

Southern Health NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Elmleigh	RW1AM
	Melbury Lodge	RW119
	Antelope House	RW1GE
	Parklands Hospital	RW1AC
Long stay/rehabilitation mental health wards	Forest Lodge	RW134
	Hollybank	RW1AN
Adolescent mental health and forensic wards	Trust Headquarters - Bluebird House	RW1
	Leigh House	RW121
Wards for older people with mental health problems	Gosport War Memorial Hospital	RW158
	Western Community Hospital	RW155
	Melbury Lodge	RW119
	Parklands Hospital	RW1AC
Wards for people with learning disabilities or autism	Evenlode	RW1Z8
	Moorgreen Hospital	RW154
	Ridgeway Centre	RW1ZZ
	Woodhaven	RW190
Community -based mental health service for adults of working age	Trust Headquarters	RW1
	Southampton CMHT	
	Winchester and Handover CMHT	
	Eastleigh and Romsey CMHT	
	New Forest CMHT	

Summary of findings

Mental health crisis services and health based place of safety	Antelope House Elmleigh Parklands Hospital Melbury Lodge	RW1GE RW1AM RW1AC RW119
Community-based mental health services for older people	Trust Headquarters Southampton West OP CMHT Southampton East OP CMHT Fareham and Gosport OP CMHT Winchester OP CMHT New Forest OP CMHT	RW145
Community mental health services for people with learning disabilities and autism	Ridgeway Centre Buckinghamshire CLDT Slade House - Oxfordshire CLDT Trust Headquarters - Hampshire CLDT	RW1ZZ RW11V RW1
Perinatal mental health services	Melbury Lodge	RW119
Eating disorder services	April House Leigh House	RW121
Community health inpatient services	Alton Community Hospital Fleet Community Hospital Fordingbridge Hospital Gosport War Memorial Hospital Lymington New Forest Hospital Petersfield Hospital Romsey Hospital	RW194 RW1X1 RW178 RW158 RE1YM RW170 RW1FY
Community health services for adults	Alton Community Hospital Fleet Community Hospital Fordingbridge Hospital Gosport War Memorial Hospital Hythe Hospital Lymington New Forest Hospital Petersfield Hospital Romsey Hospital Trust Headquarters	RW194 RW1X1 RW178 RW158 RW1Q6 RW1YM RW170 RW1FY RW1
Urgent care - minor injuries unit	Lymington New Forest Hospital Petersfield Hospital	RW1YM RW170
Community end of life care	Alton Community Hospital Fleet Community Hospital Fordingbridge Hospital Gosport War Memorial Hospital Lymington New Forest Hospital Petersfield Hospital	RW194 RW1X1 RW178 RW158 RW1YM RW170

Summary of findings

	Romsey Hospital Trust Headquarters	RW1FY RW1
Community health services for children, young people and families	Trust Headquarters	RW1
Forensic inpatient/secure wards and community forensic mental health team	Ravenswood House Trust Headquarters	RW 148 RW146

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

Summary of findings

Ratings

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

Overall rating for mental health and community health services

Requires Improvement



Are mental health and community health services safe?

Requires Improvement



Are mental health and community health services effective?

Requires Improvement



Are mental health and community health services caring?

Good



Are mental health and community health services responsive?

Good



Are mental health and community health services well-led?

Requires Improvement



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Southern Healthcare NHS Foundation Trust delivers a wide range of community health care, mental health, learning disability and adult social care services from many locations across a wide geographical area and whilst we found many areas of good practice and services, including some outstanding practice and services, there was a lack of consistency across the trust.

We rated community health services for children, young people and families, community mental health services for adults of working age, rehabilitation mental health services, community-based mental health services for older people and eating disorder services good across all five areas (safe, effective, caring, responsive and well-led). We rated perinatal services outstanding across all five areas. However, eating disorder services and perinatal services are not part of our core services suite so these ratings do not count towards the overall provider level rating. The rating for Urgent Care services also does not count toward the overall rating as this too is not one of the core services used in the aggregation of ratings.

We found the trust had a clear vision, had developed a clear set of goals and values that most staff knew about and understood and these were gradually being embedded throughout the trust. There was evidence of good leadership and commitment from the board, the executive team and senior managers. We heard of many new initiatives and the trust was continually looking for ways to improve. However, it was clear that time was needed to fully realise the scale and complexity of the changes and embed these across the trust.

We gave an overall rating for the provider of **requires improvement** because:

- The trust was in the process of redesigning the way it delivered its services. For example, the introduction of a new divisional structure, the implementation of a recovery focussed mental health pathway for adults of working age and the introduction of integrated physical health care and older adult's mental health teams which has been recognised nationally as a model of good practice. However, these changes were at a relatively early stage of development and were not fully embedded across the trust.
- Although the trust board had been strengthened with the appointment of new non-executive directors and a number of new executive directors and clear lines of accountability and responsibility had been established, some executive directors had only recently taken up post. The director of nursing and allied health professionals had been in post four months so was still establishing her role and raising her profile so staff and stakeholders knew of her responsibilities and plans. In addition, a number of senior managers and clinical leaders had been appointed to support implementation of the changes but many of these had only been in post a short time.
- As result of a review of governance arrangements undertaken by Deloitte on behalf of the trust, several changes had been made to the trust governance framework to strengthen its arrangements to maintain the oversight needed. However, many of these changes were at an early stage of implementation, including the introduction of a new board assurance framework (BAF) which had only been agreed at the board meeting held in September 2014.
- Community health care services did not always have enough staff and the gaps were not always covered. This meant that in some community teams there were missed visits to patients and long waiting times for treatment by a therapist.
- There were delays in the supply of equipment such as hospital beds or special mattresses for home use this meant that patients could be at increased risk of pressure ulcers.
- The number of attendances at Lymington Minor Injuries Unit (MIU) had increased over the years and due to staff vacancies there were sometimes difficulties in covering shifts with the appropriate number of staff to provide a safe service.
- We found insufficient numbers of specialist palliative care staff meaning that patients did not always get the right level of care at the end of their life.
- There were issues with the management of medicines at both the MIU at Lymington Hospital and Petersfield

Summary of findings

Hospital. In the theatre suite at Lymington New Forest Hospital and Sultan ward at Gosport War Memorial Hospital the Controlled Drugs cupboards did not comply with the trust's own policies and procedures. There was insecure management of FP10 prescription pads with an incomplete audit trail of safe and appropriate use. Patient Group Directives (PDG's) for the administration of medication in both MIU's had been removed by the trust in September 2014, as these were past the review date. The trust had identified that most Patient Group Directives (PDG's) were past their review date and had initiated an action plan to resolve the situation. However, when we inspected the PGDs were not available for operational use at the Petersfield MIU.

- In community health services and some inpatient services for adults there were unsatisfactory arrangements in place for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.
- We were concerned about the trust's ability to provide safe care to patients at Ravenswood House as the building was unfit for the purpose for which it was being used. There were plans to renovate some wards in the short term and in the longer term, the service was to be moved to a new building and plans for this were being considered at the time of the inspection.
- We were concerned about ligature management at Ravenswood House, Southfields and in the seclusion room at Leigh House. Although the trust had a ligature minimisation programme risk assessments had not been carried out and staff showed a lack of understanding of how ligature risks should be managed. We asked the trust to take immediate action. The trust responded positively by making some immediate changes and by providing a clear action plan of how it would manage the risks in the future. However, many of the risks to patients at Ravenswood House remain due to nature of the building.
- In some mental health services there was inappropriate seclusion and physical intervention practices due to a lack of suitably trained staff, policies that did not provide clear direction and some staff who lacked awareness of good practices.
- Across mental health services there was inconsistent staffing levels and skill mix; wards were not always staffed to safer staffing levels. This significantly impacted upon the care and treatment to patients being delivered at the right time and in the right way. Staff reported working longer than their contracted hours in order to deliver care to patients and said that the dependency of patients was not taken into account when deciding the numbers of staff required. The trust was actively recruiting new staff and was closely monitoring staffing levels.
- Patients expressed confusion and frustration about access to crisis services. Staff lacked clarity about how these services were provided and the policy was not clear. Staff told us that the acute mental health teams and hospital at home teams did not provide crisis services although this was the plan for the future and that community mental health teams (CMHTs) provided crisis services but only during office hours. Patients and carers, particularly those wishing to access services at Parklands Hospital, told us they were given a telephone number but when they called it was rarely answered. In addition, there was no crisis service for older people; the trust is not commissioned to provide these services.
- Community mental health teams (CMHTs) often struggled to find an available bed locally for patients requiring admission to an acute mental health ward. This meant that patients were often accommodated in a hospital bed a long way from their home.
- At both Antelope House and Elmelight Section 136 suites (health based place of safety) patients were not routinely examined by a doctor on admission to determine the presence of a mental illness. This resulted in long periods of detention for patients not suffering a mental illness. This contravenes the MHA Code of Practice. There was also long waits for assessments by an approved mental health professional meaning patients stayed in S136 suites for long periods of time.
- The trust had reconfigured its learning disability services in Oxfordshire, closed inpatient services at Slade House and made several changes to improve services following an external review into a tragic death at Slade House. A special committee of the board was in place to oversee the turnaround of the services. However, staff, patients and carers still had

Summary of findings

concerns about on-going issues as they felt the trust had not been as open and honest as it could have been. It was clear this was impacting significantly on their welfare. The uncertainty about whether the trust would continue to deliver services in the future was affecting staff morale.

- Information systems, particularly in community health services and mental health community services were preventing staff from delivering services as effectively as they would like; this was having an impact on care provided to service users as records were often not accessible. Staff were aware of plans to introduce new systems but were unaware of timescales for this.

However, care was delivered by kind, sensitive and caring staff that were passionate about their work and committed to delivering high quality services. Patients and their families told us that the majority of staff treated them with respect and dignity. Many of the staff we spoke with said they were proud to work for the trust, enjoyed their work, felt they had opportunities to develop professionally and felt the trust was generally moving in the right direction to bring about improvement in services. However, several commented that the pace of change was, at times, moving too quickly to embed the changes effectively.

One of the vehicles being used to achieve the trust vision and support key changes to improve services was the trust's leadership programme 'going viral', which was available to staff at different levels of management. A new strand of the programme was being developed for all staff. The trust had a clear commitment to investing in staff and was providing a wide range of training and learning opportunities that were appreciated by staff.

The new BAF identified a red, amber or green rating for high level, strategic risks which were mapped to the priority areas of the quality programme: quality governance structures in the divisions, reporting and organisational learning, peer reviews, estates readiness, record keeping and care planning, medicines management, workforce and patient experience. The trust had introduced an innovative information system which provided high quality performance data to allow the board to monitor its performance. This information was beginning to be used by the trust board to identify and monitor risks.

Alongside this, a number of initiatives had been introduced to support improvement, including peer review visits and local audits. These were not always identifying all poor practice so improvements were not being made in a timely manner. In addition, some issues were being identified but action was not always being taken in a timely manner or was not being taken so the opportunity to improve was being missed.

In all services we found evidence of care being delivered in accordance with evidence based guidelines and in line with recognised good practice with good examples of positive outcomes for people using services. We were impressed by the recovery college and perinatal services.

We visited all locations that cared for patients detained under the Mental Health Act and found that staff generally adhered to the requirements of the Act, including ensuring people received Section 17 leave (leave to go off the ward accompanied by staff). Some patients told us that at times they could not take Section 17 leave when they wanted due to staff not being available to support them. Seclusion and restraint practice in some areas contravened MHA Code of Practice.

The trust had systems in place to safeguard people from abuse. Most staff we spoke with understood the importance of safeguarding vulnerable adults and children and knew how to raise an alert. It was also clear that staff were encouraged to report all types of incidents. There was evidence of learning from incidents and evidence of improvements being made as a result of reporting and sharing the outcomes of incidents. However, there were some areas where practice was inconsistent or not embedded.

The trust had a clear commitment to progressing research and had conducted 45 research studies between 2012/14 involving approximately 800 people. It had also won eight national awards for Equality and Diversity. We found a proactive approach to equality and diversity across the trust.

The trust had a range of patient groups and forums across several services which it encouraged patients to get involved in. The trust engaged with its stakeholders, including patients, people of all ages who used services and carers through 15 social media channels and had recently launched a listening App called Southern Health

Summary of findings

Listens. The trust offered a range of opportunities for patients to provide feedback about their experience of receiving care and we found that this feedback was beginning to improve care throughout the trust.

It is our view that the provider had made significant progress in developing services and bringing about improvements and that given time, the provider would realise its vision and deliver good and outstanding services across the trust. However, some significant work was still required to improve the quality and consistency of its services across the trust.

We found that the trust was in breach of a number of regulations. We will require the trust to meet the requirements of the regulations within a specified time period. However, we are not taking any enforcement action.

We will be working with the trust to agree an action plan to assist them in improving the standards of care and treatment.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

The numbers of staff and skill mix on wards was identified as a concern in many areas of the trust. Staff in mental health services reported working longer than their contracted hours in order to deliver care to patients and said that the dependency of patients was not taken into account when deciding the numbers of staff required. Patients had to wait for long periods of time to take Section 17 escorted leave due to staff not being available to accompany them.

Inadequate staffing levels in community health services was impacting on the delivery of safe care and waiting times, particularly in MIUs where patients had to wait for long periods of time to be seen and in community health services for adults where a number of appointments had been missed due to lack of staff. There was also inadequate numbers of experienced palliative care staff to deliver care to patients at the end of their life. However, the trust was actively recruiting new staff and was closely monitoring staffing levels.

Physical interventions were not always properly managed due to a lack of adequate numbers of suitably trained staff. Staff found the policies and procedures for seclusion confusing and did not always follow them and the recording of episodes of seclusion was not always robust.

In some of the mental health units we found that emergency equipment, including resuscitation equipment, was located a considerable distance away from ward areas; staff had to negotiate several locked doors to get to it.

We found there were significant delays in some community health services in the provision of equipment to provide protection against pressure ulcers. Equipment such as mattresses, cushions and hospital type beds took too long to be delivered.

The trust had a ligature minimisation programme in place but we were so concerned about ligature management at Ravenswood House and Southfields and in the seclusion room at Leigh House during our inspection that we raised this with the trust and asked for immediate action to be taken. Risk assessments had not been carried out and staff showed a lack of understanding of how ligature risks should be managed. At Ravenswood House there were inadequate plans to manage the risks in the short term; the trust had plans to renovate the wards and in the longer term move to a new building.

Requires Improvement



Summary of findings

Lone working practices in the Section 136 suites, acute mental health teams and hospital at home teams put people at risk. Staff did not carry personal alarms and had not considered that they might be putting themselves or patients at risks.

The trust had systems in place to report and monitor incidents and to ensure the board had a detailed understanding of the key risk in all areas. It was clear that staff were encouraged to report incidents. There was evidence of learning, across the trust, from incidents and evidence of improvements being made as a result of reporting and sharing the outcomes of incidents. However, there were some areas where practice was inconsistent or embedded.

There was good management of falls and a high incidence of pressure ulcers was reported in comparison with other NHS trusts. However, it clear that the trust was not always the primary care giver in all cases and work was being done to identify the primary care giver. The incidence of pressure ulcers was reducing year on year.

The trust had systems in place to safeguard people from abuse. Most staff we spoke with understood the importance of safeguarding vulnerable adults and children and knew how to raise an alert.

Are services effective?

We found ineffective practices in the management of medicines at both the MIU at Lymington Hospital and Petersfield Hospital. In the theatre suite at Lymington New Forest Hospital and Sultan ward at Gosport War Memorial Hospital the Controlled Drugs cupboards did not comply with the trust's own policies and procedures. There was insecure management of FP10 prescription pads with an incomplete audit trail of safe and appropriate use. The trust had identified that most Patient Group Directives (PDG's) were past their review date and had initiated an action plan to resolve the situation. However, when we inspected the PGDs were not available for operational use at the Petersfield MIU.

In community health services and some inpatient services for adults we also found unsatisfactory arrangements in place for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.

Outcomes for patients were being monitored in a number of areas across the trust but protocols had not been updated in the MIUs, nurse practitioners and nurses were not administering pain relief or other emergency medication when patients required it.

Although there was good management of the MHA across the trust, seclusion and restraint practices were often not in line with the MHA

Requires Improvement



Summary of findings

COP or nationally recognised guidelines. Patients in mental health services generally had physical health care assessments completed. However, these were not routinely carried out in adolescent inpatient and forensic services.

There were good examples of multi- disciplinary and multi-agency working which contributed to services being effective. Care and treatment was generally planned and delivered in accordance with NICE guidelines and evidence based recognised good practice.

There was access to meaningful therapeutic activity in mental health services, although little access to physical activity in PICUs and there was no transition arrangements for young people moving to adult services.

There were good opportunities for continuous professional development and the majority of staff had access to line management supervision and clinical supervision. However, allied health professionals told us that there was a lack of professional supervision and leadership for them and no access in the trust to supervision from someone of the same profession.

There was commitment to developing leadership skills for staff at all levels; the 'going viral' leadership development programme was being extended to include a number of different programmes relevant to the level of staff.

Are services caring?

All staff that we spoke with across the trust were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hardworking, caring and compassionate staff.

In all of the areas we visited patients and families were overwhelmingly positive about the way staff communicated with them, the time staff took to listen and their caring nature.

The majority of patients were involved in planning their care and were given information to help them make informed decisions about care. In older peoples mental health services and learning disability services staff were using evidence based methods to learn more about patients to support them to be involved in their care. However, young people at Leigh House weren't as involved as they should have been in planning their care.

The majority of patients that we spoke with said that they received emotional support when they needed it through individual support or through group work and therapeutic programmes and activities.

Good



Summary of findings

The trust had introduced a 'recovery college' for people with mental health problems and staff working in mental health services. The 'college' offered courses designed to increase knowledge of recovery and self-management.

There were multi-faith rooms accessible throughout the trusts inpatient settings and a chaplaincy services which is available to all and not faith specific. Patients reported positive experiences of using the chaplaincy service.

Are services responsive to people's needs?

The trust worked closely with commissioners, local authorities, people who use services, primary care services and other local providers to ensure it understood the needs of the population it served in order to plan and deliver services.

The reorganisation that has taken place in community health services to create integrated community teams was positive and provided improved care for patients, although not having social workers in the team caused delays in accessing their services.

We saw many examples of how the trust respected people's diversity and human rights. The trust provided people using services with information about how to complain and complaints were generally responded to in a timely manner. Staff told us they received feedback about complaints and that actions were taken as a result of complaints.

Accessing mental health crisis services was difficult. Staff and patients were confused as to how and who provided crisis services, particularly out of hours. Staff said that they thought that in the future home treatment teams would provide crisis services but they didn't at present. Community mental health teams said that providing a crisis service out of hours was impossible as the CMHT service only operated during core hours. Patients and their families told us of their frustration at being given a telephone number but never receiving an answer when they called it. There were no crisis services provided for older people; the trust was not commissioned to provide these services.

There were concerns about access to section 136 suites; the suite at Elmleigh had been closed for 27 days over a three month period. There were long waits to assessment from approved mental health professionals and on all suites patients were often not routinely seen by a doctor on admission to establish whether the patient had a mental health problem.

Good



Summary of findings

We found that the seclusion room at Hamtun ward (PICU) at Antelope House was not fit for purpose. It was located in the middle of the ward so other patients and visitors could see who was being placed in seclusion. It did not meet the requirements of the Mental Health Act Code of Practice.

Are services well-led?

Although the trust had developed a clear vision and understanding of what was required to achieve the vision, many of the initiatives to achieve the vision were at the early stage of implementation and not fully embedded across the trust.

Most staff were signed up to the values of the trust, generally proud to work for the trust and positive about their work. However, we spoke to some staff that had little knowledge of the vision and some staff felt they weren't listened to.

Several of the executive and senior leadership/management team were relatively new in post and still working to establish their role and gain the support of staff.

There were many challenges facing the trust in developing the right culture and managing a large change programme. The main challenges were around the scale and complexity of implementing change in a large organisation, the timescales to deliver these and ensuring staff were signed up to developments. Many staff said the pace of change was having a significant effect on their ability to fully embed the changes. Some staff and stakeholders identified a disconnect between those delivering services and senior managers at both divisional and trust level. However, there was strong and committed leadership from the board, the executive team and senior managers.

The trust offered a range of opportunities for patients to influence developments and to provide feedback about their experience of receiving care. There was evidence that feedback was being used throughout the trust to improve care.

Requires Improvement



Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Shaun Clee, Chief Executive, Together NHS Foundation Trust, Gloucestershire

Team Leader: Karen Wilson, Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

The team included CQC inspection managers, inspectors, Mental Health Act reviewers, pharmacy inspectors, CQCs national professional advisor for learning disabilities, analysts and inspection planners.

There were also over 100 specialist advisors, which included consultant psychiatrists, psychologists, senior nurses, student nurses, social workers, GPs, district nurses, health visitors, school nurses and an occupational therapist. In addition, the team included Experts by Experience who had personal experience of using or caring for someone using the types of services that we inspected. Five Experts by Experience were involved in the inspection of mental health and learning disability services and two were involved in inspecting community health services.

Why we carried out this inspection

We inspected the trust as part of our on-going comprehensive inspection programme looking at trusts providing mental health and community services.

How we carried out this inspection

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

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

Before our inspection visit, we reviewed a range of information that we hold about the trust and the services it delivers and also asked other organisations to share what they knew. We held a number of listening events attended by users of services, carers, user representative groups and some staff; we attended a number of service user support groups and collected written feedback from a number of voluntary and user representative groups.

We carried out an announced visit on 7-10 October 2014. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and managers at all levels. We attended multi-disciplinary meetings and observed how people were being cared for. We also reviewed care or treatment

records of people who use services. We talked with people who used services, carers and family members who shared their views and experiences of the core and specialist service and collected feedback from comment cards.

The team inspecting the mental health services at the trust inspected the following services.

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient/secure wards.
- Wards for older people with mental health problems
- Wards for people with learning disabilities or autism
- Wards for adolescents with mental health problems (including secure services)
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Community-based mental health services for older people

Summary of findings

- Community mental health services for people with learning disabilities or autism

The specialist eating disorder services and perinatal services provided by the trust were also inspected and rated but the ratings do not count towards the overall rating for the provider.

The team focussing on the community services at the trust inspected the following services:

- Community health services for children, young people and families
- Community end of life care
- Community health services for adults

The urgent care services (minor injury units) provided by the trust were also inspected and rated but the ratings do not count towards the overall rating for the provider.

Before the inspection we undertook separate inspections at 15 social care services provided by the Trust:

- 4 & 8 Piggy Lane
- Slade House DCA North and West
- Slade House DCA City and South
- Oxford Respite Service
- Swindon Family Breaks
- House 2 Slade
- Unit 42 New Forest Enterprise Centre
- 3 Tensing Close
- Birdwood Grove
- Jacobs Lodge
- Tamarine
- 1 Hamilton Road
- The Potteries DCA
- 30 Church Road

- Pinewood, Locksheath

11 services were found to be fully compliant. 4 services were found non-compliant with the Health and Social Care 2008 (Regulated Activities)

Regulations 2010. The Trust has provided CQC with a report that states what actions it is going to take to meet these regulations:

Compliance actions

- 4 Piggy Lane: Regulation 20 - Records
- Swindon Family Breaks: Regulation 22 – Staffing and

Regulation 20 – Records

- House 2 Step down unit: Regulation 10 - Assessing and monitoring the quality of service provision

- Slade House DCA City and South: Regulation 13 –

Management of medicines

Separate reports have been published for each of these locations.

Following the inspection week we carried out unannounced visits, to Gosport War Memorial Hospital (Dryad and Daedalus wards) on 14 October, Emleigh in patient wards, PICU and health based place of safety on 17 October, Petersfield and Lymington MIU on 16 October 2014 and to Antelope House PICU 22 October.

The team would like to thank all those who met and spoke with inspectors during the inspection and were open and balanced when sharing their experiences and their perceptions of the quality of care and treatment at the trust.

Information about the provider

Southern Healthcare NHS Foundation Trust is one of the largest providers of mental health, specialist mental health, community, learning disability and social care services in the UK with an annual income of £350 million.

The trust provides these services across the south of England covering Hampshire, Dorset, Wiltshire, Oxfordshire and Buckinghamshire although 90% of the care provided is in Hampshire.

The population of Hampshire is approximately 1.3 million of which 5.1% is non-white. Hampshire is broadly prosperous although there are some areas of extreme poverty in the two large urban areas of Southampton and Portsmouth. Life expectancy is 6.7 years lower for men and 4.8 years lower for women in the most deprived areas than in the least deprived areas.

In 2013/14 the trust reported that 8000 staff enabled it to treat or support 255,000 patients by providing 1,510,760 community contacts, 282,031 outpatient appointments

Summary of findings

and 235,257 occupied bed days. The trust has 730 inpatient beds spread between 23 sites and 200 main sites including community hospitals, health centres and inpatient units. The trust's total bed occupancy for mental health (87%) and general, acute care (89%) (delivered from hospitals) was above the national average (87%) (October 2011 to March 2014). It is generally accepted that when occupancy rates rise above 85%, it could potentially affect the quality of care and the orderly running of the trust. Bed occupancy for learning disabilities has fallen below the national average.

The trust received foundation status in April 2009 under the name Hampshire Partnership NHS Foundation Trust. Southern Health NHS Foundation Trust was formed on 1st April 2011 following the merger of Hampshire Partnership NHS Foundation Trust and Hampshire Community Health Care (the provider arm of Hampshire PCT). In November 2012 the trust acquired the Oxfordshire Learning Disabilities NHS Trust; so providing learning services in Oxfordshire, Buckinghamshire, Wiltshire and Dorset.

The trust provides the following core services:

Mental health and learning disability

- Adult inpatient services including psychiatric intensive care units
- Long stay/rehabilitation services
- Forensic inpatient /secure services
- Adolescent mental health inpatient services
- Inpatient services for people with learning disabilities
- Inpatient services for older people
- Community-based mental health services for adults of working age
- Mental health crisis services and health based places of safety
- Community-based services for older people
- Community mental health services for people with learning disabilities

The trust also provides other specialist services that we inspected:

- Eating disorder services
- Perinatal services

Community health services

- Community services for adults

- Community inpatient services
- Community services for children, families and young people
- End of life care
- Urgent care – Minor Injuries Unit

The trust splits its services using an integrated model of care as detailed:

Integrated mental health, learning disabilities and social care services

- Mental health services – adult mental health and specialist secure services for adults and young people
- Learning disabilities – community and inpatient services providing specialist support to adults
- Social care services (also known as TQ21) – social care services for older people, people with mental and learning disabilities (not part of this report)

Integrated community services

- Physical healthcare services for adults and older people and older peoples mental health services
- Children's services including health visiting and school nursing services for children and families

Inspection history

Southern Health NHS Foundation Trust mental health and learning disability services have been inspected on 83 occasions. Community health services have not previously been inspected. At the time of the inspection the trust was non-complaint for at least one regulation at four sites:

- Antelope House, Trinity, Saxon, Humton and Abbey wards: Regulation 9 Care and welfare of people who use services and Regulation 10 Assessing and monitoring the quality of service provision
- Evenlode: Regulation 15 Safety and suitability of premises and Regulation 10 Assessing and monitoring the quality of service provision
- The Ridgeway Centre: Regulation 13 Management of medicines
- Parklands Hospital, Beechwood and Elmwood wards – Regulation 17 Respecting and involving people in who use service, Regulation 9 Care and welfare of people

Summary of findings

who use services, Regulation 13 management of medicines, Regulation 16 Safety, availability and suitability of equipment, Regulation 10 Assessing and monitoring the quality of services

The non-compliance was followed up across the relevant locations as part of the comprehensive inspection.

What people who use the provider's services say

Before the inspection visit took place we met with five different groups of people who use the services provided by the trust. We also held four listening events in Gosport, Basingstoke and Oxford to allow people who use services to talk with us. They shared their views and experiences of receiving services from the provider. In addition, we attended an open event run by the trust and listened to the views of patients, carers and their families.

We reviewed information shared with us from a number of groups including reports from local Healthwatch and that provided directly to CQC through our website and by calling out phone line.

During the inspection we placed comment cards in many services areas and received over 150 completed comment cards providing feedback; the majority (127) provided feedback about community health care services. We received 137 positive comments related to the caring nature of staff and only eight negative comments. A number of comments received through the comment cards said that staff went 'the extra mile' to deliver care. The health visiting and perinatal services were highly praised for their responsiveness to patients and family's needs. Respondents also felt that the hospitals at Romsey and Lymington were welcoming, comfortable and staff were very caring.

The majority of the feedback received from all sources highlighted how caring and compassionate staff were. Patients and carers said that they felt staff were working incredibly hard but that the majority still took time to provide clear explanations about care, to listen and to provide good quality care. Patients using inpatient mental health services told us of their positive experience of attending therapeutic groups and their involvement in developing a recovery focussed approach to planning and reviewing care. However, some patients told us that their care could be better planned to suit their individual needs.

At Bluebird House and Leigh House we were told about the innovative approaches staff were using to involve young people in having a say about how the services were run, which they really appreciated. Patients told us of their positive experience of using the recovery college to support recovery and self-management. Patients who had attended the courses told us how helpful and informative these were.

However, we received many negative comments throughout the inspection and at our focus groups about access to crisis services for adults and older people, particularly out of hours. Patients and their carers told us of their confusion and frustration. They told us that they were given telephone numbers but no one ever answered and they were unsure who was meant to deliver the service. Many said they resorted to going to Emergency Departments where they were often not treated appropriately but had no option as crisis services were not available at the trust.

Other negative comments, from all sources, related to staffing levels and skills mix in a number of services across the trust. Patients and their families said that often had to wait for long periods in the MIUs and some told us that staff missed the appointments with them in the community. Patients also told us that they often had to wait long periods of time to take Section 17 escorted leave due to the lack of staff. Several patients commented that they could see how busy staff were and that there appeared not to be enough nurses on wards. Some patients at Ravenswood House said that the environment wasn't suitable and that at times they did not feel safe.

Summary of findings

Good practice

Trust wide

- ‘Going viral’ leadership and development programme
- Peer review programme
- Research programme
- Information system and providing high quality performance data for use from ward and team level through to board level
- Equality and diversity initiative
- Use of information from patient feedback and complaints
- Advocacy service

Mental Health Services

Summary of findings

Acute ward for adults of working age and psychiatric intensive care units

All locations

- Patients could attend therapeutic groups provided through the intensive support programme and could often continue to do so after discharge.

Summary of findings

Melbury Lodge

- Melbury Lodge had successfully integrated spirituality and recovery approaches as part of providing holistic care to patients.
- There was evidence of strong input from psychology services.
- A 'recovery focussed narrative' approach had been developed and put into practice in response to feedback from patients. This approach aimed to achieve greater collaboration between patients and health professionals when planning and reviewing care.

Antelope House

- There was good planning and monitoring of people's physical health care

Summary of findings

Parklands Hospital

- The acute ward employed a peer support worker, who worked with staff and patients to support them and their input into service development.

Long stay/rehabilitation mental health wards for working age adults

- Service managers worked well with external stakeholders and other providers to ensure that information about recovery oriented opportunities for patients was shared and social inclusion promoted.
- There were good systems in place for individual risk assessment and good evidence of positive risk taking which was appropriate for patients using a rehabilitation and recovery oriented service;
- Specific outcomes for patients were measured. One of the ward managers had conducted a review and analysis of all discharges from the unit in the last three years as a way of demonstrating outcomes for people using the service. The results showed that a period of intense rehabilitation and recovery focussed work had been beneficial for patients and enabled discharge into the community.

Forensic inpatient/secure wards

- We found excellent practice in the management and administration of "as required (PRN)" medication.
- The trust's vocational pathway on which occupational therapists took the lead had been praised by the Quality Network Forensic Mental Health Services (QNFMHS)

Adolescent inpatient and forensic services

- We found high levels of staff commitment and enthusiasm in Bluebird House, where there was a real quality user-focus to the service and young people were involved in all aspects of their care and support.
- At Leigh House the innovative user engagement approaches led by the allied health professionals ensured that young people had a say in how the service was run, and the staff who worked there.
- There was good use of best practice guidance to ensure that young people received a service that was evidence-based and in accordance with recognised good practice.

Wards for older people with mental health problems

- A trial which was being undertaken relating to the use of different colours of lighting to aid relaxation.
- Strong local leadership and commitment from the management team at Western Community Hospital.
- Good insight learning from all the older people's mental health inpatient wards within the same division.
- Provision of a 'soft room' on Beaulieu ward for patients with dementias who were at higher risk of harm from falls had access to an environment where harm could be minimised due to the design of the room.
- Integration between community services and older people's mental health services meaning that patients on the older people's mental health wards could benefit from the skills and expertise of staff that were based in community health teams and community inpatient wards.

Wards for people with learning disabilities or autism

- Behaviour support plans that reflected patient's individual needs and where the patients receiving a service had been able to contribute to the development of these plans.
- On Willow ward the use of a specialist sensory assessment in a dedicated sensory integration room by occupational therapy staff was innovative.
- In the Ridgeway Centre the rotation of support workers to work as occupational therapy assistants was supporting the provision of improved activities across the whole week and further developing multi-disciplinary working.

Community based services for adults of working age

- Several of the community teams shared examples of how the trust supports them to undertake local initiatives to review and improve service delivery. For example, the Romsey CMHT had piloted a scheme which looked at positive risk taking, and had been facilitated by an external trainer.
- The introduction of a "recovery college", offered courses to staff and people using the service designed to increase their knowledge of recovery and self-management.

Summary of findings

- The teams operated a daily review of all people on their caseloads within a `shared care` risk rating system. This identified any changes to the person's risk levels and staff could call upon extra support to enable the increased risks to be safely dealt with.
- Designated leads for safeguarding systems within each team. These were social workers employed by the local authority, who worked within each CMHT. They had been trained to a higher level than their colleagues employed by the Trust, which enabled them to carry out investigations.
- In the Eastleigh and Romsey CMHT a dedicated carer's support worker had been employed whose role was to provide practical support and information to carers.
- The Winchester CMHT worked in close collaboration with the Winchester Undergraduate Teaching Team, based in the same building, facilitating learning experiences for doctors on GP rotations and medical students, as well as participating in audits and research to contribute to wider service developments.
- The New Forest Community Treatment Team and Winchester and Andover Community Treatment Teams had undertaken comprehensive audits of their patient case load to ensure that patients with specific additional physical health monitoring requirements were identified and effective plans put in place, for example, people on high doses of anti-psychotic medication.

Mental health crisis services and healthcare place of safety

- A rag rated whiteboard which uses coloured discs to show level of need and risk to individual patients was in use.
- An intensive support team chaired a multi-agency, high intensity, user group which met quarterly to review the care, treatment and support of people who were frequent users of a range health and emergency services and devised effective multi-agency management plans for them. Group meetings strengthened multi-agency working across the area, ensured appropriate information was shared and resources used effectively to support patients.

Community based mental health services for older people

- The trust had the memory matters course which provided patients with diagnosed dementia and their relatives with useful information and strategies to manage their needs separately.
- There was a strong focus on integration between mental and physical health care and evidence of effective integrated working which meets patient's needs.
- Staff were committed and passionate and were valued and appreciated by people who use the service and their relatives.
- Services were signposted through dementia advisors to available groups and broader community support for people with dementia and their relatives.
- There was a strong research focus through the MARC (Memory Assessment and Research Centre) which ensures that practitioners had access to current research and best practice and patients who use services had access to participate in research trials, where appropriate.

Community services for people with learning disabilities

- Staff working across the teams had developed a range of accessible materials to provide information to support patients using the services. They had also developed training materials to support patients using the services and other carers to improve the standards of care provided.

Eating disorder

- There was evidence of joint, flexible working between other service providers to ensure safe and effective care of the patient`s needs.
- Service led audits and evaluation which have led to improvements in service provision.
- The clinical leads were actively involved in collaborative research and committed to service development, whilst valuing contributions and suggestions by other team members.

Summary of findings

Perinatal services

- The service provided support to a range of health professionals, via a telephone advisory service, responding to requests for clinical advice from those working with women at risk.
- The service was proactive and engaged in considerable preventative work and awareness raising in respect of the needs of women with perinatal mental health needs.
- The service used a range of creative methods to engage and support women using the service. This included the effective use of video recording both as a diagnostic and therapeutic tool and use of information technology to reach more women at risk of perinatal mental ill-health.
- The service had analysed the patient population and compared this with the make-up of the local community population in order to identify under-represented groups of women in terms of use of the service. Plans were in place to raise awareness of perinatal mental health issues and the perinatal service, targeted at the groups/communities identified.
- The service was exceptionally well led at a local level and there was a strong culture of innovation and continuous improvement.

Community health care services

Summary of findings

Community health services inpatient wards

- At Petersfield Hospital staff recognising the distress and anxiety of a patient, supported them to visit their spouse who was a patient in another hospital.
- There was a holistic approach to providing care and support to patients and their families. There were examples of staff supporting family members to be able to provide care and support for their relative when they were discharged and families and the patient being fully involved in the decision making process for the planning of care.

Community health services for adults

- Where well-resourced and well managed integrated teams had been implemented, there had been significant improvement in patient outcomes.
- The trust had a diabetic information and education service. Staff provided education to newly diagnosed adult diabetic patients and an open telephone service for staff or patients to access expert advice. The team had been able to identify localities where additional education of patients could improve the management of their condition. They worked with the ambulance service to provide guidance over the telephone in management of hypoglycaemia.
- Health and wellbeing cafés to reduce social isolation and encourage uptake of the leg ulcer service. Evaluation of the clinics and research indicated that people's wounds improve and there are significant health benefits from the social aspect of the cafés.

Summary of findings

Community health services for children, young people and families

- The service had been proactive in redesigning its health visiting service to reflect the needs of the community and to support the newly qualified staff joining the service.
- The service as a proactive member of the local MASH and was influential in setting up the early help hubs to improve the multidisciplinary working with partners to reduce risks for vulnerable children and young people.
- The trust and the commissioners had worked together to create ten additional projects alongside the healthy child programme which included the innovative idea for the improving of emotional and psychological wellbeing for children and young people. Projects had resulted in school-nurse drop-ins in secondary school and also the raising of the school nurse profile through attending public health events and multi-disciplinary meetings. Examples include the attendance at CAMHS health forums, the Young People's conference for emotional health and wellbeing and the young carer's capacity building events.

- The service had also undertaken an initiative to engage with the Nepalese community regarding healthy eating and access to services.

Urgent care – minor injuries unit

- The MIUs provided an urgent care service close to home, where patients were seen quickly and prioritised appropriately.
- Staff were emotionally supportive and caring to patients attending the minor injury units

End of life care

- There were “virtual ward rounds” where health care professionals come together to discuss the on-going of patients and the support to be given to them and their family highlighted how seamless care could be provided.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Areas for improvement

Action the provider MUST take to improve

Mental health services

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

Elmleigh

- The trust must ensure that appropriate and safe staffing levels are consistently maintained at Elmleigh based upon a detailed review of the needs and acuity of patient using the acute wards and PICU.
- The trust must ensure that emergency equipment including resuscitation equipment and an automated external defibrillator is located on or close to the acute wards at Elmleigh.

- The trust must ensure that high quality clinical supervision and performance appraisal should be provided to Elmleigh ward staff at regular intervals and that staff are adequately supported to provide effective and safe care and treatment.
- The trust must address shortfalls in basic life support and intermediate life support training at Elmleigh and ensure all staff are appropriately trained.
- The trust must address shortfalls in proactively reducing incidents for safer services (PRISS) training at Elmleigh and ensure all staff are appropriately trained.
- The trust must ensure that ligature risks at Elmleigh, identified for removal, are removed.
- The trust must ensure that systems in place to assess and monitor the quality of service provision at Elmleigh are effective in bringing about improvements.

Antelope House

- The trust must ensure that the seclusion facility on Hamtun ward complies with the Mental Health Act Code of Practice and allows continuous observation of people by staff.

Summary of findings

Forensic inpatients/secure wards

- Appropriate measures must be taken to mitigate and manage environmental ligature risks on wards at Ravenswood House and Southfield.
- Staff on wards at Ravenswood House and Southfield must ensure they are familiar with the procedure for checking and replacing ligature cutters.
- The provider must record all incidents of restraint and seclusion in line with the Mental Health Act Code of Practice.
- All staff at Southfield must ensure they are familiar with the trust's Seclusion and Segregation Policy as some patients at Southfield were not afforded the safeguards of the Mental Health Act Code of Practice when being "de-escalated" in the units seclusion area.

Adolescent mental health wards and forensic services

- The trust must ensure there is an appropriate policy for the use of restraint and that there is appropriate recording of this.
- The policy for seclusion did not comply with the Code of Practice: Mental Health Act 1983, and there was a lack of sufficient records to demonstrate this had been managed appropriately. The trust must take action to rectify this.
- Ligature risks within the environment were not always appropriately managed. In particular, the seclusion area at Leigh House had a number of ligature risks that had not been assessed or minimised to reduce risks to young people. The trust must take action to address this immediately.
- The trust must take action to ensure the appropriate management of young people nursed on close observations, and that general observations are robust and recorded appropriately to demonstrate that young people are monitored.
- During the night at Leigh House there were three staff on duty, which did not take into account the dependency needs of the young people, or of the management of incidents during this time. The trust must take action to address this immediately.
- The trust must ensure that capacity assessment and consent in relation to the requirement of the Mental Capacity Act 2005 and Gillick Competencies/ Fraser Guidelines are carried out.

Wards for older people with mental health problems

- The trust must ensure that there are robust plans exist on each ward to manage identified ligature risks, and where patients are at risk of self-harm and suicide that risk management plans relating to ligatures in the ward environment are identified in individual risk assessments and care plans.

Wards for people with learning disabilities or autism

- The trust must ensure that all staff are aware of incidents that have taken place in the service and where relevant in other parts of the trust and the learning from these incidents.
- The trust must ensure the environments in Oxfordshire and Buckinghamshire where people are cared for are safe.
- The trust must ensure that all staff including support workers have training to enable them to meet the specific needs of patients.
- The trust must ensure it supports staff working in the Oxfordshire service Evenlode so they have regular line management input, understand the changes that are taking place and receive support in an appropriate style to facilitate them to perform their roles.

Mental health crisis services and health care places of safety

- The trust must ensure that there are sufficient appropriately trained staff available to provide care to people in the Elmleigh health based place of safety, when in use, so that safe staffing levels on the PICU and in-patient wards in the unit are not compromised and people put at risk of unsafe care.
- The trust must ensure that staff working in or covering the Elmleigh health based place of safety have up to date training in how to restrain a person safely, break away and de-escalation techniques and basic or intermediate life support.
- The acute mental health teams and hospital at home teams must have operational procedures which inform its staff how to provide services which include risk assessment, care planning and sharing information and protect patients using the service and staff.

Summary of findings

Community mental health services for people with learning disabilities or autism

- The trust must ensure it supports staff working in the Oxfordshire and Buckinghamshire community services appropriately in order to facilitate them to perform their roles effectively.

Community health care services

Community health services inpatient wards

- The trust must ensure that controlled medicines are safely stored in accordance with legislation, trust policies and national guidance.
- The trust must ensure that it has accurate assurance that medicines are stored at a temperature that ensures their effectiveness.
- The trust must ensure FP10 prescription pads are securely managed in accordance with trust policies and national guidance.

Community health services for adults

- The trust must take action to ensure sufficient numbers of suitably qualified staff in all community teams and ensure safe caseload levels.
- The trust must take action to ensure sufficient numbers of suitably qualified staff and reduce the waiting time for therapy assessment and treatment in those community teams where waiting times are excessive.
- The trust must take action to ensure that medicines and prescription (FP10) pads are safely managed.
- The trust must take action to ensure medication is available and relevant staff are trained in procedures when and where it may be required in a foreseeable emergency.
- The trust must take action to ensure that when staff are administering medicines a risk assessment has been undertaken and if required appropriate arrangements are in place for the management of anaphylactic shock.

Urgent care – minor injuries unit

- The trust must ensure that appropriate arrangements are in place to support the administration of appropriate medicines to meet the needs of patients
- The trust must ensure that Patient Group Directions are authorised by the trust, are agreed by staff and are aligned to the medicines that are stocked.

- The trust must review the storage and security of medicines held in the Lymington MIU.
- The trust must improve the management of FP10s and ensure an audit trail for safe and appropriate use.

End of life care

- The trust must ensure there are sufficient numbers of suitably qualified, skilled and experienced staff to provide end of life care to all patients that need it.
- The trust must improve the overall recording of information and decision making on Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms.

Action the provider SHOULD take to improve

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

All locations

- The trust should ensure that there is sufficient and detailed recording and documenting of mental capacity and consent to treatment in patient's care records.
- The trust should ensure all patients using the service are involved in discussions and decisions about their care and this is consistently recorded in their care records.

Elmleigh

- The trust should ensure that staff are appropriately trained and actively support people to stop smoking.
- The trust should ensure there are sufficient opportunities for physical exercise for patients on Elmleigh PICU.

Melbury Lodge

- The trust should ensure that bedroom doors at Melbury Lodge provide sufficient privacy for patients whilst enabling staff to maintain adequate visual observations.
- The trust should ensure recording of the determination of patient's mental capacity is detailed and includes evidence underpinning the judgement at Melbury Lodge.
- The trust should ensure that explanations of patient's rights under Section 132 of the Mental Health Act 1983 are consistently documented at Melbury Lodge.

Summary of findings

- The trust should ensure that on-going and planned work to improve the environment, in terms of removal of ligature risks, is completed at Melbury Lodge.

Antelope House

- The trust should ensure that, at Antelope House, individual risk assessments are completed for people prior to going on section 17 leave and this should be recorded appropriately.
- The trust should ensure that episodes of restraint are minimised in the 'face down' position in line with Department of Health guidelines on the safe use of restraint.
- The trust should ensure that enhanced observations of people using the service are recorded accurately and contemporaneously.
- The trust should ensure that, on Hamtun ward, the blanket restrictions in place in respect of a limit of two telephone calls a day, no baths after 10.00pm and restrictions on the availability of snacks and drinks to patients using the service are reviewed to make sure that patient's individual needs are being met.

Parklands Hospital

- The trust should ensure that where CCTV cameras are used in communal areas and on individual wards at Parklands Hospital that people using the service are informed of this..
- The trust should ensure environmental risk assessments of the acute wards at Parklands Hospital are completed clearly, action taken to remove risks, and a record made of arrangements in place to manage or mitigate the risks.
- The trust should ensure at Parklands Hospital that the dirty utility facilities, such as a sluice sink and disposable bed pan macerator, are not in the laundry room where people's clothing is washed, because of the risk of cross contamination.

Long stay/rehabilitation mental health wards for working age adults

- The findings from the ligature audit at Forest Lodge should be used to ensure a risk based plan of works is in place.
- The programme of activities should be reviewed to ensure that people have access to enough activities to keep them occupied.

- Patients using the service should be supported to have access to a copy of their care plan.
- The trust should consider if staff working in these services could have more opportunities to meet senior staff.

Forensic inpatient/secure ward

- The provider should ensure that forensic directorate leaders and senior trust managers are visible and approachable to ward staff at Ravenswood House and Southfield.
- There was a governance structure in place and to ensure its efficacy all staff should be familiar with it.
- All staff at Ravenswood House and Southfield should be familiar with safeguarding procedures and their responsibilities should they be concerned that a patient was at risk of abuse.
- The provider should ensure that on all wards there are sufficient staff to facilitate Section 17 escorted leave.

Adolescent mental health wards and forensic services

- Health checks were not carried out routinely. Some care plans around physical health checks were lacking, whilst others were generic for the young people. The trust should take action to address this.
- The trust should ensure that young people at Leigh House are encouraged to be involved in care planning or the review of their care.
- The trust should develop appropriate transition arrangements to support young people transitioning into adult services, or clear care pathways for young people.
- The trust should ensure that young people with mental health problems receive the same level of service as those receiving eating disorder services. At the time of the inspection young people felt that this was not the case.
- The trust should ensure the development of specific trust-wide initiatives to seek feedback from young people using its service.

Summary of findings

Wards for older people with mental health problems

- The trust should ensure improvement in understanding of the interplay between the Mental Health Act and the Mental Capacity Act to ensure that patients are protected from the risk of unauthorised deprivations of liberty.
- The trust should ensure that recruitment continues so that staffing levels and stability of staff teams can be embedded.
- The trust should ensure that relevant learning from the Mental Health division is not lost and the specialism within older people's mental health is retained on a ward level and that teams are aware of their responsibilities under the Mental Health Act.
- The trust should ensure that there are systems in place to report and follow up safeguarding alerts which are raised with the local authority to ensure that learning from alerts and referrals can be brought back into the service.
- The trust should ensure that patients and their carers are involved in consultations and discussions about changes in the models of care while they are being piloted.

Wards for people with learning disabilities or autism

- The trust should consider whether it is safe for staff to start working at the Ridgeway Centre prior to their disclosure and barring checks being in place.
- The trust should record, at the Ridgeway Centre, what steps are taken to safeguard people who have been involved in a safeguarding alert to ensure that where needed a suitable protection plan is in place.
- The trust should ensure that records of multi-disciplinary meetings at the Ridgeway Centre contain a clear record of actions and the dates for these to be completed.
- The trust should ensure on Woodhaven that blanket restrictions about the use of pens are kept under review.
- The trust should ensure that when patients are in seclusion on Woodhaven that they are medically reviewed at the correct time intervals. They should also ensure on Evenlode that the times of medical reviews are recorded.

- The trust should review the physical environment in the seclusion room located in the Ashford Unit in Woodhaven to ensure patient's privacy and dignity is maintained if they use the toilet. The window in the seclusion room in Evenlode should also be reviewed to ensure patient's privacy is maintained.
- The trust should try and hold regular community meetings on Woodhaven to support patients using the service to be engaged in how the service is operating.
- The trust must ensure on Woodhaven that emergency resuscitation equipment is easily accessible across the two units.

Community-based mental health services for adults of working age

- The trust should work with local commissioners of services to improve access to local acute psychiatric admission beds.
- The trust should monitor the caseload of Southampton CMHT to assess the impact of the proposed new staffing structure.
- The New Milton and Winchester community team bases were in poor repair in some places and staff were unclear about whether there were plans to move to improved facilities; the trust should make clear plans or invest and improve maintenance in the existing building.
- The trust should ensure that cleaning staff are compliant with infection control and COSHH regulations.

Mental health crisis services and health-based place of safety

- The trust should review the S136 policy and consider how those detained under S136 are assessed in a timelier manner by a doctor in the first instance. Mental Health Act 1983 Code of Practice 10.31
- The trust should ensure that approved mental health professionals (AMHPs) attend the health based places of safety in a timely manner. The Mental Health Act 1983 Code of Practice 10.28 states that the 'Assessment by the doctor and AMHP should begin as soon as possible after the arrival of the individual at the place of safety'.
- The trust should ensure all staff involved in the implementation of S136 receives the necessary training. (Mental Health Act 1983 Code of Practice 10.16.)

Summary of findings

- The trust should review its lone working procedures, and ensure they adequately protect staff in the S136 suite, the acute mental health teams and the hospital at home service.

Community-based mental health services for older people

- The trust should improve the systems in place to monitor the caseloads of staff at Fareham and Gosport OP CMHT to ensure the wellbeing of patients and staff.
- The trust should work with local authorities to ensure that social services input is flexible, responsive and that teams are facilitated to work closely to ensure the best outcomes for patients and their families
- The trust should ensure that patients have sufficient access to clinical psychology input if their needs for talking therapies are too complex to be managed by IAPT

Community mental health services for people with learning disabilities or autism

- The trust should ensure that capacity assessments can be located and accessed with ease in the electronic patient records. They should also ensure that best interest meetings are structured in line with the Mental Capacity Act and staff are trained to be able to implement this.
- The trust should review the referrals to the community learning disability teams that have breached target timescales to ensure patient's needs are met.

Community health care services

Community health inpatient services

- The trust should ensure there is better communication between the surgeons and Lymington New Forest Hospital theatre team, to reduce risk of sudden cancellation of day surgery lists.
- The trust should develop processes to effectively monitor outcomes for patients undergoing day surgery at Lymington New Forest Hospital.
- The trust should ensure staff are aware of the descriptors for Never Events that relate to their area of working.
- The trust should ensure that the Mental Capacity Act 2005 is followed where the environment and locked doors could restrict patient's movement in and out of the wards/buildings.

- The trust should ensure that anaesthetists document their checks of anaesthetic machines prior to surgery.
- The trust should ensure pre-operative assessment processes are streamlined so patients only have to visit Lymington New Forest Hospital on one occasion.
- The trust should ensure that where required food and fluid monitoring charts are fully completed.

Community health services for adults

- The trust should take action to ensure timely ordering and provision of specialised equipment. This is so that patients who require items such as mattresses, cushions or similar equipment which are to be used to prevent harm such as pressure ulcers receive the equipment in time to protect their health and welfare.
- The trust should take action to ensure timely completion of patient records. Electronic patient record systems were found to be unreliable or difficult to use in the community setting. The trust should review and mitigate against the effects of this on patient safety, information governance and staff welfare.
- The trust should take action to ensure relevant emergency resuscitation is regularly checked and available use, including in premises not belonging the trust but where services are provided.

Community health services for children, young people and families

- The trust should develop a transition process for transfers from child to adult services.

Urgent care – minor injuries unit

- The trust should ensure that up to date treatment protocols that reflect NICE and evidence based practice guidance are in place and used by staff in MIUs.
- The trust should consider how Petersfield MIU can access electronic systems of other emergency departments and accesses the child at risk register.
- The trust should consider developing the use of technology and telemedicine to support the delivery of effective clinical care.
- The trust should consider how X-ray services and fracture clinics can become more assessable to patients attending Lymington and Petersfield MIU's.

Summary of findings

- The trust should ensure that MIU staff have opportunities for training and development to enhance their clinical practice
- The trust should ensure that MIUs are able to support the needs of patients in vulnerable circumstances.
- The trust should work with staff, patients and partner organisations to develop a service strategy and vision for the MIU's based on assessment of needs of the local population and health economy.

End of life care

- The trust should fully develop and implement an evidence based end of life pathway.
- The trust should improve the processes for reporting and learning from incidents, accidents, near misses, complaints and safeguarding concerns.
- The trust should improve the timeliness of the provision of equipment to patients receiving end of life care at home.

Southern Health NHS Foundation Trust

Detailed findings

Requires Improvement 

Are services safe?

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

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

Summary of findings

The numbers of staff and skill mix on wards was identified as a concern in many areas of the trust. Staff in mental health services reported working longer than their contracted hours in order to deliver care to patients and said that the dependency of patients was not taken into account when deciding the numbers of staff required. Patients had to wait for long periods of time to take Section 17 escorted leave due to staff not being available to accompany them.

Inadequate staffing levels in community health services was impacting on the delivery of safe care and waiting times, particularly in MIUs where patients had to wait for long periods of time to be seen and in community health services for adults where a number of appointments had been missed due to lack of staff.

There was also inadequate numbers of experienced palliative care staff to deliver care to patients at the end of their life. However, the trust was actively recruiting new staff and was closely monitoring staffing levels.

Physical interventions were not always properly managed due to a lack of adequate numbers of suitably trained staff. Staff found the policies and procedures for seclusion confusing and did not always follow them and the recording of episodes of seclusion was not always robust.

In some of the mental health units we found that emergency equipment, including resuscitation equipment, was located a considerable distance away from ward areas; staff had to negotiate several locked doors to get to it.

Are services safe?

We found there were significant delays in some community health services in the provision of equipment to provide protection against pressure ulcers. Equipment such as mattresses, cushions and hospital type beds took too long to be delivered.

The trust had a ligature minimisation programme in place but we were so concerned about ligature management at Ravenswood House and Southfields and in the seclusion room at Leigh House during our inspection that we raised this with the trust and asked for immediate action to be taken. Risk assessments had not been carried out and staff showed a lack of understanding of how ligature risks should be managed. At Ravenswood House there were inadequate plans to manage the risks in the short term; the trust had plans to renovate the wards and in the longer term move to a new building.

Lone working practices in the Section 136 suites, acute mental health teams and hospital at home teams put people at risk. Staff did not carry personal alarms and had not considered that they might be putting themselves or patients at risks.

The trust had systems in place to report and monitor incidents and to ensure the board had a detailed understanding of the key risk in all areas. It was clear that staff were encouraged to report incidents. There was evidence of learning, across the trust, from incidents and evidence of improvements being made as a result of reporting and sharing the outcomes of incidents. However, there were some areas where practice was inconsistent or embedded.

There was good management of falls and a high incidence of pressure ulcers was reported in comparison with other NHS trusts. However, it clear that the trust was not always the primary care giver in all cases and work was being done to identify the primary care giver. The incidence of pressure ulcers was reducing year on year.

The trust had systems in place to safeguard people from abuse. Most staff we spoke with understood the importance of safeguarding vulnerable adults and children and knew how to raise an alert.

Our findings

Track record on safety

The CQC Intelligent Monitoring system was used to give an indication of the potential risk for the trust in preparation for the comprehensive inspection. There were no elevated tier 1 or tier 2 indicators so no identified elevated risk relating to the safety of patients. In addition, there were no safety concerns raised from the Department of Health Mental Health Minimum Data Set. There were also no concerns raised by tier 2 indicators from the Royal College of Psychiatrists or the Survey of NHS Staff relevant to safety.

NHS trusts are required to submit notifications of incidents to the National Reporting and Learning System (NRLS). Between September 2013 and August 2014 the trust reported 2607 incidents that were categorised as abuse, moderate, severe or death. The NRLS notification analysis system indicated that this is within the expected range for a trust of this size, delivering the types of service it does.

The number of incidents of abuse or allegations of abuse (broken down as physical, other, verbal, sexual, and racial) reported by the trust had increased in 2014. However, a high level of incident reporting can be an indication of a healthy reporting culture; evidence collated during the inspection from staff indicated that the trust encouraged reporting.

Seventy eight per cent of these abuse incidents were related to disruptive, aggressive behaviour (including patient to patient). There were a total of eight deaths reported during this period, of which only one was reported as 'suspected suicide (actual)' The largest proportion of incidents occurred within mental health (1492 incidents). Of these incidents, 39% occurred within adult mental health, 30% in older adult mental health and 19% within adolescent mental services.

One hundred and fifty six incidents occurred within community health care services. The trust had a good track record on safety over time across children, young people and family services and care settings. Where concerns arose they had been addressed in a timely way. Appropriate safety and safeguarding performance information was regularly reported and discussed at all levels.

The NHS Safety Thermometer measures a monthly snapshot of four areas of harm, including falls. The number

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of falls resulting in harm in both the older people's mental health patients and community hospitals has fluctuated widely during the 11 month period ending June 2014. The rate reached its peak, in community hospitals, at 5% during March 2014. It is important to note that comparisons with the national average are difficult due to small sample numbers meaning even a small rise could push the trust over or under the England average.

We inspected older people's mental health inpatient wards and found robust falls management plans in place and incidents involving falls were monitored across all wards using the safety cross system. We found that falls incidents had reduced on Dryad and Daedalus wards at Gosport Memorial Hospital between the periods April to June 2014 and July to September 2014.

Trusts are required to report serious incidents and never events through the Strategic Executive Information System (STEIS); the trust had reported no never events since December 2011 and had reported a total of 483 serious incidents between 1 September 2013 to August 2014. However, a serious incident in Lymington Hospital theatres met the criteria but was not reported as a Never Event. The electronic incident reporting system (Ulysses) did not provide an opportunity to report an incident as a Never Event at ward/department level.

The most common type of incidents, the majority of which occurred within community health services, was pressure ulcers, which made up of 95% of the total 385 incidents in this service. Grade 3 pressure ulcers accounted for 43% of all serious incidents. This was followed by Grade 4 pressure ulcers which accounted for 34% of all incident types. This is higher than organisations delivering similar services. However, it was clear that the trust was not the 'primary care giver' in all cases.

The trust was concerned about the high incidence of pressure ulcers and as such worked with stakeholders to develop a definition of 'primary care giver' to identify the organisation responsible for the pressure ulcer in the first instance. Clinical indicators were used to determine who the 'primary care giver' was for each patient. Following all pressure ulcer incidents a pre panel (48hrs) was undertaken by clinicians from the trust and a rigorous clinical triage process was implemented, led by a tissue viability specialist nurse. A decision was then made as to whether a pressure ulcer was deemed avoidable or unavoidable using agreed structured criteria. An audit trail provided to

evidence of the 'primary care giver' for each patient. Those pressure ulcers deemed unavoidable had the learning shared with other organisations and avoidable pressure ulcers had an root cause analysis completed. A further SIRI panel was undertaken to establish the actions to be taken and identify any further learning required. Southern Health quality account 2014-15 priorities included sharing and implementing learning across the trust to reduce pressure ulcers. The trust had a team of tissue viability nurses who were supporting trust staff, and those in local care homes, in the prevention, early identification and treatment of pressure ulcers.

Every six months the Ministry of Justice publishes a summary of Schedule 5 recommendations which had been made by coroners with the intention of learning lessons from the causes of death. There were no concerns regarding the trust in the most recent report (October 2012 – March 2013). Staff had a good understanding of reporting and said the trust encouraged reporting. They said they felt confident that if a concern was raised that it would be addressed and that there were good governance systems in place to provide feedback. For example, since May 2013 the Ridgeway Centre had four serious incidents requiring investigation. The trust closed the service to admissions until March 2014 when the investigations were complete and changes made to the services.

Learning from incidents

The trust had a clear reporting structure relating to quality and risk, from team meeting level through to trust board. However, these were in the early stage of implementations and some staff were unaware of how to report incidents through the Ulysses reporting system. There was a general lack of understanding about the classification of incidents, the identification and levels of risk and what action would be taken as a result. However, staff said that if they reported an incident they were confident that action would be taken. In the minor injuries units staff said they received little feedback on incidents reported but in some areas staff told us that there were meetings designed to help improve the service after incidents.

The trust had developed a new Board Assurance Framework (BAF) which comprised a suite of reports relating to team, service and divisional level performance across a wide range of themes. Evidence presented had been triangulated from a variety of sources to form a view of quality across a number of data themes, including those

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relating to safety such as serious incidents restraint and complaints. The BAF was introduced for approval at the board meeting in September 2014 so had not had time for staff to fully understand the reporting framework, the risk that would be escalated to the board and how required actions would be fed back.

In the previous year the trust had not been able to investigate all serious incidents within the expected timescales. The trust had identified this as a concern and a plan had been established to reduce the backlog. As of June 2014 there were 299 open and 191 of these were overdue. External stakeholders said there had been an improvement in the quality of incident management and learning but that all investigations were not always fully robust. Their concerns related to the quality of action plans and sharing of learning across the organisation.

At divisional and team level incidents were reported and presented to divisional or service quality and safety groups and fed up to be reported in the BAF according to the level of risk. Staff said that the local quality and safety groups gave an opportunity to learn from incidents reported and to share learning across services and divisions. Regular quality dashboards reports allowed services to monitor quality and risks. Managers had access to past incidents so they are able to look at trends, benchmark with other services in their division and across the trust to ensure improvements were made as a result of reporting.

In some areas staff told us that there were meetings designed to help improve the service after incidents. These 'learning first groups' assessed incidents and trends, and captured learning points, which were then disseminated across the teams. Memos were sent to teams to inform staff about specific learning points or themes developing. We examined a newsletter entitled Putting Quality First which had articles about serious incidents and reports about observation visits so that staff could learn from audit results. However, at both Ravenswood House and Southfield the systems in place were not robust or embedded and staff were unsure whether there was any learning from incidents. The 'Hotspots' newsletter was used to share information about incidents and improvements that had been made as a result of reporting.

Safeguarding

The trust had systems in place to safeguard people from abuse. There was a clear policy on how to raise an alert and who to contact. Most staff we spoke with understood the importance of safeguarding vulnerable adults and children and knew how to raise an alert.

The trust, in partnership with other local safeguarding agencies had launched a multi-agency safeguarding hub (MASH), which provided a multi-agency triage, assessment and decision making system that ensured a consistent and co-ordinated response. The MASH team was made up of children's and adult services, police and health professionals and was based at Parkway Hospital. The trust had a large safeguarding team and had recently appointed two 'safeguarding' doctors in recognition of the key role doctors play in safeguarding. The vulnerable adults committee reviewed all referrals and oversaw all safeguarding concerns to ensure that appropriate action is taken and that learning occurs as a result. In August 2014, the trust issued its first newsletter on safeguarding. This raised awareness of safeguarding developments and issues and also contained information about what had been learnt from incident that had occurred. A number of staff told us that they found this useful in considering safeguarding relevant to their team.

Safeguarding training was delivered at three levels; staff must attend the level specific to the role they perform. For example, all staff must attend level 1 training but only those working directly with children and young people need attend the level 3 children's safeguarding training. Information from the data the trust collected about attendance at statutory and mandatory training confirmed that the majority of staff have attended the required level of training. In children's and family services there were effective safeguarding policies and procedures which were fully understood and implemented by staff, including agency and locum staff. Staff had received safeguarding awareness training at levels one, two and three which was confirmed by training records.

The school nurses and health visitors worked alongside the children's safeguarding teams and were able to discuss any issues or concerns with them. Safeguarding procedures were coordinated with other agencies so that children's protection plans were implemented effectively. The trust was also playing a pivotal role in establishing the Early Help

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Hubs (eight hubs had been set up with partner organisations across the region) whereby those children and families that did not meet the threshold for social services assessments could obtain on-going support.

Lone worker and remote working

The trust had a lone worker policy. Many staff we spoke with were aware of the lone working policy and were clear on their responsibilities to ensure colleagues knew of their whereabouts during their shift. Records of visits and contact numbers were kept for staff visiting patients in their own homes. In community health care staff 'buddied' each other and worked in pairs when working evenings and during twilight shifts.

Practice in the Section 136 suites (S136), acute mental health teams and hospital at home teams put people at risk. Staff in the acute mental health teams and hospital at home teams did not carry personal safety alarms of any other safety devices and staff could not explain any specific ways of managing their safety when they saw patients alone. In S136 suites staff told us that they often worked alone with patients that were agitated.

Assessing and monitoring safety and risk

Risk register

The trust had a single risk register and any member of staff could add a risk to the risk register. The register could be analysed at a variety of different levels. For example, at risk level, service or divisional level, committee level etc., to aid monitoring. A matrix was used to determine the impact and level of risk. The risk was then allocated to a monitoring committee responsible for ensuring that action was taken to address the risk. The majority of risks were addressed at service area or divisional level but higher level impact quality and safety risks were escalated as needed to the quality improvement and development forum, then to the quality and safety committee through to the trust board and reported as part of the BAF.

Other risks, for example, financial or workforce risks were escalated through divisional boards, divisional performance reviews and executive group through to the trust board; also reported as part of the BAF. In September 2014, 57 active risks were reported to the trust board.

Safer staffing levels

The director of nursing provided leadership on safer staffing issues. Safer staffing issues were reported to the board each month. There is a national requirement to submit information relating to inpatient ward staffing levels and skill mix to NHS England.

In September 2014, the safer staffing report to the board (for the three months leading up to the report) showed that NHS England indicated that in June 2014, ten of the trusts inpatient units submitted a safer staffing position status of less than 80% of establishment (a fall below 80% is considered a risk to the delivery of good care). In July 2014, this had improved with three inpatient units reporting under 80% staffing establishment. However, skill mix remained a problem on 17 wards. The only ward highlighted as consistently reporting low fill rate over the 3 month period was Beechwood Ward at Parklands Hospital. The report to the board identified that only Gosport War Memorial Hospital reported below 80% for August 2014.

The trust had piloted the use of an acuity and dependency measurements for pre-selected inpatient units across the trust with the second acuity and dependency measurement due to be taken in October 2014 when the results of both would be presented. This would be used to determine the staff required based on the level of care patients on the wards needed. The trust monitored staffing at a strategic level through the dashboard using three categories: staff competency, including training, staff availability, including back and agency usage and sickness/absence and turnover, including the number of staff with less than 12 months service.

External stakeholders recognised that recruitment and retention was a challenge although recognised that good relationships have developed with education providers to attract students/trainees. However, some concerns were expressed about staffing levels; 13 locations had a vacancy rate of greater than 50%, in the rest of the trust the vacancy rate was 11%. Staffing levels are of particular concern in community health services. However, the majority of bank and agency usage was in mental health and learning disabilities. Staff turnover in the twelve months up to June 2014 was 13%. Staff sickness rates at the trust had been consistently lower than the England average for mental health and learning disabilities over the two years between April 2012 and March 2014.

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The director of nursing confirmed that 45 new health visitors and 130 mental health nurses were due to start work in the trust shortly. Staffing levels were monitored on a day to day basis and the actual staffing levels against those planned for each ward displayed at the entrance of both mental health and community hospital wards. Some forensic mental health wards did not display these in public areas for staff safety reasons. The director of nursing told us that she personally monitored staffing levels in all areas on a daily basis.

Staffing issues for nursing and allied health professionals were escalated locally to the matrons within those services who would deal with the majority of issues but would escalate if agency staff were required; incident reports were completed if issues are escalated above the matron level.

Current funding for staffing establishments was historical. The trust was working with an external experts and the Department of Health on developing a safer staffing tool for community hospitals and mental health wards. In addition, two members of staff were working with a national steering group to develop a safer staffing model for learning disability services. Information from the NHS Staff Survey indicated that the trust was tending towards worse than average for three items relating to staffing issues including, staff working extra hours (75% said they worked extra hours) and feeling unsatisfied with their quality of work and the patient care they were able to deliver. It was tending towards better than average for one item in the survey relating to staff experiencing physical violence from other staff in the last 12 months; this is a tier 2 indicator.

A workforce diversity scorecard was used to track the workforce profile against nine protected characteristics; bullying and harassment, grievance, disciplinary, sickness absence, employment banding, turnover and recruitment and selection. This showed that in the last 12 months the trust has made improvements against all areas; one significant improvement identified was a 50% reduction in BME staff subject to a disciplinary.

In community health services the number of staff and skills mix was determined by the nature of the contract to ensure there were sufficient personnel with the appropriate skills to safely run the service. Staff had allocated caseloads which were regularly reviewed to ensure staff did not have too many child protection cases. The trust had been actively recruiting health visitors and in response to the

'call for action' over 100 newly qualified health visitors had been successfully appointed in the past 3 years. In many teams in community bases we found there were not always enough staff and the gaps were not always covered. This meant that in some community teams there were missed visits to patients. We found long waiting times for treatment by a therapist, gaps in the supervision of staff, and increasing stress levels of staff.

In mental health services staff reported insufficient staffing levels to provide safe care. In older peoples mental health community teams staffing levels were identified as a risk on the divisional risk register. Staff said they were working longer hours that they weren't being paid for in order to ensure patients received care. At Leigh House there were only three staff on duty at night; staff said this did not take into account the level of dependency of the young people and meant that young people were being put at risk. In addition, staff said there was not always enough appropriately trained staff to manage good restraint practices.

Similarly, at Elmleigh wards and PICU there were not always sufficient, suitably trained staff to restrain patients safely when this was required. We found there were inconsistencies between staff deployment across areas. Some staff were not reassured that gaps in their teams or the workload would be covered. As vacancies arose re-evaluation was undertaken and the grade and hours of replacement had to be approved by a trust panel before going to advert. This had added to the delays in recruiting staff. Some staff said there had been blocks in place so that agency staff could not be used. However, in some teams there had been reorganisations and significant improvements around staffing.

Use of physical interventions (restraint)

The trust had a violence and aggression policy which had been produced in collaboration with Hampshire Police. One of the trust's priorities detailed in the quality account report 2014/2015 was to reduce the number of cases of violence and aggression to minimise the risk of restrictive practice, to introduce a framework of positive behavioural support (PBS), including the use of behavioural support plans and improve environments to help minimise the negative impact of oppressive environments on how patient behave and recover. Information submitted by the trust to CQC identified that there were 1406 incidents where physical interventions (restraint) had been used to

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manage individual's behaviour in the last six months. In 504 of these incidents, patients were restrained in the prone position; 104 of these incidents resulted in rapid tranquilisation being given, either orally or by intramuscular injection. Over 60 of these incidents of restraint took place on wards at Bluebird House (medium secure adolescent wards). Prone restraint and the use of rapid tranquilisation had occurred in three other inpatient units in the last six months: Malcolm Faulk ward at Ravenswood House (medium secure adult ward), Elmleigh PICU and Kingsley Unit at Melbury Lodge (mental health admissions ward).

The trust told us that all staff involved in the restraint of patients must be PRISS trained. Training compliance records showed that 94% of staff working in mental health had completed initial training but only 69% had attended refresher training. 75% of staff had completed Basic Life Support training; a requirement for those using restraint and seclusion. However, we were told repeatedly that in several areas, for example, Elmleigh wards and PICU, Ravenswood House, Southfields and Leigh House that there was frequently a lack of suitably trained staff available to practice restraint safely. Staff said that due to shortages of staff agency staff were often used to cover shifts that weren't adequately trained.

Use of seclusion

Data submitted by the trust to CQC identified that there were 656 incidents of seclusion across 24 wards in the last six months. Three of the wards (Hill, Stewart and Moss) at Bluebird House, forensic adolescent inpatient wards). There was no data available on long-term segregation; the policy is being revised to provide clearer definition of this term.

The trust had a seclusion policy which was approved in March 2013. The policy used definitions from the Mental Health Act Code of Practice (MHA COP) for seclusion and long term segregation. The policy stated that staff should only apply seclusion in circumstances where an individual is placing others on the ward at risk of significant harm and where other methods of managing individual's behaviours have failed or are inappropriate. However, we heard that staff found these confusing and did not always follow them. Recording of episodes of seclusion was not always robust. At Ravenswood House in half of the records that we looked at seclusion episodes had not been recorded in line with the MHA COP. At Leigh House episodes of seclusion had not been recorded and medical reviews of young people

following seclusion did not always take place. We raised these issues with the trust at the time of the inspection. The trust accepted that policies and procedures needed attention and assured us that this work would commence immediately and staff would be briefed and trained accordingly.

We also raised some specific issues about the use of the seclusion room at Hamtun ward (PICU) at Antelope House. The trust provided us with an action plan identifying immediate action it would take and what it would implement over the next two months to ensure practice was in line with recognised best practice. In addition, the trust provided a specific action plan for the closure of the seclusion room and the development of a de-escalation area and related practices. This provided assurance that the trust would improve care for patients.

Understanding and management of potential risks

Medical devices and resuscitation equipment

The trust had a register of medical devices and a programme of maintenance. Medical devices were checked regularly to ensure they were fit for purpose; weekly checks were carried out and recorded.

In some of the mental health units emergency equipment and resuscitation equipment was kept behind locked doors for safety purposes. In a number of areas we found that emergency equipment, including resuscitation equipment, was located a considerable distance away from ward areas. In the PICU at Elmleigh staff had to go through three sets of locked doors which were difficult to negotiate whilst carrying the 'grab bag' and automated external defibrillator (AED). Staff confirmed potential risks and difficulties experienced in accessing this equipment. We asked the trust whether they were assured that equipment could be accessed within the Resuscitation Council guidance that resuscitation should be attempted within three minutes of a person suffering a cardiorespiratory arrest. The trust provided test times showing the length of time, at normal walking pace, it would take to collect the equipment. The longest length of time was at Trinity ward (3 minutes) and Saxon ward (2 minutes) at Antelope House and Bluebird House (2 minutes).

In community health services we found inconsistent use of medicines for treating anaphylaxis. In the day theatres at Lymington New Forest Hospital the anaesthetic machine checks were not signed by the anaesthetists - in

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accordance with guidance from the Association of Anaesthetists. However, we were told by theatre staff that they observed that the anaesthetists did check the machines prior to use. We also found there were significant delays in some areas in the provision of equipment to provide protection against pressure ulcers. Equipment such as mattresses, cushions and hospital type beds took too long to be delivered. This was variable across the trust but meant that some patients were at risk of developing pressure ulcers before the equipment arrived. Community staff told us there were frequent delays in obtaining specialist mattresses and beds for their patients, including those receiving end of life care.

Management of ligature points

The trust had undertaken a project to establish the current position in relation to the management of ligature risks. The project looked the environment as well as the policies and practice of care. It identified a number of shortfalls including inconsistency in who undertook ligature assessment and how forms were completed, the lack of ligature registers on wards, the lack of training and patients not being involved in assessment. A report had been produced that identified what the trust needed to do to manage ligature risk more effectively.

The trust's incident data showed that from January 2014 to August 2014 there had been 22 ligature incidents involving a ligature point and 467 other types of ligature incidents. The majority of incidents had occurred in patients bedroom and then in bathrooms and toilets. One incident had happened in seclusion. Applying the Manchester ligature risk audit tool showed that incidents level were in line with most other NHS trusts. However, during the inspection we were so concerned about the management of ligature at Ravenswood House and Southfields and in the seclusion room at Leigh House that we raised this with the director of integrated services. We found that the risks to young people were not properly managed at Leigh House. An assessment of the risks had not been undertaken, and staff showed a lack of understanding about how risks were being managed.

At Ravenswood House we found inadequate plans to mitigate risks in the short term. The trust had plans to renovate the wards and in the longer term move to a new building. However, we found that vulnerable patients could not be observed properly and that those needing additional support were being moved nearer to the nursing

office so staff could 'keep an eye' on them but there had been no work to minimise ligature points in this room. We also found that ligature cutters were not being checked regularly and changed after use. We had to instruct staff to remove used ligature cutters and ensure they were replaced and ready to use. We also found poor management of ligature cutters and lack of knowledge about their use at Southfields.

Following the site visit we detailed our concerns formally in writing and asked the trust to set out the immediate actions it would take in response. The trust provided a response identifying the immediate and short term actions it would take; this provided assurance that it would take action to address our immediate concerns and manage the risk to patients appropriately in the short term until longer term plans were able to be realised.

The trust have since provided a comprehensive action plan identifying how the trust intended to manage ligature risks across services in the future. This included, completing aspects of work to buildings more quickly than previously identified where this could be done, linking environmental risk with individual care plans, amending policies that staff should follow, providing information to staff, providing training and undertaking audits of whether actions had been taken and whether risks to patient had been minimised.

Management and suitability of premises

The trust had an estates and building management strategy and plan and had a detailed estates risk register. The trust's aim was to have high quality, fit for purpose buildings located in the right place for its population. It had identified that the sites requiring the most investment included: Ravenswood House, which did not currently comply with national standards for medium secure facilities, Fleet, Petersfield and Romsey, Gosport War Memorial and Parklands Hospitals.

The main building that presented a risk to patients in mental health services was Ravenswood House. An outline business plan had been developed to re-provide Ravenswood House, currently at Fareham on a different site. However, we found that the building compromised the quality of care that staff were able to provide and posed some serious risks to patients. For example, the layout of

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the wards made observation of patients difficult and ligature minimisation was difficult due to the nature of the facilities. The trust had plans to improve the building in the short term until re-provision of the facility was agreed.

Generally, care was provided from well-maintained, clean facilities that were fit for purpose. All of the services we visited were accessible to people using mobility aids by use of ramps and /or lifts. Disabled parking was available at the hospital and surgery sites we visited. In community health services the hospitals, clinics and health centres visited were well-maintained and visibly clean.

Infection control prevention and control policies and procedures were implemented and audited. On Ford ward at Fordingbridge Hospital six beds had been closed to reduce the risk of cross infection. It had been identified that the position of beds close together had increased the risk of transmission of infection. Hospitals had patient-led assessments of the care environment (PLACE) audits undertaken. Overall, the PLACE assessments gave a cleanliness score between 100% to 85% across the inpatient areas.

Are services effective?

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

Summary of findings

We found ineffective practices in the management of medicines at both the MIU at Lymington Hospital and Petersfield Hospital. In the theatre suite at Lymington New Forest Hospital and Sultan ward at Gosport War Memorial Hospital the Controlled Drugs cupboards did not comply with the trust's own policies and procedures. There was insecure management of FP10 prescription pads with an incomplete audit trail of safe and appropriate use. The trust had identified that most Patient Group Directives (PDG's) were past their review date and had initiated an action plan to resolve the situation. However, when we inspected the PGDs were not available for operational use at the Petersfield MIU.

In community health services and some inpatient services for adults we also found unsatisfactory arrangements in place for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.

Outcomes for patients were being monitored in a number of areas across the trust but protocols had not been updated in the MIUs, nurse practitioners and nurses were not administering pain relief or other emergency medication when patients required it.

Although there was good management of the MHA across the trust, seclusion and restraint practices were often not in line with the MHA COP or nationally recognised guidelines. Patients in mental health services generally had physical health care assessments completed. However, these were not routinely carried out in adolescent inpatient and forensic services.

There were good examples of multi-disciplinary and multi-agency working which contributed to services being effective. Care and treatment was generally planned and delivered in accordance with NICE guidelines and evidence based recognised good practice.

There was access to meaningful therapeutic activity in mental health services, although little access to physical activity in PICUs and there was no transition arrangements for young people moving to adult services.

There were good opportunities for continuous professional development and the majority of staff had access to line management supervision and clinical supervision. However, allied health professionals told us that there was a lack of professional supervision and leadership for them and no access in the trust to supervision from someone of the same profession.

There was commitment to developing leadership skills for staff at all levels; the 'going viral' programme was being extended to include a number of different programmes relevant to the level of staff.

Our findings

Assessment and delivery of care and treatment

The trust used the electronic patient record system RiO to manage individual patient records, including for recording assessments and care plans. In most of the areas we visited we found that comprehensive assessments had taken place by either multi-disciplinary teams or appropriate individual staff.

In mental health and learning disability services these also included an assessment of physical health needs, although in adolescent inpatient, forensic services and some Section 136 suites this was not routinely carried out. Learning disability services used a variety of assessment specifically related to patients' diagnosis. For example, for people with a diagnosis of autism and additional assessment would be undertaken alongside the routine care assessment. Similarly, in older people's services specific the Waterlow pressure ulcer risk assessment plus other specific assessments would be undertaken.

There was some good evidence that patients were being assessed and that care was planned and delivered in

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accordance with National Institute of Care and Excellence (NICE) guidelines and other recognised evidenced based, good practice. For example, mental health rehabilitation services used wellness and recovery plans (WARP), and eating disorder services use guidance on the management of really sick patients with anorexia nervosa (MARSIPAN), including junior MARSIPAN for young people, to support care delivery care.

At Melbuy Lodge a 'recovery focused narrative' approach had been developed and implemented in response to feedback from patients. The approach aimed to achieve greater collaboration between patients and health professionals. In rehabilitation services we found good evidence of positive risk taking and recovery orientated ethos. We saw evidence that a number of clinical pathways were being developed and used with patients with complex needs who might need input from a range of clinicians.

The majority of patient that we spoke with said they had been involved in planning their care and a number had a copy of their care plan, although some said they hadn't wanted a copy.

A range of meaningful therapeutic groups and activities were available throughout mental health and learning disability services. On some acute inpatient wards activity programmes were provided seven days a week. However, in the PICUs there was a lack of physical activity. In adolescent inpatient and forensic services there was no transition policy to support young people moving to adult services. The discharge of young people was not discussed or planned as part of the admission process.

Medicines management

Staff across the trust told us that they felt supported by the trust's pharmacy services. We found that the trust had not always adhered to its own policies in relation to controlled drugs cupboards in that they were screwed, not bolted to the walls. Medicines cupboards were not all metal, although the policy stated that they should be; this was not a legal requirement.

In community services controlled drugs weren't always ordered in accordance with the trust policy. In July 2014, the trust had undertaken a trust wide medicines audit involving 549 patients. This showed improvements in

medicines management from the previous audit in 2013. However, the Ulysses incident reporting system was still not being completed properly after incidents relating to medicines.

In addition, at Petersfield and Gosport community health services bases expired medicine were still in stock and available for use. There was insecure management of prescription pads with an incomplete audit trail to ensure safe and appropriate use. In the theatre suite at Lymington New Forest Hospital and Sultan ward at Gosport War Memorial Hospital the Controlled Drugs cupboards did not comply with the trust's own policies and procedures. There was insecure management of FP10 prescription pads with an incomplete audit trail of safe and appropriate use. The trust had identified that most Patient Group Directives (PDG's) were past their review date and had initiated an action plan to resolve the situation. However, when we inspected the PGDs were not available for operational use at the Petersfield MIU.

In inpatient services the management of medicines on some wards and services compromised patient safety. In some areas no action was identified or taken when records of fridge temperatures identified that medicines were stored outside recommended temperature limits. The storage of controlled medicines in some wards did not comply with the trust's policies and procedures and national guidance. The management of FP10 prescription pads in some areas did not comply with national guidance to reduce the risk of misuse.

In most mental health services we found that medicines were being managed properly. In inpatient forensic mental health services we found excellent practice in the management and administration of 'as required' (PRN) medication. The trust had also conducted clinical audits of the use of lithium, antibiotic, high dose antipsychotics and controlled drugs.

Outcomes for people using service

The trust had recently introduced a performance monitoring dashboard to allow it to monitor performance across all its divisions. This had a number of indicators that monitor outcomes for patients, including patient outcomes and patient experience. Outcome measures had been developed, in collaboration with clinicians, for all clinical services. At the time of the inspection these had just started to be integrated into the new team level monitoring information. The majority of clinicians received monthly

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patient experience reports for their teams; this was the used to inform a 'you said, we did' template that outlined actions that needed to be taken as a result of patient feedback. This information was available to the public as well as teams and the board.

A programme of peer reviews had commenced to audit the quality of care provided to patients. The programme was in its infancy but had been welcomed by staff; all we spoke with about the programme were very positive about the potential to care and service delivery and improve outcomes for patients. Commissioners also welcomed this approach, which provided a critical view of a service. The trust had been commended by external partners, staff and patients; patient had been involved in several peer reviews.

There was evidence of the use of national guidance and best practice tools in use to ensure people using services received care and treatment based on good practice. Staff told us that to keep up to date they used the trust website, and received a weekly trust bulletin and emails from managers regarding updates to NICE guidance. Staff referred to NICE guidelines in discussions. Policies and procedures quoted NICE and other professional guidance. As part of its quality assurance system the trust was in the process of seeking accreditation of inpatient mental health wards (AIMS) from the Royal College of Psychiatrists. Some services have already achieved accreditation in relation to various Royal College schemes including;

- Parklands, Elmleigh and Antelope House ECT services - ECT accreditation (ECTAS)
- Willow ward – peer review by the Quality Network for learning disability inpatient services
- Southfields and Ravenswood House - peer review by the Quality Network for forensic mental health services
- Hampshire Community perinatal services and Winchester mother and bay unit – peer review by the Quality Network for perinatal mental health services
- Bluebird House and Leigh House – peer review by the Quality network for in-patient CAMHS
- Department of Psychological Medicine – Psychiatric Liaison accreditation

The trust had carried out a large number of audits, some on-going and some one off audits. Between December 2013 and May 2014 the trust carried out 34 clinical and non-

clinical audits. The trust also participated in a number of national clinical audits including the National Audit of Schizophrenia 2011 and the Prescribing Observatory for Mental Health audit.

The children and family community health services systematically identified relevant legislation, current and new best practice and evidence based guidelines and standards at organisational level and throughout the service. These were communicated, implemented and the use of them monitored. Delivery of care and treatment achieved positive outcomes for children and families which were in line with expected norms. Performance had improved over time. Outcome measures were routinely used. The outcome measures identified were appropriate to the service, support key aims of the service, such as the delivery of the healthy child programme, and were appropriately stretching.

Adults community health teams were undertaking a range of monitoring of, for example, therapy input, falls prevention and audits also used peer review. A programme of audits had been completed during the year 2013/2014 in the inpatient areas. These included audits of compliance with the WHO surgical check list in theatres at Lymington New Forest Hospital, infection control in the endoscopy unit at Lymington New Forest Hospital, inpatient falls, management of controlled drugs and standard infection control precautions across all inpatient areas. Changes made as a result of these audits included the revision of the WHO surgical check list in order to establish full compliance with the completion of this. However, there was no indication that the treatment protocols used in both MIUs had been updated in line with recognised guidance and evidence based practice.

Some treatment pathways and protocols had been recently developed but did not cover all types of conditions and patients presenting at the units. We found that at the Petersfield MIU nurse practitioners and nurses were not administering pain relief or other emergency medication. PGDs were not available for operational use at the Petersfield MIU.

The trust had conducted 45 research studies between 2012/14 involving approximately 800 patients. It was clear that there was a real commitment to research supporting the development of clinical practice. For example, there was a strong research focus through the MARC (Memory

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Assessment and Research Centre) which ensured that practitioners have access to current research and best practice and patients who use services have access to participate in research trials where they are appropriate.

Staff skill

The trust was committed to developing its staff and was seen as a key enabler to achieving its goals. The majority of staff we spoke with confirmed this and said they had lots of opportunities for training and development.

A leadership development programme called 'going viral' had been developed. The aim of the programme was to support approximately 1,000 senior leaders across the trust to redesign and integrate their services to enhance every aspect of the patient experience. The programme had won the Guardian Healthcare Leadership Innovation Award in 2013. The programme was in the process of being extended; 'viral quality', a one day development course was being planned for all staff to allow them time to work through challenges from their workplace and build positive cultures and 'viral essentials', which would be open to all line managers to help them develop effective management skills and confidence.

The majority of staff were accessing statutory and mandatory training. The trust had a rolling training programme and staff told us they were regularly informed regarding training due. There were effective induction programmes, not just focused on mandatory training, for all staff, including students, trainees and agency staff.

The trust had mechanisms in place to monitor levels of supervision and appraisal of all staff. The trust had a process in place for managing the poor or variable performance of staff/teams. The board report of September 2014 confirmed that there had been a significant improvement in compliance with statutory and mandatory training requirements which had reached 92% and 81% respectively. Statutory and mandatory training was broken down into three categories; statutory training, mandatory training for all staff and role specific mandatory training. The equality and diversity training had a clear focus on driving outcomes for patients, staff and the organisation. Over half the staff in the trust had completed this training in the last 12 months. The trust used electronic staff records to identify what training staff required and when they were

due to attend updates. However, we found shortfalls in completion of basic life support and intermediate life support across the trust and in the completion of PRISS updates in mental health services.

Staff in Bluebird House said they were not provided with training in the MCA or the Gillick competencies or Fraser guidelines.

In community health services staff had the appropriate qualifications and had undertaken the trust's induction programme. Records confirmed that 99% of school nurses had received annual appraisals. Most health visitor teams had 100% of staff appraisals completed. The learning needs of staff were identified and training put in place which had a positive impact on outcomes for children. There were opportunities for professional development. Core competencies were being developed for staff working in community teams across disciplines.

Inpatient wards had very recently appointed 'end of life champions' and they were going to be trained to ensure 'end of life' care was well embedded on the ward. However, we found that this was a very recent initiative and had not been embedded as yet.

Staff were positive about the support received from their line managers and service managers and had access to team meetings. Many clinical staff confirmed that they had good access to clinical supervision. However, at Elmleigh there was inconsistent provision of supervision and poor levels of staff appraisal. In some teams the staff said clinical supervision was recognised as needing to be improved and team meetings did not formally include clinical supervision. There was a new supervision policy but this was not fully implemented yet. A number of allied health professionals across the trust told us that there was a lack of professional supervision and leadership for them and no access in the trust to supervision from someone of the same profession.

The trust was developing a rolling programme of multidisciplinary, occupational therapy (OT), physiotherapy, nursing training for health care assistants to provide opportunity to keep staff updated. In the NHS Staff Survey 2013 the trust scored within the top 20% best trusts nationally on findings relating to staff appraisal, staff work related stress, staff having equal opportunities and the availability of career progression and or promotion.

Are services effective?

Multi-disciplinary working

Most teams we visited demonstrated either excellent or good multi-disciplinary working, with staff from a range of professional backgrounds supporting assessment, care and treatment delivery, discharge from services or on-going care. Multi-disciplinary teams (MDTs) respected and supported one another in ensuring patients received the best package of care from the best clinicians, health or social care worker to meet their needs. We observed positive MDT meetings which were held on a regular basis in all areas to discuss individual patient needs and possible options for care and treatment. One exception was Cedar ward at Southfields where staff said the MDT didn't work well together. Some ward staff said that decisions would be made and then overturned by senior staff which made them feel undervalued.

Previously, social workers employed by county councils had worked as an integral part of community mental health teams and were line managed by staff from the trust. They felt this supported integrated working. However, social workers had recently been removed from community mental health teams which made it challenging to respond appropriately to people's needs in a timely manner. Members of staff told us this posed a 'massive risk'. This was identified as a risk on the divisional risk register but we were told that no action had been taken.

Staff from both health and mental health community services said that integration of teams was a positive move for older people, making delivery of holistic care easier. Workers from voluntary organisations such as MIND were also seen as key members of the MDTs.

We also observed positive cross trust and multi-agency working. Feedback from councils and the police was positive but CCGs reported that there was some gaps in service, due to a lack of MDT working, for people with dual diagnosis.

In community health services there were virtual ward rounds where a group of healthcare professionals come together to discuss patients and the palliative care given to them. These virtual ward rounds allowed healthcare professionals to discuss care given to patients with a number of other healthcare professionals involved in the care of that particular patient.

In inpatient services multidisciplinary team worked together to reduce delayed discharges. There were

challenges relating to the discharge process for some patients, mainly when they lived in rural areas and were in need of complex care packages. Data provided by the trust showed that for the inpatient services there had been 9% of days lost because of delayed discharges in August 2014. However, this figure did not include Lymington New Forest Hospital that recorded 11% of days lost in August 2014. Weekly multidisciplinary team meetings were held to review progress with social services. However, whilst some of this was outside of the control of the hospitals and wider trust, some people remained in hospital longer than was required to meet their health needs.

Information and Records Systems

The trust used the RiO system in mental health and learning disability services to manage individual patient records, including risk assessments and care plans. However, in the majority of services we heard that the IT system was unreliable and would often not function properly so the majority of wards and community teams kept paper records, creating duplication and presenting a risk of information not being properly stored or shared appropriately. On examination of records we found that the majority were well kept and up to date. However, agency staff did not have access to RiO meaning that permanent staff had to input information on their behalf which staff recognised as neither efficient nor effective.

The trust used the Ulysses system to report incidents and there were effective systems in place to record and receive performance information. The trust was in the process of upgrading its IT systems. It had a detailed programme of when each site would be upgraded to ensure better connectivity. In addition, it had developed a programme of communication with staff to inform them about developments at appropriate times and had produced a regular newsletter that described developments, timescale and what it would mean for them.

In community health services staff told us there was data interchange between the trust electronic patient record system and acute service IT systems. This meant that details were shared such as admission, discharge and attendances at A&E. However, whilst Lymington MIU used an electronic patient record the Petersfield MIU used paper records so it could not share information with other emergency departments and did not have access to the child at risk register. Paper based risk assessments were completed in therapy services. We were told there was a

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section in the electronic record system but the some therapy staff were not familiar with the system. They did not know who would add an alert onto the record if safeguarding concerns were identified.

Commissioners in West Hampshire told us that the telemedicine system was proving successful for a selection of people with long term conditions. The patients and carer were less anxious and were able to monitor and send vital signs via an IT link where they were regularly viewed by a clinician able to take action as necessary.

Consent to care and treatment

The majority of staff we spoke with across the trust had a good understanding of the need to seek consent before carrying out care and treatment and patients confirmed that they had been given enough information to make decisions about whether to consent. Staff also had a good understanding of the Mental Capacity Act (MCA) and most had received training as part of the safeguarding training programme. However, some staff at Ravenswood House, Southfields, Bluebird House and Leigh House lacked an understanding and some staff at Bluebird House and Leigh House lacked an understanding of the Gillick competencies and Fraser guidelines. We saw that mental capacity assessment were being carried out and that these were appropriate and detailed although recording of assessments was not consistent or standardised across the trust. Advance directions were in place in learning disability services and adult forensic services which described how patients who were known to present challenging behaviour wished to be managed should their behaviours become difficult. We found instances where there was no record of mental capacity assessments being undertaken to assess patients' capacity to make decisions about their end of life care.

Assessment and treatment in line with Mental Health Act (MHA)

The Mental Health Act reviewers undertook eight routine MHA monitoring visits during the inspection:

- Kingsley ward, Melbury Lodge
- Hamtun ward, Antelope House
- Evenlode Clinic
- Ashford Unit, Woodhaven
- Meon Valley ward, Ravenswood
- Hill ward, Bluebird House
- Stephano Olivieri Unit, Melbury Lodge
- Elmwood ward, Parklands hospital

Separate MHA monitoring reports will be published in respect of the above. MHA monitoring reports specifically detail adherence to the MHA, as such judgements of compliance or non-compliance with Health & Social Care Act are not made. However, the reports do include issues that were found regarding seclusion and patient input into care planning as these issues are included in the MHA Code of Practice. MHA monitoring reports also include issues raised by patients who met the MHA reviewers during their ward visit.

More generally, we found that the trust had good systems in place to support the appropriate operation of the MHA and the Code of Practice. Documentation throughout the trust was mostly up to date and correctly stored. People were informed of their rights and updated about their rights every three months. There were clear notices on acute inpatient ward doors advising people of their position regarding leaving wards depending on their status. However, the seclusion of young people at Leigh House and Bluebird was not always consistently documented. The Code of Practice was not always followed when people had to be restrained or secluded and there was a lack of clear policies and procedures.

We found good use of community treatment orders with all records lawful and in place and good examples of assessments involving advocates and relatives in learning disability community services.

Are services caring?

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

Summary of findings

All staff that we spoke with across the trust were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hardworking, caring and compassionate staff.

In all of the areas we visited patients and families were overwhelmingly positive about the way staff communicated with them, the time staff took to listen and their caring nature.

The majority of patients were involved in planning their care and were given information to help them make informed decisions about care. In older peoples mental health services and learning disability services staff were using evidence based methods to learn more about patients to support them to be involved in their care. However, young people at Leigh House weren't as involved as they should have been in planning their care.

The majority of patients that we spoke with said that they received emotional support when they needed it through individual support or through group work and therapeutic programmes and activities.

The trust had introduced a 'recovery college' for people with mental health problems and staff working in mental health services. The 'college' offered courses designed to increase knowledge of recovery and self-management.

There were multi-faith rooms accessible throughout the trusts inpatient settings and a chaplaincy services which was available to all and not faith specific. Patients reported positive experiences of using the chaplaincy service.

Our findings

Dignity, respect and compassion

All staff that we spoke with across the trust were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hardworking, caring and compassionate staff.

We observed many examples of positive interactions between staff and patients throughout the inspection visit. For example, we observed that staff delivered care to children and young people in accordance with 'child and young person friendly' standards and took into account their age and specific wishes.

In adolescent inpatient forensic services we saw staff showing a high degree of tolerance, care and understanding even when young people where exhibiting extremely challenging behaviour. We saw older people with dementia treated with patience, kindness and consideration and staff recognised the support families needed in helping their relative to cope with everyday life.

Community health and inpatient health services were caring and there were examples of staff going the 'extra mile' to provide support to patients. We observed staff treating patients with dignity and respect in the community hospital wards, in clinics and in patients own homes.

Across mental health and learning disabilities services we saw patients being treated with kindness and empathy and this was supported by our discussions with staff, patients and their families.

The CQC Community Mental Health Patient Experience Survey 2013 identified the trust as in the worst 20% of trusts in relation to the indicator, 'the proportion of respondents who stated that the last time they saw a health professional or social worker the person did not treat them with respect and dignity relating to how caring staff were'. In addition, information from the Patient Opinion website (that offers people the opportunity to have meaningful conversations with providers) identified that patients had highlighted a lack of respect and dignity for patients. In contrast, the feedback from the trust's own patient's survey showed that the majority of patients said

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they were treated with dignity and respect by staff, 96% said they would recommend the service to a friend and 96% of all comments were positive. In all of the areas we visited patients and families were overwhelmingly positive about the way staff spoke to them, the time staff took to listen and their caring nature.

Involvement of Service Users

During the inspection we looked at whether patients were involved in decisions about their care. Most of patients that we spoke to said that they felt involved in making decisions about the care and treatment that they received and had been given enough information from staff to support them to make informed choices.

In addition, an abundance of information leaflets were available covering a wide range of subject areas, from information about specific conditions through to information about local support services.

In community health services we found overwhelming evidence of staff involving patients and families in their care and treatment and the promotion of self-care. We observed children and parents being involved in care planning, making choices and informed decisions about their care and treatment. Inpatients were engaged with their plan of care and agreed to their plans for discharge. On Ford ward at Fordingbridge Hospital this was formalised with invitations going to the patient and their representatives to attend a planning meeting. Following the meeting the patient was given a copy of the records of the meeting.

In mental health and learning disability services we found that the majority of patients were involved in planning their care and many had copies of their care plan. In older peoples services a variety of tools were used including, a 'my life story' document to learn about patients and encourage them to be involved in their own care planning. Some wards used a 'this is me' document to aid care planning and ensure people's holistic needs were identified. Community learning disability services in Oxfordshire and Buckinghamshire used 'mind maps' to support involvement in care planning. Inpatient forensic services had specific plans that ensured patients maintained contact with their families and friends. However, we found that young people at Leigh House were not encouraged to be involved in care planning or reviews and were also not involved in ward rounds that discussed their care.

Many wards and service areas held 'community meetings' and patients were encouraged to attend and share their views about good aspects of care but also how things could be improved. We saw that actions were taken as a result of contributions from patients. In some wards the improvements were displayed in the form of 'you said, we did' posters, similar to those provided on feedback forms from the trust's patient survey.

Advocacy services were available across the service and patients told us that there was good support from advocates in care programme approach (CPA) meetings. On the Patient Opinion website the trust was shown as receiving 2.7 stars out of 5 for providing information and involving patients in decision making.

Emotional support for people

The majority of patients we spoke with said that they received emotional support when they needed it through individual support or through group work and therapeutic programmes and activities.

The trust had introduced a recovery college for people with mental health problems and staff working in mental health services. The college offered courses designed to increase knowledge of recovery and self-management. Several patients who had attended the courses said they had found them invaluable in supporting them emotionally as well as providing helpful information to help them cope with their illness and daily living. The trust ran a 'memory matters' course in a number of locations across the trust that helped support patients with dementia and their carers. Courses were available aimed specifically at carers and held separately to those for patients. Memory advisors had been jointly employed by the trust and Age UK specifically to support carers and sufferers of dementia cope with living at home and also support them to access information and services that might provide emotional support. We received positive feedback about these services.

Patients in adult forensic services told us that they were 'buddied' with another patient on admission to help them settle into the ward. Throughout the inspection we heard about work done by the trust to support people with recovery.

Are services caring?

There were multi-faith rooms accessible throughout the trusts inpatient settings and a chaplaincy services which was available to all and not faith specific. Patients reported positive experiences of using the chaplaincy service.

One of the questions on the trusts patient survey specifically asked about whether family and friends were

provided with support. Result for the three months leading up to August 2014 showed that 70% thought that appropriate support was provided, whilst only 8% said that it wasn't sufficient.

Are services responsive to people's needs?

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

Summary of findings

The trust worked closely with commissioners, local authorities, people who use services, primary care services and other local providers to ensure it understood the needs of the population it served in order to plan and deliver services.

The reorganisation that has taken place in community health services to create integrated community teams was positive and provided improved care for patients, although not having social workers in the team caused delays in accessing their services.

We saw many examples of how the trust respected people's diversity and human rights. The trust provided people using services with information about how to complain and complaints were generally responded to in a timely manner. Staff told us they received feedback about complaints and that actions were taken as a result of complaints.

Accessing mental health crisis services was difficult. Staff and patients were confused as to how and who provided crisis services, particularly out of hours. Staff said that they thought that in the future home treatment teams would provide crisis services but they didn't at present. Community mental health teams (CMHTs) said that providing a crisis service out of hours was impossible as the CMHT service only operated during core hours. Patients and their families told us of their frustration at being given a telephone number but never receiving an answer when they called it. There were no crisis services provided for older people; the trust was not commissioned to provide these services.

There were concerns about access to section 136 suites; the suite at Elmleigh had been closed for 27 days over a three month period. There were long waits to assessment from approved mental health professionals and on all suites patients were often not routinely seen by a doctor on admission to establish whether the patient had a mental health problem.

We found that the seclusion room at Hamtun ward (PICU) at Antelope House was not fit for purpose. It was located in the middle of the ward so other patients and visitors could see who was being placed in seclusion. It did not meet the requirements of the Mental Health Act Code of Practice.

Our findings

Planning and delivery of services

The trust provided care over a large geographical area and a range of clinical commissioning groups (CCGs) commissioned the provision of care. This meant that there was a variance in the different localities as to what the trust provided. We saw that there were different initiatives and services offered to people in each locality. NHS England commissioned forensic services.

The trust worked closely with commissioners, local authorities, people who use services, primary care services and other local providers to ensure it understood the needs of the population it served in order to plan and deliver services.

Community health teams and older people mental health teams had been brought together to form integrated teams. The integrated care model was based on local demographics and patient's clinical need. Some of the community teams were co-located with older people's community mental health teams. However, social workers were no longer working as part of the team (Local Authorities had removed them), which was seen as having a negative effective on the speed at which patients were be seen by a social worker. Where teams had been reorganised and received investment, following recognition of a local problem, there had been significant improvements in patient outcomes. Staff told us that the reconfiguration had improved the way they worked with colleagues in other services and across the trust.

As a result of reorganisations and investment we saw that clinics across community health services were being extended to offer a more accessible service. The rapid assessment clinic in Winchester was being extended to

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offer a service up to 18:30hrs and had weekend opening hours. Additional staff had been recruited to enable this improvement designed to prevent unnecessary admissions to hospital. In addition, there was an in-reach service provided to secure early discharge from hospitals. The service was flexible and seen as effective. The service could help to develop urgent packages of care at home for people who were at risk of falling.

The local population and patients attending the MIUs appreciated having an urgent care service close to home where they could be seen quickly.

Inpatient services were also changing to deliver service differently. The feedback from a consultation with local area patient groups and organisations was shaping new models of service at Lymington New Forest Hospital. At Fordingbridge Hospital the trust was working with commissioners to reduce the number of beds to improve patient care and to recruit a community geriatrician who would work in the community but who would provide specialist support the ward at Fordingbridge.

At Alton Hospital the trust had worked with GPs to secure their input so that Rowan ward could be reopened. The trust identified that it had a high Nepalese population in Hampshire; 25% of the population. As such, it had worked with commissioners to deliver appropriate services to Nepalese children and their families. Healthy eating and accessing services were highlighted as areas of concern. A school nurse spent time in Nepal with a Nepali family to gain insight into their daily living needs. This has resulted in the translation of letters being sent to Nepali parents after a possible problem was identified.

Mental health services were being reorganised to provide more support for people in the community. Community mental health teams provided crisis services and were 'gatekeepers' for admission to the hospitals. Hospital at home teams were being established to provide intensive care to patients in their own home when they were most unwell and provide access to hospital beds if needed and support patients on discharge. However, staff told us that the hospital at home team just supported discharge and didn't provide an admission prevention or crisis service. We were told that there were plans to extend the service later in the year and they would then provide a crisis response service.

A new mental health pathway for working age adults had been developed but staff told us they found it difficult to understand which service should be delivering which services and were concerned that there were gaps in service.

Commissioners had identified that there wasn't enough health based places of safety (S136 suites) at the trust; this was highlighted as a risk on the trusts risk register. The S136 suite at Elmleigh was also used for seclusion which meant that if the suite was being used for seclusion it would be closed to S136 admissions; patients would then be detained in police custody. The suite had been closed 27 times during the three months prior to our inspection.

We found that the seclusion room at Hamtun ward (PICU) at Antelope House was not fit for purpose. It was located in the middle of the ward so other patients and visitors could see who was being placed in seclusion. There was a 'blind spot' that prevented observation when patients were accessing the toilet facilities. The nurse undertaking observation was stationed within the ward office so could easily be distracted. There was no window in the door to the seclusion room so the nurse undertaking the observations could not provide reassurance or verbal de-escalation as needed. This was contrary to the MHA COP.

Throughout the trust there were generally appropriate arrangement to provide single sex bedrooms and bathroom facilities. However, at Gosport Memorial Hospital we found that guidelines relating to same sex accommodation were not being followed. There were no specific zones for men or women and toilets and bathrooms were unisex. We raised this with the trust at the time of the inspection and immediate action was taken to rectify the situation. We undertook an unannounced visit a few days after our main inspection and found that appropriate action had been taken to rectify the issues. In addition, toilets at Parklands Hospital were labelled as unisex and we saw that women used bathrooms in the male corridor.

The perinatal service provided care that was responsive to people's needs and the service was named Psychiatric Team of the Year 2013 by the Royal College of Psychiatrists in recognition of the way it worked to responded to individual needs.

Are services responsive to people's needs?

Diversity of needs (equality and diversity and human rights)

The trust had a real commitment to ensuring a positive culture relating to equality, diversity and inclusion throughout the organisation. Nominated staff from each division sat on the equality impact group which was responsible for ensuring the trust met the requirements of the Equality Act 2010 and other legal and regulatory requirements, plus the requirements of the commissioners. There was a network 350 diversity champions from all teams across the trust to help communicate and embed the work and equality impact leads (EILs) in each clinical service. The equality and diversity team had designed an equality standard. The EILs submitted evidence that demonstrated how their service was meeting the standard and could be judged to meeting the standard at bronze, silver or gold level. In 2013/14 55 clinical services across the trust had qualified for a bronze level award. Throughout the trust we found that people's diversity needs and human rights were respected.

We found that every effort was made to meet people's individual needs including, cultural, language and religious needs. Contact details for representatives from different faiths were on display and the trust had information leaflets that helped patients understand how to contact representatives of their faith, interpreters, or advocates.

Communications, including letters to patients could be provided in a person's own language, large print for people with visual impairment or in easy read versions. The trust has a zero tolerance policy towards all types of abuse.

A choice of meals was available on wards. A varied menu enabled patients with particular dietary needs, including religious and dietary preference, to access appropriate food and drink.

Right care at the right time

Between January and March 2014 the trust's bed occupancy for all types of beds was 83% compared to the England average of 87%. However, in community health services inpatients it was 95% for this period and 84% in mental health services. It is generally accepted that any rise above 85% can affect the quality of patient care and access to beds.

Wards at Lymington Hospital (Knightwood, Deerleap and Waverly 2), Gosport Memorial Hospital (Sultan ward), Parklands Hospital (PICU and Willow ward), Leigh House,

Bluebird House, the Ridgeway Centre and the mother and baby perinatal unit all had bed occupancies below 60%. However, all delivered very specialist services so the complexity of care delivered may constitute a lower bed occupancy in order to ensure services are safe and of good quality.

The Department of Health publishes monthly data relating to delayed transfers of care across acute and non-acute NHS trusts, including the number of days and the number of patients who experienced a delay each month. Information from our intelligent monitoring system showed that both the number of days delayed and the number of patients experiencing a delay was variable over the period July 2013 to July 2014. In both cases there was a peak in the summer of 2014 with dips either side of this period with a rapid decline in July 2014.

In community health services the effects of being short of staff in some areas meant there were negative consequences for patients. We found there were very long waits for therapy staff to commence treatment or rehabilitation. At Petersfield community team there were long waiting lists for therapy assessment with patients waiting from April to October 2014. Staff told us that staffing concerns had been placed on the risk register as they could not meet demand. In other areas waiting lists to be seen by a therapist was over three months. Staff in some teams told us this had been a problem in the past but due to additional staff appointments and waiting list 'cleansing' and management the situation was now better controlled and wait times were around nine weeks.

There were some long waits for assessment prior to equipment being ordered. Some therapy staff said waiting time for routine physiotherapy assessment for equipment was at least four months with urgent assessments waiting four weeks. For occupational therapy (OT) equipment routine assessment waits was four weeks and urgent assessment was one week. Equipment delivery then usually took about five to seven days but we were told this could be up to three months.

There were many community health teams whose key focus was to either prevent hospital admission or promote early supported discharge. These services such as community stroke teams, rapid response teams and access units were established to promote patient's independence at home and reduce inpatient admissions. Referrals to the Fleet rapid response teams were by

Are services responsive to people's needs?

telephone, fax, and email. Two trained nurses within the team completed assessments. Staff respond within two hours. Staff were health care assistants who had core occupational therapy, physiotherapy and nurse training. They provided health and personal care and monitored the situation and were able to identify when additional intervention was required. The service operated 365 days a year 8.00am to 9.00pm. An evening shift (twilight team) was also available if needed. This meant that patients could stay at home with a quickly arranged package of support and treatment rather than be admitted to hospital. The rapid access unit in Lymington took referrals on the day of request. Patients with suspected venous thromboembolism or cellulitis skin infection were provided with diagnostic testing and commenced on treatment by specialist nurses. The team had clear protocols to enable nurses to complete testing and commence treatment without referral to medical staff. Treatment was continued for patients with daily visits to the clinic for injections and monitoring. This meant that patients with certain blood clots or infections did not have to be admitted to hospital.

The pre-assessment service for patients undergoing day surgery at Lymington New Forest Hospital was disjointed. The availability of this service was only for patients having a general anaesthetic, not patients who were going to have a local anaesthetic. The process meant that patients were required to make two to three visits to the hospital for the full process to be completed, rather than it being a 'one stop shop' process. There were occasional issues with operations being cancelled at short notice at Lymington New Forest Hospital, due to lack of communication from surgeons. At the MIUs at both Lymington and Perterfeild Hospital there was limited access to x-ray services which meant that staff referred patients to attend other emergency departments or asked them to return the next day. Fracture clinics were available at Lymington but not at Petersfield.

Staff had set up wellbeing cafes to support people who were housebound. Patients could have leg ulcers and physical health needs assessed but also benefitted from the opportunity of socialising and attending talks on health and welfare advice. The trust funded the transport to support the initiative.

In mental health services staff told us that the local community mental health teams provided a crisis service and were the 'gatekeepers' for admissions to the hospital.

From April 2014 to August 2014 the community mental health teams undertook crisis assessments, during the day, within four hours of referral for 90% of referrals. However, at night only 67% of referrals were seen within these timescales. Accessing mental health crisis services was difficult out of hours and staff and patients were confused as to how and who provided crisis services. Patients and their families told us of their frustration at being given a telephone number but never receiving an answer when they called it. Some staff and patients told us that the teams were under resourced and that visits were often short. There was no crisis service for older people outside of office hours and patients were reliant on GP support. However, the trust was not commissioned to provide crisis services for older people.

Hospital at home teams supported patients on discharge from acute inpatient wards and did not provide a crisis or admission prevention service. People were seen within 48 hours of discharge, with the frequency of subsequent visits varying from daily to once a week. The teams provided a service from 9am to 5pm seven days a week. There was no out of hours service, and there was a reduced service provided at weekends. There was no direct telephone number for people using the service, but people told us they contacted the service through the switchboards at the hospitals.

The trust had a central number for the police to call when a person was placed on a Section 136; the most appropriate suite was then identified based on where the person lived and the availability of the suite. At Elmleigh the S136 suite had been closed on 27 occasions in the previous three months due to the suite being used for seclusion. In addition, there were some long delays in obtaining an approved mental health professional (AMHP) to assess patients on admission. Records showed that between June and August 2014 AMHPs took more than 12 hours to attend the place of safety on 12 occasions. On one occasion an AMHP took 43 hours and 50 minutes to arrive to assess the person. There was also a lack of triage on admission by a doctor which caused delays to discharge from S136 where there is no evidence of mental disorder. On average, patients spent 29 hours in S136 waiting for an assessment or a bed to become available on an acute admission ward. There were no S136 suites in the area for people under the age of 18 years: a dedicated service is provided at Northampton Hospital.

Are services responsive to people's needs?

In learning disability services the intensive support team in Buckinghamshire was meant to provide a 24 hour service but at the time of the inspection support at night and weekends was provided by inpatient services. For the assertive outreach teams the length of intervention varied. In Buckinghamshire the interventions lasted between four and 17 months at which point patients were transferred back to the community learning disability teams. Data submitted by the trust on the actual average time from a person being referral for assessment for the period January 2014 to June 2014 showed that out of 114 mental health and learning disabilities locations 33 (29%) had average referral to assessment times above the target of 18 weeks.

There were clear pathways for referral to eating disorder services and perinatal services and assessment and treatment was prompt. The adult eating disorder services were commissioned in such a way that allowed flexibility and enabled the opportunity to undertake preventative work. The perinatal service responded to 100% of referrals from community mental health teams and referrals had doubled in the last two years; those requiring urgent care would be triaged by telephone and then prioritised. Mothers using the service said they had an extremely prompt and excellent response.

There was good access, within appropriate timeframes, in both adolescent and adult forensic service. However, discharge planning did not routinely start on admission in adolescent services and the trust did not have a transition policy to support young people moving to adult services. Despite this, there was a good success rate in moving young people to less supportive services and adult services.

Staff told us that a referral to the child and adolescent mental health services (CAMHS) was often very difficult with children and young people having to wait a considerable time. The service had a referral to assessment target of 65 days but we found that waits could be considerably longer; up to 90 days in some localities. School nurses said they worked alongside the CAMHS team which helped them to support children and young people whilst making the referrals. The trust did not deliver CAMHS.

From data submitted by the trust, there had been a total of 304 readmissions across 29 wards within 90 days (no precise time period given). The locations with the highest

number of readmissions were: Limington Hospital (medical assessment unit), Elmleigh, Melbury Lodge (Kingsley ward), Parklands Hospital (Hawthorns 2), Antelope House (Trinity and Saxon wards).

Learning from concerns and complaints

The trust received 470 written complaints between April 2013 and March 2014, 71 more than the previous year. Of the 470 complaints 46% were upheld; 31% of these complaints related to aspects of clinical treatment. Comments on NHS Choices identified a lack of response to complaints as something the trust could improve upon. However, in April 2014 the trust responded to 94% of complaints within three days. Since August 2013, the Parliamentary and Health Service Ombudsman (that investigates complaints when people feel that their complaint has not been dealt with adequately by trusts), made two recommendations that the trust were required to produce action plans for; a failure to properly explain diagnosis/failure to explain a communications plan in place and a lack of clinical documentation and supporting evidence of risk consideration and psychological assessment.

In all the services we visited we saw that information was available on how people using services and their families could complain should they wish. The trust website had clear information of the process. Patient advice and liaison services (PALS) were available throughout the trust to support patients and their families to complain.

In learning disability, in patient forensic and adolescent inpatient and forensic services the use of advocates was encouraged and would support patients to raise concerns and complaints if they needed.

A number of people we spoke with during the listening events we carried out prior to the inspection said that they'd had a poor experience of reporting complaints to the trust. Some said that they hadn't had a satisfactory response from the trust about how their complaint would be investigated. A number felt the trust was very defensive and not as open as it should be. However, most of the patients we spoke with during the inspection told us that they knew how to complain and that they had been provided with information, including written material on how to complain and felt their concerns would be taken

Are services responsive to people's needs?

seriously. Some said they would ask staff if they wanted to make a complaint. A small number of patients in forensic inpatient services said they had not received a response to complaints that they had made.

The trust kept records of all complaints that it received which detailed the action being taken to investigate the complaint. However, we found that no records of complaints received at ward level were kept in learning disability services.

Staff told us that complaints were fully investigated and learning was fed back at team meetings. Notes of minutes of team meetings evidenced that learning and actions arising from complaints were discussed and actions taken as a result.

Are services well-led?

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

Summary of findings

Although the trust had developed a clear vision and understanding of what was required to achieve the vision, many of the initiatives to achieve the vision were at the early stage of implementation and not fully embedded across the trust.

Most staff were signed up to the values of the trust, generally proud to work for the trust and positive about their work. However, we spoke to some staff that had little knowledge of the vision and some staff felt they weren't listened to.

Several of the executive and senior leadership/management team were relatively new in post and still working to establish their role and gain the support of staff.

There were many challenges facing the trust in developing the right culture and managing a large change programme. The main challenges were around the scale and complexity of implementing change in a large organisation, the timescales to deliver these and ensuring staff were signed up to developments. Many staff said the pace of change was having a significant effect on their ability to fully embed the changes. Some staff and stakeholders identified a disconnect between those delivering services and senior managers at both divisional and trust level. However, there was strong and committed leadership from the board, the executive team and senior managers.

The trust offered a range of opportunities for patients to influence developments and to provide feedback about their experience of receiving care. There was evidence that feedback was being used throughout the trust to improve care.

Our findings

Vision and strategy

The trust had a clear vision and a set of values developed in consultation with staff, patients and external stakeholders. The trust had a clear ambition to put quality at the centre of all that it did and as such had developed a set of strategic objectives and goals and a number of specific strategies to ensure delivery of the vision. For example, trust wide strategies such as the quality governance strategy, workforce strategy and estates strategy and related policies and procedure and a number of divisional/service strategies and plans.

The trust had commissioned the King's Fund to evaluate whether culture changes had taken place over the last two years since the introduction of the vision, values and related changes. The survey result showed that over 70% of respondents (staff) agreed that there was clarity about organisational goals and over 85% agreed that the trust had a strong commitment to high quality care.

A quality governance strategy 2014–2016 had been produced and set out a number of patient centred quality improvement goals for the next two years. Its aim was to promote a culture of continuous improvement where every member of staff had the pride, confidence, compassion and skill to champion the delivery of safe and effective care. The quality programme was developed to support the trust to realise vision but only commenced in June 2014, so was in its infancy. We asked staff, during focus groups and interviews, whether they knew about the vision and strategies to achieve the vision. A large number of staff across the trust knew about the vision and strategic direction but recognised that it was early days in terms of implementation and that it would take time to achieve change.

Staff working in older peoples mental health and community health services generally welcomed the direction of travel to integrate the service and staff in community healthcare services and told us of the effective teamwork that had developed as a result of integrated teams.

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A number of staff said that changes being implemented were positive but some felt the pace of change was too fast to embed a change in culture and practice that would benefit patients. Staff also said there were gaps in the vision and strategy for some services such as the minor injuries unit, end of life care and community health services that were faced with increasing demands for services outside of traditional hospital settings and for services for patients with complex needs.

There was a clear vision and strategic framework comprising of an evidenced based five point plan to embed equality, diversity and inclusion across the trust. The trust had won several national awards for its work and had developed a reputation as a national leader in this field.

Governance

In November 2013, in response to a number of regulatory concerns, the trust commissioned an external review of the board governance and quality governance arrangements from Deloitte LLP. The greatest risk identified was the risk associated with maintaining board oversight and control during a period of significant change with the trust moved towards a model of integrated services, a new divisional structure and greater divisional autonomy. As result the trust has made several changes to its governance framework to strengthen its arrangements to maintain the oversight needed. However, many of these changes were at an early stage of development and implementation.

The trust board had been strengthened with the appointment of new non-executive directors and a number of new executives who were accountable for running the trust. In addition, there was a Council of Governors, which included public, staff and appointed governors, to represent the public voice.

A clear governance infrastructure had been introduced that provided assurance at every level of the trust, from team meetings, service/area meeting through to divisional groups, divisional boards and various board committees which fed into the trust board. Strengthened reporting arrangements through specific board committee existed to deal with quality issues whilst other committees monitored performance. Where performance issues, such as workforce or finance, had a direct impact on quality the issues would be considered by all relevant committees so the full range of issues would be addressed.

The quality improvement and development forum (QID) was responsible for delivery of the quality programme. Eight priority areas had been identified including, quality governance structure in the divisions, reporting and organisational learning, peer reviews, estates readiness, record keeping and care planning, medicines management, workforce and patient experience. A workstream group had been established to lead the delivery of quality improvement plans for each of these and reported monthly on the outcomes achieved to date to the QID.

Risks were mapped to each of these eight priority areas and reported to the relevant groups or committees; high level risks were reported against the priorities through the new board assurance framework (BAF). Each division and service area had its own quality and safety group, which was responsible for identifying concerns and implementing learning at a local level. Discussions with staff evidenced that these groups provided an opportunity to raise issues through the governance structure through to trust board, as well as an opportunity to receive information and feedback from the trust board.

In addition, the QID monitored delivery against the priorities set out in the quality account and the quality schedules which formed part of the contract with commissioners and reporting to Monitor. The trust had identified gaps in relation to monitoring both trust wide and divisional quality improvement plans generated as a result of external and internal learning opportunities and those at team level, such as those written in response to serious incident or complaints. The trust was undertaking a review of action planning processes across the trust to ensure all of these would be picked up and monitored in the future.

A system of peer review had recently been established. The process involved a small peer review team, from another service or area within the trust, visiting a ward or team and assessing it against set of criteria. The reviews were reported using the CQC domains of safety, effectiveness, caring, responsiveness and well-led. Staff told us that reviews had helped teams make improvements. For example, a review identified that average length of stay at Anstey ward at Alton Hospital was 28 days which, in comparison with other community health hospitals, was much longer. This prompted an internal review that

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identified concerns about leadership and quality of care, which resulted in suspending admission for a period of time, and bringing in a senior team to turn the service around.

However, some staff felt that only minor issues were being identified through the peer reviews and this could mean that the trust was not made aware of major issues that needed senior management intervention to make improvements. For example, reviews of older people's community mental health teams did not identify staffing issues as a risk although this featured on the divisional risk register.

In addition to peer reviews, 'matron's walk audits' were completed monthly in community health services. The audits followed a similar process to the peer reviews. The results were translated into an easy read document highlighting areas for improvements and positive observations.

Leadership and culture

Throughout our inspection visit it was clear that there were real challenges that faced the executive team in providing strong leadership to the organisation. The trust was one of the largest trust in England covering a wide geographical area and provided a significant number of different services from multiple locations.

There had been a number of high profile incidents that had proved challenging to manage, some still on-going, and the trust had received some negative press. For example, at the time of the inspection Verita were undertaking an independent review into commissioning, assurance and governance of learning disability services in Oxfordshire in response to a tragic death at Slade House in July 2013. A previous external review had found that the death had been preventable but the trust had initially failed to arrange an external review. The trust had since reconfigured its services in Oxfordshire, closed inpatient services at Slade House and made several changes to improve services. A special committee of the board was in place to oversee the turnaround of the services. However, staff, patients and carers still had concerns about the way the trust was dealing with the situation and the changes to services; it was clear this was impacting significantly on their welfare. The uncertainty about whether the trust would continue to deliver services in the future was affecting staff morale.

The scale of change and range of developments was not always known or appreciated by staff and therefore some staff were negative about the leadership of the trust. However, we found strong and committed leadership from the board, executive team and senior managers. There was a clear vision for the future and a thorough understanding of what needed to be done to achieve the vision. The chief executive was passionate about developing the right culture to underpin the delivery of good quality care and services and this was translated into a real commitment to investment in supporting staff to develop at all levels. Several of the executive directors were relatively new in post but were clear about their roles and what was required of them in relation to implementation of the programme of change. However, several were still working to establish their roles and gain the support of staff.

Whilst we found strong strategic leadership, professional leadership still needed strengthening. Many nurses told us that there was a lack of professional leadership and that the current system of having professional leads was not effective in some areas and was confusing. Allied health professionals were concerned at the lack of professional leadership, which was provided by the director of nursing and allied health professionals. During a focus group with a large number and wide range of allied health professionals they said they felt senior professional leadership should be provided by someone with an allied health professional background in order to understand and fully realise the contribution they could make to the trust. They said that at present the trust wasn't making the most of what they could offer. The director of nursing and allied health professionals told us that she was developing plans to strengthen professional leadership for both nursing and allied health professionals. In addition, some medical staff that we spoke with told us that they were not engaged with senior clinical leaders and felt neglected as a result of service changes and expansion.

The chair and non-executives had a strong understanding of the issues the trust was facing and provided positive challenge to the executive team. As a result of a challenge about the quality of care and the framework of reporting information to provide assurance of the quality of care and the risks facing the trust a new board assurance framework (BAF) had been developed.

Are services well-led?

In most of the teams we visited we found that staff felt proud of working for the trust and positive about their work. They spoke openly about the challenges facing the trust but were keen to support the trust to improve the quality of services. In the focus groups we held staff were positive about the culture within the organisations although several said that the quality of leadership in some of the teams and at divisional level was variable and some senior managers lacked experience.

Staff working in adult forensic mental health services said there was a lack of senior management input into their services so didn't feel there was clear leadership. They also said that there was a lack of understanding at senior level within the trust as to what was happening on a day to day basis in services. However, in community health services for adults staff said leadership at divisional director level was very good and in children and family services staff said leaders modelled and encouraged cooperative, supportive relationships and compassion towards children, young people and their families that used services.

During the inspection we found some variation in the quality of care provided by the divisions and also within the services delivered by the divisions. This was, on some occasions, reflected in the quality of the leadership of those services.

We received positive feedback from external organisations that worked with the trust. We were told that the senior leadership team was open and honest in sharing information and working together to address concerns. They said that the latest senior management reorganisation had shown benefits in terms of engagement which had increased significantly over recent months. Clinical commissioning groups (CCGs) welcomed the engagement and commitment of senior leaders at the monthly clinical quality review meetings. However, some felt there was still a disconnect between local management and senior managers at both divisional and trust level.

Engagement with people and staff

Patient and public engagement

The trust had a number of ways to engage with patients. It had a range of patient groups and forums across a several services which it encouraged patients to get involved in.

Prior to the inspection we attended a number of these groups to seek feedback from patients about care delivered by the trust. Patients attending these groups/forums were positive about the care they received.

As a foundation trust patients were encouraged to become members of the trust and become more involved with the trust. Members were provided with access to a member's website and received a member's newsletter.

Most of the community health hospitals had very active League of Friends and fundraising committees with a large investment from the community in the community hospitals. There was also a commitment to engaging local communities in developing services. For example, at Lymington New Forest Hospital links had been developed with various local groups and organisations and they had been consulted on changes. This resulted in the production of a vision and strategy, 'Building on Success', for Lymington Hospital over the next 10 years.

The trust had embraced social media to communicate with patients and the public through its website, Facebook, Twitter, YouTube and had recently launched a 'Listening App'.

There was a patient advice and liaison service (PALS) which patient said provided a good service. The trust had developed its own patient survey. Patients were asked to complete a survey after their first appointment and on discharge and for longer term patients at their first appointment, every six months and then at the point of discharge. However, patients could provide feedback at any point during their care. In the three months prior to August 2014, 7,595 surveys were returned, 7,331 were positive and 264 were negative. From September 2014 patient experience results had been displayed on a page of the trust website. In addition, actions were also published in a 'you said, we did' format so patients could see what actions had been taken as a result of their feedback. A carer's survey also captured the experience of carers.

Throughout our inspection we saw examples of user involvement through ward and group meetings that provided opportunities to discuss what was happening in the service.

The Trust had a Council of Governors in place two of the eight governors had been elected within the last year. When we spoke with the council members some said that they were often not provided with the same information as

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the board so it was difficult for them to hold the board to account. Some said they had seen positive changes since the appointment of the current chairman who they described as open and engaging.

Staff engagement

We found a strong commitment to engage effectively with staff and the trust saw this as important in creating a culture where staff felt motivated and engaged in their work. The 'going viral' leadership development programme and the wide range of learning and development opportunities underpinned engagement with staff. The executive team undertook roadshows on a quarterly basis. At the time of the inspection 15 sites across the trust have been visited. Many staff had not had the opportunity to attend but we spoke to a small number of people who said they had found these useful as it was an opportunity to talk face to face with the executive team. Both the executives and non-executives undertook regular walkabouts.

A quarterly newsletter, 'Southern Health Journal', was produced and run by staff with the support of the communications team. Feedback from staff was encouraged. A weekly bulletin, pay slip attachments, web chats and web casts were used to provide news and updates on developments across the trust.

The trust had good procedures in place for staff to raise 'whistleblowing' concerns outside of their line management arrangements. It had a 'speak up' service which provided confidential and impartial advice. Each person contacting the service was allocated someone to handle their individual case so they would always speak to the same person after the initial contact and throughout any investigation. The service was confidential and provided impartial advice. Staff we spoke with knew of the service and felt confident about using it if they needed to.

In addition, the trust had an annual staff 'star award', undertook a staff friends and family test, staff surveys and held an annual staff conference. The council of governors also had staff representative. Staff spoke positively about the developments but said that the trust was so big that it was difficult to know about all the developments that were happening and some felt that there was a disconnect between front line staff and senior managers. The majority of staff knew who the chief executive was but had little knowledge of other members of the executive team, except when they had a direct connection. For example, all of the consultants knew who the medical director was.

Continuous Improvement

There was a clear commitment to continuous improvement and a commitment to developing a culture of learning and driving improvement through the use of information.

In July 2014 the trust introduced an information reporting system that provided information to all teams to support them in making improvements to their service. The system produced monthly reports called performance suites for teams which provided feedback on patient experience, workforce, patient outcomes, quality and safety issues such as incidents and restraint, financial and operational issues. In addition, individual members of staff received their team's results from the trust's patient experience survey. The trust was developing a system where teams would be able to build their own reports from a standard repository of information to support continuous improvement.

Staff across the trust were committed to improving experiences and outcomes for patients and all staff we spoke with had a focus on improving services. A number of staff said that they felt the trust was making progress in ensuring a focus on improving the quality of services. Quality dashboards at team and divisional provided monthly key performance information specifically relevant to the service being delivered. Service managers told us that this provided invaluable information to support discussions about resources to improve services.

In addition, local audits were being used to make improvements to services; community mental health treatment teams had undertaken audits of patients requiring additional physical healthcare needs as a result of their treatment and developed specific plans to address these. For example, those patients on high doses of antipsychotic medication. We found a particularly strong culture of innovation and continuous improvement in perinatal services.

There was recognition that some services were at the early stage of development in progressing audits and monitoring of service such as those services delivering end of life care. We also found that local audits had been carried out but had not identified poor practice. For example, during our inspection visit we identified poor practice in adult forensic services; environmental ligature risk assessments, audits of restraint and seclusion had been carried out but had not identified potential risks and where some risks had been identified action had not been taken to minimise the risk.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity

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

Regulation

Regulation 11 HSCA 2008 (Regulated Activities)
Regulations 2010 Safeguarding people who use services from abuse

How the regulation was not being met:

The registered provider did not have suitable arrangements in place to manage the restraint of young people.

There were no trust policies in relation to the restraint of young people. The records relating to restraint did not demonstrate that this was always managed appropriately.

The provider did not have regard to relevant guidance in relation to the appropriate use of methods of control and restraint in that adult of working age were not being afforded the safeguards of the Mental Health Code of Practice when subject to restraint or seclusion.

Regulated activity

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

Regulation

Regulation 9 HSCA 2008 (Regulated Activities)
Regulations 2010 Care and welfare of people who use services

How the regulation was not being met:

The registered provider did not have suitable arrangements in place to ensure the welfare and safety of young people.

The trust seclusion policy did not provide clear information in relation to the use of seclusion of young people. The records relating to seclusion did not demonstrate that periods of seclusion were always managed safely.

This section is primarily information for the provider

Compliance actions

The management of young people nursed on close observations, and general observations were not robust or recorded appropriately to demonstrate that young people were appropriately monitored.

Patients attending Petersfield MIU were not being provided with medicines to meet their needs

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities)
Regulations 2010 Staffing

How the regulation was not being met:

The registered provider did not have suitable arrangements in place to ensure that there were sufficient numbers of suitably qualified and skilled staff on duty at all times.

At Leigh House there were three staff on duty during the night. Across the staff team not all staff employed were trained in the use of restraint. This meant that people's needs could not be adequately met in the event of an incident.

The registered provider had not taken appropriate steps to ensure, that at all times, and there were sufficient numbers of suitably qualified and skilled staff on duty at Elmleigh to safeguard the health, safety and welfare of people using the service.

People who use community health services and others were not protected against the risks associated with insufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity:

- Vacancies and low staffing levels in some community teams was impacting on quality of patient care.
- There were delays in recruitment to fill vacancies.
- Waiting times for therapy services were affected by availability of therapy staff.

People who use services and others were not protected against the risks associated with insufficient numbers of staff in the specialist palliative care team and some community teams providing end of life care.

This section is primarily information for the provider

Compliance actions

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA 2008 (Regulated Activities)
Regulations 2010 Consent to care and treatment

How the regulation was not being met:

The registered provider did not have suitable arrangements in place to obtain the consent of service users in relation to the care and treatment provided.

There were no trust policies in relation consent for children and young people at Leigh House. The staff did not demonstrate a clear understanding of their responsibilities in relation to the Mental Capacity Act 2005 or Gillick Competencies which meant that capacity and consent for young people was not appropriately captured.

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA 2008 (Regulated Activities)
Regulations 2010 Respecting and involving people who use services

How the regulation was not being met:

The registered provider did not have suitable arrangements in place to ensure that young people were involved in all aspects of planning their care and treatment.

Young people at Leigh House were not routinely involved in care planning or ward rounds, so were not promoted to be involved in decisions made about their care and treatment.

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA 2008 (Regulated Activities)
Regulations 2010 Safety and suitability of premises

How the regulation was not being met:

This section is primarily information for the provider

Compliance actions

The registered provider did not have suitable arrangements in place to ensure that risks to young people within the environment were appropriately managed.

The seclusion area of Leigh House had a number of ligature risks that had not been assessed or minimised to reduce risks to young people.

The provider had not ensured that people who use the service were adequately protected against identified risks posed by unsafe or unsuitable premises in relation to environmental ligature risks in mental health services.

The registered person must ensure that service users and others of mental health services have access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of:

- suitable design and layout:

The trust must assess and remove ligatures at the Ridgeway Centre, complete the removal of ligatures at Evenlode, provide sufficient rooms with observation panels at the Ridgeway Centre, provide observation mirrors to improve the line of view at the Ridgeway Centre, ensure male service users can move around the building safely at the Ridgeway Centre and provide a secure external fence at Evenlode.

The registered provider had not ensured that people were protected against the risks associated with unsafe or unsuitable premises. At Elmleigh, essential work needed to remove ligature risks from people's bedrooms had not been carried out in a timely manner; and on Hamtun ward, at Antelope House, the design of the seclusion room did not allow continuous observation of the person inside by staff

Regulated activity

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

Regulation

Regulation 16 HSCA 2008 (Regulated Activities)
Regulations 2010 Safety, availability and suitability of equipment

How the regulation was not being met:

This section is primarily information for the provider

Compliance actions

The provider had not made suitable arrangements to protect people from the use of unsafe equipment as staff were not aware of the procedure for replacing single use ligature cutters and single use ligature cutters had not been replaced once their seal had been broken.

The provider had not ensured that equipment was available in sufficient quantities in order to ensure the safety of service users.

The registered person had not ensured that there was sufficient emergency equipment available to ensure the safety of people on the acute admission wards at Elmleigh. There was one emergency 'grab' bag (equipment used for resuscitation and treating anaphylaxis) and one automated external defibrillator in the unit which was not easily accessible to the acute wards. Consequently there was a risk to people's health and safety in an emergency.

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities)
Regulations 2010 Assessing and monitoring the quality of service providers

How the regulation was not being met:

The registered provider had not protected people at risk of inappropriate or unsafe care. There was not an effective system to ensure that all staff were aware of incidents either in their service or in other relevant services provided by the trust in order to reflect on this information and make changes to the treatment or care provided.

The registered person had failed to take action to protect people against the risk of unsafe care and treatment by means of the effective operation of systems designed to identify, assess and manage risks to the health, welfare and safety of people using the service. At Elmleigh although systems were in place to assess and identify poor performance and risks they were not always effective in bringing about improvements.

This section is primarily information for the provider

Compliance actions

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 23 HSCA 2008 (Regulated Activities)

Regulations 2010 Supporting staff

How the regulation was not being met:

The provider had not ensured that staff had received appropriate training to enable them to deliver care and treatment to service users safely and to an appropriate standard.

The trust had not provided training, especially to support workers on caring for people with a learning disability, autism awareness, communication skills, training on mental health including how to support people with a personality disorder.

The provider had not ensured that persons employed for the purposes of carrying on a regulated activity were appropriately supported in relation to their responsibilities.

The ward manager and staff team at Evenlode had not received regular interim line management support in the absence of their usual line manager.

The registered provider did not have suitable arrangements in place to ensure that persons employed were appropriately supported to undertake their responsibilities effectively.

The staff working in Oxfordshire and Buckinghamshire did not know the names of senior staff and many had not met those staff. Staff felt that the culture and approach of the trust was inflexible and top down and did not feel valued.

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA 2008 (Regulated Activities)

Regulations 2010 Management of medicines

How the regulation was not being met:

The provider had not protected people against the risks associated with the unsafe use and management of medicines

This section is primarily information for the provider

Compliance actions

The trust had not ensured at Evenlode that treatment rooms are designed to facilitate the safe administration of medicines.

The trust had not ensured at Evenlode and the Ridgeway Centre that Controlled Drugs were stored in accordance with trust policies.

Community health services

Controlled medicines were not always stored securely in accordance with the trust's own policies and procedures.

Controlled medicines were not always stored in a manner that ensured patients were protected from the risks of administration of incorrect doses.

Monitoring of drug fridge temperatures did not provide assurance that medicines were stored at a temperature that ensured their effectiveness.

FP10 prescription pads were not managed securely

There was no audit trail to ensure that FP10 prescription pads were being used appropriately and safely.

In some community bases there were expired medicines available for use. Medication ordering was not dated and no routine stock checks undertaken.

The cupboards for storage of medicines at Lymington MIU did not comply with the trust's own policies and procedures.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 20 HSCA 2008 (Regulated Activities)
Regulations 2010 Records

How the regulation was not being met:

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were not always completed correctly. Information about the basis for decisions for DNACPR, involvement of the patient and family and mental capacity assessments were not always documented.