

Southern Health NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Wards for People with Learning Disabilities	Ridgeway Centre	RW1ZZ
Wards for People with Learning Disabilities	Evenlode	RW1Z8
Mental health crisis services and community mental health services for people of working age (Southampton)	Antelope House	RW1GE
Mental health crisis services and community mental health services for people of working age (Southampton)	Trust Headquarters	RW146
Acute Wards for adults of a working age and psychiatric intensive care units	Antelope House	RW1GE
Acute Wards for adults of a working age and psychiatric intensive care units	Parklands Hospital	RW1AC
Acute Wards for adults of a working age and psychiatric intensive care units	Elmleigh	RW1AM
Acute Wards for adults of a working age and psychiatric intensive care units	Melbury Lodge	RW199

Summary of findings

Child and Adolescent mental Health Wards	Trust Headquarters - Bluebird House	RW146
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Child and Adolescent mental Health Wards	Leigh House	RW121
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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.

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Ratings

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

Overall rating for services at this Provider

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

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.

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Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

Our remit in this inspection was to:

- review the trust's governance arrangements and approach to identifying, reporting, monitoring, investigating and learning from incidents with a particular focus on deaths, and review how the trust was implementing the action plan required by Monitor in light of Mazars review;
- review how the trust was implementing the Duty of Candour;
- review the trust's approach to managing complaints;

follow up on the improvements required from previous CQC inspections.

Summary of what we found and the action we took as a result

- We found that the trust had not put in place robust governance arrangements to investigate incidents. As a result, the trust had missed opportunities to learn from these incidents and to take action to reduce the likelihood of similar events happening in the future.
- The trust had not put in place effective arrangements to identify, record or respond to concerns about patient safety raised by patients, their carers, staff or by the CQC. We found examples of this in a number of the trust's mental health and learning disability services. Where the trust and others, including CQC had identified risks to the delivery of safe care arising from the physical environment, the trust had not ensured that these risks were mitigated in a timely and effective way. The trust had also failed to identify, record or respond effectively to staff who expressed concerns about their competence to carry out their roles.
- These key risks, and actions to mitigate them, were not driving the senior management or board agenda.

- We asked the trust to take immediate action to ensure the safety of patients at Evenlode and Kingsley ward at Melbury Lodge. We served a warning notice that informed the trust that:
 - it must make significant improvements to protect patients from risks posed by some of the mental health and learning disabilities ward environments
 - It must put in place effective governance arrangements to ensure robust investigation and learning from incidents, including deaths, to reduce future risks to patients
- We required the trust to provide CQC with a report by 13 April 2016 setting out the actions it will take to become compliant with Regulation 17 (2) (a) (b). Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 imposes a legal duty on the trust to ensure good governance.

The trust's response

- The trust did not challenge the warning notice. It identified a number of actions that it had taken because of issues raised by CQC during, immediately following the inspection and in response to the warning notice. For example, it wrote to us describing the improvements it had made at Kingsley ward at Melbury Lodge, including increasing staffing levels and security and reviewing environmental risk assessment. It also described improvements it has made to its governance arrangements for reporting, investigating and learning from incidents and deaths; for example, ensuring the initial management assessment completed following an incident contains all relevant information from the patients care records, ensuring the investigation process has clinical and senior oversight and implementing a variety of methods to share learning with staff across the trust.

Review of incidents, including deaths

- Following the publication of the Mazars report, the trust accepted that the quality of its processes for reporting and investigating the deaths of patients needed to be better. In response to the

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recommendations of the report, the trust developed a mortality and serious incident action plan. Monitor (now NHS Improvement), clinical commissioning groups and NHS England were overseeing this.

- On 1 December 2015, the trust introduced a new, trust-wide system for reporting and investigating deaths. Its purpose was to improve the quality of reports and investigations, increase monitoring and scrutiny and ensure that the trust shared learning with all staff. From 1 December 2015 to the date of our inspection, the trust identified that it had reported and investigated 74 deaths through its new system.
- We reviewed a random sample of 58 investigations into deaths and four investigations of other serious incidents. These were drawn from a range of services, not just mental health and learning disabilities and had occurred between April 2015 and February 2016. We found that the quality and detail of the incident reports (reports on the electronic incident reporting system) and initial management assessments (IMAs) varied considerably. Some of the reports we reviewed were the result of a comprehensive investigation and adequately reflected the information available in the care records. However, in a quarter of initial management assessment reports that we reviewed, we found deficiencies relating to one or all of the following:
 - the accuracy and/or detail of the content of the IMA did not adequately reflect all the relevant details relating to the death/incident in the care plans;
 - the review had not been undertaken within the required timescale;
 - appropriate actions had not been taken;
 - learning points had not been well identified and/or there had been missed opportunities to identify learning.
- We asked the trust to look again at three specific investigations. This was because we found that the investigation by the trust had not considered key facts. These related to one unexpected death of a patient on an older persons' mental health ward, one unexpected death of a patient on a learning disability ward and one expected death of a patient on a community health ward. The trust had undertaken two of these investigations before it had introduced its new process. The trust agreed to re-open the investigations of these deaths and contacted all the families involved to explain what had happened and what action it was going to take going forward. We also asked NHS England to undertake an independent review of one of the investigations due to the nature of the patient's death and inaccuracy/lack of details of the information contained in the IMA.
- In addition, we reviewed 38 incident reports from across the core services we inspected. An incident report is a form completed in order to record details of an unusual event that occurs at the trust, such as an injury to a patient. We found that there was a lack of consistency and that the level of detail contained in the reports varied considerably. The trust had failed to take appropriate action and ensure lessons had been learnt in a number of the incidents reviewed. For example, nine reports of incidents involving assaults on staff had not been completed accurately and subsequently had not been followed up appropriately. This was despite the fact that the incident report had been subject to the trust's own quality assurance process through which the incident reports were sent to 10 different people, including senior managers. None of the people reviewing the incident reports had questioned any of the errors or omissions.
- From information supplied by the trust, we concluded that the trust did not have effective systems in place to meet statutory reporting requirements of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) consistently or to analyse data to understand organisational risks and take proactive action to protect patients or staff.
- Commissioners and the trust reported that the trust had made some improvements in the reporting of serious incident requiring investigation (SIRI) over the 12 months prior to our inspection. All organisations providing NHS funded care are required to report SIRIs to the Strategic Executive Information Systems (STEIS) within 48 hours and completed investigations within 60 days. Despite these improvements, at the time of this inspection, the trust accepted that it still failed to achieve these targets and that the quality and the closure of incidents remained unacceptable.
- Whilst it was too early to gauge the impact of the new process introduced by the trust on 1 December 2015, we concluded that it had the potential to monitor

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serious incidents and deaths more robustly and to identify when further investigation was required. We recognised that the process was at an early stage of implementation and was not fully embedded. To ensure that it is effective, the trust would need to ensure it encouraged an open and transparent culture of reporting. This would require training and support for staff and senior and robust oversight to ensure that incidents are investigated properly.

Review of the implementation of the Duty of Candour regulation

- The Duty of Candour regulation requires healthcare providers to be open with patients and to apologise when things go wrong. When staff reported incidents on the trust's electronic incident reporting system, the system required staff to confirm that they had considered or acted in accordance with the Duty of Candour. However, this identification consisted of ticking a box named 'Duty of Candour applied'. There was no requirement for staff to provide any further information. There was therefore no record of whether discussions had taken place with families. The trust could not supply information about what actions had been taken in any of the incidents where staff had ticked 'Duty of Candour applied'. It informed the CQC that said this would mean manually searching each care record to identify action taken.
- We reviewed data supplied by the trust for 15 SIRIs in the Southampton community teams and for 182 deaths (across five divisions) from 1st April 2015 to 11th January 2016. We cross-checked these with the data that the trust provided for all incidents where the trust had identified that the Duty of Candour had applied. Only four of the incidents reported as SIRIs and nine of the deaths were included in the list of incidents that had been identified by the trust as having the Duty of Candour applied.
- We reviewed the sample of 58 investigations into deaths and the four serious incidents to see how the trust had applied the Duty of Candour. The reports and records did not describe clearly how decisions were made about when the Duty of Candour should be applied or whether patients and families had been involved. We found that entries in patient records varied considerably from brief notes to comprehensive letters. In one of the deaths that we asked the trust to

investigate further, the trust had identified that the Duty of Candour was not applicable. The poor quality of several IMA reports meant that the trust might have missed several opportunities to involve patients and families.

- We wrote to 75 patients and carers who the trust had identified that it had informed about or involved in an investigation in relation to the Duty of Candour regulation to ask about their experiences. Two were returned as 'not known at this address'. We only received one response. One person told us that they were unhappy with the discharge process and felt that this had contributed to the incident; they confirmed that the trust had involved them in the investigation.

Review of the management of complaints

- We reviewed a sample of ten complaints received from patients and carers between April 2015 and April 2016. The trust had improved the way it managed and responded to complaints since our last inspection. Overall, the tone of responses to complaints had improved over that period. However, some letters did not answer all of the concerns that had been raised by the complainant. Some reports into the investigation of complaints were superficial and appeared rushed and not challenging. Most of the action plans were poor, incomplete and did not identify actions, learning or change of practice. There was some evidence of learning from complaints in some clinical teams but this was not widespread across the teams inspected.

Review of patient safety risks

- We had serious concerns about the safety of patients with mental health problems and learning disabilities in some of the locations inspected. Although staff were working hard to provide good quality care, governance arrangements were ineffective in identifying and prioritising risks arising from the physical environment. These included risks posed by ligature anchor points, falls from heights and from patients absconding.
- The trust had a poor understanding of the current risks in ward environments including, how to prioritise these and address them effectively and promptly to mitigate the serious risk they posed. CQC had identified concerns relating to ligature risks in inspection reports for acute inpatient mental health and learning disabilities services in January 2014,

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October 2014 and August 2015. During this inspection (January 2016), we found that the trust had failed to make sufficient changes to specific environments such as Kingsley ward at Melbury Lodge and Evenlode. The trust had failed to mitigate sufficiently against the risks posed by these environments and make them safe for patients. The trust's governance arrangements did not facilitate effective, proactive, timely management of these risks. Where substantive action was taken by the trust to mitigate risk, this was delayed and mainly done in response to concerns raised and/or repeatedly raised by the CQC.

Positive findings

- Staff were kind, caring, and supportive and treated patients with respect and dignity. Patients reported that some staff went the 'extra mile'.
- The child and adolescent mental health service wards at Leigh House and Bluebird House had undertaken comprehensive risk assessments. At Leigh House, the trust had completed work to improve the safety of the environment in October 2015. For example, in the high care area bathroom, the trust had replaced the mirror with special shatterproof glass and fitted new sanitary ware with sensor taps. In Bluebird House, staff had undertaken comprehensive ligature risk assessments on all three wards. These had identified areas of concern and there was a clear plan to address or mitigate the risks.
- The trust had made a number of improvements to the acute mental health care pathway that it hoped would reduce patients' experience of repeated transfers between different teams and improve communication and joint working between the teams. For example, it had combined the acute mental health teams (which provided intensive support for those in a crisis) with its acute inpatient wards to form a single care pathway for patients. The trust had introduced the care navigator role at Elmleigh acute mental health unit, and the plan was to extend this to other in-patient units. This was a role developed to support safe transitions through the acute care pathway.
- In Southampton, the trust had redesigned the community pathway as part of its improvement plan. The community teams were based across three hubs. These delivered all functions of community mental health care. Staff undertook mental health assessments and, where allocation within the team was appropriate, a range of more specialist assessments and interventions. The trust had redesigned the crisis care pathway and established a 24-hour team that was available seven days a week to support patients who were acutely unwell. The team worked with people at home or arranged admissions and discharge from hospital as needed. There was a plan to increase the psychiatric liaison service at Southampton General Hospital by March 2016. The improvement plan included a focus on improving the pathway for patients who were in hospital. The aim was to ensure that patients did not remain in hospital any longer than they needed and that local beds were available when patients needed admission. The majority of staff felt that they had been consulted and engaged with the improvement plan and thought that it would improve services.
- The acute mental health teams performed an effective gatekeeping role to beds on the acute wards. They managed most admissions and discharges from the local inpatient units, supported by each locality acute care transfer coordinator. Beds were usually available at a local acute inpatient unit and patients rarely had to transfer out of the area to receive acute inpatient care.
- Transition and discharge processes at Leigh House and Bluebird House had significantly improved and there was clear documented evidence of discharge planning.
- The trust had a clear vision and a set of values developed in consultation with staff, patients and external stakeholders. It had developed some innovative approaches to services that were starting to have benefits for patients.
- By the time of our inspection, the trust had taken some action in response to CQC's previous inspections and the Mazars review. The trust had implemented or was starting to implement some governance structures and processes with the potential to provide it with robust oversight and assurance. For example:
 - standardised divisional governance arrangements which were beginning to be embedded, renewed processes for reporting, recording and investigating

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incidents and deaths and the introduction of a dedicated investigation team and a corporate panel for reviewing the investigation of serious incidents and deaths;

- the electronic management of complaints;
- the quality improvement programme;
- the introduction of 'Tableau' (the trust's new business intelligence tool).

- Some of these were beginning to have some positive effects and show improved outcomes as evidenced by improved key performance indicators in a number of areas. However, it was too early to be assured that the systems and processes would have the desired effect. Many staff working with these new or revised systems and processes for reporting and investigating incidents and complaints still did not fully understand them or have the capability to use them.

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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?

We found the follow issues that need to improve:

- The physical environments at some of the acute mental health and learning disability units posed a significant risk to the safety of patients. The trust had failed to mitigate against a number of risks adequately.
- The garden used by patients on Kingsley ward at Melbury Lodge posed security and safety risks. A low roof was easily accessible by patients. They could easily climb onto the roof and then leave the site or fall from the second storey part of the roof. The trust had been aware of these risks for a number of years, with eight incidents recorded between 2010 and 2015. We asked the trust to take immediate action to ensure patient safety.
- While the trust had undertaken some work to reduce the risk from potential anchor points (ligatures), the trust was not able to provide detailed information that clearly identified what actions it had taken to reduce or remove ligature risks on the wards, or which were priorities for action. At the time of our inspection the estates services was undertaking a review of all of the trust`s ligature assessments to identify what work was required.
- Some environments were not fit for the purpose for which they were being used; for example, the clinic room at Evenlode and the seclusion room on Hamtun psychiatric intensive care unit at Antelope House, which did not comply with the requirements of the Mental Health Act 1983: Code of Practice. The trust advised that work was due to commence March 2016 but there were no interim measures in place to mitigate the privacy, dignity and confidentiality issues.
- The trust had developed an epilepsy map and toolkit, which had been rolled out across north learning disability services in 2013/14. However, a specific ‘protocol for the safe bathing and showering of people with epilepsy’ was awaiting completion and final sign off by the board more than two and a half years after a much-publicised death by drowning of a young person at one of the trust’s other

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learning disability services. This patient had drowned while bathing, unobserved by staff, after having an epileptic seizure. We noted that the new protocol had been made available on the trust's intranet from 1 February 2016 and was 'signed off' by the board during our inspection

- Out of hours medical cover was not consistent in CAMHS. Neither the responsible clinician nor the duty doctor (or equivalent) carried out the young people's medical review within one hour of the start of seclusion, as outlined in the Code of Practice: Mental Health Act 1983.
- The trust and commissioners reported that some improvements had been made in the reporting of serious incident requiring investigation (SIRI) over the 12 months prior to this inspection. However, there remained a failure to achieve consistent quality and meet set targets for reporting and the closure of incidents. The trust accepted it needed to improve this.
- The trust did not have effective systems in place to meet statutory reporting requirements of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) consistently or to analyse data to understand organisational risks and take proactive action.
- In December 2015, the trust had implemented a new trust-wide process for recording, reporting and investigating deaths. Whilst the process was in place, the quality and detail of the incident reports and initial management reviews varied and did not always accurately represent the information available in the care records. This meant that appropriate and detailed information was not always available so decisions about whether further investigation might be needed could be made. The trust made changes to the IMA process when we raised this.

However, we found the following areas of good practice:

- The trust had reviewed the policies and procedures relating to restraint in line with national guidance about the restraint of young people. In Leigh House, there were appropriate levels of staff on duty and trained in restraint to ensure the safety of young people in the event of an incident.
- Each of the community teams inspected held daily meetings to discuss referrals and patients that may be presenting with increased risks or support requirements.

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The acute mental health team held daily telephone conferences with the community mental health teams to discuss patients on their caseload and potential transfers between the teams.

- The trust had undertaken work to ensure all environments met the requirement set out in Department of Health's guidance on single sex accommodation.
- Incident reporting had improved in a number of the wards/units that we inspected and there was evidence of local learning in a number of services. The trust had introduced learning networks to support and facilitate learning from incidents. These were operating well in some services but not across all of the services inspected.

Are services effective?

We found the following areas of good practice:

- The trust had made improvements to the acute mental health care pathway that it hoped would reduce patients' experience of transfer between different teams on multiple occasions and improve communication and joint working between the teams. There was a specialist assertive outreach team to work with patients with severe and enduring complex mental health needs.
- The care navigator role was in place at Elmleigh acute mental health unit. The plan was to extend this to other inpatient units. This role supported patients' safe transitions through the acute care pathway. Staff reported that it had been effective in increasing clinical time for patient care.
- In the learning disability services staff completed comprehensive, timely assessments of patients' needs on admission, undertook thorough physical examinations and ongoing monitoring of patients' physical health problems. Care plans were personalised to individuals' different needs and there were plans available in different formats to meet patients' personal wishes.
- There was a very low use of psychotropic medication (medication capable of affecting a person's mind, emotions, and behaviour) at Evenlode. Staff adopted a therapeutic approach in line with National Institute for Health and Care Excellence (NICE) guidance and other best practice, which included a focus on positive risk taking.

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Patients and their relatives were keen to stress the progress they had made following their admission to the service in comparison with progress made at other units (outside the trust).

- The young people at Leigh House and Bluebird House had access to a wide range of therapies. The multidisciplinary team worked in partnership with young people to review their care and plan for the future.
- The community mental health teams in Southampton facilitated health and wellbeing clinics and identified clinicians who focused on the physical health and wellbeing of patients. A range of psychological therapies and social support was available to patients. The acute mental health team used crisis workbooks with people to help manage emotional distress.

However, we found the following issues that needed to improve:

- We found a variation in quality and detail of care records. Investigations undertaken by the trust into serious incidents had highlighted that poor recording was an issue in a number of serious incident investigations across the trust. There were inconsistencies across teams in relation to where they recorded patient information on the electronic care record system. The community teams informed us that they did not currently have a written standard of what was expected and where it should be recorded. The trust stated there was a standard operating procedure as well as quick reference guides, although they recognised that more work was required to standardise where on the electronic care system entries were required.

Are services caring?

During our comprehensive inspection in October 2014, we gave a rating of 'good'.

We did not review this key question in detail during this inspection. However, we found that staff were kind, caring, supportive, and treated patients with respect and dignity. Some patients reported that some staff went the 'extra mile'.

Are services responsive to people's needs?

We found the following areas of good practice:

- Whilst the trust faced some significant pressures in relation to access to acute inpatient beds, the acute mental health

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teams had developed effective gatekeeping practices and managed most admissions to and discharges from the local inpatient units, supported by each locality acute care transfer coordinator. Beds were usually available in local inpatient units when required and patients rarely had to go outside of the trust to receive acute inpatient care.

- Transition and discharge processes at Leigh House and Bluebird House had significantly improved and there was clear documented evidence of discharge planning.
- The trust had redesigned the community pathway in Southampton as part of a trust improvement plan. The improvement plan included a focus on improving the pathway for people who were in hospital, ensuring people did not remain in hospital any longer than they needed to and that local beds were available when people needed admission.
- The crisis care pathway had been redesigned. One 24 hour team had been established to be available seven days a week to support people who were acutely unwell, and either worked with people at home or arranged admission and discharge from hospital where indicated.

However, we found the following issues that needed to improve:

- Staff identified that increasingly acutely ill patients were being admitted to Kingsley ward at Melbury Lodge and were concerned about their ability to manage them safely and effectively with the current staffing numbers and skills levels. They had raised this with the senior team but little had been done to support the team.
- The trust regularly used the beds, in all acute wards, of patients who were on Section 17 leave for admissions. The trust told us that they endeavoured to avoid this where someone was on short term Section 17 leave, and that it was preferable to sending the patient to another area.
- While the trust had improved the way it managed and responded to complaints and the overall the tone of responses to complaints had improved, we found that some letters did not answer the concerns fully. Some investigation reports were very superficial and appeared rushed and not challenging. Most of the action plans were

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poor, incomplete and did not identify actions, learning or change of practice. There was some evidence of learning from complaints in some teams but this was not widespread

Are services well-led?

We found the following issues that the trust need to improve:

- A revised quality governance strategy 2014–2016 was in place and set out a number of patient-centred quality improvement goals. Staff within the services that we inspected had limited knowledge of the strategy. The links between the quality governance strategy and the trust's quality programme was not clear because there was no reference made to strategy in the quality governance programme. The board regularly received a variety of reports on quality issues but reporting specifically about on-going progress with the quality strategy was not cohesive or comprehensive. It was therefore difficult for the board to have a clear oversight of progress with the strategy. The trust was aware that improvements were needed to its quality governance strategy and had commenced a review. At the time of the inspection the trust were in the process of drafting a new strategy.
- Governance arrangements were ineffective in identifying and prioritising risks arising from the physical environment. As such, the trust did not respond in a timely manner to concerns about patient safety. In addition, there were gaps in governance systems and processes, which prevented the trust from carrying out robust incident investigation. Key risks and actions to mitigate the risks were not driving the senior management or board agenda. However, the trust was starting to address this (see below).

However, we found the following areas of good practice:

- The trust had a clear vision and a set of values developed in consultation with staff, patients and external stakeholders.
- The trust had implemented or was starting to implement some sound governance structures and processes with the potential to provide it with robust oversight and assurance. For example:
 - standardised divisional governance arrangements which were beginning to be embedded, renewed processes for

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reporting, recording and investigating incidents and deaths and the introduction of a dedicated investigation team and a corporate panel for reviewing the investigation of serious incidents and deaths;

- the electronic management of complaints;
 - the quality improvement programme;
 - learning networks to share learning from incidents and complaints;
 - the introduction of 'Tableau' (the trusts' new business intelligence tool).
- Some of these were beginning to have positive effects and show improved outcomes as evidenced by improved key performance indicators in a number of areas.

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Our inspection team

Our inspection team was led by:

Team Leader: Karen Bennett-Wilson, head of inspection for mental health, learning disabilities and substance misuse, Care Quality Commission

The team of 22 people consisted of:

- two inspection managers
- eight inspectors
- one assistant inspector
- two governance specialist advisors
- one nurse specialist advisor who is also an approved Mental Health Act Reviewer
- one specialist advisor who is an `approved mental health professional` and has current experience in mental health crisis services
- one social worker specialist advisor with experience in adult community mental health services
- one expert by experience who is a carer for someone who has used services
- two Mental Health Act reviewers
- an inspection planner

Why we carried out this inspection

In January 2016, the Care Quality Commission carried out a short notice, focussed inspection of Southern health NHS Foundation Trust.

Following the publication of the Mazars report in December 2015 CQC announced that it would undertake an inspection of the Southern Health NHS Foundation Trust early in 2016.

The Mazars report, commissioned by NHS England, details the findings of an independent review of the deaths of people with learning disability and mental health problems in contact with the trust between April 2011 and March 2015. The report described a number of serious concerns about the way the trust reported and investigated deaths, particularly of patients in older person's mental health and learning disability services. It also identified that the trust had failed consistently and properly to engage families in investigations into death of their loved ones.

In response to the publication of the Mazars report the Secretary of State requested that CQC:

- review the trust's governance arrangements and approach to identifying, reporting, monitoring, investigating and learning from incidents; with a particular focus on deaths, including ward to board assurance and
- review how the trust was implementing the action plan required by Monitor (now NHS Improvement).

In addition, we wanted to check whether the trust had made the improvements that we had told it to make following the comprehensive inspection in October 2014 and the focussed inspection of the learning disability services at the Ridgeway Centre, High Wycombe and the forensic services, which we had carried out in August 2015. We had also received a number of complaints about some of the trust services, had contact from a number of whistle-blowers (people who expose activity or information of alleged wrong doing in a private or public organisation) and had identified a high suicide rate in the Southampton area.

As such, this inspection focussed on mental health and learning disability services delivered by the trust, in particular;

- mental health acute inpatient wards (all 4 units)
- learning disability in-patient services in Oxfordshire and Buckinghamshire
- crisis/community mental health teams for people of working age in Southampton
- child and adolescent mental health in-patient and forensic services

We also reviewed how the trust managed and responded to complaints and how the trust complied with the Duty of Candour regulation. The Duty of Candour regulation requires organisations registered with CQC to be open and transparent and apologise when things go wrong.

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We gave the trust several days' notice of the date of the inspection as we could not conduct a meaningful inspection of the issues that were the focus of this inspection without gathering information from the trust in advance of the site visit and we needed to ensure that members of the senior team were available to meet with us.

We did not provide a rating for any of the core services we inspected or an overall rating for the trust.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following 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?

However, as this was a focussed inspection our emphasis was on following up on the improvements that we had asked the trust to make in previous inspections and on specific governance arrangements. As such, some key questions received more focus than others. For example, there was a greater emphasis on whether care was safe and whether the services inspected and the trust were well-led.

Before the inspection, the inspection team:

- requested data and policies from the trust in order to review the trust's governance arrangements and approach to identifying, reporting, monitoring, investigating and learning from deaths. We specifically asked the trust to provide a list of all the deaths that had occurred between April 2015 and January 2016 and a list of all patients and carers who had been the subject of a notifiable safety incident defined by the Duty of Candour regulation between April 2015 (when the regulation came into force) and January 2016
- asked Monitor, NHS England and clinical commissioning groups for information
- reviewed the Mazars report, the trust's action plan in response and spoke to the author of the report

During the inspection, the inspection team:

- wrote to 75 patients and carers who the trust had identified as being subject to a notifiable safety incident defined by the Duty of Candour regulation to ask about their experiences. We received one response.
- met three patients and two carers who asked to see us
- spoke with 48 patients receiving inpatient care
- spoke with eight whistleblowers from four different services
- spoke with the chair, chief executive, two non-executive directors and several members of the executive team
- spoke with members of the governance team
- spoke with 150 members of staff, including divisional managers, heads of service, ward and team managers, doctors, nurses, administrative staff, allied health professionals, support workers, estates staff
- visited three community teams (in Southampton) and 14 inpatients units/wards
- attended and observed four handover meetings and three multidisciplinary meetings
- held a focus group attended by seven staff at Evenlode
- explored, in all inpatient and community services included in this inspection, staff knowledge of the trust's approach and policies relating to the identification, reporting, monitoring, investigation, feedback and learning re: deaths, incidents and complaints
- reviewed information sent to us by members of the public
- attended a board meeting
- attended a governors' meeting
- reviewed 69 individual patient records
- reviewed medication charts in learning disability, acute and child and adolescent mental health services

Summary of findings

- reviewed governance processes (some newly implemented) – including board assurance, ward to board understanding of the reporting of deaths and other serious incidents and the trust’s policies
- reviewed a random sample of 58 individual records of people who had died between April 2015 to February 2016 from a total of 226. Twenty nine were subject to the trust’s new investigation process which commenced on 1 December 2015
- reviewed four serious incident investigations
- reviewed the complaints processes and looked at a sample of complaints that had been made from April 2015 to February 2016
- reviewed the serious incident tracking system and a number of incident reports in each of the core services inspected
- reviewed the trust’s approach to the monitoring and investigation of suicides (patients in contact with the trust services) in the Southampton area
- reviewed a range of policies, procedures and other documents relating to the running of the services.

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

Information about the provider

Southern Health 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 £340 million. The Trust provides these services across the south of England covering Hampshire, Oxfordshire and Buckinghamshire along with some social care services in Dorset. Ninety percent of the care is provided in Hampshire.

In 2014/15 the trust reported that 7,766 staff enabled it to treat or support 244,000 patients by providing 1,353,751 community contacts, 244,845 outpatient appointments and 219,665 occupied bed days. The trust has 776 inpatient beds spread between 25 sites and 251 main sites including community hospitals, health centres and inpatient units.

The trust received foundation status in April 2009 under the name Hampshire Partnership NHS Foundation Trust. Southern Healthcare Foundation NHS Trust was formed on 1st April 2011 following the merger of Hampshire Partnership NHS Foundation Trust and Hampshire Community Healthcare NHS Trust. In November 2012 the trust acquired the Oxfordshire Learning Disabilities NHS Trust; providing learning disability services in Oxfordshire and Buckinghamshire.

CQC undertook a comprehensive inspection of Southern Health NHS Foundation Trust in October 2014. We published the report in February 2015. The report identified several breaches of regulations (not meeting required standards of safety and quality) across the trust. The trust developed an action plan that detailed how the trust was going to meet the requirements.

On 5 August 2015, we carried out an unannounced, focused inspection at the Ridgeway Centre and forensic services to check whether the trust had made required improvements identified in the comprehensive inspection in 2014. We had also received additional information of concern about the services. At that inspection in August 2015, we found that the trust had not taken steps to address risks posed by the environment at the Ridgeway Centre that it had identified and that we had highlighted in our comprehensive inspection in October 2014. At the time of the inspection we asked the trust to take immediate action to address the concerns.

What people who use the provider's services say

- Members of the public had contacted us in the last 12 months and shared concerns about their experience of the trust; some raised concerns that the trust had not always dealt with their complaints effectively. With permission, and as appropriate, we have shared some of these with the trust who have either taken appropriate action or fed back on plans to make improvements

Summary of findings

- Members of the public raised concern with us that an extraordinary board meeting was held in public in January 2016. They understood that the meeting would provide an opportunity for the trust to present its response to the independent review of the investigation of deaths at the trust; the Mazars report. The meeting presented an opportunity for the board to receive and respond to questions from members of the public, including those who may have had direct experience of the trust investigating the death of a loved one. The meeting started at 08.30hrs; several people had to travel considerable distances and so had to get up very early in the morning to get there on time. Only half an hour was allocated for the public to ask questions as the main board meeting commenced at 09.00hrs. Many reported that they had to stand for the whole of the board meeting until a limited opportunity to ask questions was provided at 10.30hrs. The whole meeting was drawn to a close at 11.00hrs. We felt this showed little consideration by the trust of whether people could access the meeting easily and gave little opportunity for full explanation of the detail of the report and for questions to be asked and answered fully.
- We wrote to 75 patients and carers who the trust had identified as being subject to a notifiable safety incident defined by the Duty of Candour regulation to ask about their experiences. Two were returned as 'not known at the addresses. We only received one response. One person told us that they were unhappy with the discharge process and felt that this had contributed to the incident; they confirmed that the trust had involved them in the investigation.
- We met with three patients and two carers who had asked to meet us to talk about their concerns about how the trust had treated them. They told us that they felt the trust had treated them poorly and had not responded adequately to their questions, complaints and had not involved them in investigations of incidents.
- Young people at Leigh House and Bluebird House were positive about their experience and felt respected and listened to by staff. All said that staff were kind, supportive, and enthusiastic and worked with them to promote recovery.
- Patients receiving care in the acute services said staff were polite and treated them with respect. At Parklands Hospital and Elmleigh a small number of patients said there were not enough activities and not enough staff at Melbury Lodge and Elmleigh. We spoke to three carers at Elmleigh who said that they felt that the trust had discharged patients (their loved ones) too quickly.
- Most of the patients we spoke to in learning disability services said they were satisfied with the care and treatment although feedback varied more at Evenlode than the Ridgeway Centre with some patients saying that some staff treated them well and others not so well. However, a number of patients in both services named staff who they thought were excellent and gave more than was expected of them.
- We did not have the opportunity to speak with people who used the service in the community mental health teams. We asked the staff from the teams to speak with their patients about whether they wanted to share their experiences with us and if they did to share their contact details with us. We did not receive any contacts.

Good practice

Child and adolescent mental health inpatient services

- At the October 2014 inspection, we found high levels of staff commitment and enthusiasm in Bluebird House, where young people were involved in all aspects of their care and support. At this inspection in January 2016, we found this was again the case and Leigh House had worked hard to achieve the same high standard.

Wards for people with learning disabilities and autism

- Patients in Evenlode had complex needs with elevated risks necessitating the need for admission to the medium security setting. Staff managed these needs with a therapeutic approach and very low use of

Summary of findings

psychotropic medication. At the time of inspection, only four of the nine patients were prescribed it, and two of those were prescribed medication 'as required' that was rarely administered.

Areas for improvement

Action the provider MUST take to improve

Trust level

- The trust must make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements;
- are effective in identifying and prioritising risks to patient safety arising from the physical environment including ligature risks, falls from height and risks from patients absconding;
- are effective in recording and implementing interim and long-term control measures to mitigate risks to patient safety arising from the physical environment including ligature risks, falls from height and risks from patients absconding;
- are effective at delivering robust incident investigation to ensure opportunities for future risk reduction are identified and acted upon;
- identify, record and effectively action concerns about patient safety raised by staff;
- identify, record and effectively action concerns raised by staff about their competence to carry out their roles.

Community- based mental health services for adults of working age

- The trust must ensure that staff undertake risk assessments for all patients that use the service and that those patients' care plans include the risks that have been identified and the actions required to manage these.
- The trust must ensure that staff follow a consistent procedure for following up on patients who do not attend their appointments, especially those identified as posing a high risk of harm to themselves and/or to others.

Child and adolescent mental health inpatient services

- The trust must ensure that it follows the Mental Health Act Code of Practice (chapter 26, paragraph 26.128).

This requires that the responsible clinician or duty doctor (or equivalent) undertakes the first medical review of a young person in seclusion within one hour of the commencement of seclusion, if the seclusion was authorised by an approved clinician who is not a doctor or the professional in charge of the ward.

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

- The trust must ensure that premises and equipment are safe. The trust must identify and prioritise action required to address environmental risks on the wards, such as management of ligature points.
- The trust must ensure it takes sufficient action to manage the safety of patients at Kingsley ward, Melbury Lodge, including ensuring staff can clearly observe patients to mitigate environmental risks
- The trust must ensure that it protects patients' privacy and dignity in a safe way on Kingsley ward.
- The trust must ensure that works on the seclusion room on Hamtun psychiatric intensive care unit are completed so that it is fit for purpose.
- The trust must ensure that staff at Elmleigh and Kingsley ward at Melbury Lodge check and record medicine fridge temperatures to ensure medicines are stored at the correct temperature.

Wards for people with learning disabilities and autism

- The trust must ensure that environmental risks are addressed at Evenlode and that appropriate measures are implemented to effectively mitigate the risks to patients using the service.
- The trust must take action to address the remaining environmental risks at the Ridgeway Centre.
- The trust must ensure that that the clinic room at Evenlode is fit for purpose and contains all appropriate essential equipment for resuscitation.

Summary of findings

- The trust must ensure staff at Evenlode receive appropriate and up to date specialist training to be able to carry out their jobs as safely and effectively as possible.
- The trust must ensure that its 'Protocol for the Safe Bathing and showering of People with Epilepsy' is embedded as swiftly as possible and that staff receive appropriate training to ensure understanding and consistency of practice.
- The trust must ensure that learning takes place following serious incidents.
- The trust must ensure that staff at the Ridgeway Centre and Evenlode receive consistent and regular supervision and senior management oversight.
- The trust must make the necessary improvements to the environment at both services in order to protect people's dignity and privacy at all times.

Action the provider SHOULD take to improve Trust-wide

- The trust should review its policies relating to complaints to ensure they reflect current legislation, best practice, role and responsibilities and the management of local concerns. It should continue to improve the way it responds to complaints and ensure robust, consistent systems for sharing and learning from complaints across the trust.
- The trust should continue to develop its complaints reports to the board to contain more detailed analysis and explanation so the board is provided with more robust information for assurance.

Community-based mental health services for adults of working age

- The trust should ensure that staff in all teams receive regular supervision and that this is used to support implementation of the improvement plan. Supervision should include a review of caseloads and monitoring of care records.

Child and adolescent mental health inpatient services

- The trust should ensure that there are suitable arrangements in place to ensure that all young people are involved in all aspects of planning their care and treatment in Bluebird House.

- The trust should ensure that where rapid tranquilisation is used by intramuscular injection, young people in Bluebird House have their physical health observations monitored on the format within their care files.
- The trust should ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. The provider should ensure that they address the high levels of prone restraint and provide staff at Bluebird House with appropriate restraint training as agreed.
- The trust should ensure that suitable arrangements are in place to obtain the consent of patients in relation to the care and treatment provided in Moss and Stewart wards in Bluebird House.
- The trust should ensure that staff in Bluebird House always record the length of seclusion and the time when seclusion has ended.
- The trust should ensure that staff in Bluebird House continue to monitor the use of prone restraint and there is senior oversight of this.
- The trust should ensure that a medical emergency bag is available on all wards at Bluebird House. We noted the wards were spread out and it would take staff in the region of five minutes to go to Hill ward where the bag was kept, potentially putting young people at risk.

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

- The trust should ensure that it clearly documents the decision-making behind judgements of a patient's capacity to make a decision.
- The trust should ensure it clearly documents when patients have been involved in the development of their care plan.

Wards for people with learning disabilities and autism

- The trust should make every effort to ensure there are enough qualified nursing staff recruited to fully staff both services.
- The trust should ensure it engages and consults effectively with patients whenever significant changes are to be made that will affect them or will impact on the service they receive.

Summary of findings

- The trust should consult with patients and review the activities provided for them at both services, to make sure that the activities provided meet people's needs and are in line with their wishes.
- The trust should consult openly with the staff at Evenlode about the long-term future of the service. The trust should take steps to improve staff morale, to ensure all staff at the service feel fully supported and are able to share in the trust's vision and values.

Southern Health NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

Please see main body of the report (Effectiveness)

Mental Capacity Act and Deprivation of Liberty Safeguards

Please see main body of the report (Effectiveness)

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

We found the follow issues that need to improve:

- The physical environments at some of the acute mental health and learning disability units posed a significant risk to the safety of patients. The trust had failed to mitigate against a number of risks adequately.
- The garden used by patients on Kingsley ward at Melbury Lodge posed security and safety risks. A low roof was easily accessible by patients. They could

easily climb onto the roof and then leave the site or fall from the second storey part of the roof. The trust had been aware of these risks for a number of years, with eight incidents recorded between 2010 and 2015. We asked the trust to take immediate action to ensure patient safety.

- While the trust had undertaken some work to reduce the risk from potential anchor points (ligatures), the trust was not able to provide detailed information that clearly identified what actions it had taken to reduce or remove ligature risks on the wards, or

Detailed findings

which were priorities for action. At the time of our inspection the estates services was undertaking a review of all of the trust's ligature assessments to identify what work was required.

- Some environments were not fit for the purpose for which they were being used; for example, the clinic room at Evenlode and the seclusion room on Hamtun psychiatric intensive care unit at Antelope House, which did not comply with the requirements of the Mental Health Act 1983: Code of Practice. The trust advised that work was due to commence March 2016 but there were no interim measures in place to mitigate the privacy, dignity and confidentiality issues.
- The trust had developed an epilepsy map and toolkit, which had been rolled out across north learning disability services in 2013/14. However, a specific 'protocol for the safe bathing and showering of people with epilepsy' was awaiting completion and final sign off by the board more than two and a half years after a much-publicised death by drowning of a young person at one of the trust's other learning disability services. This patient had drowned while bathing, unobserved by staff, after having an epileptic seizure. We noted that the new protocol had been made available on the trust's intranet from 1 February 2016 and was 'signed off' by the board during our inspection
- Out of hours medical cover was not consistent in CAMHS. Neither the responsible clinician nor the duty doctor (or equivalent) carried out the young people's medical review within one hour of the start of seclusion, as outlined in the Code of Practice: Mental Health Act 1983.
- The trust and commissioners reported that some improvements had been made in the reporting of serious incident requiring investigation (SIRI) over the 12 months prior to this inspection. However, there remained a failure to achieve consistent quality and meet set targets for reporting and the closure of incidents. The trust accepted it needed to improve this.
- The trust did not have effective systems in place to meet statutory reporting requirements of the

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) consistently or to analyse data to understand organisational risks and take proactive action.

- In December 2015, the trust had implemented a new trust-wide process for recording, reporting and investigating deaths. Whilst the process was in place, the quality and detail of the incident reports and initial management reviews varied and did not always accurately represent the information available in the care records. This meant that appropriate and detailed information was not always available so decisions about whether further investigation might be needed could be made. The trust made changes to the IMA process when we raised this.

However, we found the following areas of good practice:

- The trust had reviewed the policies and procedures relating to restraint in line with national guidance about the restraint of young people. In Leigh House, there were appropriate levels of staff on duty and trained in restraint, to ensure the safety of young people in the event of an incident.
- Each of the community teams inspected held daily meetings to discuss referrals and patients that may be presenting with increased risks or support requirements. The acute mental health team held daily telephone conferences with the community mental health teams to discuss patients on their caseload and potential transfers between the teams.
- The trust had undertaken work to ensure all environments met the requirement set out in Department of Health's guidance on single sex accommodation.
- Incident reporting had improved in a number of the wards/units that we inspected and there was evidence of local learning in a number of services. The trust had introduced learning networks to support and facilitate learning from incidents. These were operating well in some services but not across all of the services inspected.

Detailed findings

Our findings

Safe environment

- During our comprehensive inspection of the trust in October 2014, we found that the trust needed to make improvements to a range of acute mental health and learning disabilities ward environments to make them safer. In August 2015, we found that although the trust had made some improvements to make the environment at the Ridgeway Centre safer, the environment still posed a significant risk for patients. We asked the trust to take immediate action following that inspection. During this inspection (January 2016) we checked if the trust had made the required changes identified in both previous inspections. We found that the trust had failed to make sufficient changes to the environment to make it safe for patients. It has also failed to mitigate against the risks posed by the environment sufficiently, particularly in relation to the identification and prioritising of fixed ligature points (a point that a person could attach a cord, rope or other material for the purpose of hanging or strangulation).
- In the majority of the wards inspected, some changes to the environment had been made, or staff were trying to ensure they mitigated ligature risks in other ways. We were informed by the trust that risks to patients posed by the environment were mitigated through individual risk assessments and staff observations. Insufficient consideration had been given to making physical changes to the environment to remove or more reliably reduce risk. This approach failed to take account of co-existing and multiple risks; such as staffing levels and the competency of staff, variability in quality of risk assessments, variable and unpredictable patient mix, culture and understanding of risks, the time available to staff to carry out effective observations and the physical ward layout. This meant that staff observations were not always an effective control measure.
- The garden used by patients on Kingsley ward at Melbury Lodge posed security and safety risks. A low roof was easily accessible by patients. They could easily climb onto the roof and then leave the site or fall from the second storey part of the roof. The trust had been aware of these risks for a number of years, with eight incidents recorded between 2010 and 2015. These incidents including patients (a number of who were detained on a section of the Mental Health Act (MHA)) absconding from the ward and a patient who had sustained serious injury falling from the roof. Insufficient action was taken following each of these incidents to review the arrangements in place to manage these risks and ensure timely and effective action was taken to reduce risk and keep patients safe.
- We shared our concerns with the trust during our inspection. On 8 March 2016, we revisited the ward to assess what interim measures the trust had taken to reduce the risks and to assess progress with the proposed physical improvements to the roof. We identified that little effective interim action had been taken to reduce risks and no confirmed plans been prepared by the trust despite three additional incidents, although the ward team were had increased staffing to enable observations in the garden. We found that in February 2016, patients detained under the MHA had attempted to climb on to the roof; one had succeeded in climbing onto the roof, leaving the ward and leaving the country and another had sustained a significant injury requiring hospital treatment. Staff had raised concerns about their ability to manage the environmental risks for a patient group whose acuity of illness had increased considerably in recent years with the current staffing levels and skill mix but the trust had taken little action. We requested that the trust took urgent action to maintain patient safety. The trust responded positively by increasing staffing level to support the ward team to supervise patients using the outside area and agreed to immediately assess and undertake some remedial work to mitigate risks whilst it considered a longer-term plan.
- While we saw some examples of comprehensive individual risk assessments, this was not consistent practice across the services inspected and did not always reflect what an individual patient's risks from the environment might be. A recent investigation report of an incident on Kingsley ward at Melbury Lodge highlighted that the use of generic care plans might have contributed to the lack of specific risks to the individual from the environment being identified. Delays in undertaking environmental work placed the responsibility for mitigating the risks on the ward staff, even where it was difficult for them to reduce risks; for

Detailed findings

example, areas that were difficult to observe, such as ligature points in the bathrooms and bedrooms, which were a particular risk as this was where patients spent time alone.

- We found that the trust had a poor understanding of the current environmental risks, how to prioritise them and address them to effectively and promptly mitigate serious risk. CQC identified environmental risks in acute inpatient mental health and learning disability services following inspections in January 2014, October 2014 and August 2015. The trust-wide action plan prepared by the trust following the inspection in October 2014 stated that actions were 'on track' to manage risks and stated that it was managing risks 'as part of the ligature program'. However, ligature reports presented to the executive group meeting in August 2015 and a subsequent ligature review undertaken in October 2015 highlighted concerns about poor governance, the estates ligature works plan, ligature risk assessments, lack of clinical and estates interface and staff awareness. This demonstrated that the ligature program was not effectively underway and reflected issues identified during this inspection.
- During this inspection, we found that while the trust had undertaken some anti-ligature work, it had not linked the estates ligature works tracker to the service risk assessments. The trust was not able to provide detailed information that clearly identified what actions it had taken to reduce or remove ligature risks on the wards, or which were priorities for action. At the time of this inspection the estates services was in the process of undertaking a review of all of the trust's ligature assessments to identify what work was required.
- Whilst a considerable amount of work had been carried out at Ridgeway Centre to remove identified ligature points following our previous inspections we identified a number of outstanding and clear risks that needed further work to be more effectively reduced. At Evenlode, we identified multiple ligature points throughout the unit. We asked the trust, at the time of our inspection, to provide us with an assurance that it would take steps to reduce the risk of ligatures until it could complete scheduled work. On a return visit to the service (one week after the January 2016 site visit), we were saw that a number of steps had been taken to more effectively mitigate the risks from ligatures. However, several of these had caused distress to patients, as the trust had not informed them that amendments would need to be made to some of their personal equipment (such as shortening cables to TVs and entertainment equipment). In addition, the clinic room at Evenlode was not fit for purpose and did not contain appropriate essential resuscitation equipment. The intercom that would allow patients placed in the seclusion room to talk to staff outside the room was not working. We asked the trust to put this right this immediately.
- However, the child and adolescent mental health service (CAMHS) wards at Leigh House and Bluebird House had undertaken comprehensive risk assessments. At Leigh House identified work had been completed in October 2015. For example, in the high care area bathroom, the mirror had been replaced with special shatterproof material and there was new sanitary ware with sensor taps. There were ligature-proof tracks for both shower curtains and curtains in the living area. Staff had ensured the lights and room sensors would not hold a person's weight to ensure young people's safety. In Bluebird House all the three wards had comprehensive ligature risk assessments, which identified areas of concern with a clear plan to address or mitigate the risk. The wards' layout did not allow staff to observe all parts of each ward. For example, staff could not clearly see young people in the area between the communal area and the bedrooms. Staff positioned themselves in these areas whilst young people were in their rooms to ensure their safety.
- We informed the trust that the seclusion room on Hamtun ward at Antelope House was unfit for purpose at the time of our inspection in October 2014. This was because there was a blind spot that meant staff could not clearly observe patients in seclusion. The trust had made some improvements. It had added mirrors for better observation of patients and had improved the ventilation system. However, the room remained unfit for purpose at the time of our inspection in January 2016. The observation panel for the seclusion room was a large window on the back wall of the nursing office. Measures were in place to keep the number of staff in the nursing office to a minimum to ensure the dignity of the person in seclusion. However, on the day of inspection, there were several staff present in the office on many occasions. Staff kept the lights in the nursing office off to minimise the level of noise and activity. This

Detailed findings

meant that staff were working without adequate lighting. The patient who was in seclusion on the day of our visit was clearly visible to all other patients and visitors on the ward. The layout of the room made it possible for patients in seclusion to observe computers in the staff office. We observed this happen during the inspection. A member of staff left a computer displaying patient care records unattended and in full view of a patient inside the seclusion room.

- The area manager confirmed that a funding request and plan for alterations to the seclusion room had been submitted to the trust in October 2015 and had been agreed with work due to start in March 2016. The trust had estimated that building work would take approximately four to six weeks. The trust had planned to keep the observation window even though it planned to complete other building work. We raised our concerns with the ward manager, the area manager and the chief executive. Following the inspection, we received confirmation that the trust was reconsidering plans and it had put temporary measures had been put in place to protect patients' dignity.
- We were concerned that the trust did not undertake effective proactive, timely management of the range of environmental risks. The trust had a poor understanding of the current environmental risks, how to prioritise them and address them to effectively and promptly mitigate serious risk. Where the trust had taken substantive action to address risk, this was delayed and reactive to concerns raised and/or repeatedly raised by the CQC. We have taken separate enforcement action against the trust in relation to this.
- CQC identified ligature risks in inspection reports for acute in-patient mental health and learning disabilities services following inspections in January 2014, October 2014 and August 2015. We found that the trust had failed to make sufficient changes to the environment to make it safe for patients and failed to mitigate against the risks posed by the environment sufficiently. The trust's own governance arrangements did not facilitate effective proactive, timely management of these risks.
- We undertook enforcement action, serving a warning notice, in which we told the trust that it was required to make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements were effective in identifying and

prioritising risks to patient safety arising from the physical environment including ligature risks, falls from height and risks from patients absconding. The trust needed to improve their effectiveness in recording and implementing interim and long-term control measures to mitigate risks to patient safety arising from the physical environment. We also requested that the trust identify, record and take effectively action when staff raised concerns about patient safety or their competency to carry out their roles. In addition, the trust were required to demonstrate that it was investigating adverse events robustly to ensure opportunities for future risk reduction are identified and acted upon.

- In addition, health and safety was not fully embedded within the trust. For example, until September 2015 there has been limited integration of the health and safety team into wider aspects of the trust such as the ligature management group and serious incident panels. The trust employed too few specialist staff to undertake regular health, safety and security visits of trust premises. Between January 2015 and September 2015, there was only one person employed within the dedicated health and safety team. At the time of our inspection, there was one health and safety manager and one health and safety advisor in post, with part time administration support. The trust informed us that there were also three fire officers and one security specialist to support this function. Their remit included covering all 145 sites across five counties covered by the trust, health and safety visits, emergency planning, Ulysses incident, injury and accident investigations, staff training, policy writing, ligature and environmental assessments. The trust acknowledged that the current system whereby teams submit their risk assessments is not working effectively and does not provide a robust system to ensure that each area and building or part of a building is assessed. The trust health and safety committee agreed a cyclical process to assess and audit all critical sites (bedded units) on 25 January 2016 to commence from April 2016. The trust informed us following the inspection that they have commissioned an independent review of their health and safety arrangements to commence in May 2016.

Safe staffing

Detailed findings

- During the October 2014 inspection, we found that 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. During this inspection, we found there were enough staff across the services we visited to meet the needs of patients. The ward managers on all wards informed us that staffing was based on acuity and that they were able to staff the ward as necessary to meet people's needs. However, we did find some evidence that existing permanent staff at Evenlode were under pressure due to staffing problems, for example, some staff told us that repeated long shifts continued to have a negative effect on their wellbeing.
- The board received a monthly safer staffing report, which was compiled by the trust designated safer staffing lead. Additional information had been provided with the report to inform the board where professional judgement decisions had been applied to improve staffing levels in inpatient unit or where staffing levels had fallen below 80% establishment. We reviewed the safer staffing report for December 2015. The trust used an internally developed RAG risk rating system (using red, amber, green to denote risk). This showed that five sites were rated red for staffing levels for this reporting period: one learning disability site, three mental health sites and one community hospital site. This meant that five sites had staffing levels under their establishment for at least three out of the past four consecutive months.
- The trust had a number of local systems in place to monitor staffing requirement and had developed an overarching safer staffing project. The trust encouraged staff to report staffing issues on the electronic incident reporting system. These were then included in the monthly board safer staffing reports. They also highlighted safer staffing risks, such as any inpatient unit using more than 50% of temporary staff to fill their staffing requirement. Safer staffing was reviewed quarterly through the West Hampshire clinical commissioning group (CCG) scrutiny and oversight committee.
- The trust raised with us that recruitment and retention of qualified nursing staff was their greatest staffing

challenge. There were also known challenges in some areas and in some professional groups. This trust reported that this was being focused through the workforce resourcing forum. We did not review this as part of the inspection.

Reporting incidents

- All staff we spoke with were aware of the trust's incident reporting system and were confident they understood how to report incidents. However, many did not fully understand new processes that had been brought in and were not fully conversant with what the trust expected of them regarding reviewing and investigating incidents.
- The trust was in the process of implementing learning networks. These networks would generate the topics from incidents that occurred in different services that could be shared in the new weekly learning hotspots bulletin so that learning about incidents could be driven from the bottom to top of the organisation. Currently, incidents were discussed at team meetings and at the weekly divisional meetings with the clinical director. We saw an example of the first learning hotspots bulletin at Southampton, which gave an overview of key themes and learning from incidents throughout 2015. There was variation across the core services we visited in relation to embedded reporting practices and evidence of learning from incidents. For example, in CAMHS we saw that incident reports weren't completed when doctors did not review young people in seclusion (as required). However, there was evidence of learning from a serious staff assault. At Evenlode, there was lack of learning from incidents, including investigations following serious staff assault. At the acute mental health team in Southampton, the area manager had implemented a new review process that took place at each handover following recognition that staff were not reporting incidents effectively. At Elmleigh there was no action plan or evidence of learning following a serious ligature incident.
- We reviewed 38 incident reports across the core services we visited. An incident report is a form completed in order to record details of an unusual event that occurs at the trust, such as an injury to a patient. There was a lack of consistency and detail varied. We were concerned about the consistency in quality of learning and the trust lack of ensuring it took appropriate actions

Detailed findings

as a result. For example, we saw nine examples of incident reports for incidents involving assaults on staff that had not been accurately completed. Subsequently the trust had not followed up on these appropriately, despite internal quality assurance processes, through which the incident forms were sent to 10 different people, including senior managers. None of the errors or omissions were questioned by any of those who reviewed them.

- We were concerned that inaccurate information meant that statutory reporting requirements were not consistently met. For example, NHS Protect (to monitor staff incidents of violence and aggression) and incidents which should have been notified to the Health and Safety Executive (HSE) - when involving staff, under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Reporting certain incidents is a legal requirement. The HSE states that, 'the report informs the enforcing authorities (HSE, local authorities and the Office for Rail Regulation (ORR)) about deaths, injuries, occupational diseases and dangerous occurrences, so they can identify where and how risks arise, and whether they need to be investigated. Reporting accidents and incidents at work allows the enforcing authorities to target their work and provide advice about how to avoid work-related deaths, injuries, ill health and accidental losses. From information submitted by the trust, we saw that there were delays in submitting RIDDORS. Some of these were significant delays. For example, an incident in 2014 was not submitted for seven months. HSE guidance states that a report must be received within 10 days of the incident. Twenty-six out of the 33 incidents the trust told us they had reported exceeded this timeframe.
- From April 2015 the CQC assumed responsibility (from the Health and Safety Executive -HSE) for all safety and quality of treatment and care matters involving patients and service users, under Regulation 12 of the Health and Social Care Act 2008 (regulated activities) regulations 2014. There was not effective clinical support in place for the health and safety team to help make decisions about when incidents affecting patients might be considered reportable under RIDDOR. We were aware of two retrospective RIDDOR reports submitted to the HSE in March 2016; these were in relation to deaths in 2013. Two more recent patient incidents had not been reported to CQC, although through our discussion with

HSE we identified that they should have been reported under RIDDOR. We have discussed this with the trust and asked it to undertake an urgent review in order to understand the extent of this issue so that it is assured that staff are trained effectively and that incident data is accurate. We were not assured that systems in place were effectively implemented to consistently meet statutory reporting requirements or analysing data to understand organisational risks and take proactive action.

Learning from incidents

- The Mazars report, an independent review of the deaths of people in contact with the trust between April 2011 and March 2015, commissioned by NHS England, identified a number of serious concerns about the trust's reporting and investigating of deaths, particularly in relation to patients in older person's mental health and learning disabilities services. Southern Health NHS Foundation Trust board have now fully accepted that the quality of process for investigating and reporting patient deaths needed to be better. The trust had consistently failed to engage families properly in investigations into their loved ones' deaths. The poor quality of its investigation reports had meant that the trust might have missed several learning opportunities. The report made the following recommendations:
- Recommendation 1 - the board needs to address the culture of lack of review and reporting of unexpected deaths, ensure staff at all levels recognise the need for timely, high quality investigation, how to include families and to ensure learning is demonstrated.
- Recommendation 2 - the board or its sub-committees should receive regular reports of all incidents of deaths.
- Recommendation 3 - the 2015/16 annual report should provide a more transparent breakdown of deaths
- Recommendation 4 - there is clear national and trust policy guidance on reporting and investigating deaths. It includes a full set of templates and processes - the board should ensure these policies are being followed and templates being used.
- Serious Incidents Requiring Investigation (SIRIs) are defined clearly by the NHS England Serious Incident Framework 2015. When they occur, organisations must make sure that there are systematic measures in place

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to respond to them. These measures must protect patients and ensure that robust investigations are carried out, which result in learning from serious incidents to minimise the risk of the incident happening again. When an incident occurs, it must be reported to all relevant bodies. All organisations providing NHS funded care are required to report all SIRIs to the Strategic Executive Information System (STEIS). This is expected within 48 hours of the incident occurring. Investigations and reports are required to be completed within 60 days.

- The trust recognised from monitoring performance indicators that national standards set for timeliness around the serious incident requiring investigation (SIRI) investigation process were currently, and have in the past, been regularly missed. Commissioners had also expressed concerns and required a significant improvement in the timeliness and quality of reporting. Although the trust and commissioners reported that some improvements have occurred over the 12 months prior to this inspection, the trust accepted that failure to achieve consistent quality and meet targets around time to report and the closure of incidents remained unacceptable.
- In response to identified problems, a process of corporate panel overview led by the previous medical director commenced in December 2014. At the time of this inspection, the panel was being chaired by the director of performance, quality and safety (the trust's chief operating officer). The aim was to highlight quality issues present in SIRI reports and provide final sign-off to all SIRI reports prior to sharing externally with commissioners. This function also aimed to ensure that a root cause was identified and the incident was graded correctly. Each division had a divisional SIRI panel, which reviewed divisional serious incident reports. These panels acted as feeder groups to the corporate panels. The trust recognised that much greater scrutiny and focus was required at this 'feeder group' level (local level) to improve understanding of what was expected within a quality incident investigation report. Without this, there was a continued risk that investigations would not be undertaken appropriately.
- The trust had established a mortality task and finish group, comprised of non-executive and executive directors, senior managers and governors. The trust

stated that the purpose of the group was to review the four recommendations identified in the Mazars report that related to board leadership and to provide oversight of the systems and processes. This group reported to the board and minutes were available on the trust website. The trust held a conference on serious incidents and mortality on 12 August 2015 to present its proposals for the improvement of SIRI investigation quality and to reach an agreement on the recording, reporting and investigation of deaths. The trust reported that over 40 staff (and others) had attended the event including operational managers, senior clinicians and members of the executive team. Leads were invited from all local commissioners and the NHS England local area team. The clinical commissioning group and NHS England hold a monthly oversight meeting with the trust to monitor progress on a number of safety and quality issues within the trust. As part of this, the commissioners have also established a mortality work stream setting out how it will work with the trust in addressing the recommendations from the Mazars report. A follow up conference on serious incidents and mortality was scheduled for 1 February 2016 where improvements to date would be discussed, as well as wider system challenges such as multi-agency investigation.

- The trust had developed a mortality and serious incident action plan in response to the recommendations of the Mazars investigation. This was being implemented with oversight from Monitor (now NHS Improvement). The trust had stated that it aims to ensure that 60% of all SIRI reports meet national timescales by 31 March 2016 and 90% of all serious incident investigation reports meet national timescales by 30 June 2016. As part of this plan, the trust had established a central investigation team. The aim of the team was to focus on closing the SIRIs that were overdue, as well as improving the investigation and learning from incidents. The trust hoped that this would help to improve the quality and consistency of investigation reports by working alongside the staff in the divisions. The trust plan to evaluate the project after 6 months. In addition, a 'live' register of investigating officers was held by the corporate governance team ensuring that only those trained will, in future, undertake any investigations required. The trust reported that two incident investigators courses were

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held in early November 2015 attended by 55 of its staff. The trust reported that it had also established training for the Ulysses electronic investigation report that would be rolled out to staff from February 2016.

- On 1 December 2015, the trust introduced a new, trust-wide system for reporting and investigating deaths to increase monitoring and scrutiny, share learning with staff and improve the quality of reports and investigations. It intended that all deaths would be reported on Ulysses, the trust electronic incident reporting system. The trust no longer graded deaths as 'expected' or 'unexpected'. Following this, and as soon as possible but within 48 hours the most senior person on duty was responsible for completing and submitting an initial management assessment (IMA). The purpose of the IMA was to assess whether there were any concerns about care, identify issues and risks and to determine if further investigation was required. The IMA should be reviewed within 48 hours of the incident occurring by a 48-hour panel. The aim of the 48 hour panel was to agree if further investigation was required or if the incident should be considered reportable as a serious incident requiring investigation (SIRI) reportable. The trust had set a target whereby 48 hour panels would be held 75% of the time by January 2016. It had not met this target and reported that in early February its compliance rate was 55%. The trust told us that it reached 100% compliance with the 48 hour timeframe in March 2016.
- The new trust procedure for 'reporting and investigating deaths' outlined that all deaths should be reported by staff onto the trust electronic incident reporting system, Ulysses. It also identified when families should be involved in the process (in line with the Duty of Candour regulation). The reporting templates on Ulysses had been updated in line with the new procedure. The updated templates included a requirement for staff to note that they had involved families at the initial stage of the initial management assessment and the outcome of the 48-hour panel by ticking a box 'Duty of Candour applied'. However, it was not clear what ticking the box 'Duty of Candour applied' meant; no other detail was required so it was unclear what discussion had taken place with families. Staff told us that they were unsure when they had to tick the box and what they had to do to meet the Duty of Candour requirements. It was therefore not clear how the decisions would be made and documented to apply the Duty of Candour.

Nonetheless, even 'ticking the box' should have improved the trust's ability to monitor whether staff were considering the Duty of Candour. However, when we requested data on any incidents where Duty of Candour was implemented the trust found it difficult to supply information as it said this meant manually extracting the information from care records. We reviewed data supplied by the trust for 15 SIRIs in the Southampton community teams and for 182 deaths (across five divisions) from 1st April 2015 to 11th January 2016. We crosschecked these with the data that the trust provided for all incidents where the trust had identified that Duty of Candour had applied. Only four of the incidents reported as SIRIs, and nine of the deaths, were included in the list of incidents that had been identified by the trust as having the Duty of Candour applied. This seemed to be an unusually low proportion. We found that notes in patient records of contact with patients and carers varied considerably from brief notes to comprehensive letters. In one of the deaths that we asked the trust to investigate further, the trust had identified that the Duty of Candour was not applicable. As a result, we were not assured that the trust had an accurate picture and details of all notifiable incidents and that all patients and families that should have been notified, involved and received an apology had been.

- Whilst it was too early to gauge the impact of the new process, we concluded that the process put in place had the potential to more robustly monitor serious incidents and deaths and identify those that required further investigation. However, for the new system and process to be effective accurate initial reporting was required along with effective senior management oversight of the process.
- We reviewed a random sample of 58 investigations into deaths (from the 226 reported from April 2015 to February 2016), in addition to four serious incidents. Twenty-nine of the serious incidents and/or deaths we looked at were reported after 1 December 2015, and part of the new procedures. The deaths were from a range of services provided by the trust (not just within mental health and learning disabilities) from April 2015 to January 2016. We looked at deaths within this timeframe because from April 2015 the CQC assumed responsibility (from the Health and Safety Executive - HSE) for all safety and quality of treatment and care matters involving patients and service users in receipt of

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a health or adult social care service from a provider registered with CQC, including health and safety issues. In addition, from April 2015 the Duty of Candour regulation put in place a requirement for healthcare providers to be open with patients and apologise when things go wrong. Furthermore, this period was after the time period of the Mazars review of the investigation of deaths.

- We reviewed the investigation process from reporting of the incident to final decision/outcome. We cross-referenced incident reports and initial management assessment reports with individual care records. We looked at the accuracy, detail and quality of the investigation to check it conveyed all necessary information about the incident. We looked at the investigation process, to check if it considered all the relevant information and evidence to ensure appropriate decisions were made, and learning was identified. We checked that decisions made were the outcome of an objective and comprehensive investigation and that families were involved.
- We found that the quality and detail of the incident reports and initial management reviews varied considerably. We reviewed some that were comprehensive and/or adequately reflected the information available in the care records. However, in a quarter of all those reviewed we found issues in relation to one or all of the following: accuracy or detail of information when cross referenced with care records, timeliness of review, appropriate actions taken, initial learning identified and/or missed opportunities. In 11, (five within the new system), the information within the initial management review (IMA) alone did not have sufficient detail to provide the 48 hour panel with all the relevant information. This meant that decision-making may not have been as robust as it needed to be and there was potential for a more detailed investigation to be missed when one might have been warranted or that opportunities for learning had been missed. This indicated the need for much more robust staff training and quality assurance process. We also found basic inaccuracies such as incorrect dates and missing sections, as well as some investigations, which did not accurately reflect information available in the care records, for example, levels of concern or risks that were not reflected. We discussed our findings and the implications in detail with the trust and asked it to take action to address the issues.
- We asked the trust to look again at three investigations, as we were concerned about the poor quality of the investigation in which key facts had not been considered. These related to one unexpected death of an individual who had been a patient on an older persons' mental health ward, one unexpected death of a patient on a learning disabilities ward and one expected death of a patient on a community ward. Two of these investigations were undertaken before the new process was in place. The trust agreed to relook at these and contacted all the families involved to explain what had happened and what would happen going forward. We have asked NHS England to undertake an independent review of one of these investigations, as we were concerned about the trust failure to recognise that an unexpected death of a patient in learning disability services needed thorough investigation.
- With the exception of the three investigations outlined above, from the sample we reviewed, the decisions for further investigation into serious incidents or deaths were taken appropriately, although not always with full information/accurate detail available. However, we remained concerned that if accurate, timely information was not available in the IMA at the time of review an appropriate decision about whether further investigation was required could potentially be missed. Opportunities for learning could also be missed and similar incidents that could have been prevented could occur.
- We discussed our findings in detail with the trust. The trust advised that it would implement an audit process whereby 10% of IMAs would be audited monthly. In addition, the 48-hour panel would be required to record if the quality of the IMA was acceptable. The trust also told us that it would be amending its processes to include the reporting of deaths of people under the care of learning disabilities and acute mental health inpatient services as SIRIs. This would mean that in future they would all undergo full investigation (albeit some of these may later be downgraded). All root cause analysis reports (that are not SIRIs) would go through the same processes as SIRIs, including having corporate

Detailed findings

panel sign off to ensure they are of the same quality that would be expected for a SIRC investigation. This was not in place at the time of inspection and therefore we cannot comment on the effectiveness of this.

- The trust and commissioners were also concerned that root cause analysis did not always identify opportunities for staff to learn from incidents or result in evidence that concerns had been addressed or actions completed. The trust stated that the new processes would increase focus on learning. The trust identified that making a link between improved quality of investigations would lead to more specific, detailed action planning and changes to practice. However, it had not set out a clear plan of how it would support and train its staff in effective incident reporting, or how it would evaluate whether action plans were implemented effectively and lead to sustained change in practice.
- Opportunities to learn from serious incidents continued to be missed in other areas. For example, the trust identified a history of people who 'did not attend' (dna) appointments as a common theme in serious incidents, particularly within the community mental health teams. During the January 2016 inspection we identified examples of patients not actively followed up after a 'dna', despite being identified as high risk. Examples of this were found in the current Southampton acute mental health team caseload on 19 January 2016. In addition, recent serious incidents in December 2015 involving a patient who seriously self-harmed and attempted suicide and the suicide of a second patient confirmed the continuing theme of dna history. Despite this, there was no clear process for staff working in community mental health teams identifying what action they should take where a patient does not attend an appointment. Learning was identified from a number of investigation reports in relation to the quality of care records. However, we found limited evidence that this had led to improvements in care planning and risk assessing across teams.
- The identification of risks relies on using all available information, and learning from incidents. It is important

to have a full understanding of these so that the risk of future incidents can be minimised. We were not assured that the trust had learnt from previous serious incidents in relation to assessing and managing risks in the environment (discussed in detail previously).

- The trust board recognised that significant work was required at Southampton in order to ensure it provided safe and effective services. As such, it had put an improvement team in place, which had developed a plan of action to achieve a number of changes. The improvement team had reviewed serious incidents in the Southampton mental health services to understand common themes. The team used the information to contribute to develop the improvement plan. For example, transferring patients frequently between teams had been highlighted as a causative factor in serious incidents. To address this, the teams were now able to transfer care between teams without the need for additional assessments. The improvement team met weekly to review the impact of actions, such as reducing the number of transitions a person might have to make between teams. In addition, the team monitored progress against key performance indicators such as themes from serious incidents.
- There were examples of learning from incidents in the CAMHS service. In March 2015, a staff member had been assaulted with an item of cutlery. Following this, a cutlery protocol was put in place and all staff signed the document to show that they had read and understood it. There was also a review of the location of corridor locks as, in the investigation; the staff team identified these locks had been a contributory factor in the incident. Staff members in all wards told us about the learning following a recent incident where a staff member had been injured in the face and new guidelines had been put in place to prevent a reoccurrence. All staff that attended in the focus groups knew about the incident and could describe the subsequent learning.

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 the following areas of good practice:

- The trust had made improvements to the acute mental health care pathway that it hoped would reduce patients' experience of transfer between different teams on multiple occasions and improve communication and joint working between the teams. There was a specialist assertive outreach team to work with patients with severe and enduring complex mental health needs.
- The care navigator role was in place at Elmleigh acute mental health unit. The plan was to extend this to other inpatient units. This role supported patients' safe transitions through the acute care pathway. Staff reported that it had been effective in increasing clinical time for patient care.
- In the learning disability services staff completed comprehensive, timely assessments of patients' needs on admission, undertook thorough physical examinations and ongoing monitoring of patients' physical health problems. Care plans were personalised to individuals' different needs and there were plans available in different formats to meet patients' personal wishes.
- There was a very low use of psychotropic medication (medication capable of affecting a person's mind, emotions, and behaviour) at Evenlode. Staff adopted a therapeutic approach in line with National Institute for Health and Care Excellence (NICE) guidance and other best practice, which included a focus on positive risk taking. Patients and their relatives were keen to stress the progress they had made following their admission to the service in comparison with progress made at other units (outside the trust).

- The young people at Leigh House and Bluebird House had access to a wide range of therapies. The multidisciplinary team worked in partnership with young people to review their care and plan for the future.
- The community mental health teams in Southampton facilitated health and wellbeing clinics and identified clinicians who focused on the physical health and wellbeing of patients. A range of psychological therapies and social support was available to patients. The acute mental health team used crisis workbooks with people to help manage emotional distress.

However, we found the following issues that needed to improve:

- We found a variation in quality and detail of care records. Investigations undertaken by the trust into serious incidents had highlighted that poor recording was an issue in a number of serious incident investigations across the trust. There were inconsistencies across teams in relation to where they recorded patient information on the electronic care record system. The community teams informed us that they did not currently have a written standard of what was expected and where it should be recorded. The trust stated there was a standard operating procedure as well as quick reference guides, although they recognised that more work was required to standardise where on the electronic care system entries were required.

Our findings

Assessment and planning of care and best practice in treatment and care

- The trust had made a number of improvements to the acute mental health care pathway that it hoped would reduce patients' experience of transfer between different teams on multiple occasions and improve

Are services effective?

communication and joint working between the teams. For example, it had combined the acute mental health teams (which provided intensive support for those in a crisis) with its acute inpatient wards to form a single care pathway for patients. The trust had introduced the care navigator role at Elmleigh acute mental health unit, and the plan was to extend this to other in-patient units. This was a role developed to support safe transitions through the acute care pathway. For example, ensuring that community staff were aware of discharge plans and identifying actions required to support effective transition of patients. Staff reported that it had been effective in increasing clinical time for patient care.

- The trust had redesigned the community pathway in Southampton as part of its improvement plan. The community teams were based across three hubs, central, east and west. The teams delivered all the functions of community mental health care, undertaking mental health assessments and, where allocation within the team was appropriate, a range of more specialist assessments and interventions. The trust had also redesigned the crisis care pathway. One 24 hour team had been established and was available seven days a week to support people who were acutely unwell. They worked with patients at home or arranged admission to and discharge from hospital where indicated. There was a plan to increase the psychiatric liaison service at Southampton General hospital by March 2016. The improvement plan included a focus on improving the pathway for people who were in hospital, ensuring people did not remain in hospital any longer than they needed to and that local beds were available when people needed admission. Although there were still a number of improvements required and changes to be evaluated and embedded, most staff felt consulted and engaged with the improvement plan and felt it would improve services.
- The trust had made significant improvements to the child and adolescent mental health wards since the last inspection and had addressed all the requirements of the previous compliance actions (now requirement notices) placed at our comprehensive inspection in October 2014. For example, there were now trust policies in place for the restraint of young people and

access to physical healthcare monitoring. We saw examples of comprehensive assessments and newly implemented collaborative care plans, completed with the young people.

- We saw evidence that Evenlode provided treatments in line with National Institute for Health and Care Excellence (NICE) guidance and other best practice, including dialectical behaviour therapy and a sex offender treatment programme. Patients at Evenlode had complex needs with elevated risks necessitating the need for admission to the medium security setting. Staff managed these needs with a therapeutic approach and very low use of psychotropic medication. We saw, from reviewing care plans at the Ridgeway Centre, that staff completed comprehensive, timely assessments of patients' needs upon admission.
- Assessment procedures varied across the acute mental health wards and units. For example, the procedure on Elmleigh was for nursing staff to complete an initial nursing assessment after admission. This was a paper document completed together with the patient, which administrative staff entered into the electronic records system. On Kingsley ward there was no nursing assessment on admission. The four records we reviewed had an initial medical clerking assessment and '24-hour narrative' recovery orientated discussion. This outlined the reason for their admission, what would help them, and the people with which staff could share information.

Information and records Systems

- There was a wide variation in quality and detail of records, which we identified during our inspection of the services and in our review of how the trust undertook investigations. We saw examples of comprehensive and detailed records and assessments. However, we also saw care records that had serious omissions. For example, no care plan, risk assessments or relapse management plans in place. On some wards, patients had a large number of care plans that were out of date. We reviewed care plans in three electronic patient records on Hawthorn 1 and found staff had placed multiple care plan items on each individual patient's care record, ranging from 12-22 items.
- There were inconsistencies across teams in where they recorded patient information on the electronic care

Are services effective?

record system. The teams did not currently have a written standard of what was expected and where they should record specific aspects of information. The trust stated there was a standard operating procedure as well as quick reference guides, although they recognised that more work was required to standardise where on the electronic care system entries were required. There was inconsistent practice of using the care plan and risk assessment field on the electronic care note system. There was a common practice to have both in a progress note only. Therefore, for a staff member to review and understand a care plan or risk issues, they would need to search progress notes. The trust was aware of these issues and in June 2015 had established a trust-wide care records work stream. However, this was still in the process of assessing the key issues and developing strategies with the divisions to address and monitor the issue. The trust told us that it planned to make changes to the electronic record system to suit the purposes of individual teams and clinical pathways. However, in the meantime the risks of inconsistency were still apparent.

Adherence to the MHA and the MHA Code of Practice

- We did not undertake any scheduled Mental Health Act (MHA) monitoring visits during this inspection. However, we noted the following relating to the Mental Health Act:
- The trust had several MHA administration offices located on hospital sites across the geographical area. All detention paperwork we reviewed was present and correctly completed.
- In acute mental health services, there was variability in the way capacity to consent to treatment was recorded in admission medical entries, at ward rounds and when nurses administered medication. An assessment pro-forma was generally not used. In the majority of records reviewed, there was a statement that someone had or lacked capacity without evidence of the assessment undertaken. Of ten records of detained patients reviewed, only one had details of a capacity assessment to support the judgement. References to capacity were generally in the progress notes; it was often stated 'has capacity' or 'lacks capacity'. The issue in question was often not clearly stated but appeared to be predominantly in relation to issues around consent to treatment. We found that there were no patients detained under Deprivation of Liberty Safeguards (DoLs) in the acute wards we visited.
- When a patient was admitted to a psychiatric intensive care unit staff explained to them what their rights were and repeated this explanation on several occasions. On the acute wards, four out of seven records indicated that staff had explained patients' right and that these had been repeated. However, we found one instance of a patients being transferred without having their rights repeated and one case where a patient had been detained for four months and there was no evidence that they had had their rights explained during that time.
- We examined seven sets of documentation in relation to young people detained under the MHA. These were in good order and young people had their rights explained in accordance with section 132 of the Act. There was good access to Independent Mental Health Advocacy services, and young people knew how to contact them.
- When young people were nursed in seclusion there was a lack of consistent documentation in relation to the seclusion practice. A doctor did not always visit the young person in seclusion to undertake a four or eight hour review of their needs. Young people at Bluebird House often were a long way from their place of residence but staff would make every effort to support them to access to their own communities, regardless of the distance and even if it required multiple staff escorts.
- Receipt and scrutiny of MHA documentation was good and records of capacity and consent in relation to the MHA was appropriately documented, apart from one capacity assessment dated 2013; there was no evidence of a more recent assessment in accordance with the MHA.
- We looked at nine files, randomly selected from a range of services, to examine whether section 117 assessments and pre-discharge planning considerations had been documented. We did not find any section 117 assessments or considerations in any of the files we looked at. We reviewed if safeguarding issues and

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concerns were considered when discharge was being planned and found a mixed picture. However, we saw some files where safeguarding was considered and recorded in the weekly multi-disciplinary meeting.

Are services caring?

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

Summary of findings

During our comprehensive inspection in October 2014, we gave a rating of 'good'.

We did not review this key question in detail during this inspection. However, we found that staff were kind, caring, supportive, and treated patients with respect and dignity. Some patients reported that some staff went the 'extra mile'.

Our findings

We did not review this key question in detail as at the comprehensive inspection in October 2014 we rated, 'are services caring' as 'good'.

In three of the core services that we inspected:

- We observed good care on all the acute mental health wards we visited. Staff interactions with patients were kind and caring. We overheard interactions that were respectful and supportive. We saw feedback that patients had provided about staff on Trinity ward at Antelope House, which was very positive about the whole team. One patient had nominated the nursing team as well as an individual staff member team for a 'People's Choice' award. A peer review consultation took place at Antelope House on 15 September 2015. Patients commended staff from Trinity ward for 'going the extra mile'.

- At our inspection in October 2014, we found high levels of staff commitment and enthusiasm in Bluebird House, where young people were involved in all aspects of their care and support. At this inspection, we found this was again the case and Leigh House had worked hard to achieve the same high standard.
- At both the Ridgeway Centre and Evenlode, we observed that staff interacted effectively and positively with patients. However, we noted an apparent lack of interaction and meaningful engagement with some of the male patients at the Ridgeway Centre. At Evenlode, named staff were described very positively as being excellent and as giving more than was expected of them. However, feedback from patients was not unanimous and patients raised a number of specific concerns with us about the conduct of some members of staff. The trust were aware of these and had taken steps to address concerns.

However,

- We felt that the trust showed a lack of consideration for the views and dignity of patients in its response to our request for it to address the ligature risks at Evenlode. Although the trust had taken action when requested, it had not engaged or consulted effectively with patients or explained the rationale behind the changes causing concern and distress for several patients.

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

We found the following areas of good practice:

- Whilst the trust faced some significant pressures in relation to access to acute inpatient beds the acute mental health teams had developed effective gatekeeping practices and managed most admissions to and discharges from the local inpatient units, supported by each locality acute care transfer coordinator. Beds were usually available in local inpatient units when required and patients rarely had to go outside of the trust to receive acute inpatient care.
- Transition and discharge processes at Leigh House and Bluebird House had significantly improved and there was clear documented evidence of discharge planning.
- The trust had redesigned the community pathway in Southampton as part of a trust improvement plan. The improvement plan included a focus on improving the pathway for people who were in hospital, ensuring people did not remain in hospital any longer than they needed to and that local beds were available when people needed admission.
- The crisis care pathway had been redesigned. One 24 hour team had been established to be available seven days a week to support people who were acutely unwell, and either worked with people at home or arranged admission and discharge from hospital where indicated.

However, we found the following issues that needed to improve:

- Staff identified that, increasingly, acutely ill patients were being admitted to Kingsley ward at Melbury Lodge and were concerned about their ability to manage them safely and effectively with the current staffing numbers and skills levels. They had raised this with the senior team but little had been done to support the team.

- The trust regularly used the beds, in all acute wards, of patients who were on Section 17 leave for admissions. The trust told us that they endeavoured to avoid this where someone was on short term Section 17 leave, and that it was preferable to sending the patient to another area.
- While the trust had improved the way it managed and responded to complaints and the overall the tone of responses to complaints had improved, we found that some letters did not answer the concerns fully. Some investigation reports were very superficial and appeared rushed and not challenging. Most of the action plans were poor, incomplete and did not identify actions, learning or change of practice. There was some evidence of learning from complaints in some teams but this was not widespread.

Our findings

Access and discharge

- There were significant bed pressures within the acute wards. On one of the acute wards we witnessed a conversation identifying that there were six patients waiting for admission and only one acute bed available in the trust. We saw evidence, on all of the acute wards, that the beds of patients on section 17 leave were used for new admissions which could mean that the patient on leave didn't have a bed to come back to. The acute mental health teams performed the gatekeeping role to beds within acute wards and managed most admissions to and discharges from the local inpatient units, supported by each locality acute care transfer coordinator. The acute care transfer coordinator was responsible for bed management and supporting the 'gatekeeping' function (access to acute beds). They monitored inpatient progress by visiting the wards daily and used a risk rating system to highlight when patients may be ready for discharge. The acute care transfer coordinators kept a tracking spreadsheet to monitor bed usage and had daily telephone conferences to track bed availability across the trust. The community staff we

Are services responsive to people's needs?

met told us they could usually access a bed when required. Information provided by the trust reflected that beds were rarely required outside of the trust. This meant that people were usually admitted to a bed within the trust, and where possible their local unit.

- The medical director advised that she had delivered a presentation to the trust's quality and safety committee on how the trust would use indicators to provide assurance on quality of services within mental health. The indicators that the trust planned to use include, monitoring the numbers of people readmitted within two weeks of discharge and serious incidents after discharge.
- Staff expressed concern about safely managing increasingly acutely unwell patients in Kingsley ward at Melbury Lodge with the current staffing and skill mix. They told us that they had raised these with the senior team but the trust had taken little action to address this issue.
- At this inspection, we found that the discharge and transition process had improved in both Leigh House and Bluebird House. There was clear evidence in all files reviewed of discharge planning and a trust transitional policy was in place.
- In response to identified concerns, the trust had put an improvement team in place at the Southampton community mental health services. The team had developed a plan of action to achieve a number of changes. The main components of the first phase had already been implemented at the time of the inspection; this included the introduction of a redesigned community and crisis care pathway. Transferring patients frequently between teams had been highlighted as a causative factor in the occurrence of serious incidents. To address this, the teams were now able to transfer care between teams without the need for additional assessments. Whilst patients were most commonly referred by their GP, the service also operated a rapid access referral system for patients who had received a service within the previous year. Patients could self-refer and get an appointment quickly. The teams discussed new referrals within the daily referrals meetings to identify how quickly an assessment needed to take place.

Learning from concerns and complaints

- The trust recorded its complaints per calendar year. During 2015 it received 451 formal complaints and 511 informal complaints; a small reduction on the previous year and comparable with other NHS trusts of similar type. According to information supplied by the trust for 2015, there were 330 closed complaints and 69% were either upheld or partially upheld (30% and 39% respectively). However, CQC's intelligent monitoring identified that between 1 November 2014 and 31 October 2015 443 complaints (48%) were either upheld or partially upheld (21% and 27% respectively); a disparity of over 100 complaints in the two sets of numbers, (even allowing for the two months difference) CQC's intelligent monitoring identified that the rates upheld appeared low.
- Twelve complaints had been referred to either the Health Service Ombudsman or Local Government Ombudsman during 2015. Six cases were ongoing, two asked for information with no investigation, two were closed and not upheld and had no recommendations, one had a draft response and was partially upheld and one had a mediated resolution.
- The trust had a complaints and patient advice and liaison service policy and procedure, which provided the foundation for the trust's complaints management system. Neither incorporated any reference to the Duty of Candour regulation although the trust had a separate Duty of Candour policy. However, from discussions with the complaints team it was evident that practice had moved on from the policy. This meant that practice within the trust was different from the policies it had for complaints and the application of Duty of Candour.
- The trust used the Ulysses software system to report, record and manage all complaints and there was a clear reporting structure, monitoring and management system in place. The trust had recognised that there was insufficient senior oversight of complaints and had recently introduced corporate panels, performance reviews, quality groups and resolution meetings to strengthen corporate oversight and support and scrutinise local services. However, it was not clear if the decision by the investigating office to uphold a complaint or not was endorsed or challenged by the senior team to ensure trust wide consistency.
- Complaints were reported and discussed at all levels of the trust; evidenced by a number of reports and minutes

Are services responsive to people's needs?

of the meetings. Reports to board did include complaints data but there was little evidence of analysis and 'so what' explanation to the board. However the trust told us that more detailed reports on complaints were seen by the executive-led quality improvement and development forum and the quality and safety board sub-committee on behalf of the board.

- In November 2015, the trust had trained 162 staff across the trust to take on the role of investigating officers (IO's). Feedback from staff in the core services that we inspected confirmed that they were aware of how to use the complaints arrangements. The trust also provided customer care training at staff induction; the training material appeared to indicate that this was of good quality.
- Managers and staff were encouraged to resolve complaints and concerns locally and quickly when appropriate and within a described timescale. There was no evidence that this was being recorded and then used to identify areas for development, themes and learning across the trust. The trust had recently implemented a change to the complaints process to ensure all concerns and complaints were recorded on the Ulysses incident reporting system. It was too early to gauge the effectiveness of this development in identifying areas for development and learning.
- Up to one year ago the trust was consistently failing to meet its key performance indicator for providing a final letter of response to complainants within timescale. The target had been extended nationally and the trust was now meeting this.
- There was no evidence of the complaints system being subject to either internal or external audit. However, the complaints manager checked an extraction of the data for completion on a monthly basis. Managers and staff discussed the complaints data extraction report at one to one and team meetings and also checked data quality.
- We reviewed 10 randomly selected closed complaint files. In all cases, the trust had met the timescales for both an initial and final response. However, the quality of the complaints management varied from very good through to quite poor (even spread across the 10 reviewed). Overall, the tone of the final letters was good, written with compassion and with sincere and appropriate apologies. There was very little jargon and most answered the concerns raised. However, there were some exceptions where some letters did not answer the concerns and appeared very light on specifics, some investigation reports were very superficial and appeared rushed and not challenging. We were told that an executive director would see the final letter and that the chief executive would sign all final letters. Most of the action plans were poor, incomplete and did not identify actions, learning or change of practice.
- There was no widespread evidence of learning from complaints across the services we inspected, although there was some evidence in a few of the services. The trust recognised that effective trust wide learning needed improvement and was taking steps to address this through the governance teams' leadership and actions to move the culture further forward. The complaints team had a clear objective to improve learning from complaints, which was detailed in the quality and governance business plan for 2015/16; due to be achieved in April 2016.
- In order to promote a culture of learning from complaints the trust have recently asked complainants to attend its quality conferences in order to allow staff to hear directly from patients and carers. In addition, a number of patients, some of whom have complained had been asked to speak at the 'gone viral' leadership development programme.
- Staff could also record compliments on the Ulysses systems. The trust shared 'compliments of the week' with staff across the trust on its intranet.

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

We found the following issues that the trust need to improve:

- A revised quality governance strategy 2014–2016 was in place and set out a number of patient-centred quality improvement goals. Staff within the services that we inspected had limited knowledge of the strategy. The links between the quality governance strategy and the trust's quality programme was not clear because there was no reference made to strategy in the quality governance programme. The board regularly received a variety of reports on quality issues but reporting specifically about on-going progress with the quality strategy was not cohesive or comprehensive. It was therefore difficult for the board to have a clear oversight of progress with the strategy. The trust was aware that improvements were needed to its quality governance strategy and had commenced a review. At the time of the inspection the trust were in the process of drafting a new strategy.
- Governance arrangements were ineffective in identifying and prioritising risks arising from the physical environment. As such, the trust did not respond in a timely manner to concerns about patient safety. In addition, there were gaps in governance systems and processes, which prevented the trust from carrying out robust incident investigation. Key risks and actions to mitigate the risks were not driving the senior management or board agenda. However, the trust was starting to address this (see below).

However, we found the following areas of good practice:

- The trust had a clear vision and a set of values developed in consultation with staff, patients and external stakeholders.

- The trust had implemented or was starting to implement some sound governance structures and processes with the potential to provide it with robust oversight and assurance. For example:
 - standardised divisional governance arrangements which were beginning to be embedded, renewed processes for reporting, recording and investigating incidents and deaths and the introduction of a dedicated investigation team and a corporate panel for reviewing the investigation of serious incidents and deaths;
 - the electronic management of complaints;
 - the quality improvement programme;
 - learning networks to share learning from incidents and complaints;
 - the introduction of 'Tableau' (the trusts' new business intelligence tool).
- Some of these were beginning to have positive effects and show improved outcomes as evidenced by improved key performance indicators in a number of areas.

Our findings

Vision, values and strategy

- The trust had a clear vision and a set of values developed in consultation with staff, patients and external stakeholders. The board viewed the trust as an integrated trust crossing multiple sectors.
- A revised quality governance strategy 2014–2016 was in place and set out a number of patient centred quality improvement goals. It stated that its aim was to promote a culture of continuous improvement where every member of staff has the pride, confidence, compassion and skill to champion the delivery of safe and effective care. We found that staff within the services that we visited in this inspection had limited knowledge of the strategy. The trust was aware that

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improvements were needed to its quality governance strategy and had commenced a review. At the time of the inspection the trust were in the process of drafting a new strategy to reflect the trust's five year plan.

- The links between the quality governance strategy and the trust's quality programme was not clear because there was no reference made to strategy in the quality governance programme. The board regularly received a variety of reports on quality issues but reporting specifically about on-going progress of the quality strategy was not cohesive or comprehensive. It was therefore difficult for the board to have a clear oversight of progress with the strategy.

Good Governance

- A quality programme, with eight work streams was in place. The quality programme detailed required actions from the CQC inspection in 2014. A quality programme steering group was responsible for holding the work streams to account for the delivery of the work plans and ensuring learning was shared across the trust. Performance information relating to the eight work streams was available to staff via the data warehouse and dashboards.
- One key component of the internal quality assurance system was the divisional peer review programme. A team made up of staff from the trust and a service user and senior manager had undertaken scheduled internal reviews of each service. The programme covered all inpatient units (by ward) as well as community services. The aim was to focus on the current operational issues as well as issues from previous reviews and inspections to show how improvements were being made and assess whether these were being embedded within practice and service delivery. The trust acknowledged that this programme was still not fully in place across all its divisions. However, this programme had the potential to provide the trust with a good understanding of all of its services. The reports we saw, for example, the ones for the Ridgeway Centre and Evenlode, were very comprehensive and accurately reflected our findings during this inspection and inspections in October 2014 and August 2015. However, the trust had generally made minimal improvements as a result of the peer review programme.
- The trust had developed some sound governance structures and processes, many of which it had only recently introduced or was in the process of introducing. For example, standardised divisional governance arrangements which were beginning to be embedded; renewed processes for reporting; recording and investigating incidents and deaths; a dedicated investigation team; the introduction of a corporate panel for reviewing the investigation of serious incidents and deaths; the electronic management of complaints; the quality improvement programme and the introduction of 'Tableau' (a new business intelligence tool). Some of which were beginning to have some positive effects and show improved outcomes, as evidenced by improved key performance indicators in a number of areas. However, many staff working with these new or revised systems and processes were at an early stage of understanding and capability to use these. As a result, there was a wide variation in the quality of reporting, investigations, complaints handling and engagement with the systems and processes.
- The trust's new business intelligence tool (Tableau) had been installed and rolled out to clinical and corporate teams; this contained clinical, governance and staffing data. Monthly area quality meetings looked at governance issues and weekly executive flash reports monitored targets. For example, the use of bank staff and bed stays. Some of the management team we spoke with recognised that more work was needed as these did not reflect a clear focus on identifying learning from incidents and clear actions to be taken, or how the board assured itself that issues coming from the service fitted with trust wide themes and work streams. For example, how the trust wide theme or work stream looked at poor risk assessments and recording within specific teams.
- It was too early to be assured that the quality governance systems and processes would have the desired effect. The trust had introduced or revised its systems in response to criticisms in a variety of reviews and reports (most recently the Mazars report) and as a result, we found that staff were not always clear about what the latest system or process to follow was and what was expected of them.
- Commissioners had developed a multi-agency concordat to agree how all organisations involved in a

Are services well-led?

patient's care would come together to investigate or identify a lead organisation to undertake an investigation into incidents and deaths. This followed issues highlighted in the Mazars report. This report had indicated that the trust may not have investigated all the deaths of patients in its care that it should have done, (the trust believes it had investigated all the deaths it had clear responsibility to investigate) and highlighted that there was a lack of clarity in the NHS systems about which organisation should investigate a person's death when more than one was involved in their care.

Reporting and investigation of deaths and serious incidents

- On 1 December 2015, the trust had introduced a new, trust-wide system for reporting and investigating incidents and deaths to increase monitoring and scrutiny, share learning with staff and improve the quality of reports and investigations. The system, if operated effectively, had the potential to be an example of good practice in investigating incidents and deaths and the trust had made significant progress in implementing a number of aspects of the system. However, it was at an early stage of implementation and there was considerable variability in its application and staff knowledge and understanding of requirements of reporting and investigation.
- Staff were required to report all deaths using the Ulysses electronic incident reporting system. The most senior person on duty would complete an initial management assessment (IMA) within 48 hours, which would be reviewed to assess whether it required further investigation. The trust had introduced a corporate panel, which included an executive member to review all those that required further investigation. In response to issues that we identified with a lack of appropriate reporting and therefore investigation the trust made the decision that all deaths of people under the care of learning disability and acute mental health in-patient services should be reviewed by the corporate panel. The new process was being monitored daily by the trust's quality and governance team and the panel had started to consider the quality of reports to make sure they were thorough, clearly written and understandable.
- Since December 2015, the trust no longer defined deaths as 'expected' or 'unexpected'. Instead, all deaths of patients, outlined in the new procedure, were recorded to ensure that every death would be subject to scrutiny and investigated further, if required.
- Information supplied by the trust showed that under this new system, 100% of the 289 deaths reported onto the new system between 1 December 2015 and 29 February 2016 had been reviewed by the clinically led panel and that if required, a full investigation into a patient's death had been launched. The trust also reported that every family had been offered the opportunity to be involved in an investigation into the death of their loved one/relative (wherever possible). It told us that all clinical staff had been informed of the requirement for them to adhere to the new system for reporting patient deaths. However, we found that staff were unsure of when and how to involve families and it was not always clear what discussions or communications had taken place to involve families.
- We spent time with the governance team, who showed us how the Ulysses system worked, including all underpinning electronic systems and processes. The governance team demonstrated a good understanding of the system and had implemented clear procedures, and allocated specific responsibilities to different members of the team, to enable them to track and monitor the progress of incidents and investigations. The completed Ulysses form was checked for accuracy and severity (red amber green (RAG)) rating and whether staff had 'ticked' that they had made contact with family/carer/next of kin. If the RAG rating was not appropriate or more information was required, we were informed that these would be returned to the service for further detail. All serious incidents requiring investigations (SIRIs), including deaths, that rated moderate or above were passed to the SIRI manager for action and oversight. There were particular categories that would automatically be sent to them for review regardless of RAG rating. These included, deaths, absent without official leave, slips, trips and falls and pressure ulcers. However, we found a wide variation in quality and detail of incident reports, which indicated that the trust could not be assured that it had accurate data to enable it to take appropriate action. For example, undertaking timely investigations, meeting the statutory reporting requirements and learning from incidents.

Are services well-led?

- Once the incident was logged on Ulysses the person entering the information did not have any further access. Only ward managers, deputies and key managers had access and received updates to ensure controls over amendment of information. However, we identified that whilst the audit trail showed if a 'permitted' person had accessed the report it did not show whether, what or why the report had been changed. We raised this with the trust who agreed to explore this further.
- Staff told us that they felt that local and informal processes for reviewing less serious incidents had always been managed well, that all incidents were investigated and feedback discussed in team meetings. However, they had little knowledge of what happened at a high level within the trust. Staff could identify some incidents that related to their local services, although none of the staff we spoke with could identify any specific trust wide learning from serious incidents or what the executive board or senior management team were doing in response to the recent independent investigation into the trust. Most staff were aware that a new trust-wide process for recording, reporting and investigating deaths had been implemented in December 2015 but understanding of the overall process and the expectation of staff was variable in the services inspected.

Responding to concerns and incidents

- During and after our inspection visit in January 2016 staff at three of the trust's mental health and learning disability services expressed concerns that they did not feel listened to if they raised concerns with senior managers or the executive team. However, staff told us that local managers were supportive. They reported a poor response to concerns raised with senior managers about the safety of services, including known environmental risks, increasing acuity of patients and risks arising from a lack of specialist training. We also received eight whistleblowing contacts to this effect. In December 2015, West Hampshire clinical commissioning groups wrote to the trust expressing similar concerns that had been raised by an anonymous whistleblower. During our inspection of acute mental health in-patient and learning disability services in

January 2016 we too found that the trust had taken little action to assess and prioritise environmental risks, respond to staff concerns in a timely manner and communicate effectively and involve staff in plans.

- We served a warning notice advising the trust that it was required to make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements were effective in identifying and prioritising risks to patient safety arising from the physical environment including ligature risks, falls from height and risks from patients absconding. In previous inspections (October 2014 and August 2015) CQC had identified a number of environmental risk, some of which we found had been addressed by the trust whilst others had not. We recognised that the trust must prioritise and allocate funds accordingly, which may involve difficult choices. However, the trust was unable to provide comprehensive records evidencing the progression or completion of tasks relating to assessing and managing risks in the environment or the reasons why capital bids for environmental works were accepted or rejected.

Leadership and culture

- There had been some significant changes in the trust board since our comprehensive inspection in October 2014. Nine of the current board members had joined the board since this time. There was a new chair, several new non-executive directors, a change of medical director and the appointment of a multi-speciality community development director. In addition, the trust had recently appointed a new director of nursing who was due to start in post on 1 May 2016.
- The chief executive explained that the trust was in the process of shifting its decentralised and locally accountable culture that had little corporate oversight to one that has a more balanced approach. She identified her key priorities as:
 - completing a comprehensive review of the quality & governance structure and the ratification of a proposed new model
 - ongoing implementation of team based business plans and dashboards in order to engage staff in locally led quality improvement

Are services well-led?

- ensuring the trust executive team used team based data on a weekly basis to ensure risks, mitigations and actions were positively affecting outcomes for patients and providing team to board assurance
 - ensuring the reformed capital planning delivered increased clinical scrutiny to ensure the appropriate clinical prioritisation and identification of clinical risks
 - However, we did not see an organisational development programme or plan to achieve this. This was illustrated by the delay in putting a trust-wide patient engagement strategy and specific epilepsy protocol in place. The 'protocol for managing a patient who has epilepsy at bath time' was ratified during the inspection (more than two and half years after it was identified that this was required). The trust recognised that its previous approach might have missed opportunities to ensure consistent standards and practice across the trust. The trust also recognised the importance of patient engagement and their experiences. As a result the trust had included this as one of the trust goals and the medical director had taken a lead for progressing work related to this.
 - There was a clear difference in views about the impact of the Mazars report and its focus between the trust board members and staff delivering services. Trust board members felt that the report and the high level of publicity it brought had seriously affected staff. However, staff were generally not focussed on the report and many told us they saw it as only relating to learning disability services and not the wider trust.
 - It was clear that the board had focussed its time and attention on the Mazars report since its publication. The board was upset and concerned that the report was unfair and had misrepresented the trust and its actions. The focus for the board had been on the mortality data and they appeared to have spent a significant amount of time reviewing, challenging and creating comparative data to demonstrate the inaccuracies in the report. This focus on one aspect of the report appeared to have led to delays in addressing the other issues highlighted, including the patient experience, family engagement and application of Duty of Candour since April 2015. The board members had various arguments to support this but this generally centred on what they saw as the misinterpretation and presentation of data and the disconnect between the findings and recommendations. The trust board felt bruised, although some individual members were obviously more affected than others. Board members told us that they thought that Southern Health was probably not the only NHS trust in the situation. By the time of our January 2016 inspection senior managers at the trust had started to take action to address some of the criticism about systems and processes and were beginning to recognise that they needed to restore the trust's reputation with staff and the public to where they believed it should be; a trust that is 'caring, successful, innovative, safe and a good place to work and be cared for'. Actions included introducing a new trust wide system for reporting and investigating deaths, including the introduction of a corporate panel to provide oversight of investigations, the introduction of a mortality task and finish group and the development of a mortality and serious incident plan. However it was too soon, during the inspection, to assess whether these would have the desired effect in ensuring robust investigation of deaths.
- The chair told us that he was focussed on getting the board back to having a healthy balance between a concentration on business as usual and effectively managing "incidents" (the Mazars report and other highly publicised issues) with longer term and reputational consequences.
 - The chief executive told us that she believed that she now had to lead the trust through the challenges ahead. She stated that she accepted that governance arrangements needed to improve and embed in order to support staff effectively to deliver high quality care and provide the required level of assurance to the board and public.
 - It was clear that there were real challenges facing the board in providing strong leadership to the organisation going forward: not least, managing the current financial climate while fundamentally transforming models of care to meet the needs of patients and the population the trust serves.

Engagement with staff and staff morale

Are services well-led?

- In the Southampton community services, CAMHS wards and most of the acute mental health wards, we found that staff morale was good, and staff felt supported by local managers and that they would be listened to if they raised concerns.
- All staff we met in the community teams said that the area management team had managed the major redesign of Southampton community services very effectively. Some staff were not happy to have left their previous teams and admitted that they were still adapting to the change. However, they said they felt genuinely listened to and valued by their team managers and the area manager. Overall staff morale was good and staff were positive about the potential benefits of the new model. Staff told us that the area manager was `inspirational`, approachable and highly visible. This was seen as a real achievement given that all the staff in Southampton that we spoke with said that the previous redesign process, four years previously, had been very badly planned and managed, resulting in poor staff morale and a poor model of care.
- At the Ridgeway Centre, we found that there had been improvements in staff morale and sense of being part of the wider trust since our previous inspection. Staff told us that senior management were now more visible on the unit. Staff were positive about the changes in the physical environment and the investment that had been made. They also told us that support from senior managers had also increased considerably recently. Inspectors were particularly impressed with the behaviour and professionalism of a senior charge nurse during the inspection. The charge nurse demonstrated good engagement with and knowledge of patients, alongside good leadership skills in coordinating staff to meet patient needs.
- None of the staff that we spoke with at Evenlode felt part of the wider trust, and staff at all levels expressed their sense of isolation from the trust. This clearly made it difficult for staff to share in the trust's vision and values. Staff raised concerns with us that there was an ongoing sense of uncertainty about the future for the service, and that they did not feel they had been effectively supported by the trust's senior management team. For example, staff told us they were unhappy that they had only received a visit from members of the trust's executive team the week prior to our inspection in January 2016. Staff felt this was simply in anticipation of us carrying out an inspection visit at the service. This lack of support from and engagement with senior management had contributed directly to a staff team that 'didn't feel like part of the trust'. It was to the credit of the local level team at Evenlode that staff who had recently joined the service reported to us that they felt it was a strong and supportive team, who helped them and who were positive about patient care.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	Community-based mental health services for adults of working age
Treatment of disease, disorder or injury	Risk assessment processes were not consistently used. Crisis plans were not used consistently. There was no clear process for following up on patients who did not attend their appointments, even when a person was identified as high risk of harm to themselves and/or others.
	This is a breach of Regulation 12(2)(a)
	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)
	Child and adolescent mental health inpatient services
	In Bluebird House medical staff were not able to attend young people's medical reviews, within one hour of the commencement of seclusion, as they had other commitments.
	This is a breach of Regulation 12 (2) (a) (b)
	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)
	Acute wards for adults of working age and psychiatric intensive care units
	There had been insufficient action taken to identify and prioritise actions required to address environmental ligatures on the wards.

This section is primarily information for the provider

Requirement notices

Insufficient action had been taken to manage the safety of patients at Kingsley ward. Staff could not clearly observe patients and patients could access the roof and climb out of the ward's garden.

The seclusion room on Hamtun psychiatric intensive care unit was not fit for purpose.

Staff did not always check and record medicine fridge temperatures at Elmleigh and on Kingsley ward at Melbury Lodge to ensure medicines were stored at the correct temperature.

This is a breach of Regulation 12 (2) (b) (d) (g)

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Wards for people with learning disabilities and autism

The environmental risks at Evenlode posed potential serious risks. Until the necessary changes are made to make the environment as safe as possible, appropriate measures must be implemented immediately to mitigate effectively the risks to people using the service.

The clinic room at Evenlode was unfit for purpose and did not contain all appropriate essential equipment for resuscitation.

Known environmental risks at the Ridgeway Centre had not been addressed.

This is a breach of Regulation 12(2)(d)

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

This section is primarily information for the provider

Requirement notices

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 (RA) Regulations 2014 Good governance

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

The trust had not ensured security arrangements were in place to keep patients safe whilst receiving care, including, restrictive protection required in relation to the Mental Health Act 1983. Patients detained under the Mental Health Act 1983 have absconded from Kingsley ward via the fence and the roof. The most recent abscond was 21 February 2016.

This is a breach of regulation 17(1)(b)

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Wards for people with learning disabilities and autism

The trust had not analysed and responded to information gathered from internal reviews to take action to address issues where they were raised, or used information to make improvements and demonstrated they have been made. The trust had not monitored progress against plans to improve quality and safety.

This is a breach of Regulation 17(2)(a)

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The training, learning and development needs of staff had not been identified and actions taken to meet any gaps.

This section is primarily information for the provider

Requirement notices

Staff did not receive appropriate on-going supervision in their role.

This is a breach of Regulation 18(2)(a)

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Wards for people with learning disabilities and autism

The trust had not made the necessary improvements to the environment at both locations in order to protect people's dignity and privacy at all times.

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

The trust had not ensured that patients' privacy and dignity is protected in a safe way on Kingsley ward.

This is a breach of Regulation 10(2)(a)

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Diagnostic and screening procedures	The trust did not have effective governance arrangements that identified, prioritised and mitigated risks to patient safety, for example, ligature risks, fall from heights and risks from patients absconding
Treatment of disease, disorder or injury	The trust did not have effective governance arrangements to deliver robust incident investigation or respond to concerns raised by patients and staff
	Key risks and actions to mitigate risks were not driving the senior management team or the board agenda
	This is a breach of Regulation 17 (2) (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)