with drinks and snacks. However, during staff shortages especially at night staff locked the kitchen door to ensure safety. Staff also locked the kitchen occasionally to manage risks and ensure patients' safety. Patients still had access to drinks and snacks via staff.

The food provided to patients on the wards was of good quality. The table below shows the scores in the 2017 patient-led assessments of the care environment. Radbourne Unit scored highly for food on the wards with 99%, well above the England average of 92%. However, Hartington Unit scored 84%, lower than the trust and England average.

Site name	Ward food

Hartington Unit	84.3%
Radbourne Unit	99.3%
Trust overall	**94.7%**
England average (mental health and learning disabilities)	**91.5%**

Patients' engagement with the wider community

The wards had a range of information for patients on services available in the community. The recovery hubs in each unit actively promoted community engagement through their three-phase pathway. Phase one involved basic ward-based activities, phase two involved access to and participation in the hub, and phase three involved community access. The hubs in each unit had developed some links with the local community. In particular, the hope and resilience hub at Radbourne Unit had links with a number of groups and activities in the local community, for example, an art project, a women's group, and a dance class.

The occupational therapy teams that oversaw the recovery hubs in each unit offered patients access to the hubs for up to six weeks after discharge.

Staff encouraged patients to maintain contact with their families and friends. Staff encouraged relatives to attend care reviews and facilitated visits on the wards or in the visitors' rooms.

Meeting the needs of all people who use the service

The service tried to meet the needs of all the people who used the service. Two of the wards at Radbourne Unit were single sex only. All the other wards had separate male and female shower rooms, bathrooms and toilets. All the mixed gender wards had female-only bathroom facilities and lounges. The mixed-gender wards had single rooms that staff could use for patients with specific needs, such as transgender.

The service had some adaptations for people with disabilities, mobility issues or other conditions. Each unit had lift access to the first floor wards. Patients with mobility issues or frailty had personal evacuation plans. Ward 34 in Radbourne Unit and Morton ward in Hartington Unit had ensuite bariatric bedrooms with bariatric fixtures and fittings. Ward 33 had a hoist. Each of the wards at Radbourne Unit had an assisted bathroom. Ward 35 had assisted bathroom on its female corridor and ward 36 had one on the male corridor. Morton ward had an assisted bathroom on the female corridor and Tansley ward had one on the male corridor. As these wards linked through a set of doors (kept locked), staff found it easy to accommodate the needs of patients who required an assisted bathroom while preserving their privacy and dignity. Staff also took into account such needs when they admitted a patient with mobility issues. For example, where possible, staff admitted a female patient to Morton ward, which had an assisted bathroom in the female corridor.

Pleasley ward catered for up to 12 elderly patients with functional mental illness, and any patients deemed frail and vulnerable. The ward was located on the ground floor of Hartington unit. The ward was spacious with wide corridors and spacious rooms. The ward had a hoist and other equipment to support frail patients. The ward-based occupational therapist had identified environmental issues and procured equipment that supported the patient group. However, the ward did not have an assisted bathroom although the trust had plans to install one. This meant patients who needed to use assisted bathrooms had to go to the other wards on the first floor.

The units and wards had a wide range of accessible, patient-friendly information displayed on the wards, in the reception areas and in the hubs. In addition, the ward area had noticeboards that displayed a range of useful information for patients. The information available included patients' rights, how to complain, and details of advocacy services. In addition, wards had information displayed on physical health conditions and self-help, and ward 33 had information displayed about sexuality and gender identity.

The trust provided patient information leaflets in languages other than English on request. Staff had easy access to interpreters. Staff booked interpreters for telephone and face-to-face meetings, as appropriate.

The trust had a contracted catering service on each site. The catering service offered patients food that met their specific needs and preferences. This included special diets such as vegetarian or halal and consideration of health issues such as nut allergies or diabetes. The wards had colourful menus displayed in their dining rooms. The menu had a two-week rotation. Most of the patients we spoke with during our inspection gave positive or mixed comments about the quality and choice of food on their wards.

Patients had access to multi-faith rooms on both sites.

Listening to and learning from concerns and complaints

Patients knew how to make complaints and raise concerns and felt confident to do so. Information on how to make a complaint was widely available throughout the units. Patients said they received outcomes to their complaints. The table below shows that the acute wards received 56 complaints in the 12 months to February 2018. Ward 35 had the most complaints (15) and the enhanced care ward had the least complaints (one). The acute wards received 202 compliments in the same period, which accounted for 26% of all compliments received by the trust as a whole.

Ward name	Total Complaints
Radbourne Unit - Ward 35 Adult	15
Radbourne Unit - Ward 36 Adult	12
Hartington Unit - Pleasley Ward	9

Radbourne Unit - Ward 34 Adult	8
Hartington Unit - Tansley Ward	4
Radbourne Unit - Ward 33 Adult	4
Hartington Unit - Morton Ward	3
Radbourne Unit - Enhanced Care Ward	1

Staff knew how to handle complaints. They helped patients put complaints in writing and referred them to the trust's patient advice and liaison service (known as PALS). Staff dealt with complaints informally or referred them to the ward manager, as appropriate. Staff received the outcomes of complaints and any action they needed to take at handovers, team meetings or in one-to-one supervision sessions.

Is the service well led?

Leadership

Most ward managers had the skills and knowledge to perform their roles. Ward managers at Hartington unit had long service with the trust and had a good understanding of the services they managed. However, the wards at Radbourne Unit had experienced a high turnover of management staff and had new managers in post. Most of the new managers had previous experience of the trust but had just started to get to know the wards and staff teams. All the ward managers at Radbourne Unit expressed concerns about staff recruitment and retention, and the difficulties they experienced in ensuring safe staffing levels.

Ward managers and other local senior managers were visible on the wards and units. At Hartington Unit, staff found their managers and leaders approachable. Staff at Radbourne Unit gave positive feedback about their ward managers and staff teams but gave mixed feedback about their senior managers. Wards managers at Radbourne Unit described good support from their immediate managers. However, many of the staff we spoke with felt that the senior managers at the trust did not provide effective leadership. Staff commented on a lack of direction, a reactive approach to care, and a critical culture. Staff did not feel listened to or valued by senior management, and expressed concerns about their safety on the wards due to staffing levels.

There were development opportunities available to managers and staff. For example, some senior nurses had completed short leadership courses.

Vision and strategy

Staff understand the trust's vision and values. We found the trust's values demonstrated in the care staff gave to patients and their commitment and compassion in spite of the challenges they experienced (such as staffing issues at Radbourne Unit).

Staff contributed to discussions about possible changes to their service.

Ward managers explained how they worked to deliver high quality care within their budgets. Ward managers took steps such as block-booking bank staff, and identifying the need for specific staff on their wards, for example, ward-based occupational therapists, a medicines optimisation lead.

Culture

The staff culture varied considerably between the two units. Most of the staff at Hartington Unit felt respected, supported and valued by their managers and colleagues. Staff gave examples of support they had received with work-related and personal issues such as illness and childcare. All the staff teams worked well together. Staff supported each other and the teams on the other wards in Hartington Unit. However, staff at Radbourne Unit had low morale and experienced high levels of stress. Their wards had high vacancy levels, and managers struggled to fill shifts with sufficient staff and skill mix. Staff supported each other and their patients in spite of their limited resources.

Staff at Hartington Unit found that the shift patterns and staffing rotas worked well and generally met their personal preferences. However, at Radbourne Unit, staffing shortages meant that staff worked extra shifts regularly. Ward managers at Radbourne Unit described staff as 'tired' and 'worn out.'

Staff knew how to use the whistle blowing process and about the role of the Speak Up Guardian. Staff and ward managers at Hartington Unit felt they could raise concerns with their managers and senior managers. Ward managers at Radbourne Unit regularly raised concerns with their immediate line managers. However, although staff at Radbourne Unit trusted their ward managers, they did not feel confident about sharing their concerns with their senior managers. Staff did not feel listened to and described a critical culture.

Managers dealt with poor staff performance in line with the trust's policy, however, some staff reported slow progress with this. In the 12 months to 28 February 2018, the trust reported five cases where they needed to investigate concerns raised about staff in this core service.

Staff had the opportunity to discuss their development and career aspirations with their managers, for example, in supervision or at their annual appraisals. However, staff at Radbourne Unit had poor access to supervision. Staff had access to development opportunities although staff at Radbourne Unit could not always take them up due to staffing shortages.

The sickness rate exceeded the average for the trust at 8% (compared to 5%). The trust had an occupational health service that staff had access to. Radbourne Unit had developed a staff health and wellbeing area, which was a breakaway space for staff to help them relax and unwind. However, staff did not always have the chance to take breaks although the trust planned to introduce formal breaks within shifts in the future.

Governance

Overall, we found a poor quality of governance at core service level. The core service had not addressed all the issues identified from our last inspection, and we found additional issues on this inspection. Wards at Radbourne Unit did not always have a sufficient number and skill mix of staff required to cover shifts. Not all staff were up-to-date with their mandatory training, or received regular supervision, or their annual appraisals. Staff on wards at Radbourne Unit reported low morale due to staffing pressures and changes of ward managers. Staff did not always recognise or report safeguarding concerns and incidents. Most wards had poor medicines management practices. The quality of patients' care records was variable, and staff did not always update risk assessments and care plans. The new paper-free observation process was onerous for staff and potentially unsafe. Staff were unaware of the trust's policy and guidance on contraband items. Some staff conducted searches of patients' property without adequate training. Staff did not always complete or record physical health checks. Staff and patients struggled to comply with the trust's smoke-free policy. Patients had little or no access to psychological therapies. The service had a medically led rather multidisciplinary model of care. Few therapeutic activities took place on the wards. Staff did not always comply fully with the trust's policies and the Mental Health Act Code of Practice. However, wards were clean. Staff treated patients well. Some patients had access to a recovery hub, which provided a range of structured, recovery-based activities.

The local meetings that occurred covered a range of operational and strategic matters relevant to the service, for example, the daily red to green meeting on each unit reviewed patient flow and managed bed status. The well-attended weekly multidisciplinary meeting reviewed all patients in the unit, and then continued as a business meeting. Staff at Hartington Unit had access to regular team meetings on their wards although these did not occur regularly on wards at Radbourne Unit. Staff on both units relied heavily on shift handovers for up-to-date information. Through the various meetings, staff found out about new initiatives, changes, strategies and developments at local, service and trust level.

Staff and managers implemented changes following recommendations from reviews and investigations.

Although a range of clinical audits took place at trust, core service and ward level, these audits did not provide us with assurance that staff did robust checks and addressed any issues. For example, our checks of pharmacy audits showed errors that needed attention, yet staff made the same errors repeatedly.
The trust had appropriate arrangements to meet the needs of patients. For example, the trust had a physical healthcare team to provide training and support to staff on the wards. The trust had a physical healthcare committee that discussed a range of physical health-related matters and a

named senior level accountable person for physical healthcare. The trust had a physical healthcare strategy that outlined the strategic priorities for physical healthcare for the next three years.

Management of risk, issues and performance

Ward managers submitted items to the trust's risk register via their senior management and governance structure. Equally, staff escalated concerns through their line managers.

As of 28 February 2018, the trust's risk register included a high risk for Radbourne Unit related to staffing vacancies. The trust's risk assessment set out the main risks, which matched staff's concerns at the time of our inspection:

- 34% vacancy levels for qualified nurses
- insufficient qualified nursing staff to meet the required skill mix
- the impact on ward staff of the need to provide 'bleep' cover (for the health-based place of safety and daytime on-call rota)
- difficulties maintaining operational duties and staff supervision.

The trust had plans to deal with emergencies while ensuring the continuity of care. During our inspection, some of the wards were undoing redecoration and refurbishment. The ward managers and staff had considered the impact of these works on patients and made adjustments. For example, Tansley ward had an additional six staff to support the ward during this time.

Information management

The trust had implemented an electronic care records system that held all information on patients' care. The trust had an electronic incident reporting system that all staff used to report incidents. These systems had the functionality to generate management information and reports. However, the expectation for staff to record all observations of patients directly onto the electronic care system was not effective and potentially unsafe as it took staff away from their work.

The trust provided staff with the equipment and technology they needed in their work but staff experienced difficulties with it. For example, access to the patient electronic care record system created a burden on staff because of issues with the application (delays, glitches); the need to locate a work station and computer (this might involve collecting a laptop and setting it up); and occasionally, insufficient laptops to meet staff needs.

Staff found it difficult to find information quickly and easily due to inconsistencies in recording and record-keeping on the electronic system. Our interviews with staff, patients and their relatives alongside our observations indicated that staff provided appropriate care but did not always record their interventions on the system due to the issues they experienced. We also found that information discussed at meetings did not always match the information held in the patient's electronic care record.

Information governance systems and processes ensured the appropriate protection of confidential information about patients.

Ward managers had access to a range of information collated by the trust such as management information and performance reports relevant to their service. These included data on bed management, length of stay, delayed discharges, incidents, complaints, and staffing data (sickness, vacancies, turnover).

The core service did not always identify and report safeguarding issues and incidents appropriately. In our review of patients' care records, we identified a number of safeguarding concerns and incidents that staff had not followed up.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the trust and the services they used. The trust used a number of methods to communicate with staff, patients and carers that included its own website, bulletins, emails, newsletters, displays, intranet, patients' meetings and carers' forums.

Staff, patients and carers had opportunities to give feedback on the service they received. For example, the trust had a strong carers' network that engaged in many of the trust's projects that affected patients. Managers and staff involved patients and carers in service developments and used feedback to make improvements.

Senior managers engaged with external stakeholders such as Healthwatch, the Care Quality Commission, NHS Improvement and commissioners.

Learning, continuous improvement and innovation

Staff raised issues and gave ideas for improvements. This was more evident at Hartington Unit. Locally, on the wards, staff and managers considered opportunities for improvements and innovation, which led to changes. For example, Hartington Unit had allocated a lead nurse to improve the staff supervision programme, which resulted in regular and better quality supervision for staff.

The trust participated in the commissioning for quality and innovation framework to help improve the quality of services. The trust had started to implement the Safewards model on the acute wards.

The trust contributed to national audits, for example, the Prescribing Observatory for Mental Health. At this inspection we did not see evidence of remedial action against issues raised through audit. However, we have subsequently seen evidence that the trust regularly reviewed medicines audits and completed actions to reduce further risk.

Community-based mental health services for adults of working age

Facts and data about this service

Team name	Patient group (male, female, mixed)
Amber Valley Neighbourhood	Mixed
Bolsover & Clay Cross Neighbourhood	Mixed
Chesterfield Central Neighbourhood	Mixed
County & City Early Intervention	Mixed
Derby City Neighbourhood	Mixed
High Peak & Derbyshire Dales North Neighbourhood	Mixed
Killamarsh & North Chesterfield Neighbourhood	Mixed
North Derbyshire Early Intervention	Mixed
Placement Review Team	Mixed
South Derbyshire & Derbyshire Dales South Neighbourhood	Mixed
Hartington Unit Outpatients	Mixed

Is the service safe?

Safe and clean environment

Not all the buildings where teams were based were owned by the trust and some buildings were shared by other teams and organisations. The environments were visibly clean but some were tired looking.

The High Peaks, Amber Valley and Dale Bank View environments were small and staff struggled to book rooms to see patients in. In addition, there was not enough room for staff to work, access a computer and write up notes. High Peaks rooms were cluttered and had old equipment in that was waiting to be removed by the estates department. There was also damage to the walls.

Killamarsh reception was not manned full time. There was a voice intercom that patients used to announce their arrival for their appointment. Staff then let them through to the waiting area. There were no cameras or CCTV so staff were unaware who patients had brought with them to the appointment or if anyone else had managed to access the area after the patient had been let through to the waiting area.

Staff saw patients in all the bases we visited. Not all the interview rooms had alarms but staff had access to personal alarms. All the staff we spoke with could explain the procedure if an alarm was raised.

None of the managers or staff we spoke with were aware of their bases having an environmental risk assessment that included a ligature risk assessment. However, staff assured us that patients were not left alone in any interview rooms and escorted to and from the waiting areas.

The clinic rooms at all the bases except for Killamarsh were clean and records showed they were cleaned regularly, including the equipment. They all contained the necessary equipment to carry out physical examinations. All equipment was well maintained, calibrated and had visible safety stickers in place. Killamarsh kept their medication in a locked cupboard in the staff office and their medication fridge in a cupboard with the door propped open. This was to control the temperature. Records showed all but one team checked fridge and room temperatures daily and any concerns were raised with pharmacy. We saw at Buxton their fridge and room temperatures had only been checked four times between 1 June 2018 and the date of inspection 12 June 2018.

All areas had emergency bags and except for Killamarsh records showed they were checked regularly. Killamarsh had not checked their emergency bag to the required Trust standards.

Staff could explain infection control principles and said they would wash their hands prior to carrying out a clinical activity. We saw lots of staff wearing gel nails and nail polish. We looked in the infection control policy and there was no guidance for staff to say whether this was within infection control guidelines.

Safe staffing

Definition

Substantive – All filled allocated and funded posts.

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

Substantive staff figures			Trust target
Total number of substantive staff	At 28 February 2018	334.5	N/A
Total number of substantive staff leavers	1 March 2017 – 28 February 2018	35.5	N/A
Average WTE* leavers over 12 months (%)	1 March 2017 – 28 February 2018	11%	10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 28 February 2018	18.8	N/A
Total vacancies overall (%)	At 28 February 2018	5%	10%
Total permanent staff sickness overall (%)	Most recent month At 28 February 2018	8%	5%
	1 March 2017 – 28 February 2018	5%	5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 28 February 2018	177.5	N/A
Establishment levels nursing assistants (WTE*)	At 28 February 2018	32.3	N/A
Number of vacancies, qualified nurses (WTE*)	At 28 February 2018	-1.6	N/A
Number of vacancies nursing assistants (WTE*)	At 28 February 2018	2.0	N/A
Qualified nurse vacancy rate	At 28 February 2018	-1%	10%
Nursing assistant vacancy rate	At 28 February 2018	6%	10%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 March 2017 – 28 February 2018	212 (<1%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 March 2017 – 28 February 2018	3853 (7%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 March 2017 – 28 February 2018	11 (<1%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	98 (1%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	0 (0%)	N/A

Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	0 (0%)	N/A

*Whole-time Equivalent

This service reported an overall vacancy rate of -1% for registered nurses at 28 February 2018.

This service reported an overall vacancy rate of 6% for registered nursing assistants 28 February 2018.

This service reported a vacancy rate for all staff of 5% at 28 February 2018. The Trust authorised over recruitment to relive pressure on staff with higher caseloads or waiting list pressure to support staff. This was over and above the budgeted establishment. This was an active decision to reduce patient safety risks and in line with our staff first model.

	Registered nurses			**Health care assistants**			**Overall staff figures**		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Psychol Complex Case Supp	0	0	0%	0	0	0%	1.0	1.0	100%
Psychology AC CountyNorth	0	0	0%	0	0	0%	0.6	1.5	40%
Psychology EI	0	0	0%	0	0	0%	1.0	3.1	32%
Medics Neighbourhood Sth	0	0	0%	0	0	0%	2.4	10.7	22%
Early Int Clin Specialist	0.6	3.1	20%	0	0	0	0.6	3.1	20%
DynamPsychotherapy-DuffRd	1.7	9.3	18%	0	0	0%	2.3	12.5	18%
Psychology SpecialistServ	0	0	0%	0	0	0%	0.8	4.8	17%
HP+NthDales Nhood Adult	1.0	14.0	7%	1.1	4.3	25%	4.5	27.7	16%
Medics Neighbourhood City	0	0	0%	0	0	0%	1.5	10.7	14%
Placement Review Team	0.6	5.0	12%	0	0	0%	0.6	5.0	12%
Amber Valley Nhood Adult	-0.9	13.5	-7%	0	0	0%	1.6	19.5	8%
Psychology Neighbourhood	0.2	1.7	13%	0	0	0%	1.9	27.0	7%
CountyN Early Int	-0.6	10.8	-6%	0	2.0	0%	0.9	15.5	6%

DCity Early Int	-0.4	6.8	-6%	0	2.5	0%	0.6	10.9	6%
KillNthCfld Nhood Adult	0.5	10.7	5%	0.1	2.5	0%	1.0	20.3	5%
Bolsover+CC Nhood Adult	-0.2	12.4	-2%	-0.1	2.7	-2%	0.8	20.7	4%
CountyS Early Int	-0.5	5.7	-9%	0	2.0	0%	0.5	10.7	4%
Erewash Nhood Adult	0.5	13.0	4%	-0.1	1.5	-5%	0.5	18.0	3%
Derby City Adult Nhood C	0.3	19.1	1%	0.1	3.1	3%	0.5	26.8	2%
Sth DD Nhood Adult	-0.6	13.0	-4%	0	2.0	0%	0.3	19.7	1%
Specialist Psyc Therapy	0	1.0	0%	0	0	0%	0	1.0	0%
City Early Int Medical	0	0	0%	0	0	0%	0	1.0	0%
Medics Neighbourhood Nth	-1.0	0	0%	0	0	0%	-0.2	14.8	-1%
H Unit - The Hub	0	0	0%	-0.1	3.1	-3%	-0.1	4.1	-2%
Derby City Adult Nhood B	-0.6	21.8	-3%	-0.1	3.5	0%	-0.7	29.1	-2%
CfldCentral Nhood Adult	-2.1	16.7	-13%	1	3	33%	-0.9	26.6	-3%
Trainee Clin P/ologists	0	0	0%	0	0	0%	-2.0	8.0	-25%
Psychology Sexual Health	0	0	0%	0	0	0%	-0.4	1.4	-29%
Cnty N Early Int Medical	0	0	0%	0	0	0%	-0.6	1.1	-50%
Service total	**-1.6**	**177.5**	**-1%**	**2.0**	**32.3**	**6%**	**18.8**	**356.6**	**5%**
Trust total	**116.2**	**970.5**	**12%**	**34.3**	**375.2**	**9%**	**310.3**	**2490.1**	**12%**

NB: All figures displayed are whole-time equivalents

Between 1 March 2017 and 28 February 2018, bank staff filled less than 1% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 7% of shifts for qualified nurses. Less than 1% of shifts were unable to be filled by either bank or agency staff.

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Amber Valley Nhood Adult	2044	0 (0%)	161 (8%)	0 (0%)

AmberValley Neighbourhood	3018	0 (0%)	0 (0%)	0 (0%)
Bolsover+CC Neighbourhood	2219	0 (0%)	0 (0%)	0 (0%)
Bolsover+CC Nhood Adult	1890	0 (0%)	284 (15%)	0 (0%)
CfldCentral Neighbourhood	2561	0 (0%)	0 (0%)	0 (0%)
CfldCentral Nhood Adult	2540	0 (0%)	438 (17%)	0 (0%)
CountyN Early Int	2630	0 (0%)	0 (0%)	0 (0%)
CountyS Early Int	1522	0 (0%)	0 (0%)	0 (0%)
DCity Early Int	1680	43 (3%)	470 (28%)	2 (<1%)
Derby City Adult Nhood B	3381	0 (0%)	534 (16%)	2 (<1%)
Derby City AdultÂ Nhood C	2850	0 (0%)	781 (27%)	0 (0%)
Derby City Neighbourhood	5939	0 (0%)	0 (0%)	0 (0%)
DynamPsychotherapy-DuffRd	2490	0 (0%)	0 (0%)	0 (0%)
Early Int Clin Specialist	816	0 (0%)	0 (0%)	0 (0%)
Erewash Neighbourhood	2428	0 (0%)	0 (0%)	0 (0%)
Erewash Nhood Adult	1981	0 (0%)	85 (4%)	0 (0%)
HP + North Dales DRRT	55	0 (0%)	0 (0%)	0 (0%)
HP+NthDales Neighbourhood	2246	2 (<1%)	21 (1%)	0 (0%)
HP+NthDales Nhood Adult	2002	0 (0%)	0 (0%)	0 (0%)
KillNthCfld Neighbourhood	1912	0 (0%)	0 (0%)	0 (0%)
KillNthCfld Nhood Adult	1631	102 (6%)	342 (21%)	0 (0%)
Placement Review Team	1296	0 (0%)	0 (0%)	0 (0%)
Psychology EI	81	0 (0%)	0 (0%)	0 (0%)

Psychology Neighbourhood	418	0 (0%)	0 (0%)	0 (0%)
Specialist Psyc Therapy	198	0 (0%)	0 (0%)	0 (0%)
Sth DD Neighbourhood	2375	0 (0%)	0 (0%)	0 (0%)
Sth DD Nhood Adult	1981	65 (3%)	737 (37%)	7 (<1%)
Service total	**54184**	**212 (<1%*)**	**3853 (7%*)**	**11 (<1%*)**
Trust Total	**248873**	**1416 (<1%)**	**5000 (2%)**	**293 (<1%)**

***Percentage of total shifts

Between 1 March 2017 and 28 February 2018, 1% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, no agency staff covered nursing assistant shifts. No shifts were unable to be filled by either bank or agency staff.

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
AmberValley Neighbourhood	215	0 (0%)	0 (0%)	0 (0%)
Bolsover+CC Neighbourhood	430	0 (0%)	0 (0%)	0 (0%)
Bolsover+CC Nhood Adult	406	0 (0%)	0 (0%)	0 (0%)
CfldCentral Neighbourhood	524	0 (0%)	0 (0%)	0 (0%)
CfldCentral Nhood Adult	389	0 (0%)	0 (0%)	0 (0%)
CountyN Early Int	528	0 (0%)	0 (0%)	0 (0%)
CountyS Early Int	528	0 (0%)	0 (0%)	0 (0%)
DCity Early Int	636	0 (0%)	0 (0%)	0 (0%)
Derby City Adult Nhood B	413	0 (0%)	0 (0%)	0 (0%)
Derby City AdultÂ Nhood C	469	0 (0%)	0 (0%)	0 (0%)
Derby City Neighbourhood	1084	0 (0%)	0 (0%)	0 (0%)
Erewash Neighbourhood	377	0 (0%)	0 (0%)	0 (0%)

Erewash Nhood Adult	231	98 (42%)	0 (0%)	0 (0%)
HP + North Dales DRRT	61	0 (0%)	0 (0%)	0 (0%)
HP+NthDales Neighbourhood	748	0 (0%)	0 (0%)	0 (0%)
HP+NthDales Nhood Adult	658	0 (0%)	0 (0%)	0 (0%)
KillNthCfld Neighbourhood	491	0 (0%)	0 (0%)	0 (0%)
KillNthCfld Nhood Adult	385	0 (0%)	0 (0%)	0 (0%)
Sth DD Neighbourhood	325	0 (0%)	0 (0%)	0 (0%)
Sth DD Nhood Adult	154	0 (0%)	0 (0%)	0 (0%)
Service total	**9052**	**98 (1%*)**	**0 (0%*)**	**0 (0%*)**
Trust Total	**83457**	**15372 (18%)**	**0 (0%)**	**2497 (3%)**

***** Percentage of total shifts

This service had 35.5 (11%) staff leavers between 1 March 2017 and 28 February 2018.

Team	Substantive staff	Substantive staff Leavers	Average % staff leavers
Psychology EI	1.6	1.0	61%
Medics Neighbourhood City	11.0	3.0	26%
Placement Review Team	4.0	1.0	24%
KillNthCfld Neighbourhood - Adult	17.9	3.2	19%
Bolsover+CC Neighbourhood - Adult	19.9	3.5	18%
County North Early Intervention	14.6	2.6	16%
HP+NthDales Neighbourhood - Adult	22.4	3.4	14%
Medics Neighbourhood Sth	9.6	1.4	14%
Derby City Neighbourhood - Adult Team B	29.8	3.8	14%
CfldCentral Neighbourhood - Adult	27.5	3.0	12%

Derby City Early Intervention	10.3	1.0	11%
Sth DD Neighbourhood - Adult	19.4	1.9	11%
Medics Neighbourhood Nth	16.7	1.6	10%
Dynamic Psychotherapy Duffield Road	10.2	1.0	9%
Erewash Neighbourhood - Adult	16.0	1.0	7%
Amber Valley Neighbourhood - Adult	18.8	1.0	6%
Psychology Neighbourhood	25.9	1.6	6%
County South Early Intervention	9.2	0.5	5%
City Early Intervention Medical	1.0	0	0%
County N Early Int Medical	1.1	0	0%
Derby City Neighbourhood - Adult Team C	26.3	0	0%
Dist Psych Therapy Medical	0.5	0	0%
Early Intervention Clinical Specialist	3.0	0	0%
H Unit - The Hub	4.2	0	0%
Specialist Psyc Therapy	1.0	0	0%
Trainee Clinical Psychologist	10.0	0	0%
Psychology AC County North	0.9	0	0%
Psychology Sexual Health	1.8	0	0%
Service total	**334.5**	**35.5**	**11%**
Trust Total	**2167.7**	**219.3**	**10%**

The sickness rate for this service was 5% between 1 March 2017 and 28 February 2018. The most recent month's data (February 2018) showed a sickness rate of 8%.

Team	**Total % staff sickness (February 2018)**	**Ave % permanent staff sickness (1 March 2017 to 28 February 2018)**

Derby City Neighbourhood - Adult Team C	20%	12%
Early Intervention Clinical Specialist	50%	9%
Medics Neighbourhood Nth	7%	9%
Bolsover+CC Neighbourhood - Adult	16%	8%
Amber Valley Neighbourhood - Adult	15%	8%
Sth DD Neighbourhood - Adult	8%	8%
Medics Neighbourhood City	10%	7%
Derby City Neighbourhood - Adult Team B	4%	7%
County South Early Intervention	11%	7%
Derby City Early Intervention	5%	6%
Psychology Sexual Health	8%	5%
HP+Nth Dales Neighbourhood - Adult	5%	4%
Dynamic Psychotherapy Duffield Road	11%	4%
Psychology Specialist Services	2%	3%
KillNth Cfld Neighbourhood - Adult	2%	3%
H Unit - The Hub	7%	3%
Erewash Neighbourhood - Adult	10%	3%
Cfld Central Neighbourhood - Adult	5%	2%
Trainee Clinical Psychologist	1%	2%
County North Early Intervention	10%	2%
Medics Neighbourhood Sth	1%	2%
Placement Review Team	2%	1%
Psychology Neighbourhood	1%	1%
Cfd Central Locality - Adult	0%	1%

Psychology EI	0%	1%
Dist Psych Ther Medical	0%	0%
City Early Intervention Medical	0%	0%
County N Early Int Medical	0%	0%
County South Adult Locality	0%	0%
Psychology AC County North	0%	0%
Specialist Psyc Therapy	0%	0%
Service total	**8%**	**5%**
Trust Total	**7%**	**5%**

Medical staff

Between 1 March 2017 and 28 February 2018, there were no medical locum shifts filled by bank staff to cover sickness, absence or vacancy.

In the same time period, agency staff covered 12% of shifts. There were no medical locum shifts that were to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
City Early Int Medical	253	0 (0%)	0 (0%)	0 (0%)
Cnty N Early Int Medical	298	0 (0%)	0 (0%)	0 (0%)
Dist Psych Ther Medical	132	0 (0%)	0 (0%)	0 (0%)
Medics Neighbourhood City	2917	0 (0%)	446 (15%)	0 (0%)
Medics Neighbourhood Nth	3335	0 (0%)	175 (5%)	0 (0%)
Medics Neighbourhood Sth	2827	0 (0%)	591 (21%)	0 (0%)
Service total	**9762**	**0 (0%*)**	**1212 (12%*)**	**0 (0%*)**
Trust Total	**41564**	**0 (0%)**	**4944 (12%)**	**0 (0%)**

***** Percentage of total shifts

Managers we spoke with told us most of their vacancies had been recruited to apart from at Ilkeston Resource Centre base they were struggling to recruit a band 5. The advert had been out four times with no success.

There was not a psychiatrist at Dale Bank View at the time of inspection. There were bookings for some locum psychiatrists for a few days in July and then they were hoping to block book a locum for a three-month block after that. We were told previous psychiatrists that had been in a substantive post or as a locum during the past two years said the reason recruitment was so hard was because the patch was too big for one consultant and a junior doctor was required.

The average caseload for a full time nurse was between 30 and 45 cases. The highest caseloads were in Killamarsh. Five staff out of 25 we spoke with said their caseload was high and they were struggling to manage.

All the managers we spoke with told us they met regularly with staff to review their caseloads but they did not use a caseload management tool and the approach varied depending on the manager. At the time of inspection there were 995 patients that had been seen for an initial assessment and were waiting for their first contact, which could include waiting for a care coordinator.

Managers ensured cover was arranged for staff sickness and leave.

All the staff said there was rapid access to a psychiatrist if required, except for at Dale Bank View. Staff at Dale Bank View contacted one of the other psychiatrists if urgent access was required. The timeliness of this response varied.

Mandatory training

The compliance for mandatory and statutory training courses at 28 February 2018 was 73% (for the current financial year) compared to 81% reported in the previous financial year.

Managers and staff that we spoke with said they were focusing on increasing their training rates and any outstanding training was discussed in supervision. One manager felt that mandatory training was sometimes cancelled due to capacity issues and prioritising patients.

Key:

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

Training Course	**Trust Target %**	**Training compliance % for this service**	**Trust Wide Training Compliance %**
Data Security Awareness (Previously IG) (Annual)	95%	87%	91%
Equality, Diversity and Human Rights - Level 1 (3 yearly)	85%	75%	78%
Fraud Awareness (3 yearly)	85%	94%	95%
Health, Safety & Welfare (3 Yearly)	85%	77%	81%

Moving & Handling Level 1 (3 yearly)	85%	80%	83%
Promoting Safer & Therapeutic Services Clinical Staff (3 yearly)	85%	80%	85%
Promoting Safer & Therapeutic Services Non-Clinical Staff (3 yearly)	85%	83%	86%
Safeguarding - Adults Level 1 (Non Clinical) (3 Yearly)	85%	85%	87%
Safeguarding - Children Level 1 (once only)	85%	99%	98%
Aseptic Non-Touch Technique (ANTT) - 2 yearly	85%	50%	79%
Autism (ASD) Awareness Level 1 (Once)	85%	59%	57%
Care Certificate (Once Only)	85%	87%	84%
Deprivation of Liberty Standards (Once)	85%	86%	83%
Dual Diagnosis Level 1 (Once)	85%	63%	70%
Dual Diagnosis Level 2 (Once)	85%	67%	57%
Fire Safety - Fire Warden (3 Yearly)	85%	40%	64%
First Aid at Work Certificate (3 Yearly)	85%	100%	84%
Food Hygiene Awareness Update (Annual)	85%	41%	64%
Food Hygiene Certificate (3 Yearly)	85%	4%	35%
General Risk Assessor Training (3 Yearly)	85%	27%	21%
Investigating Incidents, Complaints, Claims & Report Writing (Once only)	85%	73%	71%
Medic - Approved Clinician (EXTERNAL COURSE 5 Yearly)	85%	96%	86%
Medic - Section 12 Approval (EXTERNAL 5 Yearly)	85%	91%	63%
Meds Mgmt - Admin & Documentation (3 yearly)	85%	0%	36%
Meds Mgmt - Controlled Drugs (3 yearly)	85%	0%	34%
Meds Mgmt - Use of Medication in the Management of Violence & Aggression v5 (3 yearly)	85%	13%	62%
Mental Capacity Act (Once)	85%	90%	84%
Mental Health Act 2007 (Once)	85%	80%	79%
Moving & Handling Level 2 - Inanimate Objects (2 Yearly)	85%	0%	75%
Moving & Handling Level 2 - MEDICAL EXEMPTION (See individual risk assessment) 1 Year	85%	100%	75%
Moving & Handling Level 2 - People (2 yearly)	85%	65%	68%
Physical Health in Mental Health (3Yearly)	85%	22%	24%

Positive & Safe - Breakaway (Annual)	85%	20%	36%
Positive & Safe - Teamwork - inc PSTS (Annual)	85%	50%	67%
Positive & Safe - Teamwork (C&R) MEDICAL EXEMPTION (See individual risk assessment) (Annual)	85%	100%	100%
R Resuscitation - Basic Life Support & AED (annual)	85%	56%	64%
Resuscitation - Immediate Life Support - ILS - (annual)	85%	64%	73%
Safeguarding - Adults Level 3 (2 Yearly)	85%	50%	55%
Safeguarding - Children Level 2 (3 yearly)	85%	94%	90%
Safeguarding - Children Level 2 (once only)	85%	91%	93%
Safeguarding - Children Level 3 (3 yearly)	85%	79%	80%
Safeguarding - Children Level 3 (annual)	85%	0%	73%
Safeguarding - PREVENTing Radicalisation - Level 1 (3 yearly)	85%	78%	86%
Safeguarding - PREVENTing Radicalisation/WRAP Level 3 (3 yearly)	85%	88%	90%
Smoking Cessation Level 1 (Once Only)	85%	18%	33%
Staff Recruitment Training - All Recruiters (3 Yearly)	85%	67%	59%
Total		**73%**	**75%**

Assessing and managing risk to patients and staff

Assessment of patient risk

The trust had developed a safety plan that acted as the risk assessment tool for all patients. Safety plans were present and up to date in all 41 patient records we looked at. We saw that staff had completed these comprehensively and they provided detailed information to develop plans from. Staff reported they updated safety plans every six months, following incidents or after any identified changes to risk.

The safety plan was built into the electronic patient record and accessible to all clinical staff in the trust. The plan included assessments of violence, substance misuse, exploitation, and was used across all locations including inpatient settings.

We saw good examples of crisis plans and advance statements, particularly in the records at Ilkeston resource centre base.

Staff could respond promptly to a sudden deterioration in patients' mental health but this would sometimes mean other patients in their diary had to be cancelled. We saw two examples of this during our inspection. Staff would rearrange the cancelled appointments as soon as possible.

Management of patient risk

All the team manages we spoke with monitored waiting times for the neighbourhood teams differently. The waiting lists in both teams in Derby City were difficult to understand and it was not clear which patient was already open to a different part of the service and waiting for a care coordinator or which patients had only received an initial assessment and were not being seen by anyone. It was also not clear from the waiting lists whether there was any risk issues and what intervention the patient was waiting for. To find this level of detail you had to look in the electronic record system which was not timely. Each team manager said they reviewed the waiting lists every week to see if any information had been received from the GP or whether the patient had called the duty worker or attended the accident and emergency department. The service relied on the patients themselves or the GP to contact them if they were deteriorating. There had been a serious incident of a patient on the waiting list and an investigation was currently underway. It was not clear what impact being on the waiting list had on the patient's mental health and risk issues.

There were also long waits for psychology service. This team was managed outside of the neighbourhood teams. The psychologists also relied on the patients or referrer to contact them if there was any deterioration while on the waiting list.

There were 501 patients waiting for an appointment with the psychology service in May 2018 These patients had been seen and had been assessed as meeting the criteria for a service. The average wait was 31.81 weeks and the longest wait was 107.29 weeks. It was not clear from the psychology waiting lists whether patients were open to other areas of the service or were not receiving a service at all.

The trusts waiting list policy was being reviewed at the time of inspection following feedback from managers who had said the timelines were not realistic.

There was not a consistent robust approach to monitoring any of the waits for any part of the service. Relying on patients and referees to contact the team in case of deterioration in patients' mental health could lead to risk escalating and mental health deteriorating. All the staff and managers used the electronic patient record system slightly differently and used different headings to record the intervention patients had been seen for or what they were waiting for. We saw there were three different headings assessment could be recorded under.

Staff followed good personal safety protocols and we saw each team recorded staff movements and phoned them at the end of the day to check their safety and well-being.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has its own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

All staff we spoke with had a good understanding of when and how they would report a safeguarding and could give us examples of when they had done this.

The trust has stated that there is the potential for safeguarding referrals to have been made without a datix incident report having been completed. Both Safeguarding Adult Boards maintain data of referrals received into the local authorities but, currently, "health" referrals are not currently represented by organisation.

Staff could describe how they would protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. This included applying knowledge and skills learned from safeguarding training, guidance from trust polices, and discussion with local safeguarding services and leads.

Staff access to essential information

Staff had access to all patients records via the electronic patient record system accessed via Wi-Fi including their mobile phones. However, staff told us there were issues in accessing this information when they were out in the community or in bases like GP practices. Staff said they had to print out any relevant information to take with them. Staff said this can be an issue as there could be a delay in patients' notes being written up. Staff also had to come back to the base to make a safeguarding referral raise an incident or make a referral for admission

Medicines management

The trust provided policies on good practice medicines management. This included guidance for community based practitioners.

We looked at 40 drug cards, the majority, were completed correctly, except for staff in Killamarsh and High peaks teams did not routinely record allergy status. We checked seven clinic rooms. There was good medicines management practice, all medicines we looked at were in date and stored correctly. We saw bags for when staff transported medication. staff could explain to us the procedure for correctly checking and administering medication.

We saw staff regularly reviewed (or ensured GPs regularly reviewed) the effects of medication on patients' physical health in line with guidance from the National Institute for Health and Care Excellence. This included patients who were prescribed, injectable antipsychotic medication and lithium. Staff could describe the checks they completed at regular intervals that were in accordance with National Institute for Health and Care Excellence. This included blood pressure checks, blood tests and electrocardiograms. Patients at Derby City had access to a physical health clinic where staff monitored physical health. They also had a Clozaril monitoring machine so doses could be altered immediately.

Track record on safety

Trusts must report all serious incidents to the Strategic Information Executive System within two working days of an incident being identified.

Between 1 March 2017 and 28 February 2018 there were 32 Strategic Information Executive System incidents reported by this service. Of the total number of incidents reported, the most common type of incident was apparent/actual/suspected self-inflicted harm with 20.

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

The number of serious incidents reported during this inspection was higher than the 23 reported at the last inspection.

Number of incidents reported

	Apparent /actual/suspected self-inflicted harm	Apparent /actual/suspected homicide	Pending review	Medication incident	Serious Incident by Outpatient (in receipt)	Suicide	Treatment delay	Total
Early Interventions Team - County North	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Early Interventions Team - County South	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Early Interventions Team - Derby City	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**2**
Neighbourhood - Amber Valley	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Neighbourhood - Bolsover & Clay Cross Locality	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**2**
Neighbourhood - Chesterfield Central	2	1	1	0	0	0	0	4
Neighbourhood - Derby City (A)	1	0	0	1	0	0	0	2
Neighbourhood - Derby City (B)	3	0	1	0	0	0	0	4
Neighbourhood - Derby City (C)	3	2	1	0	0	0	0	6
Neighbourhood - Erewash	2	0	0	0	0	0	0	2
Neighbourhood - High Peak & North Dales	3	0	0	0	0	1	0	4
Neighbourhood - Killamarsh & Chesterfield North	0	1	0	0	0	0	0	1
Neighbourhood - South	1	0	0	0	0	0	0	1

County and South Dales								
Placement Review Team	1	0	0	0	0	0	0	1
Service Total	**20**	**4**	**4**	**1**	**1**	**1**	**1**	**32**

Reporting incidents and learning from when things go wrong

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

In the last two years, there has been one 'prevention of future death' report sent to Derbyshire Healthcare NHS Foundation Trust.

All staff we spoke with knew how to report an incident and were confident about reporting incidents. Staff could give us examples of when they had reported an incident in the past.

Staff could explain Duty of Candour and demonstrated they were open and transparent and explained to patients when things went wrong. We saw an example of this during the inspection when a doctor gave incorrect information to a patient. The nurse phoned the patient immediately when she discovered the error and contacted the patient to explain and offered reassurance.

Staff held regular business meetings and discussed learning from incidents and any changes to practice because of this. An example of a change following an incident was staff no longer consider children as a protective factor when completing a mental health assessment.

Staff received debrief and said they were well supported by each other and managers following a serious incident.

Is the service effective?

Assessment of needs and planning of care

We looked at 41 patient records and saw comprehensive assessments had been completed in a timely manner, including physical health assessments. Care plans were mostly up to date, personalised, holistic and recovery focused. The care plans in the early intervention service were particularly good.

Patient information was stored in the electronic records system which was only accessible for staff from a base. We were told by some staff they could not access when out in the community or in GP practices where they regularly saw patients, but that it could be accessed if there was an internet connection. Psychology stored paper Eye Movement Desensitisation and Reprocessing records in a locked cupboard and recorded their contacts on the electronic system. Staff said and we observed the electronic record system was difficult to navigate and there were inconsistencies in where patient information was stored and recorded.

Best practice in treatment and care

Managers and staff told us they participated in the following audits; care records, cleaning records of clinic room.

We looked at 40 drug cards and saw doctors followed National Institute of Health and Care Excellence guidance when prescribing.

There were therapies offered as recommended by National Institute of Health and Care Excellence but there were long waits for access to psychology service. This was a concern during the last inspection.

Staff could explain where they would signpost patients to for support regarding employment, housing and benefits.

Staff considered physical healthcare needs and were aware of the need for an annual healthcare check. Teams approached physical healthcare in different ways dependent on resources. Some teams had staff trained in electrocardiograms, phlebotomy and took the lead with physical healthcare monitoring. Other teams relied on the GP to take bloods and complete annual healthcare checks. Where this was the case, staff were in communication with GPs to ensure these needs were met.

We saw some evidence that rating scales or outcome measures were collected and analysed and used to inform the development of the service and to ensure the interventions provided were effective. These included community occupational therapists use of outcome measures in all therapy groups and also in individual assessments and interventions. Also, a range of Model of Human Occupation assessments were used. Individual staff also spoke to us about the scales and measures they used, but in isolation, these included Health of the Nation Outcome Scales.

The trust provided staff with technology to support patient care. The electronic record system allowed information sharing and referrals between teams across the trust. Staff reported that the trust provided information technology systems that allowed them to access patients' physical health results. This included blood test, x-rays and computer tomography scan results.

Staff supported patients to live healthier lives. This included signposting them to stop smoking interventions, information on healthy eating, alcohol screening, and referral to community wellness and healthy living groups.

Skilled staff to deliver care

There was a good range of skills and experiences across all the teams. Newer staff said they had received a corporate induction and then an appropriate role specific induction.

Staff had all received relevant training for their role but many staff felt additional training requests were always declined. We were told the trust send around a list of training that may be available and staff indicate their preferences but then it comes back not approved.

Managers said they were able to address poor staff performance promptly and effectively and had the support of HR if required.

The trust had details about volunteering opportunities and a volunteer coordinator on its website.

The trust's target rate for appraisal compliance is 90%. As at 28 February 2018, the overall appraisal rates for non-medical staff within this service was 70%. Fifteen teams failed to achieve the trust's appraisal target.

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 72% reported for the previous year.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Placement Review Team	4	0	0%
Specialist Psyc Therapy	1	0	0%
Dynamic Psychotherapy Duffield Road	13	2	15%
County South Early Intervention	10	3	30%
CfldCentral Neighbourhood - Adult	33	12	36%
Psychology Sexual Health	2	1	50%
Derby City Early Intervention	12	7	58%
Psychology Neighbourhood	37	24	65%
Derby City Neighbourhood - Adult Team C	30	20	67%
Amber Valley Neighbourhood - Adult	23	16	70%
HP+NthDales Neighbourhood - Adult	28	21	75%
Psychology Specialist Services	4	3	75%
Derby City Neighbourhood - Adult Team B	33	26	79%
Bolsover+CC Neighbourhood - Adult	21	18	86%
County North Early Intervention	17	15	88%
Trainee Clinical Psychologist	10	9	90%
Sth DD Neighbourhood - Adult	23	21	91%
Erewash Neighbourhood - Adult	18	17	94%
KillNthCfld Neighbourhood - Adult	23	22	96%
Early Intervention Clinical Specialist	3	3	100%
H Unit - The Hub	5	5	100%
Medics Neighbourhood Nth	1	1	100%
Psychology AC County North	1	1	100%
Psychology EI	2	2	100%
Service total	**354**	**249**	**70%**
Trust wide	**2406**	**1858**	**77%**

The trust's target rate for appraisal compliance is 90%. As at 28 February 2018, the overall appraisal rates for medical staff within this service was 60%. The trust informed us that 100% compliance with NHE England targets was achieved at year end.

The teams failing to achieve the trust's appraisal target were County North Early Intervention Medical Team with an appraisal rate of 50%, Medics Neighbourhood North Team at 53%, Medics Neighbourhood South Team at 60% and Medics Neighbourhood City Team at 64%.

The rate of appraisal compliance for medical staff reported during this inspection was lower than the 83% reported at the last inspection.

Team name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
County N Early Int Medical	2	1	50%
Medics Neighbourhood Nth	17	9	53%
Medics Neighbourhood Sth	10	6	60%
Medics Neighbourhood City	11	7	64%
City Early Intervention Medical	1	1	100%
Dist Psych Ther Medical	1	1	100%
Service total	**42**	**25**	**60%**
Trust wide	**114**	**77**	**68%**

The trust's measure of clinical supervision data is sessions delivered. Between 1 March 2017 and 28 February 2018, the average rate for the non-medical staff in this service was 72%.

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

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
MGT + Administration - Psychology Sexual Health	24	0	0%
County South Neighbourhood - Early Intervention Clinical Specialist	38	8	21%
County South Neighbourhood - Sth DD Neighbourhood - Team B	71	24	34%
Nursing (L4) - Divisional Nurses	27	10	37%
City Neighbourhood - Derby City Neighbourhood - Team C	108	46	43%
City Neighbourhood - Trust Wide Discharge Liaison Team OP	36	16	44%
City Neighbourhood - Derby City Neighbourhood - Adult Team B	184	82	45%
County South Neighbourhood - Erewash Neighbourhood - Team B	70	36	51%

County North Neighbourhood - Bolsover+CC Neighbourhood - Adult	124	68	55%
City Neighbourhood - Derby City Neighbourhood - Adult Team C	171	102	60%
County South Neighbourhood - County South Early Intervention	131	78	60%
City Neighbourhood - In Reach + Home Treatment OP	71	43	61%
County North Neighbourhood - HP+NthDales Neighbourhood - Adult	148	90	61%
City Neighbourhood - Derby City Neighbourhood - Team B	136	89	65%
County South Neighbourhood - Sth DD Neighbourhood - Adult	126	87	69%
County North Neighbourhood - HP+NthDales Neighbourhood - Team B	98	69	70%
County North Neighbourhood - KillNthCfld Neighbourhood - Adult	116	81	70%
City Neighbourhood - Derby City Neighbourhood - Team A	109	78	72%
County North Neighbourhood - KillNthCfld Neighbourhood - Team A	39	28	72%
County North Neighbourhood - CfldCentral Neighbourhood - Adult	158	116	73%
County South Neighbourhood - Derby City Early Intervention	120	89	74%
Neighbourhood (L4) - Psychology Neighbourhood	426	326	77%
County North Neighbourhood - CfldCentral Neighbourhood - Team A	54	42	78%
County South Neighbourhood - Amber Valley Neighbourhood - Team B	84	67	80%
Early Intevention - Psychology EI	19	16	84%
County North Neighbourhood - Bolsover+CC Neighbourhood - Team A	66	56	85%
County North Neighbourhood - HP+NthDales Neighbourhood - Team A	82	70	85%
County South Neighbourhood - Amber Valley Neighbourhood - Adult	137	116	85%
County South Neighbourhood - Erewash Neighbourhood - Adult	112	95	85%
County North Neighbourhood - KillNthCfld Neighbourhood - Team B	76	66	87%
County South Neighbourhood - Amber Valley Neighbourhood - Team A	86	75	87%

County North Neighbourhood - Bolsover+CC Neighbourhood - Team B	76	70	92%
County North Neighbourhood - CfldCentral Neighbourhood - Team B	109	101	93%
County South Neighbourhood - Erewash Neighbourhood - Team A	77	72	94%
County North Neighbourhood - County North Early Intervention	188	182	97%
County South Neighbourhood - Sth DD Neighbourhood - Team A	69	67	97%
Psychological Therapies - Dynamic Psychotherapy Duffield Road	130	129	99%
County North Neighbourhood - Cfd Central Locality - Adult	2	2	100%
County North Neighbourhood - North DRRT	5	5	100%
Service total	**3903**	**2797**	**72%**
Trust Total	**19680**	**12660**	**64%**

The staff we spoke with said they received regular managerial supervision and regular clinical supervision. Staff explained they were also to request additional supervision and support when required and they used the team meetings for peer supervision. Psychologists and occupational therapists received regular professional specific supervision.

Multidisciplinary and interagency team work

There were weekly multi-disciplinary team meetings held in every team. These meetings consisted of staff from the neighbourhood teams, psychiatry and psychology. And sometimes members of the crisis team, social services and other organisations if appropriate. There was no psychiatry representative at Dale Bank View at the time of inspection. Psychology and crisis team attendance varied between teams.

Records showed there were good working links with other professionals and organisations. These included; primary care, local authority, housing, police service, fire service and voluntary organisations. A representative from the neighbourhood teams in each area attended their local Multi Agency Risk Assessment Conferences.

We spoke to 25 nurses and two thirds of them said they found trying to refer into the crisis team was difficult, particularly in the South of the region. Nurses felt the crisis team could be obstructive and it was felt they put barriers in place so they could reject referrals.

We spoke to three psychiatrists who felt multi-disciplinary working was good across teams. They offered advice, support and training to other staff members. For example, explaining what blood levels mean and the action that should be taken.

We spoke to five occupational therapists who said they worked well with the other members of the team. They run joint groups with psychology and were currently planning groups with the nurses.

We spoke to eight psychologists. Psychologists were not line managed by the service managers. We found this could cause tensions within teams when discussing the most appropriate intervention for a patient.

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

As of 28 February 2018, 80% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and is completed once.

The training compliance reported during this inspection was lower than the 84% reported for the previous year.

Staff we spoke with had a good understanding of the Act and knew when and how to arrange a Mental Health Act assessment if required.

Staff had access to local Mental Health Act policies and procedures, and to the Code of Practice. Managers had told staff only access online policies and procedures, this ensured that practice followed most recent guidance and the trust emailed staff when policies were updated. Copies of the Code of Practice were available at team bases we visited and trust posters displayed guided staff specifically on Community Treatment Orders.

We looked at 15 Community Treatment order records and all the documentation was up to date and stored appropriately.

Records showed patients' rights were read at the start and routinely thereafter. Staff also supported them in accessing advocacy services. This was an improvement since the last inspection.

Staff were not aware of regular audits by the trust to ensure that the Mental Health Act was being applied correctly. Staff did not identify learning from local or trust wide audits.

Good practice in applying the Mental Capacity Act

As of 28 February 2018, 90% of the workforce had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all services for inpatient and community staff and is completed once.

The training compliance reported during this inspection was lower than the 94% reported for the previous year.

Staff we spoke with had a good understanding of the Mental Capacity Act and when they would need to complete a capacity assessment. Records showed capacity assessments were in place where required and completed on a decision specific basis. This had improved since the last inspection.

Staff did not routinely know what was in place to monitor adherence to and audit the application of the Mental Capacity Act. Some staff reported they were not aware of any arrangements. Others said local audits of patient records had taken place focussing on capacity to consent. Staff said that this had been audited at neighbourhood team level and did not provide results specific to

either working age adult or older adult teams within the neighbourhood. They reported that the trust had acted on staff feedback and planned to provide results specific to teams at the next audit.

We saw good examples of advance statements in 10 records we looked at. Advance statements are written with patients about what they would like to happen and how they would like to be treated when they become unwell and may be unable to give consent.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We observed 15 appointments and all staff were respectful and sensitive to the needs of the patients in their interactions. Staff showed warmth and understanding when discussing individual patients in meetings and with each other.

We spoke to 18 patients and all spoke positively about all staff but they said the community psychiatric nurses especially go the extra mile for them. Patients and their carers were very complimentary about the care and support they received from the service.

We were told when the water supply was cut off in the surrounding area to Dale Bank View, staff identified their most vulnerable patients and took bottled water to their door for them.

Patients waiting for a psychiatric appointment at Dale Bank View were unhappy they had to wait but felt supported by the rest of the team and felt their concerns and complaints had been taken seriously.

We saw confidentiality was maintained by staff logging off from their computers, and not leaving anything confidential around on their desks.

Involvement in care

Involvement of patients

We spoke to 18 patients and all felt involved in their care planning. Records also showed patients had been offered a copy of their care plan.

Patients gave feedback about the service in various ways; informally to staff, by completing a comment card or by contacting the trust patient advice and liaison service.

The trust's website had a feedback section that included the Friends and Family Test and details of how to contact the patient experience team.

We looked at 20 comment cards collected at Dale Bank View all were positive about feeling involved in their care.

Involvement of families and carers

We spoke to nine carers. They said staff included them in decisions and care planning where appropriate and referred them for carers assessments and carers support groups.

The trust website provided access to a carers newsletter, however no new editions had been added since June 2017.

Information about how to access a carers assessment was included in the carer and family handbook produced by the trust.

Is the service responsive?

Access and waiting times

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

The service met the referral to assessment target in 41 of the targets listed.

Name of hospital site or location	Name of team	Service Type	Days from referral to initial assessment		Days from assessment to treatment	
			Target	Actual (mean)	Target	Actual (mean)
Trust HQ	South Derbys & South Dales - Community	South Derbyshire	126	407	n/a	304.5
Trust HQ	County Adult ADHD	Learning Disability	126	327	n/a	31.5
Trust HQ	PSY COMPLEX SUPPORT	Psychological Therapies	126	302.5	n/a	22.5
Trust HQ	Erewash - OT	South Derbyshire	126	219	n/a	This service has been absorbed into a new service on closure of the building. This is an OT single stand-alone service.
Trust HQ	Derby City - Psychology	Derby City	126	161	n/a	0
Trust HQ	NORTH DERBYS STROKE PSYCHOLOGY	Psychological Therapies	126	159	n/a	34
Trust HQ	Psychosexual Psychotherapy	Psychological Therapies	126	139	n/a	27.5
Trust HQ	Placement Review Team	Kingsway Campus	126	137	n/a	294
Trust HQ	Bolsover & Clay Cross - Community	North Derbyshire	126	88	n/a	373
Trust HQ	Chesterfield Central - OT	North Derbyshire	126	83	n/a	66

Trust HQ	Erewash - MAS	South Derbyshire	126	81	n/a	87
Trust HQ	Amber Valley - SPOA	South Derbyshire	126	69	n/a	17
Trust HQ	Derby City - SPOA	Derby City	126	48	n/a	37.5
Trust HQ	Killamarsh & North Chesterfield - SPOA	North Derbyshire	126	48	n/a	35
Trust HQ	Amber Valley - Psychology	South Derbyshire	126	47	n/a	16
Trust HQ	Erewash - SPOA	South Derbyshire	126	47	n/a	5
Trust HQ	Chesterfield Central - SPOA	North Derbyshire	126	46	n/a	34
Trust HQ	Bolsover & Clay Cross - SPOA	North Derbyshire	126	45.5	n/a	27
Trust HQ	South Derbys & South Dales - Assertive Outreach	South Derbyshire	126	43	n/a	34
Trust HQ	South Derbys & South Dales - SPOA	South Derbyshire	126	43	n/a	38
Trust HQ	High Peak & North Dales - Psychology	North Derbyshire	126	42	n/a	7
Trust HQ	Derby City - Community	Derby City	126	41	n/a	65
Trust HQ	Amber Valley - Community	South Derbyshire	126	40	n/a	21
Trust HQ	High Peak & North Dales - Outpatients	North Derbyshire	126	38	n/a	105
Trust HQ	Amber Valley - Outpatients	South Derbyshire	126	37.5	n/a	49
Trust HQ	Erewash - Community	South Derbyshire	126	36	n/a	14
Trust HQ	Derby City - Outpatients	Derby City	126	35	n/a	88
Trust HQ	Killamarsh & North Chesterfield - Outpatients	North Derbyshire	126	33	n/a	49
Trust HQ	Erewash - Outpatients	South Derbyshire	126	31	n/a	84
Trust HQ	High Peak & North Dales - SPOA	North Derbyshire	126	27	n/a	27

Trust HQ	Killamarsh & North Chesterfield - Community	North Derbyshire	126	27	n/a	59.5
Trust HQ	Chesterfield Central - Community	North Derbyshire	126	26	n/a	235
Trust HQ	Psychodynamic Psychotherapy	Psychological Therapies	126	25	n/a	7
Trust HQ	Amber Valley - Assertive Outreach	South Derbyshire	126	25	n/a	23
Trust HQ	Erewash - Assertive Outreach	South Derbyshire	126	23	n/a	4
Trust HQ	South Derbys & South Dales - Outpatients	South Derbyshire	126	18	n/a	69
Trust HQ	High Peak & North Dales - Community	North Derbyshire	126	13.5	n/a	43
Trust HQ	South Derbys & South Dales - OT	South Derbyshire	126	13	n/a	5
Trust HQ	On Call Doctors	Not Known	126	10	n/a	1
Trust HQ	Chesterfield Central - Outpatients	North Derbyshire	126	7.5	n/a	77
Trust HQ	County & City Early Intervention	Early Interventions	126	7	n/a	1
Trust HQ	Radbourne In-Reach Team	Campus Assessment Services	126	6	n/a	1
Trust HQ	County North Early Intervention	Early Interventions	126	4	n/a	3
Trust HQ	Bolsover & Clay Cross - Outpatients	North Derbyshire	126	2	n/a	133
Trust HQ	High Peak & North Dales - Assertive Outreach	North Derbyshire	126	1	n/a	14
Trust HQ	Chesterfield Central - Psychology	North Derbyshire	126	0	n/a	18
Trust HQ	Derby City - OT	Derby City	126	no occurances	n/a	273
Trust HQ	Dales North Older People CMHT	North Derbyshire	126	no occurances	n/a	423
Trust HQ	Erewash – Psychology	South Derbyshire	126	no occurrences	n/a	27

At the time of inspection, the average wait for an initial assessment was 12.82 weeks, there were 297 patients on the waiting list and the longest wait was 68.71 weeks.

The average waiting time from initial assessment to first contact for a care coordinator/community psychiatric nurse appointment was just over 11.55 weeks and there were 995 patients on that list. The longest wait was 68.71 weeks. It was not clear from the waiting lists how many patients were already open to the service.

The average waiting time from initial assessment to first contact for occupational therapy was 9.57 weeks and there were 209 patients on the list.

The average waiting time from an initial assessment to first contact for an out-patient appointment (with a doctor) was 11.26 weeks and there were 915 patients on the list, with the longest wait being 70.71 weeks.

Data showed Dale Bank View received a similar number of referrals to Chesterfield Central each month. Dale Bank View had a vacancy for one whole time equivalent psychiatrist and the feedback from locums and previous substantive psychiatrists was the patch was too large for one person to cover and a junior doctor was required. In comparison, Chesterfield Central have two whole time equivalent psychiatrist and three junior doctors on rotation.

The average waiting time from an initial assessment to first contact for a psychology appointment was 31.81 weeks and the longest wait being 107.29 weeks and there were 501 patients on that list.

The number of referrals and discharges across the teams varied in numbers due to the size of the area but the number of discharges and referrals each month were steady. For example, Derby City had 116 referrals in May 2018 and 77 discharges and Chesterfield had 30 referrals and 45 discharges.

Each team reviewed their referrals daily and had a duty worker who responded to urgent referrals and telephone calls from referrers, patients or carers.

Staff would contact the crisis team if their patient was in crisis but feedback from neighbourhood staff was that the crisis team were difficult to refer into and it was sometimes easier to manage the crisis themselves. This impacted on their other patients care due to their appointments being cancelled. We were told of three examples where this had happened. Staff also said the criteria for crisis team was unclear and the procedure for initial assessment and who was responsible for arranging admission to a psychiatric hospital appeared to depend on which crisis member of staff was on duty.

The community mental health team were flexible in their approach in engaging with patients and offering them choice about time and location of their visit, within the limitations of the team hours; Monday to Friday 9am-5pm.

Staff only cancelled appointments when necessary, (as the example given in the previous paragraph) patients were informed as soon as possible and a further appointment arranged. The manager at Dale Bank View, explained there had been an increase in psychiatric appointments being cancelled due to not having a substantive psychiatrist in post and having to rely on locums.

The facilities promote comfort, dignity and privacy

In High Peaks, Dale Bank View and Amber Valley bases we were told there was not always enough rooms to see patients in. The rest of the bases we visited had a good range of rooms and

equipment to support treatment and complete physical examinations. In Derby City and Chesterfield Central they had a machine to monitor Clozaril levels.

Interview rooms had good soundproofing and waiting areas contained a range of leaflets appropriate to patients differing needs including how to complain.

Where rooms were located at street level or directly in front of car parks, frosted plastic to windows maintained privacy of patients visiting the service.

Patients' engagement with the wider community

Staff supported patients in accessing further support and activity within their wider community. They did this via recovery groups led by occupational therapy.

Staff supported patients in maintaining relationships with friends and family if this was what they wished, for example patients could bring friends to the Ilkeston football group ran jointly with Derby City football club.

Meeting the needs of all people who use the service

The service took account of patients' individual needs. The buildings were accessible for people with disabilities, there were lifts or rooms on the ground floor. Staff could access interpreters including for British Sign language when required. Leaflets were available in a language other than English upon request.

Listening to and learning from concerns and complaints

This service received 22 complaints between 1 March 2017 and 28 February 2018.
Most complaints were for appointments delays and cancellations. The Resource Centre outpatient department had the most complaints (16).

Ward name	Total Complaints
Resource Centre - Outpatient Dept.	16
Early Interventions Team - Derby City	4
Early Interventions Team - County North	2

This service received five compliments during the last 12 months from 1 March 2017 and 28 February 2018, which accounted for less than 1% of all compliments received by the trust as a whole.
Staff we spoke with knew the complaints process and how to manage complaints. Some of the teams collected feedback from patients via comment cards in the waiting area. We looked at comment cards collected at Dale Bank View, these were mostly positive and complimentary about the staff and these were put into the Datix incident reporting system and any specific comments or compliments shared with staff. Staff discuss complaints and receive feedback via supervision, team meetings and emails.

The manager at Dale Bank View said there had been an increase in the number of complaints from patients regarding the lack of psychiatrist. In order to manage this, they had put every Friday afternoon aside to meet face to face with people or return phone calls to those who were wishing to make a complaint. This method ensured a consistent approach was taken and helped the team manage the calls when they came through.

Patients we spoke with said they knew how to complain if needed and we saw leaflets in the waiting rooms.

Is the service well led?

Leadership

Team managers had the skills, knowledge and experience to perform their roles and had a good understanding of the services and teams they managed. All staff spoke positively about their team managers. Managers were also able to identify obstacles to care delivery and describe how they were working to address these.

Staff knew who their senior managers were and could provide examples of them visiting team bases. The trusts chief executive visited locations as part of an 'on the road' initiative that provided the opportunity to meet with staff and patients. Some staff felt more senior leaders were visible as they used offices in the base but were not approachable and did not make an effort to come into the staff office to say hello.

Managers reported that leadership opportunities were available including courses on managing people. However, some felt that although courses were available they were often oversubscribed and difficult to book on to. Managers also reported participating in leadership meetings and peer support groups for new managers.

Vision and strategy

Staff we spoke with had a variable understanding of the trusts vision and strategy but knew the trust had core standards and felt their team were working to them. Most of the teams held away days where the strategy and the values of the team were discussed.

The trusts vision, values and strategic objectives were available to staff and patients online. We saw these displayed on posters and computer screen savers at the team bases we visited.

During the last inspection we found staff were unsure about the implementation of the service transformation with regards to the neighbourhood model. During this inspection, staff told us that they were not really working to a neighbourhood model, they just happened to share an office with the older adult team.

The trust first moved towards the neighbourhood model of community mental health provision in 2016. It was envisioned that it would be an ageless service combining adult and older peoples' community mental health teams. In 2017 the trust undertook a review of the neighbourhood structure to develop an alternative model of service delivery. This followed concerns that neighbourhoods were not delivering desired improvements in clinical effectiveness or patient care,

and a number of challenges had emerged. The review identified that adult and older peoples' teams were now based in the same building and were able to work together to meet the needs of patients. However, teams continued to work separately operationally and in day to day management.

Staff we spoke with reported a commitment to deliver safe and high-quality care within the budgets that were available to them. This included working in partnership with other teams and community trusts.

Culture

Most staff we spoke with said they felt positive and proud about working within their team. They said staff morale had increased and they felt supported by colleagues.

Staff felt able to raise concerns and worries without fear of retribution. They were aware there was a Freedom to Speak Up Guardian but only two out of 52 staff we spoke with knew who the person was and how to contact them. We noticed the Freedom to Speak Up Guardian's contact details were on the trust screen saver but their name and role was not included. All staff knew the whistleblowing policy and how to access it.

Managers dealt with poor staff performance when needed. The trust provided managers with support and structures to address poor staff performance. Managers could provide examples of how staff performance concerns had been managed and the support they had received from human resources departments while doing so.

Teams worked well together. All staff said they worked as a team and discussed any issues in team meetings.

The services sickness and absence results were like the average for the rest of the trust.

Staff were supported with their own physical and mental health needs by their manager and/or occupational health team.

The trust ran delivering excellence awards that recognised team and staff success in the trust.

The trust published its approach to developing and delivering equality, diversity and inclusion on its website. It also included its workforce demographic report that provided detailed analysis of the trust's workforce by race, ethnicity, gender, age, religion, disability and sexual orientation. Our conversations with staff did not include how the trust promoted equality and diversity in its day to day work and in providing opportunities for career progression. However, the trusts website provided details of a black and minority ethnic support network, a lesbian, gay, bisexual, transgender and queer/questioning staff network, and disability staff support.

Governance

The trust has provided their board assurance framework, which details any risk scoring 15 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The four strategic ambitions outlined by the trust relating to this service are as follows:

1 - We will deliver **quality** in everything we do providing safe, effective and service user centred care
2 - We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time
3 - We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.
4 - We will **transform** services to achieve long-term financial sustainability.

The trust has provided a document detailing their 10 highest profile risks. Each of these has a current risk score of 15 or higher. However, none that relate to this service.

Teams did not have a standardised approach to what must be discussed in team meetings. We saw that teams used different formats to organise agenda items and share information. This did not ensure that all essential information, such as learning from incidents and complaints, was consistently shared and discussed by all staff.

Staff could describe changes to clinical practice and procedures that had been implemented as recommendations from reviews of incidents, complaints and safeguarding alerts.

Management of risk, issues and performance

Managers could access their teams risk assessments and take appropriate action. Any learning or recommendations were shared during team meetings. Managers and staff said they could submit items to the risk register as required. The trust also held a trust wide risk register identifying concerns at divisional levels.

Team managers and area service managers met regularly to discuss any issues regarding risk or performance and feedback down any learning or actions required to the staff meetings or took issues staff raised to more senior leaders.

The trust had a developed a number of policies to prepare for and manage emergencies. This included adverse weather and bomb threats.

Information management

Staff had access to the equipment and information technology available to do their job if they were at their base. They did not have access when they saw patients in their homes or GP practices.

The system used to collect data about patients was not easy to use and we saw staff use and record information under different codes or headings or areas of the system.

It was not easy to see from the waiting lists what patients were waiting for, their level of risk and whether they were open to another part of the service.

Team managers had access to staff training records and information to support them in their role.

Staff made notifications to external bodies as needed, for example the Care Quality Commission and local authority.

Engagement

The trust had a presence on several social media platforms to communicate its latest news stories, events and keep involved with the community it served. This was managed by a dedicated communications and involvement team. Staff, patients and carers also had up to date information about the work of the trust through it's 'Connections' magazine which was available online. Other online resources were available but did not always appear up-to-date.

Staff collected patient and carer feedback via friends and family test and comment cards in the waiting areas. We saw 'you said, we did' boards in waiting areas. One example of change following patient feedback were seats in the waiting room being replaced with higher back chairs that patients found easier to stand up from.

Staff had away days and staff forums where they could give feedback and contribute to the development of the service. We looked at three sets of minutes from staff forums and saw that service development was discussed with staff.

Learning, continuous improvement and innovation

NHS trusts can participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

This service has not been awarded an accreditation.

Staff in the early intervention team have developed links with 12-14 schools across the county and deliver a rolling programme around mental health issues. This team were part of the Quality Improvement programme to support with service development and won gold award from Derbyshire Healthcare Quality team.

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

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Trust HQ	Amber Valley CTLD	-	Mixed
Trust HQ	Derby City CTLD	-	Mixed
Trust HQ	Derbyshire Dales CTLD	-	Mixed
Trust HQ	Erewash CTLD	-	Mixed
Trust HQ	Learning Disabilities ATSS	-	Mixed
Trust HQ	Learning Disability Strategic Health Facilitators & Learning Disability Acute Liaison Nurse	-	Mixed
Trust HQ	South Derbyshire CTLD	-	Mixed

Is the service safe?

Safe and clean environment

Staff did not see patients on the premises. Staff saw patients in the community at community venues, clinics or patients' residence.

The service controlled infection risk well. Staff kept equipment and the premises clean and practiced good handwashing principles. They used control measures to prevent the spread of infection. Equipment used to carry out patients' physical health examinations in the community was calibrated and kept clean. Staff had access to hand gel and handwashing facilities.

Staff did not have sufficient desk space to complete their duties in a multidisciplinary team environment. All staff we spoke with across all teams told us at times they found it difficult to find a suitable workspace and that the team was often spread out across community venues. They told us that if all allocated desks at their base were full and staff required a space to carry out their work, they would work from other community or trust venues for example, the trust library.

Safe staffing

The service had a multidisciplinary staff team. However, the team was short staffed in speech and language therapists and psychology staff. The service did not use bank or agency staff to cover vacancies. There was no staff cover available for maternity leave or sick leave. This meant that some patients were waiting for a long time to access these parts of the service. However, staff we spoke with told us caseloads were manageable and managers were supportive in adjusting caseload numbers in line with risk and the intensity of the workload. This was apart from speech and language staff who expressed concerns with caseloads and waiting lists. The service was proactively recruiting to these vacancies and had adjusted the staff structure in order to create new staff roles that would address waiting times and access to services.

Staff shortages were affecting the ability to deliver parts of the service. Within assessment and treatment support service this meant that the service had suspended the out-of-hours service from 1 August – 18 September 2017 and had further plans to suspend the service for two months in 2018. Patients known to the service were informed of this in advance and advised how they could get support if needed. A recorded message informed anyone ringing the service out-of-hours where they could access support. Weekend cover within the service was maintained and prioritised to ensure patients received a service seven days a week.

The service had access to doctors within the trust and out-of-hours through the on-call rota for the trust. Staff reported good access to doctors when needed. There were two consultant psychiatrists in post for the service.

The service provided mandatory training in key skills to all staff and ensured staff had completed it. Across the core service, 84% of staff had completed mandatory training according to the updated information provided by the trust in June 2018. Where areas of completion were low, managers could demonstrate where staff included in training figures were unable to complete training due to maternity leave or sickness. Managers were also able to demonstrate areas where training was not mandatory for staff within community learning disabilities team and assessment and treatment support service. We did not find any areas of concern regarding training completion.

Definition

Substantive – All filled allocated and funded posts.

Establishment – All posts allocated and funded (e.g. substantive + vacancies).Substantive staff figures			**Trust target**
Total number of substantive staff	At 28 February 2018	92.21	N/A
Total number of substantive staff leavers	1 March 2017 – 28 February 2018	6	N/A
Average WTE* leavers over 12 months (%)	1 March 2017 – 28 February 2018	6%	10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 28 February 2018	11.47	N/A
Total vacancies overall (%)	At 28 February 2018	11%	10%
Total permanent staff sickness overall (%)	Most recent month At 28 February 2018	5%	5%
	1 March 2017 – 28 February 2018	4%	5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 28 February 2018	28.38	N/A
Establishment levels nursing assistants (WTE*)	At 28 February 2018	19.28	N/A
Number of vacancies, qualified nurses (WTE*)	At 28 February 2018	2.85	N/A
Number of vacancies nursing assistants (WTE*)	At 28 February 2018	2.37	N/A
Qualified nurse vacancy rate	At 28 February 2018	10%	10%
Nursing assistant vacancy rate	At 28 February 2018	12%	10%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	1 March 2017 – 28 February 2018	0 (0%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	1 March 2017 – 28 February 2018	0 (0%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	1 March 2017 – 28 February 2018	0 (0%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	0 (0%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	0 (0%)	N/A

Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	1 March 2017 – 28 February 2018	0 (0%)	N/A

*Whole-time Equivalent

This service reported an overall vacancy rate of 10% for registered nurses at 28 February 2018. Across the 12 months the vacancy rate ranged between -4% and 24%.

The vacancy rate for registered nurses was lower than the 18% reported at the last inspection (between 1 April 2015 and 31 March 2016).

This service reported an overall vacancy rate of 12% for nursing assistants.

The vacancy rate for nursing assistants ranged between 7% and 18% between 1 March 2017 and 28 February 2018.

The vacancy rate for nursing assistants was higher than the 6% reported at the last inspection (between 1 April 2015 and 31 March 2016).

Vacancy rates for this service ranged between 10% and 15% during the 12 months between 1 March 2017 and 28 February 2018.

	Registered nurses			**Health care assistants**			**Overall staff figures**		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
St Andrews LD Mgt + Admin	0	0	0	0	0	0	-0.45	1	-45%
County South CLDT Admin	0	0	0	0	0	0	-0.07	0.6	-12%
Trust wide CLDT SALTs	0	0	0	-0.64	0.36	-178%	-0.82	6.95	-12%
Trust wide CLDT Nursing	-0.25	14.18	-2%	-0.4	5.07	-8%	-0.65	19.25	-3%
Amber Valley CLDT Admin	0	0	0	0	0	0	0	1	0%
Dales South CLDT Admin	0	0	0	0	0	0	0	1	0%
Erewash CLDT Admin	0	0	0	0	0	0	0	0.67	0%
Learning Disabilities ATS	-1	5	-20%	-0.01	7.71	0%	-0.01	16.71	0%
Psychology LD	0	0	0	0	0	0	0.24	10.59	2%
Trust wide CLDT OT	0	0	0	0.25	1.97	13%	0.39	11.58	3%

Derby City CLDT Admin	0	0	0	0	0	0	0.07	1.6	4%
Dist LD Medical	0	0	0	0	0	0	1	5	20%
TrustÂ wide CLDT Physio	0	0	0	1.17	2.17	54%	2.25	10.09	22%
Strategic Health Fac Team	0.6	5.2	12%	0	0	0	1.97	6.9	29%
Autistic Spec Dis - Asperg	0.5	1	50%	0	0	0	1.55	5.25	30%
Commission Differently LD	3	3	100%	2	2	100%	6	6	100%
Service total	**2.85**	**28.38**	**10%**	**2.37**	**19.28**	**12%**	**11.47**	**104.19**	**11%**
Trust total	**116.22**	**970.48**	**12%**	**34.28**	**375.17**	**9%**	**310.29**	**2490.05**	**12%**

NB: All figures displayed are whole-time equivalents

Between 1 March 2017 and 28 February 2018, bank staff filled 0% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 0% of shifts for qualified nurses. No shifts were unable to be filled by either bank or agency staff.

Between 1 March 2017 and 28 February 2018, bank staff to cover sickness, absence or vacancy for nursing assistants filled 0% of shifts.

In the same time period, agency staff covered 0% of shifts. No shifts were unable to be filled by either bank or agency staff.

This service had six (6%) staff leavers between 1 March 2017 and 28 February 2018. This was lower than the 9% reported at the last inspection (from 1 April 2015 and 31 March 2016).

Team	Substantive staff (as at 28 Feb 2018)	Substantive staff Leavers	Average % staff leavers over the past year
Amber Valley CLDT Admin	1	0.0	0%
County South CLDT Admin	0.67	0.0	0%
Dales South CLDT Admin	1	0.0	0%
Derby City CLDT Admin	1.53	0.0	0%
Dist LD Medical	4	0.0	0%
Erewash CLDT Admin	0.67	0.0	0%

St Andrews House LD Management & Admin	1.45	0.0	0%
Strategic Health Fac Team	4.92	0.0	0%
Trust Wide CLDT OT	10.18	0.0	0%
Trust Wide CLDT SALTs	7.77	0.0	0%
Trust Wide CLDT Nursing	19.91	1.0	5%
Learning Disabilities ATS	18.72	1.0	6%
Psychology LD	9.35	1.0	10%
Trust Wide CLDT Physio	7.84	1.4	19%
Autistic Spec Dis - Asperg	3.2	1.6	32%
Service total	**92.21**	**6**	**6%**
Trust Total	**2167.65**	**219.26**	**10%**

The sickness rate for this service was 4% between 1 March 2017 and 28 February 2018. The most recent month's data February 2018 showed a sickness rate of 5%. This was similar to the sickness rate of 5% reported at the last inspection in March 2016. The sickness rate ranged between 1% and 5% across the 12 months.

Team	**Total % staff sickness (at latest month)**	**Ave % permanent staff sickness (over the past year)**
County South CLDT Admin	0%	0%
St Andrew's House LD Management & Admin	0%	0%
Erewash CLDT Admin	0%	0%
Commission Differently LD	0%	1%
Trust Wide CLDT Physio	0%	1%
Autistic Spec Dis - Asperg	2%	2%
Trust Wide CLDT SALTs	1%	3%
Dist LD Medical	0%	3%
Trust Wide CLDT OT	11%	3%
Amber Valley CLDT Admin	0%	4%
Strategic Health Fac Team	0%	4%
Learning Disabilities ATS	9%	4%
Trust Wide CLDT Nursing	6%	4%
Psychology LD	2%	5%
Derby City CLDT Admin	0%	9%
Dales South CLDT Admin	0%	20%
Service total	**5%**	**4%**

Trust Total	**7%**	**5%**

Medical staff

Between 1 March 2017 and 28 February 2018, No shifts were filled by bank staff to cover sickness, absence or vacancy for medical locums.

In the same time period, agency staff covered 28% of shifts. No shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Dist LD Medical	1,455	0	411 (28%)	0
Service total	**1,455**	**0**	**411 (28%)**	**0**
Trust Total	**41,564**	**0 (0%)**	**4,944 (12%)**	**0 (0%)**

***** Percentage of total shifts

Mandatory training

The compliance for mandatory and statutory training courses at 28 February 2018 was 79% (for the current financial year) compared to 91% reported in the previous financial year.

Key:

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

Training Course	Trust Target %	Training compliance % for this service	Trust Wide Training Compliance %
Data Security Awareness (Previously IG) (Annual)	95%	95%	91%
Equality, Diversity and Human Rights - Level 1 (3 yearly)	85%	82%	78%
Fraud Awareness (3 yearly)	85%	96%	95%
Health, Safety & Welfare (3 Yearly)	85%	85%	81%
Moving & Handling Level 1 (3 yearly)	85%	85%	83%
Promoting Safer & Therapeutic Services Clinical Staff (3 yearly)	85%	100%	85%
Promoting Safer & Therapeutic Services Non-Clinical Staff (3 yearly)	85%	69%	86%

Safeguarding - Adults Level 1 (Non Clinical) (3 Yearly)	85%	77%	87%
Safeguarding - Children Level 1 (once only)	85%	100%	98%
Autism (ASD) Awareness Level 1 (Once)	85%	97%	57%
Care Certificate (Once Only)	85%	94%	84%
Deprivation of Liberty Standards (Once)	85%	93%	83%
Dual Diagnosis Level 1 (Once)	85%	64%	70%
Dual Diagnosis Level 2 (Once)	85%	41%	57%
Fire Safety - Fire Warden (3 Yearly)	85%	38%	64%
First Aid at Work Certificate (3 Yearly)	85%	78%	84%
Food Hygiene Awareness Update (Annual)	85%	47%	64%
Food Hygiene Certificate (3 Yearly)	85%	53%	35%
General Risk Assessor Training (3 Yearly)	85%	43%	21%
Medic - Approved Clinician (EXTERNAL COURSE 5 Yearly)	85%	33%	86%
Medic - Section 12 Approval (EXTERNAL 5 Yearly)	85%	25%	63%
Mental Capacity Act (Once)	85%	91%	84%
Mental Health Act 2007 (Once)	85%	88%	79%
Moving & Handling Level 2 - People (2 yearly)	85%	77%	68%
Physical Health in Mental Health (3Yearly)	85%	6%	24%
Positive & Safe - PROACT SCIPr-UK - PACE (LD) - inc PSTS (annual)	85%	92%	91%
R Resuscitation - Basic Life Support & AED (annual)	85%	88%	64%
Resuscitation - Immediate Life Support - ILS - (annual)	85%	50%	73%
Safeguarding - Adults Level 3 (2 Yearly)	85%	67%	55%
Safeguarding - Children Level 2 (3 yearly)	85%	100%	90%
Safeguarding - Children Level 2 (once only)	85%	96%	93%
Safeguarding - Children Level 3 (3 yearly)	85%	88%	80%
Safeguarding - Children Level 3 (annual)	85%	0%	73%
Safeguarding - PREVENTing Radicalisation - Level 1 (3 yearly)	85%	75%	86%
Safeguarding - PREVENTing Radicalisation/WRAP Level 3 (3 yearly)	85%	100%	90%
Smoking Cessation Level 1 (Once Only)	85%	3%	33%

Staff Recruitment Training - All Recruiters (3 Yearly)	85%	61%	59%
Total		**79%**	**75%**

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff had not completed a risk assessment and risk management plan for every patient and had not updated all risk assessments at least six monthly in line with trust policy. Of the 30 patient records we reviewed, only 17 contained an up-to-date risk assessment and four records we reviewed did not contain a risk assessment at all. However, where staff had completed up-to-date risk assessments, we identified eight were comprehensive and detailed, they were of a good standard. We saw changes in risk status were updated in ongoing care notes and through use of system alerts called 'blue light' on the care record.

Staff did not record patient risk assessments in a consistent manner across the service. There were different ways of recording risk assessments within the electronic recording system. The risk assessment tool used was embedded within the electronic recording system. This was a change from the last inspection we undertook. Staff consistently told us across all teams that they had difficulty with recording and locating information through the electronic recording system. Staff were recording risks regarding patients in different ways, making it difficult for staff to locate information quickly.

Management of patient risk

Staff responded promptly to deterioration in patients' health and wellbeing. Staff were knowledgeable about their patients and maintained good contact with them and their families. Staff had good relationships with external providers of care, for example day centres and residential care homes where patients were living. This meant that if a patient's health deteriorated, staff detected this in a timely manner and responded with appropriate support.

Staff monitored patients on the waiting list monthly through phone calls and letters. Staff introduced a waiting well procedure to ensure patients and carers were kept up to date with their progress and knew where to seek support while on the waiting list.

Staff followed the lone working policy when carrying out community visits, including visits to patients' homes. Staff could clearly explain, and adhered to, local lone working practices. Staff considered information they held about patients before carrying out visits or assessments in the community and attended appointments in pairs where needed.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse.

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

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust has stated that there is the potential for safeguarding referrals to have been made without a datix incident report having been completed. Both Safeguarding Adult Boards maintain data of referrals received into the local authorities but, "health" referrals are not currently represented by organisation. A request has made of the performance department in Derby City Council to provide a breakdown of referrals made by each separate provider service.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. We saw examples of staff identifying and responding quickly and appropriately to safeguarding concerns and alerting the local authority. We saw examples of staff working with the wider multidisciplinary team and external agencies to safeguard patients from harm.

- Derbyshire Healthcare NHS Foundation Trust has submitted details of no external case reviews commenced or published in the last 12 months that relate to this service.
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Staff access to essential information

Staff did not always keep up-to-date records of patients' care and treatment. Staff used a combination of electronic and paper based recording systems. Staff reported difficulty in using the computer system and locating documents relating to patient care. For example, staff we spoke with were unable to locate some risk assessments, care planning documents and assessment forms on the electronic recording system when we requested it. Staff told us some documents relating to patient care could not be completed electronically and should be scanned and uploaded to the system when completed. We could not always locate all documents that were scanned in and staff could not always confirm whether they had been completed as a result.

Medicines management

The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time. Staff regularly monitored and recorded fridge and room temperatures where mediation was stored. There were good processes in place for the transportation of medication in the community in line with trust policy and national guidance. Prescription charts were complete and up to date. However, seven out of nine prescription charts we reviewed did not list patient allergy information.

Staff reviewed patients' physical health in line with The National Institute for Health and Care Excellence guidelines on prescribing. Nurses routinely carried out physical health monitoring and checks with patients prescribed anti-psychotic medication.

Track record on safety

Trusts must report all serious incidents to the Strategic Information Executive System within two working days of an incident being identified.

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

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with Strategic Information Executive System.

Reporting incidents and learning from when things go wrong

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

In the last two years, there have been two 'prevention of future death' reports sent to Derbyshire Healthcare NHS Foundation Trust, however none of these related to this service.

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Staff received feedback and learning from incidents. Managers investigated incidents and shared lessons learned within the team and the wider service through use of 'blue light' email alerts, team meetings and supervision.

Staff were able to give examples of when they had apologised and gave patients honest information and suitable support when things had gone wrong. Examples included, when staff had needed to cancel an appointment due to prioritising risk and patient needs and in actions following a concern or complaint. Staff documented their actions in care records and followed up in writing where appropriate.

The service had made changes as a result of learning from incidents. The service had reviewed lessons learnt through the Learning Disabilities Mortality Review. We saw an example of where practice had changed in relation to responding to suspected sepsis cases following lessons learned through this review. We saw training for staff on sepsis, constipation and raising awareness to all staff on the most common underlying causes of deaths of learning disability patients to address inequalities in mortality of people with learning disabilities.

Staff received debrief following incidents. Staff we spoke with told us they were well supported by managers and team members following incidents.

Is the service effective?

Assessment of needs and planning of care

Staff completed mental health assessments with each patient. Assessments were comprehensive from the point of view of the professional discipline completing them. However, assessments in care records we reviewed were not always completed fully or reflective of a full range of issues. For example, in nine records there was no record of religion, sexual orientation, ethnic status or

nationality. One record we reviewed had identified a family member as living in the household, but had not indicated the age, therefore we could not determine whether the person was a child.

Staff ensured patients were receiving appropriate physical health care. Nursing staff routinely carried out physical health observations at the beginning of treatment and in conjunction with prescribing medications. Health care facilitators were in post to support coordination of patients care in relation to physical health needs. There was an acute hospital liaison nurse in post to support patients with learning disability needs who were admitted to hospital. Staff signposted patients to their GP for annual health checks and liaised with GPs to ensure this had been carried out. Staff completed training in how to manage regarding patient care and recorded this in ongoing care notes.

Where there was a care plan in place, they were up to date and contained a range of patient problems and needs, including those identified at assessment. We reviewed 30 care records and found 21 records contained an up-to-date care plan for the patient. However, five records did not contain a care plan and staff could not locate this at the time of inspection. Of the 21 up-to-date care plans, 15 reflected a holistic range of needs. Only 12 of care plans we reviewed contained the views of the patient, seven were recovery orientated and six had documented that the patient or carer had been given a copy.

Staff used documents accessible for people with a learning disability in care planning. Care plans contained easy read information and pictorial representations to clearly show what was contained within them. Staff photos were used on individual care plans to show patients who was supporting them with which area of need.

Best practice in treatment and care

This service participated in five clinical audits as part of their clinical audit programme 2016 – 2018.

The service offered a range of interventions and therapies in line with guidance recommended by the National Institute for Health and Care Excellence. Staff discussed application of the guidance within monthly clinical review group meetings and this information was shared with the wider team. We observed staff discussions about adherence to the National Institute for Health and Care Excellence. The trust policies about prescribing medication followed the National Institute for Health and Care Excellence guidance in relation to prescribing and physical health observations.

Health care facilitators were in post to support coordination of patients care in relation to physical health needs. Staff signposted patients to their GP for annual health checks and liaised with GPs to ensure this had been carried out. Staff completed training in how to manage regarding patient care and recorded this in ongoing care notes.

The use of outcome measures varied according to which professional a patient was open to. We found that staff used a number of outcome measures such as the East Kent Outcome System and the Model of Human Occupation Screening Tool. However, we found staff did not always complete these consistently.

Staff actively encouraged patients to live healthier lives by accessing health care services. The service participated in a project to increase the uptake of NHS screening programmes through their GP for conditions such as cervical, breast and bowel screening for cancer. The project was successful in increasing the uptake of screening with people with a learning disability.

Staff participated in clinical audits. Clinical audits showed improvements and areas which required improvement. We reviewed clinical audits for the service and actions taken. The service had a clinical audit group and reviewed actions and learning from audits. Action required by staff were reviewed through team meetings and direct line management supervision.

Audit name	Audit scope	Service	Audit type	Date completed	Key actions following the audit
Local re-audit of POMH-UK Topic 9: Anti-psychotic prescribing in people with a learning disability	Learning Disabilities	MH - Community mental health services for people with a learning disability or autism	Clinical	26/01/2017	• To develop a standardised clinical letter template with headings and prompts to encourage comprehensive entries are made by the Learning Disability Psychiatrists • To re-audit in order to establish recommendations have been implemented and are established as best practice
Quality of case conference reports & documentation of attendance & outcomes	* CAMHS * Adult Mental Health * Child & Family * Learning Disabilities * Perinatal * Substance Misuse	Multiple	Clinical	07/10/2016	• All relevant staff to access DSCB (Derbyshire Safeguarding Children Board) training on case conference attendance • All relevant staff to use the Case Conference template as per DSCB, to maximise compliance • To re-audit in order to establish recommendations have been implemented and are established as best practice

Medical tribunal report audit	* inpatients all areas * Community Treatment Orders all areas	Multiple	Clinical	14/03/2017	• Presentation of results at both the North and South Medical Education Meetings • Asking Mental Health Act Administrators to send link to online guidance, with the email they send to clinicians, prior to sending the letter requesting a tribunal report • To create an aide memoire/checklist, that focuses on the areas of poor compliance, to reference when working on medical tribunal reports. To initially check whether one already exists. If not to devise aide memoire/checklist and make available via Connect. Staff informed of where to find document • To re-audit in order to establish recommendations have been implemented and are established as best practice
Documentation of capacity and consent for CTO patients	* Community Team	Multiple	Clinical	18/11/2016	• Implement a system that can promptly notify community consultants of patients being discharged on a CTO, so a review appointment can be arranged as a matter of priority • Create a template, similar to that used on wards, to support comprehensive collection of data • To re audit in order to establish recommendations have been implemented and are established and embedded into practice

Compliance with updating pharmacological/medication information on Paris in CAMHS	* All CAMHS Sites both county and city, ED and LD Teams	Multiple	Clinical	26/02/2018	• Presenting the results at the weekly CAMHS Consultant Meeting, as well as providing a demonstration of how to write up medications in the Medication History section of Paris. Nurse Prescribers will also be invited to attend • Updating the case note section of Paris, so that there is a Medication History alert/prompt to notify the user that this needs completing. This will be achieved by attending the Paris CRG Meeting in order to discuss the application, feasibility and timescale for applying of this recommendation • Inserting a Medication History Box into the Paris CYPIAPT form in order to try to provide some consistency in the place we record medication history, and to make it an easy, quick and (hopefully, if used correctly) accurate reference point for all prescribing clinicians to refer to. The Paris team to drop a Medication History Box into the Paris CYPIAPT form that is filled in for all interactions • Consultants to make the care co-ordinators aware of this box within the CYPIAPT form, so it is the responsibility of all clinicians, not just those prescribing to ensure accurate documentation takes place of any medication changes, and this is as up to date as possible for each interaction with the YP • To embed the above change into everyday practice by

	sending reminder emails of this change every month for the next 3 months • To re-audit in order to establish recommendations have been implemented and are established as best practice

Skilled staff to deliver care

There was a range of staff available to support patients across the service. This included doctors, nurses, psychologists, speech and language therapists, physiotherapists, occupational therapists, and health care facilitators. Health care facilitators supported staff to monitor and plan for patients to receive appropriate health checks and finding out about the health problems that people with learning disabilities may have. However, due to staffing shortages in speech and language therapists, patients who required support for speech and language, including dysphagia, were experiencing long waits for treatment.

Staff were experienced and qualified. We spoke with a range of staff across all professions and found them to be knowledgeable and skilled in their professional area. Staff received appropriate induction to the trust and we saw staff who were undertaking comprehensive local team induction at the time of inspection.

Staff had access to monthly team meetings and opportunities to meet with their teams in between meetings.

The trust's target rate for appraisal compliance is 90%. As at 28 February 2018, the overall appraisal rates for non-medical staff within this service was 81%.

The teams failing to achieve the trust's appraisal target were Commission Differently Learning Disabilities with an appraisal rate of 0%, St Andrew's House learning disabilities management and administration at 50%, learning disabilities ATS at 53%, Trust wide community learning disabilities speech and language therapy team at 56%, Autistic Spectrum Disorder – Asperger's at 75% and Trust wide community learning disabilities team physio at 89%.

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 90% reported at the last inspection (as at 31 January 2016).

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Amber Valley CLDT Admin	1	1	100%
County South CLDT Admin	1	1	100%
Dales South CLDT Admin	1	1	100%
Derby City CLDT Admin	2	2	100%

Erewash CLDT Admin	1	1	100%
Strategic Health Fac Team	8	8	100%
Trust Wide CLDT OT	13	12	92%
Psychology LD	12	11	92%
Trust Wide CLDT Nursing	22	20	91%
Trust Wide CLDT Physio	9	8	89%
Autistic Spec Dis - Asperg	4	3	75%
Trust Wide CLDT SALT's	9	5	56%
Learning Disabilities ATS	17	9	53%
St Andrew's House LD Management & Admin	2	1	50%
Commission Differently LD	1	0	0%
Service total	**103**	**83**	**81%**
Trust wide	**2406**	**1858**	**77%**

The trust's target rate for appraisal compliance is 90%. As at 28 February 2018, the overall appraisal rates for medical staff within this service was 50%. The trust informed us that 100% compliance with NHS England targets were achieved at the year-end.

The team failing to achieve the trust's appraisal target were dist learning disabilities medical with an appraisal rate of 50%.

Team name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
Dist LD Medical	4	2	50%
Service total	**4**	**2**	**50%**
Trust wide	**114**	**77**	**68%**

Clinical supervision[5] (Internal use only - Remove before publication)

Between 1 March 2017 and 28 February 2018 the average rate across all eight non-medical teams in this service was 72% of the trust's target.

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

The rate of clinical supervision reported during this inspection was lower than the 60% reported at the last inspection (between 1 April 2015 and 31 March 2016).

[5] Clinical supervision

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Learning Disability - Strategic Health Fac Team	60	60	100%
Learning Disability - Trust Wide CLDT OT	146	127	87%
Learning Disability - Trust Wide CLDT Nursing	249	212	85%
Learning Disability - Trust Wide CLDT SALTs	102	83	81%
Learning Disability - Psychology LD	143	110	77%
Learning Disability - Trust Wide CLDT Physio	97	53	55%
Learning Disability - Autistic Spec Dis – Asperg	50	20	40%
Learning Disability - Learning Disabilities ATS	152	51	34%
Service total	**999**	**716**	**72%**
Trust Total	**19,680**	**12,660**	**64%**

The service made sure staff were competent for their roles. Managers appraised staffs' work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. At the time of inspection, 90% of trust wide community learning disability physiotherapy staff were up-to-date with supervision. This was an increase from 55% shown within the table above. At the time of inspection, 81% assessment and treatment support service staff were up-to-date with supervision. This was an increase from 34% shown within the table above.

Managers ensured staff received necessary specialist training for their roles. Staff we spoke with told us they were supported and able to access training to support in their roles. However, four members of staff told us that funding for training had depleted and it had become more difficult to access courses.

Managers addressed poor performance promptly and in a supportive manner. Where concerns regarding staff performance had been identified, managers put a plan in place to support staff. This included peer support and mentorship from colleagues in a supportive environment.

Multidisciplinary and interagency team work

Staff from different professions worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. We saw good multidisciplinary team working. Staff had regular team meetings to discuss plans to facilitate patients care.

Staff shared information through effective handover meetings. We observed staff discussing patient care and sharing information in their teams. We observed meetings where patient referrals were discussed and allocated to staff effectively. Staff representatives from multiple teams within

the service attended these meetings. Meetings were documented and actions recorded in patient records.

Staff had good relationships and working links with services external to the trust. Staff effectively shared information with services involved with individual patient care. These included local authority social care, day centre services and residential care homes where patients lived. However, there was no format for gaining or recording consent from patients or carers to share information with external services.

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

As of 28 February 2018, 88% of the workforce had received training in the Mental Health Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and is only required to be completed once.

Staff understood their roles and responsibilities under the Mental Health Act 1983. There was a policy and procedure in place for staff to follow, which reflected current guidance. There was a Mental Health Act administrator who carried out audits to check that the Mental Health Act was being applied correctly. Staff we spoke with knew where they could get the advice and how to contact the Mental Health Act administrator for advice. There were three patients on a Community Treatment Order. This is a legal order that sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community.

Good practice in applying the Mental Capacity Act

As of 28 February 2018, 91% of the workforce had received training in the Mental Capacity Act. The trust stated that this training is mandatory for all services for inpatient and all community staff and is only required to be completed once.

Staff we spoke with demonstrated a good understanding of Mental Capacity Act and they could clearly explain the five principles. There was a policy and procedure in place for staff to follow, which reflected current guidance in relation to the Mental Capacity Act 2005. Staff conducted regular audits of the application and adherence to the Mental Capacity Act within records and audits showed improvement in recording since our last inspection.

Staff knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff gave patients assistance and communicated in a variety of ways before they assumed patients might lack mental capacity, including use of learning disability friendly pictures and symbols.

We found appropriate recording of capacity assessments in patient records and details of best interest decisions. Where patients had been assessed as having impaired mental capacity, we saw staff had completed capacity assessments appropriately. Staff recorded decision-specific information and considered the patient's views where possible. This had improved significantly since our previous inspection.

Staff held best interest meetings to review patients' care when a patient lacked capacity to make decisions for themselves under specific circumstances. We observed a best interest meeting and

observed staff appropriately involved the patient's family and a range of other professionals involved in the care of the patient.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff cared for patients with compassion. Feedback from patients and carers confirmed that staff treated them well and with kindness. We received feedback from three patients and seven carers/parents and observed three home visits and one best interests meeting. Feedback from patients and carers was overwhelmingly positive. They told us staff were responsive to patients in distress and offered good emotional support. Our observations of staff confirmed they understood their patients' needs and treated them with dignity and respect.

Staff understood the individual needs of patients. All staff we spoke with could confidently discuss their patients in a way that showed they knew them, their life circumstances and their needs well.

Staff could raise concerns about disrespectful, discriminatory and abusive behaviour and attitude towards patients. Staff we spoke with gave examples of where they had addressed attitudes and abuse behaviours towards their patients in the community.

Involvement in care

Involvement of patients

Staff actively involved patients in their care. Staff communicated with patients using a range of methods to ensure they understood their care and treatment. We saw good use of easy read and pictorial leaflets on a range of mental health conditions, medication and information about the staff and service. Staff routinely included speech and language therapists when carrying out initial assessments with patients to ensure any communication difficulties were supported.

Staff did not always record patient views within care plans and risk assessments to demonstrate they had considered their views. Only 12 out of 21 care plans we reviewed contained the view of the patient.

Staff gained feedback from patients through friends and family surveys and experts by experience who visited patients to ask for feedback on their care experiences. The trust had used feedback to improve on their service. There was a monthly patient and carer engagement group where they could raise any concerns or give feedback about the service. There were forms given to patients when they visited for their review meetings to give feedback or raise any issues.

Staff were aware of how to access advocacy services for patients. Families, carers and patients were given easy read leaflets that contained information about advocacy services. Patients and their families told us that they could access advocacy services when needed. Of the seven carers we spoke with, five were aware of the advocacy service and how they could access this. We saw information of how to contact advocacy service displayed in staff offices.

Patients were involved in decisions about their service. The trust trained people with learning disabilities to take part in interviews for staff recruitment. The trust had actively recruited people with learning disabilities.

Involvement of families and carers

Staff involved patients and those close to them in decisions about their care and treatment. Staff maintained good contact with parents and carers and included them appropriately in patients care. Carers were routinely offered access to support and signposted to support agencies. Carers were routinely offered referral for carers assessment. We observed staff involving family members appropriately during meetings about patient care.

Is the service responsive?

Access and waiting times

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'assessment to treatment'.

The service met the referral to assessment target in 10 of the targets listed. The autistic spectrum disorders assessment service did not meet the trust target with a referral to assessment of 535.5 days.

The service did not provide a target for assessment to treatment.

Name of hospital site or location	Name of team	Days from referral to initial assessment		Days from assessment to treatment	
		Target	Actual (mean)	Target	Actual (mean)
Trust HQ	ASD Assessment Service	126	535.5	N/A	30
Trust HQ	LD Acute Liaison Nurse	126	0	N/A	2
Trust HQ	LD ATS	126	0	N/A	0
Trust HQ	LD CAS – Amber Valley	126	75	N/A	13
Trust HQ	LD CAS – Dales South	126	31	N/A	6
Trust HQ	LD CAS – Derby City	126	108.5	N/A	5

Trust HQ	LD CAS – Erewash	126	50	N/A	10
Trust HQ	LD CAS – South Derbyshire	126	27.5	N/A	8.5
Trust HQ	LD Nurse Consultant	126	13	N/A	35
Trust HQ	LD Occupational Therapy	126	31.5	N/A	7
Trust HQ	LD Special Hearing Clinic	126	0	N/A	94.5

The community learning disabilities team and the assessment and treatment support service was accessible between 9am and 5pm Monday-Friday. The assessment and treatment support service also operated an out of hours service between 5pm-9am daily and at weekends.

The trust met their targets for days from referral to initial assessment within the services we looked at during this inspection. Autism spectrum disorder was a separate team to community learning disabilities team within the trust and was not under review at the time of inspection.

Waiting times for patients who required treatment for speech and language therapy were long. The average waiting list for speech and language therapy had reduced but remained high at 37 weeks. There is no target waiting time set by the clinical commissioning groups for the trust in the contract. When we inspected the service in 2017, there had been long average waiting lists of 27 weeks to access psychology and 41 weeks to access speech and language therapy for the core service. During this inspection we found the average waiting list for psychology had reduced to 21 weeks.

Staff monitored patients on waiting lists and gave priority to patients whose risk or needs had changed or increased. Staff contacted patients by phone or letter to check if any circumstances had changed. We saw examples where patients had been moved to the assessment and treatment support service team when risk escalated while they were on waiting list.

Staff responded promptly to all referrals and prioritised those assessed as urgent. The assessment and treatment support service responded to crisis care and managed complex needs and behaviour. Staff ensured that patients likely to be at increased risk out hours were supported and were flexible in their approach to working with patients and carers when they needed urgent or additional support. However, staff shortages meant that the out of hours service was not provided for two months in 2017 and there were plans to suspend the service for a further two months in 2018. Staff advised that the decision was taken to safeguard the effective delivery of the day service on available staffing levels. Staff mitigated risks arising from this decision by ensuring patients and carers were informed of the suspension in advance. The service ensured there was a pre-recorded message for patients who rang the out-of-hours number with information about services they could contact if they needed support.

The service actively engaged patients who found it difficult to engage with services. Staff followed up patients who did not attend appointments and maintained meaningful contact with patients and carers. Teams were flexible in where they saw patients within the community, dependant on risk, and did everything possible to ensure they saw patients where they were most comfortable.

Staff rarely cancelled appointments and when appointments were cancelled, this was based on prioritising urgent cases. When staff cancelled appointments, they explained why to patients and carers and rearranged as soon as possible.

The facilities promote comfort, dignity and privacy

The service did not see patients on the premises.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to education and work opportunities. They had developed strong links with education groups such as vocational centres and job volunteer sectors to promote meaningful engagement in work and education. The trust had employed some people with learning disabilities who started as volunteers within the trust.

Staff supported patients to maintain contact with their families and carers. Staff encouraged patients' families and carers to be involved in their care and were invited to review meetings. The service ran a group for carers and patients on a monthly basis.

Patients were encouraged to develop and maintain relationships with people that mattered to them, both within the services and the wider community. Patients had an allocated key worker that regularly visited them and promoted ongoing relationships with key people like GPs, advocates, social workers, housing associations and other specialist professionals such as dentists, chiropodist and diabetes nurse where applicable.

Meeting the needs of all people who use the service

Staff provided information in an accessible way. Information was provided in easy read and pictorial forms on a range of services and telling patients about their rights.

Staff had easy access to interpreters and information in languages spoken by people using the service.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Staff issued patients and carers with information on how to make a complaint as part of a standard information pack at the beginning of treatment.

This service received three complaints between 1 March 2017 and 28 February 2018. This accounted for 1% of complaints received by the trust.

Of these, two complaints were directly attributed to the core service inspected. One was upheld and one partially upheld. The service followed the trust complaints policy in resolving both complaints.

Team name	Total Complaints	Complaint subject
Amber Valley CLD	1	Appointments (e.g. delays and cancellations)
Medics staff – Ash Green Learning	1	Clinical treatment provided by staff in Mental Health/ Learning Disabilities/ Substance Misuse Services
Derby City CLD Team	1	Clinical treatment provided by staff in Mental Health/ Learning Disabilities/ Substance Misuse Services
Service total	**3**	

This service received 46 compliments during the last 12 months from 1 March 2017 to 28 February 2018 which accounted for 4% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

The trust had managers at all levels with the right skills and abilities to run a service. The service had profession specific managers within the community learning disabilities team who managed their professional teams individually, except assessment and treatment support service who had one manager for the team. Managers had regular contact with their teams and were approachable and supportive.

There were opportunities for staff to develop and lead within the service. We saw staff members had moved teams, changed roles and acted up into management roles within the service to gain leadership experience or experience of working in other teams. However, staff told us that recent budget cuts had led to less opportunity to access training and progression opportunities for staff across clinical and non-clinical roles.

Vision and strategy

The trust had a vision for what it wanted to achieve for learning disability services and plans to turn it into action. These were being developed with involvement from staff, patients, and carers. The service was going through consultation at the point of inspection and had formulated a new service structure that was intended to support the needs of the patients group in a more effective way. However, staff told us they believed learning disabilities were not understood well enough by

the senior leadership team for the trust. Staff told us this impacted negatively when decisions were made about the service. Staff also told us this impacted negatively on morale.

Staff consistently told us shortage in staffing was leading to low morale and increasing workloads. Staff told us shortage in staff for speech and language therapists was causing stress and worry within teams.

Staff knew the vision and values for the service and worked within these to achieve good quality care for patients and carers.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were proud and positive about working within their teams. Staff felt able to raise concerns without fear and gave examples of where they had done so. Staff knew the whistleblowing process and all staff knew who the freedom to speak up guardian was.

Managers supported staff to improve and progress in their roles and addressed poor performance in a supportive and appropriate manner. Staff we spoke with were able to provide examples of where they had been supported to access external training and courses or mentorship.

The service had access to an employee occupational health service and sickness rates were lower than trust average for the core service.

The trust had a facility to recognise staff contribution to the service. The trust used monthly emails to circulate examples of exceptional work from individual staff nominated by their peers. There were also yearly staff awards. Staff within the core service had been nominated and achieved recognition in both these ways.

During the reporting period, there were no reported cases of staffing suspended, placed under supervision or moved to a different team.

Governance

There was a clear framework of what must be discussed, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. The service routinely discussed information within dedicated clinical groups and through team meetings. Information was disseminated to teams through appropriate formats.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. We saw learning from incidents and reviews of deaths in relation to Learning Disabilities Mortality Review.

Staff undertook or participated in clinical audits and created actions following these. However, actions from audits had not been implemented effectively as we still found systemic issues with where and how staff were recording in patient records. We saw information missing in care records, including in care plans and risk assessments.

Staff engaged well with patients, staff, the public and local organisations to plan and managed appropriate services, and collaborated with partner organisations effectively. We saw good examples of staff working with external agencies to meet the needs of the patients. Staff had rolled

out training to GPs on how to implement stopping over-medication of people with a learning disability, autism or both effectively.

The trust provided their board assurance framework, which details any risk scoring 15 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The four strategic ambitions outlined by the trust relating to this service are as follows:

1 - We will deliver **quality** in everything we do providing safe, effective and service user centred care

2 - We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time

3 - We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff

4 - We will **transform** services to achieve long-term financial sustainability

Corporate risk register[6] (Internal use only - Remove before publication)

The trust has provided a document detailing their 10 highest profile risks. Each of these has a current risk score of 15 or higher. The following risk relates to this service.

Key:

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

ID	Description	Risk score (current)	Last review date
21223	SLT LD currently accepts referrals for dysphagia classed as routine and urgent Due to only 1.3 therapists currently available to provide this service, there are 52 people waiting for a service following a telephone screen, with 14 classed as urgent. Recent ISMR's and LeDeR reviews have shown that people, who are on the waiting list for this service, have died from aspiration pneumonia whilst awaiting an assessment. CQC raised concerns regarding waiting times for SLT service and we have been unable to meet this target due to limited resources	Extreme risk	22/02/2018

[6] Open Risks at Trust and Divisional Level

This is unsatisfactory and is putting people with an LD at risk and increasing the risk of complaints, reputational damage and potential litigation.

Management of risk, issues and performance

Staff maintained and had access to the trust risk register and could escalate concerns when required from a team level. There was an item on the risk register relating to the service. Staff we spoke with reflected concerns that had been identified on the risk register.

The service had a policy and protocol in place for emergencies in the event of adverse weather or ill health outbreak.

Information management

Staff had access to the equipment and information technology needed to do their work. Staff used computerised care records. However, all staff we spoke with expressed challenges with the computer system, including ability to locate information, ability to input information and effectiveness of tools available on the system in relation to learning disability work. Staff working in the community were unable to log into systems, therefore had to return to an office base to complete care records and administration work.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Managers were able to obtain information about key areas of performance within the service without delay when requested.

Engagement

There were monthly patient and carer engagement groups where they could raise any concerns or give feedback about the service. There were questionnaires given to patients when they visited for their review meetings to give feedback or raise any issues.

Learning, continuous improvement and innovation

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

No accreditations received by the Trust were related to this service.

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