

Southern Health NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Forensic inpatient/secure	Ravenswood House	RW148
	Trust Headquarters – Southfield	RW146
Wards for people with Learning Disabilities	Evenlode	RW1Z8
	Moorgreen Hospital	RW156
Wards for older people with mental health problems	Gosport War Memorial Hospital	RW158
	Western Community Hospital	RW155
	Melbury Lodge	RW119
	Parklands Hospital	RW1AC
Child and Adolescent mental Health Wards	Trust Headquarters – Bluebird House	RW1
	Leigh House	RW121
Long stay/rehabilitation mental health wards	Hollybank	RW1AN
	Forest Lodge	RW134
Acute wards for adults of working age and psychiatric intensive care units	Elmleigh	RW1AM
	Melbury Lodge	RW119
	Antelope House	RW1GE
	Parklands Hospital	RW1AC

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

Summary of findings

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

During this inspection (September 2016), we found that there had been a number of significant improvements made to the governance arrangements in order to identify and prioritise risks arising from the physical environment more effectively. The risks identified included those posed by ligature anchor points, falls from heights and from patients absconding. We saw clearer processes in place to ensure that the trust assessed the risks, tracked actions taken and that there were escalation processes in place where actions had not been undertaken or there were delays. Everyone we spoke with confirmed that there were much more effective relationships between the estates and clinical teams. We found that a range of anti-ligature work had been completed across the trust and that there was a much better appreciation of the need to drive forward and complete this work. Many of the staff and senior managers we met told us that it had become clear over the past six months that the trust were now more focused on patient safety and they were hopeful that mental health and learning disabilities services were now a higher priority.

Overall, staff morale was good. Staff felt positive about the changes taking place and the improvements to environments. However, there had been some significant changes at board and executive level and at the time of inspection, there was continued uncertainty and changes within the trust. There were a number of external reviews taking place, generating recommendations focussed on various aspects of the governance systems, including the board assurance framework, which the trust was in the process of putting in place. Whilst we recognised that the newly restructured leadership team had only recently come into post, it was our view that they demonstrated clearer recognition of the need to drive through and complete the work to assess, manage and prioritise a range of patient safety issues. There was clear evidence that action was being taken in a more timely and proactive manner.

The trust recognised that there was still significant work to do and that the new systems needed to embed. There needed to be clear assurance processes in place to ensure that effective actions had been completed. In addition, we had some areas of concern about specific sites – particularly Elmleigh. We identified on-going environmental issues at Elmleigh. In addition to the known ligature risks, during this inspection, we highlighted the layout of the wards meant that it was not easy for staff to observe patients in all areas – including those who might be at risk of acting aggressively, harming themselves or of absconding. The problem was compounded by four factors. Firstly, some of the ward fixtures and fittings could be used as ligature anchor points. Secondly, staff did not always manage the segregation of men and women well. Thirdly, there were not always a sufficient number of staff for staff to observe all areas of the ward. Fourthly, the local management team had not consistently reviewed and learned from incidents well. We raised these concerns at the time of inspection.

The trust had introduced a standardised safety and risk management plan to incorporate an individual's risks in relation to the specific ward environment. We were told that every patient now had this in place, but found that there was no safety and risk management plan relating to the environment in a quarter of the 143 records we reviewed. We also raised concerns about risk assessment processes at Ravenswood House medium secure unit.

Overall, we concluded that the trust had taken sufficient action to meet the requirements set out in the warning notice. The trust remains in breach of a number of regulations of the Health and Social Care Act 2008 (regulated activities 2014) from the previous October 2014 and January 2016 inspections; as a result of this inspection the two additional regulation breaches are listed at the end of this report.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Summary of findings

We found the following issues that need to improve:

- We remained concerned about the environment at a number of the trust's locations, where necessary improvements had either not yet been made through the programme of major works or had not been identified and prioritised through the trust's internal processes. For example, we identified environmental issues at Elmleigh in relation to poor lines of sight, multiple ligature risks, safe management of mixed gender areas, risks from patients absconding and staffing arrangements that were ineffective for the ward's layout.
- There were potential infection prevention and control issues with shared bathrooms at Forest Lodge. Some of these were in a very poor state of repair and were damp, had peeling ceilings and damaged flooring. Although necessary renovations were part of the planned estates work taking place at the service, we asked the trust to prioritise this aspect of the work. Following this inspection, the trust informed us that remedial work has been completed on the ceilings.
- We looked specifically at risk assessments and care plans relating to the assessment and management of risks from the environment to individual patients. There was variation in quality and detail. Some were completed to a high standard, and these were very detailed. Others contained minimum information and no evidence of a person centred care plan. The trust had introduced a standardised safety and risk management plan to incorporate an individual's risks in relation to the specific ward environment. We were told that every patient now had this in place. However, we found that there was no safety and risk management plan relating to the environment in a quarter of the 143 records we reviewed. We also raised concerns about risk assessment processes at Ravenswood House medium secure unit.
- Some staff raised their concerns with us about on-going issues on their wards due to low numbers of staff and an over-reliance on agency staff. This was particularly evident at Bluebird House and across the older persons' mental health wards, where an increase in acuity of individual patients' mental health problems could have a significant impact on the whole ward.

However, we also found the following areas of good practice:

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- A range of anti-ligature work had been completed across the trust, and there was a better appreciation of the need to drive forward and complete this work. Prioritisation of higher risk areas was more consistent where significant work was required and some changes had already taken place in most areas. For example, anti-ligature fixtures and fittings such as toilet roll holders and mirrors were in place. Outstanding work had been prioritised with funding approved and allocated for these priorities across the trust. There were timelines for actions and it was projected that all prioritised work on the 2016/17 capital plan would be completed by March 2017.
- Extensive improvement works had taken place at a number of the trust's sites. At Kingsley ward, Melbury Lodge, anti-climb guttering had been installed to prevent patients accessing the roof, the fence had been fixed to reduce potential footholds, mirrors had been installed to reduce blind spots, and work on introducing anti-ligature fixtures and fittings had taken place. All of the specific ligature risks that we had raised as a concern at the last inspection at Evenlode had been addressed
- Clear estates plans were displayed on each unit, and staff were aware of the trust's estates improvement plan. Most staff told us that the action being taken was positive in addressing the significant proportion of the work required that had been outstanding for a number of years. Staff described improved relationships between estates and clinical teams and felt that patient safety now had a much higher profile within the trust.

Are services well-led?

We found the following areas of good practice:

- We recognised that it was early days for the newly restructured leadership team, but it was our view that they demonstrated an improved understanding of the importance of work to assess, manage and prioritise a range of patient safety issues. There was evidence that action was being taken in a more timely and proactive manner.
- The interim chief executive provided examples of immediate changes that had made in order to assure the trust that it was aware of key risks and ensured that effective action was taken in a timely manner. For example, the trust had made changes to the quality and safety committee structures and framework, so it now included a clear escalation process to the trust executive group meeting.
- The trust's central quality governance team had been restructured to strengthen the links and lines of accountability between the central governance team and clinical areas.

Summary of findings

- Overall, staff morale was good; staff felt positive about the changes taking place and the improvements to environments.

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

- The trust had undergone some significant changes at board executive level and, at the time of inspection, there was continued uncertainty and changes taking place within the trust. A number of the governance processes required more time to embed to ensure there were clear assurance processes in place.
- Staff morale was variable on the older person `s wards, and was notably lower on the wards at Gosport War Memorial hospital. Some staff at Southfield told us that they felt less connected with the senior management team.

Summary of findings

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 11 people consisted of:

- two inspection managers
- seven inspectors
- one enforcement inspector
- one specialist advisor with specific experience in assessing clinical risk

Why we carried out this inspection

We served a warning notice on the trust following a short notice focused inspection in January 2016 and an unannounced, focussed inspection in March 2016. This required the trust to take urgent action to address issues to ensure the safety of patients. We told the trust that its governance arrangements did not facilitate effective, proactive, timely management of the risks in the environment. We identified a problem with the way in which the trust managed the risks that fixtures and fittings on some wards posed to the safety of patients. The trust had not identified the fixtures that patients who were at risk of suicide could use to tie a cord to hang or strangle themselves (ligature anchor points). The trust did not have effective governance systems to assess and manage risks. As a result, the estates department did not have clear and consistent plans to prioritise, remove or reduce the risk that posed by these ligature anchor points nor did they work closely with ward staff to improve ward safety. While some work had been undertaken the trust had not taken all of the necessary actions required to ensure the risks were addressed and managed so that patients were safe. Previous inspections had also highlighted that the physical environments at some of the trust's mental health and learning disability units posed a significant risk to the safety of patients and yet the trust had not taken the action required to ensure the risks were addressed and managed so that patients were safe.

This inspection (September 2016) focused on checking that improvements had been made to the physical environments and governance systems in place to identify and prioritise risks posed by the environment. We checked how the trust managed risks prior to estates work taking place, to make the environment safe. We also looked at staff awareness of the management of the risk, their involvement in the trusts plans to address the risks and support provided by senior leaders to help staff manage risk.

At our inspection in January 2016, we also found that the trust was not always undertaking effective investigations and learning from serious incidents. NHS Improvement and the quality oversight committee are monitoring the trust's implementation of the serious incident and mortality plan (developed following the publication of the Mazars report in December 2015). However, we intend to look again in detail at how the trust undertakes investigations, as well as the trust's implementation of duty of candour, at the next inspection we carry out. The interim chief executive officer told us they wanted to prioritise listening to patient and carer experiences and to improve people's experience of investigations. A number of changes were proposed to support this, including making permanent the central investigation team and employing a family liaison officer to work with families.

How we carried out this inspection

We visited each learning disability and mental health in-patient unit at the trust, with the exception of the Ridgeway Centre (because it was due for closure) and Stepdown service that had been recently inspected by CQC adult

social care colleagues. The inspection teams talked to staff and managers. We reviewed patient records, looking specifically at individuals' risk assessments and care plans relating specifically to assessing and managing risks from

Summary of findings

the environment. We undertook a walk-around and inspected the environment and equipment at each site. We checked documentation related to assessing and managing risks within the environment and potential risks to staff and patients. We interviewed the interim chief executive officer and a range of senior managers with responsibility for planning and implementing estates work and ensuring the safety and quality of services provided. .

Because this was a focused inspection to follow up on specific areas of concern, we did not consider all of the five key questions that we usually ask: Is the service caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led? Instead, we concentrated on whether the service was safe and well led.

During the inspection, the inspection team:

- spoke with the interim chief executive, head of compliance, health and safety manager, estates manager and local security management specialist
- spoke with 74 members of staff, including divisional managers, heads of service, ward and team managers, doctors, nurses, administrative staff, allied health professionals, support workers and estates staff
- reviewed 143 individual patient records
- requested incident data, meeting minutes and policies from the trust in order to check the trust's governance arrangements.

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 country with an annual income in excess of £330 million. The Trust provides these services across the south of England covering Hampshire and Oxfordshire. Over ninety percent of the care is provided in Hampshire.

The trust received foundation status in April 2009 under the name Hampshire Partnership NHS Foundation Trust. Southern Healthcare NHS Foundation 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, Buckinghamshire, Wiltshire and Dorset.

CQC undertook a comprehensive inspection of Southern Health NHS Foundation Trust in October 2014. We gave an overall rating for the provider of 'requires improvement' and we published the report in February 2015, this is available on our website. 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.

In January 2016, the Care Quality Commission carried out a short notice, focussed inspection of Southern Health NHS Foundation Trust. This followed the publication of the Mazars report in December 2015. 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 January 2016, CQC undertook 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 at the trust were well-led. We served a warning notice on the trust in March 2016, requiring it to take significant action to address several issues to ensure the safety of patients..

Summary of findings

Areas for improvement

Action the provider **MUST** take to improve

The trust must ensure better consistency in relation to the quality and detail of risk assessments across the wards

The trust must ensure that staff at Ravenswood House review risk assessments regularly and following incidents.

The trust must complete plans to improve and make safe the range of environments across the mental health and learning disabilities services in line with its estates improvement plan.

The trust must review the risks identified at Elmleigh in relation to lack of action following incidents, poor lines of sight, multiple ligature risks, safe management of mixed gender areas, risks from patients absconding and ineffective staffing arrangements.

The trust must continue to review and embed more effective governance systems to ensure effective monitoring of quality and safety

Action the provider **SHOULD** take to improve

The trust should ensure the arrangements for agency staff to access the incident reporting system at the Bluebird Unit are embedded

The trust should engage staff to understand the actual extent and impact of staffing levels and mix across the older person`s mental health wards and Bluebird House.

The trust should continue to actively engage and meet with staff during this time of uncertainty change of leadership

The trust should ensure it monitors the changing requirements of patients that may be admitted to the rehabilitation and older person`s wards, to ensure that patient and staff safety is maintained within the environment.

Southern Health NHS Foundation Trust

Detailed findings

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

Our findings

Safe Environment

- Previous inspections highlighted that the physical environments at some of the trust's mental health and learning disability units posed a significant risk to the safety of patients. During this inspection, we checked the environments at each learning disability and mental health in-patient unit at the trust, and assessed how the trust was prioritising action to be taken and managed risks in the meantime.
- We found that a range of anti-ligature work had been completed across the trust. There was a better appreciation of the need to drive and complete this work. The trust was prioritising the higher risk areas where significant work was required. Some actions that could be delivered quickly had already taken place. For example, anti-ligature fixtures and fittings such as toilet roll holders and mirrors were in place. Outstanding work had been prioritised with funding approved and allocated for these priorities across the trust. There were timelines for actions and it was projected that all prioritised work on the 2016/17 capital plan would be completed by March 2017. Clear estates plans were in place on each unit, and staff were aware of the trust's estates improvement plan. Most staff told us that the action taken was positive - as a significant proportion of the work had been outstanding for a number of years. Staff described improved relationships between estates and clinical teams and felt that patient safety now had a much higher profile within the trust.
- In our previous inspections in October 2014 and January 2016, we had raised significant concern about the environment at Kingsley ward, Melbury Lodge in relation to poor lines of sight, multiple ligature risks, risks from patients absconding and ease of access to the low roof. During this visit, we saw that anti-climb guttering had been installed to prevent patients accessing the roof, the fence had been fixed to reduce potential footholds, mirrors had been installed to reduce blind spots, and work on introducing anti-ligature fixtures and fittings had taken place. There was a plan to close and refurbish the ward to address some of the layout issues and undertake remaining anti-ligature work in bedrooms and bathrooms. Until this work is in place, processes were in place to help mitigate any patient safety risks.
- During our previous inspections in January 2014, October 2014 and January 2016, we had raised significant concern about the environment at Evenlode. During this inspection, we found that improvement works had been completed to a high standard. Taps had been removed from bathrooms, and replaced with push button controls for sinks and showers. New bedroom furniture was in place with fixed beds, open wardrobes and ligature proof hooks. New bedrooms doors with 'vistamatic' viewing windows, integrated hinges and no door closures had been installed. All of the specific ligature risks that we had raised as a concern at the last inspection had been addressed. The unit had introduced an "Evenlode CQC Must Do" Easy Read booklet, which had photographs of the changes with all the requirements from the last inspection and progress against these. This was very well presented and available in the staff office. There was no further major work plan planned at either of the two learning disabilities units in Hampshire, but each displayed an estates improvement plan board outlining minor works planned.
- At Leigh House, a number of improvements remained outstanding, although there was a clear plan and timeline in place to complete the works. All bathrooms were due for refurbishment, with work planned to start in January 2017. The whole unit was to be repainted. The high care area had a beverage bay that was due to be taken out and the area was shortly to be refitted. It was explained to us that the radiators got very hot, and the plan was for them all to have an anti-ligature cover. New windows were planned in the bedroom and

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therapy areas, as well as replacement lighting. This work due for completion by March 2017. Until this work is in place, processes were in place to help mitigate any patient safety risks.

- During previous inspections in October 2014 and January 2016 we told the trust that the seclusion facilities on Hamtun ward were not fit for purpose. During this inspection, Hamtun ward was temporarily closed due to staffing issues. However, the trust had started the refurbishment work required to improve the seclusion and safe care area of the ward.
- Hawthorns wards one and two, were part of the trust's improvement plan. Work was due to start at the end of September 2016 and last for nine weeks. Most staff we spoke to were aware of the trust's estates improvement plan. On Hawthorns two ward, there was some confusion among staff over where the most up to date ligature risk assessment was. We were also concerned about potential risks in the courtyard. The trust ligature manager confirmed that they were aware of the issues in the courtyard and had escalated it for action. Until this work is completed, regular staff observation has been put in place to help mitigate patient safety risks. On Hawthorns one ward, one bedroom had its en-suite bathroom locked and inactive due to flooding, which had led to damp. Whilst it was locked off from use and identified on the estates work plan, we were concerned about the smell and the mould spores up the walls. We raised these issues at the time of inspection and they were addressed as a matter of priority.
- A range of minor works was planned or had been undertaken on all of the older persons' mental health wards. We were concerned about the main communal lounge on Dryad ward, as this was an easy exit point due to an accessible emergency door release button. Staff reported a recent incident where a patient had managed to exit through this door, although staff quickly assisted them back to the ward. Although additional and extensive renovations to Dryad ward, including further removal of ligature risks, were due for completion by March 2017, we raised this specific concern with the trust at the time of inspection. The ward manager and Matron have further reviewed security and access and are satisfied that there is no risk as this is an alarmed door in a high visibility area where patients are not left unaccompanied.
- Some staff on the older person's mental health wards did not feel that they had always been involved in decisions about work to be undertaken. However, they felt that this was improving. The trust subsequently informed us that this team had been receiving additional intensive support as part of a planned improvement programme to address a number of serious concerns related to service quality and safety at the ward, and that some staff had found this process challenging. We saw that some work was being changed as a consequence of staff's involvement. For example, bathrooms on an older person's ward had been refurbished to anti ligature standards, which was not appropriate to the needs of elderly and infirm patients. All grab rails and assistance required for safe movement had been removed. We were told that they were all being removed again and more suitable suites installed. The trust openly accepted that earlier decisions around works needed had not always prioritised effectively, but they were confident the new process had improved this. Staff told us that the acuity of patients had increased, with older people being admitted with more acute mental health needs who were also more physically fit and, at times, increasingly aggressive. The trust will need to ensure that it monitors the changing patient profile on the older persons' mental health wards to manage the safety of staff and patients within the current ward. The trust told us it monitors the changing patient profile on a daily, weekly and monthly basis as part of its strategic safer staffing programme.
- Both Forest Lodge and Hollybank rehabilitation services had multiple ligature risks. These were highlighted in the trust's ligature risk assessments, together with other potential risks from the environment; including poor lines of sight. However, these rehabilitation wards accommodated patients who were at lower risk because they were preparing to return to life back in the community. Staff on both wards confirmed that they did not admit patients who had an active risk of suicide. If a patient was assessed as being of increased risk of self-harm, staff would manage this with observations but would also assess the suitability of the patient's placement. Neither service had any recorded ligature incidents from the incident data shared by the trust. We were informed that there have been occasions that patients from local acute units have needed to stay in these units due to lack of acute beds and those patients'

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risks may be less well known. The trust stated that no patient deemed at high risk of ligaturing would be accepted onto the unit. In addition, the general acuity of patient's mental health had changed and patients' needs had become increasingly more complex. For example, staff told us they had started receiving referrals from forensic services. To manage patient and staff safety in these environments, the trust will either have to undertake further work to mitigate the risks posed by the ward environment or ensure that there are clear admission and treatment pathways for these services to maintain a low risk patient group.

- There were potential infection prevention and control issues with shared bathrooms at Forest Lodge. Some of shared bathrooms at Forest Lodge were in a very poor state of repair and were damp, had peeling ceilings and damaged flooring. The trust had already identified that the bathrooms at Forest Lodge required renovation and plans were in place to refurbish the bathrooms by 17 March 2017. Staff at Forest Lodge were pleased work was finally being undertaken because they had been raising concerns about the environment for a number of years. Following this inspection, the trust informed us that remedial work has subsequently been completed on the ceilings.
- Staff at Southfield were aware that the site had a number of outstanding works, including improvements to the seclusion room that had been highlighted in previous inspections. There were a number of risks with the environment on the ward, which staff expressed concerns about being able to manage and mitigate. However, the trust advised us that plans had been submitted for capital funding with the view of decanting patients to another site in March 2017 in order to carry out the work. While staff told us they were not clear what the plan was, the trust advised that once the capital funding decision was received, staff and patients would be updated on the plans.
- We were concerned about the environment at Elmleigh due to poor lines of sight, multiple ligature risks, management of potentially mixed gender areas, risks from patients absconding and ineffective staffing arrangements. The ward was split into bays, with interconnecting doors that could be opened or closed off. When the interconnecting doors were opened, staff and patients could move through all of the bays. Staff were allocated to remain within each bay. The bays included a high dependency unit (six beds), a male area (12 beds), female area (12 beds) and four swing beds for male and female use. Following our inspection, the trust informed us that plans were in place to address these issues with all agreed works to be completed by May 2017.
- On the day of our visit, the ward had opened the bays and as a result, there was no longer any gender separation. This ward was large and spread out, with no clear lines of sight. The configuration was overly-reliant on relational security and alertness of involved staff. Staff did not always mitigate the risks adequately with individual risk assessments, and care plans did not always identify potential individual risks with the environment. The trust advised us that the unit is staffed as one ward and therefore there will not be a registered nurse specifically allocated to each bay. We were concerned about how effectively and quickly other staff could assist each other if required, and how effectively staff could observe patients' whereabouts.
- Following our previous inspection where the risk of patients absconding was highlighted at Kingsley ward, Melbury Lodge, we reviewed all incident data available from the trust about patients' absconding and security risks. We noted that there have been three recorded incidents in 2012, 2013 and 2014 of patients accessing the roof at Elmleigh. Due to the design of the building, it was relatively easy to gain access to a low lying part of the roof from the garden, which in turn then gives potential access to a roof that was three storeys high. Access to the roof had been discussed in an environment meeting in July 2016, and it was documented that part of the courtyard now had anti-climb guttering in place but that a risk assessment should be undertaken to understand risks, benefits and costs to help with the decision about what action should be taken about the rest of the roof. The ward manager and matron confirmed that this had not been undertaken at the time of inspection, although the estates manager advised that they were assessing the costs. In addition, we were not assured that all near miss incidents involving the roof had been recorded to enable an effective review of the level of risk. For example, staff told us about a recent incident when a patient stated they intended to use a garden bench to

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attempt to gain access to the roof. This had not been recorded and reported on the incident system, although action had subsequently been taken to secure the bench.

- There had been thirty-six incidents of patients recorded by the trust as absconding from Elmleigh between September 2015 and September 2016. A number of patients absconded over the perimeter fence, with seven incidents that specified climbing over the fence, taking place between September 2015 and September 2016, and three of those were in the two months before this inspection. Twenty-five of all of the incident reports for patients absconding we reviewed stated it was not known how the person left the unit, and it is reasonable to assume that some of these may also have been over the perimeter fence. Neither this risk nor the access to the roof, were identified in the trust's own security review of the service undertaken in June 2015 and August 2016. There were no plans in place to address the risks at the time of inspection, or evidence that there had been a review of incidents to help assess the risk in order to inform any subsequent action. We raised this with the trust at the time of inspection. When we shared this information with the trust they advised us that the incident data was immediately reviewed. They reported this reflected that some of the incident reports did not contain the correct information – and the trust were able to identify how some people had left the unit or that they had been prevented from leaving the grounds. Following our inspection, the trust advised there are now estates plans in place to remove the low fences that patients climbed over and add the anti-climb guttering to the other higher fences. The trust reported that the estates work was due to start in the next few weeks after inspection, with the completion date by the end of March 2017.
- During our inspection in October 2014, we found that the environment at Ravenswood medium secure hospital was unsafe and unfit for purpose. The service has been subject to an extensive refurbishment programme. Staff told us that the ligature risks in the environment were reduced greatly since the work had been undertaken. The environment still did not meet medium secure standards and the commissioners were aware of the remaining issues. However, we were particularly concerned about the security of the perimeter fence at Ravenswood medium secure

hospital. This did not meet medium secure standards and patient access to the grounds was being restricted as a result. We were aware that a patient had recently absconded via this route. The trust informed us that the patient safety environmental works relating to ligature points had been prioritised within the 2016/17 capital programme with £1.7m being spent on improvements. We saw evidence that the request for 2017/18 capital funding for a secure perimeter fence had been submitted the week after our inspection. We discussed this with NHS England who confirmed that it was their expectation that the trust addressed this.

- At the time of inspection, Hill ward at Bluebird House was only partially open to admissions, following a period of closure, due to lack of staffing and safety concerns. The interconnecting door between Hill and Moss wards was open to give patients more space and ensure effective gender segregation. This meant that staff and some patients were quite some distance from the main Moss ward. These risks were mitigated by having two staff permanently positioned in the end corridor on Hill ward. However, some staff raised concern with us about this layout and distance of the new ward arrangement. They told us that they did not always feel it was a safe arrangement, although the trust reported that no adverse incidents had occurred as a result of this arrangement. We shared this with the trust at the time of inspection.
- We reviewed ligature incidents across all the mental health and learning disabilities units to ascertain if there were any trends involving ligature points. We noted that there had been several incidents on Bluebird House involving the windows. This had led to the windows being kept shut in all areas. Staff we spoke with were aware of the risks and there were notices displayed to reduce the risk of agency staff opening the windows. Funding had been agreed to replace the windows. In the meantime, individual patients were risk assessed for having their bedroom windows open on Stewart ward. We saw evidence of this in two out of three individual risk assessments, and the third person was identified as requiring one to one nursing observations at the time of inspection.

Assessing and managing risks

- A new trust ligature management group had been established which had developed a new risk assessment

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tool, and an annual ligature risk assessment programme had been rolled out. A full new ligature risk assessment had been carried out in many services by a team made up of the trust's ligature manager, estates lead and a member of the local clinical team. There were planned dates for assessments of the remaining wards. Most staff and ward managers we spoke with felt that the ligature risk assessments had prioritised the risks that needed addressing appropriately through reduction or removal by estates, and those that could be managed at a local level.

- Most of the new ligature risk assessments were available to view on the trust's Sharepoint system, which was accessible to all staff via the intranet. In addition, each mental health and learning disabilities inpatient unit had its own site-specific environmental and estate work plan that was also available on this site. Most of the ward managers and senior managers we met were positive about Sharepoint and could show it to us. Few frontline staff we met were aware of what Sharepoint was or how to access it. When staff tried to find it with us, on the trust's intranet, they were unable to do so. However, staff were aware of the trust estates improvement plan and most were aware of specific action for their ward environments.
- Ligature care kits were present and correct in line with trust policy. We checked all ligature care kits and found that they were complete, with a range of cutters for different types of ligatures. All staff interviewed knew where the ligature kits were located on their wards. They were kept in accessible places on each ward, clearly marked in yellow pouches and with posters outlining how to use displayed in line with trust guidance. All ligature kits were part of routine ward checks.
- Most staff told us that they had received on-line ligature care training. The trust ligature manager reported that 92% of staff had completed the on-line training, although this training was not available to agency staff. Agency staff are made aware of the ligature risks specific to the unit as part of their induction. The ligature manager had undertaken the first face-to-face ligature training with a team, which included the use of ligature cutters. This face-to-face training programme was planned to be rolled out across the remainder of the inpatient mental health and learning disabilities services across the trust.
- The trust had introduced a standardised safety and risk management plan to incorporate an individual's risks in relation to the specific ward environment. We were told that every patient now had this in place. Whilst there was clear evidence for many patients that the environmental risk and safety were assessed, we found there was still inconsistency across the wards. We found that there was no safety and risk management plan relating to the environment in 37 out of 143 records reviewed. The trust advised us following inspection that if a risk is identified, an individualised safety and risk management plan is developed which is to the specific ward environment. Therefore the trust would only expect to see a safety and risk management plan for those patients who had been assessed as at risk.
- We reviewed 143 individual care records, at least a sample of a quarter of all patients from each ward. We looked specifically at risk assessments and care plans relating to the assessment and management of risks from the environment related to individual patients. There was variation in quality and detail, with some containing just minimal information and no evidence of a person centred care plan. Some were completed to a high standard, and these were very detailed. This was seen especially with patients detained under the Mental Health Act. For example, there were clear plans for patients at Ravenswood with regard to who was allowed to visit and if an escort was needed whilst visitors were on the wards. The risk assessments in place on Evenlode ward were consistently good. They clearly identified a range of individual risks, and how to manage these, and were clear and detailed.
- There were some patients with a standardised safety and risk management plan, where each patient's name was inserted into a generic plan. Other wards clearly included specific risks to individuals and how these should be managed in relation to the ward environment. Some care plans only addressed safety on the ward, if the patient was a known risk of ligaturing or absconding. We found some examples where risk assessments and care plans did not reflect known risks or incidents that may place patients at increased risk from the environment. For example, care plans and risk assessments for some patients known to be at risk of absconding, or deliberate self-harm, did not detail what the specific risks to these individuals were and how these should be managed in relation to the ward

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environment. We particularly found variation in how risks were recorded and gaps in the records checked for patients at Elmleigh, Hawthorns two ward, Kingsley ward, Saxon ward and Leigh House.

- All of the records we reviewed for patients at Ravenswood had a safety and risk management plan in place to incorporate individual risks in relation to the specific ward environment. However, we were concerned that staff had not updated patients' risk assessments and care plans following potentially serious incidents on at least two occasions. In addition, we noted that some specialist HCR-20 risk assessments we reviewed across the wards at Ravenswood House lacked detail and, whilst they had been noted as updated, sometimes did not contain any additional information from one to several years previously. We asked the trust to review the risk assessment processes at their secure units. We also updated NHS England, as lead commissioners for secure services and they confirmed they would undertake a review with the trust. Following inspection, the trust advised they have introduced fortnightly audits of risk assessments and HCR-20 assessments have been introduced with a minimum sample size each audit of 10. The audits will be reviewed after 12 weeks for compliance with target set at 100%.
- At our inspection in January 2016, we found that there was inconsistent knowledge and awareness, in some services, of the bathing protocol for patients with epilepsy introduced following a recommendation from the coroner. During this inspection, we saw that bathing protocols were displayed within bathroom areas across all wards we visited and staff were aware of the content. We reviewed a sample of care plans for patients with epilepsy and saw that the potential risks with bathing, and how to manage these, were clearly set out.
- Most wards undertook at least hourly observations to check patients, in addition to any additional specific individual observations. The mother and baby unit at Melbury Lodge undertook minimum of 15 minute observations on the babies and each baby had their own observation sheet. Overall, on most wards observation paperwork was appropriately completed. However, we found that there were some gaps in recording observations on Hawthorns one ward. The secure services conducted specific environment and security checks in line with trust policy. However, when we checked the daily perimeter check log for Ravenswood House, we found there were gaps and dates when there was no record for checks taking place. This was of particular concern given the perimeter fence does not meet medium secure minimum standards. Following inspection, the trust advised us that a monthly audit of the daily perimeter check audit has been introduced. Results of this audit will be presented to the governance meeting annually.
- At our previous inspection, we raised concern about the capacity and resource within the health and safety team, including the local security management specialist role. Regular health and safety, and security site visits had not been undertaken due to lack of resource. In addition, there were gaps in the trust RIDDOR reporting and incident analysis. The trust arranged for an independent external review into their health and safety provision. The review report outlined sixteen recommendations to improve their health and safety provision – including the need to ensure appropriate and effective resourcing of the team, with appropriately qualified and experienced staff for an organisation of the trust's size and complexity. At the time of this inspection, the trust had developed an action plan to implement the recommendations. Although it was too early to assess how effective this would be, the health and safety manager was positive that health and safety now had a much higher profile in the trust, with more resources allocated.
- The trust had introduced a new combined risk assessment tool for completion annually by ward managers. The `health and safety and security assessment` was in the process of being rolled out, and we saw that some wards had completed the new template. The purpose was to assess and record all risks to the health and safety of patients, staff and visitors, as well as security risks on one document. This document would inform the health and safety team in order to prioritise their visit schedule. An annual cycle of visits from the security and health and safety team had been developed.
- We reviewed a sample of security visit reports over the past 18 months and noted that their reports did not consistently reflect that staff had assessed the features of the environment that increased the risk that patients

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might abscond. The trust agreed that this was a gap and addressed this during inspection. The security team now receive all patient abscond incidents and intended to incorporate this risk into their security visits and report accordingly.

- The trust recognised that, previously, up to date fire risk assessments and evacuation plans had not been present in all areas. During this inspection, there was evidence that most sites had fire risk assessments and evacuation plans available, although not all wards could provide evidence that fire drills had been undertaken within the previous 12 months. Dryad ward did not have an up to date fire risk assessment in their fire folder however staff were able to show the inspector the latest assessment which was carried out in May 2016. Neither Dryad or Daedalus ward were able to show they had a ward evacuation plan, although training statistics subsequently supplied by the Trust demonstrated that 86% of staff on those wards had now received fire safety training. We were advised that the major evacuation procedure at Ravenswood House was due for update July 2016, but the staff were uncertain as to whether it has been reviewed. We shared these concerns with the trust at the time of inspection. Following inspection, the trust confirmed that the major evacuation procedure has been reviewed and there were no changes required to it. This has been circulated to all staff at Ravenswood and a copy has been placed in Ravenswood reception.
- The trust was in the process of reassessing the requirement for resuscitation and oxygen equipment across all services. All sites visited had oxygen and resuscitation equipment in place, where required. Staff completed equipment checks and recorded these on a daily basis, and we saw the recording sheets used.

Safer staffing

- The trust told us that recruitment and retention of registered nursing staff continued to be its greatest staffing challenge. There were several mental health and learning disabilities locations where there were significant on-going issues. The trust had worked with commissioners in making some difficult decisions and, as a result, had closed Hill ward at Bluebird House, Hamtun ward at Antelope House and had reconfigured Elmleigh so that it no longer provided a psychiatric intensive care unit. The board received a monthly safer staffing report as part of the wider trust oversight of

safer staffing, and had local processes in place to escalate concerns. There were some recruitment initiatives being presented. For example, the area team at Antelope House had put together an interesting staffing proposal to encourage staff to join their team. This had clear plans to enable rotation between community and ward teams, as well as a career progression plan from Band three to Band eight.

- During this inspection, we found there were enough staff across the services we visited to meet the needs of patients. However, some staff raised concern with us that there were on-going issues on their wards due to lack of staffing and a reliance on agency staffing. This was particularly noted at Bluebird House and across the older persons' mental health wards, where an increase in acuity of individual patients could have a significant impact on the whole ward. Staff on the older persons' wards explained that there was increased acuity in patients coming onto the wards, increased numbers of physically fit and aggressive patients as well as patients with increased physical needs. Staff told us that there were occasions when they could not facilitate leave, individual observations could not be undertaken as per plan and there was increased stress of staff. Some staff on the older persons' wards told us that they felt exhausted. We noted that the trust encouraged staff to record any care provision issues as incidents if they were a result of staffing shortages, although it was not clear whether staff were always doing this – this meant the trust may not have an accurate picture of the needs of the wards. The trust was also undertaking reviews of the wards using an acuity dependence tool to check staffing levels against the acuity of patients on the wards.
- Some staff at Bluebird House told us that they felt it was difficult to manage least restrictive practice and relational security effectively with the current staffing issues and this could increase incidents of self-harm or aggression. People with different conditions and in different settings may need care and support that involves both positive support (such as positive behaviour support), and some form of restrictive practice or intervention. This could be physical restraint or use of devices, medication or seclusion. Staff on Bluebird House wanted to reduce the amount of restrictive practice they use. Relational security is the knowledge and understanding staff have of a patient and of the environment, and the translation of that

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information into appropriate responses and care. Reducing restrictive practice and ensuring effective relational security relies on staff knowing patients well and full input from all staff. Staff at Bluebird House felt there were shifts when there were too few substantive staff on duty who knew the patients well, although they acknowledged that some agency staff who were block booked often knew the ward and patients well too. Staff felt able to raise these concerns with the local management team and that they were understanding and supportive of these concerns. The modern matron regularly worked shifts on the wards and had a good understanding of the staffing issues.

- All wards we visited had staff induction processes in place for new staff or agency staff. Some wards had additional safety folders for staff unfamiliar with the ward to highlight any known risks. For example, Kingsley ward had a folder that contained photographs of potential ligature points and areas with poor lines of sight. We spoke with agency staff on the wards and most of them felt that they were given sufficient information about the wards. It was highlighted to us at Bluebird House that agency staff did not have access to the incident reporting system and therefore were reliant on other members of staff inputting information about

incidents. Two staff at Bluebird House told us they did not think incidents were always recorded on the incident system because of this. However, the trust informed us that there was a process in place to supply agency staff with a generic log-in. The trust should ensure staff are aware of this process.

- We raised concerns with the trust in relation to staffing arrangements at Elmleigh, due to the layout of the ward and the skill mix of staff available on the ward. There were seventeen incidents reported by staff between March 2016 and September 2016 of insufficient staff, including lack of registered nursing staff. This showed that there were shifts that there was only one registered nurse for the whole unit, in addition to concerns raised about lack of sufficient staffing. The trust advised us that according to the trust safer staffing data reviewed following inspection, there were two occasions where the number of registered nurses fell below the required level. A review of incident data for the ward and staff feedback also reflected increased acuity of patients, and additional issues for patients such as delayed medication. The trust reported that issues impacting patient care, such as delayed medication, are highlighted within the safer staffing report to the board.

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

Our findings

Governance

- At our previous inspection, we found that key risks, and actions to mitigate them, were not driving the trust's senior leadership or board agenda. We asked the interim chief executive how she would assure herself that she was aware of key risks and ensured that effective action was taken in a timely manner. She provided us with examples of immediate change, such as to the quality and safety committee structures and framework. These included a clear escalation process to the trust executive group (TEG) meeting.
- The TEG meeting had been in place since 2012, and was a forum for operational decisions that require executive level input, receiving updates on progress and providing allocated time to discuss any relevant issues the trust is facing. The trust confirmed that formal meeting minutes were not kept for this group until 2014. We reviewed all the minutes available since 2014, and found that they lacked any detail about discussion, actions or clear audit trail of the executive decision-making process in this forum. An internal audit undertaken by the trust prior to our inspection also reflected this. As a result, the interim chief executive officer had reviewed the terms of reference and restructured this meeting, providing opportunity for wider attendance from clinical staff. In addition, all exception reports from the quality and safety committee and the CQC delivery meeting were now routinely presented at this meeting. The interim chief executive officer was confident that this would ensure a more robust framework for escalation of key risks and ensure that there was clear accountability for decisions and actions at executive level.
- The trust had commissioned an external review to review the trust's management of the CQC and serious incident and mortality action plans. The review identified the need for an overarching trust improvement plan and improvements to processes for assurance. A new risk committee, board assurance framework and corporate risk register was due to be presented to the board in September 2016. The trust had reviewed the ward-to-board reporting on quality and performance, with restructured meetings and the development of new integrated performance reports and quality dashboards. New quality dashboards and safety data packs were available to teams in real-time. The trust planned to review how these systems were helping teams and how managers, committees, trust executive group (TEG) and board were using the performance reports at the end of September 2016. Following the inspection, the trust confirmed that this took place as planned.
- Since our inspection in January 2016, the trust's central quality governance team had been restructured to strengthen the links and lines of accountability between the central governance team and clinical areas. This was being established with the introduction of a governance business partner for each division, who would be the direct link between governance and the clinical divisions. The trust was recruiting to the mental health and learning disabilities post at the time of our inspection. To support the new governance structure, the trust had created and advertised for three governance business partners, a head of incident management and patient safety, a risk manager, a clinical effectiveness facilitator, a Board Assessment Framework administrator and a family liaison officer. Following inspection, the trust informed us that as of November 2016 the majority of these roles had been filled with substantive or interim appointments.
- The CQC delivery group met weekly to monitor progress against each action on the CQC action plan. Any delays or potential issues raised at these meetings were then escalated the next day to the trust executive group (TEG) for discussion and action. Progress was also formally reported up to the Quality and Safety Committee and Trust Board on a monthly basis with members receiving a copy of the action milestone tracker with each

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report. We also saw how the evidence and submitted documents were embedded within the action plan and meeting minutes. The CQC delivery group meeting was chaired by the interim chief executive officer at the time of inspection.

- The trust was required to attend and present a range of evidence at a monthly quality oversight committee. This meeting was where clinical commissioning groups, NHS England and NHS Improvement gained assurance on the trust's implementation of its serious incident and mortality action plan and CQC action plan. We had received the minutes and papers for these meetings.
- The ligature management group had been established since our inspection in January 2016. A key role of the ligature management group was to ensure that there were processes in place to deliver the ligature management programme, including risk assessment and mitigation as well as prioritising capital expenditure for ligatures against the budget agreed by the trust's executive team. We reviewed the meeting minutes since January 2016, which detailed actions taken to monitor identified ligature works across the trust. In addition to this, a monthly environment meeting had been established. We reviewed the available meeting minutes and these reflected that a range of issues were discussed, with agreed actions noted. Minutes were available on the Sharepoint system and accessible to all staff.
- The trust had introduced a number of processes to improve the interface between estates and clinical services, with each area having an identified estates project lead and a clinical lead who worked together in identifying and tracking works to be undertaken. The trust had improved the process for allocating capital funds to projects based on clinical need and risk. In addition, if a request was deferred or rejected, there was a reason and risk mitigation plan put with the request to provide a clear audit trail of who had made the decision and why. Further, the introduction of exception reporting to the trust executive group on a monthly basis allowed for early escalation of delays in the trust's estates improvement programme.
- Staff in the ward areas confirmed that there were much improved relationships and interface with the estates team. The ligature manager advised us that clinical staff were able to contact them to review risks or attend the ligature management group to escalate why they wanted work prioritised. Most staff and ward managers we spoke with felt that the ligature risk assessments had appropriately prioritised the risks that needed to be addressed through reduction or removal by estates, and identified those risks that could be managed at a local level through observation and other control measures. Most of the ward managers and senior managers we spoke with were able to describe how estates issues were escalated.
- At our inspection in January 2016, we found that the trust was not always undertaking effective investigations and learning from serious incidents. We intend to look again in detail at how the trust undertakes investigations, as well as the trust's implementation of duty of candour, at the next inspection we carry out. NHS Improvement and the quality oversight committee were monitoring the trust's implementation of the serious incident and mortality plan at the time of inspection. The interim chief executive officer told us that she wanted to prioritise listening to patient and carer experiences and to improve people's experience of investigations and complaints. A number of changes were proposed to support this, including completing a 12 month review of the impact of introducing a new central investigation team with the view of introducing a permanent solution and employing a family liaison officer to work with families.
- The trust had undergone some significant changes at board executive level and, at the time of inspection, there was continued uncertainty and changes taking place within the trust. The chief executive officer resigned on the 30 August 2016. The interim chief executive officer had been in post for just two weeks at the time of our inspection. Prior to this post, they had been the director of nursing, a post they had held since May 2016. The chief operating officer was not in post at the trust, having been seconded to another role with NHS Improvement. In addition, the interim chair appointed by NHS Improvement resigned during our inspection. The interim chief executive officer was in the process of reviewing the executive portfolios at the time of inspection.
- We recognised that it was early days for the newly restructured leadership team, but it was our view that they demonstrated a greater understanding of the

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importance of work to assess, manage and prioritise a range of patient safety issues. There was evidence that action was being taken in a more timely and proactive manner.

- Overall, staff morale was good; staff felt positive about the changes taking place and the improvements to environments. Staff morale was much improved at Evenlode and Kingsley wards. However, staff morale was variable on the older person`s wards, and was notably lower on the wards at Gosport War Memorial hospital. The trust subsequently informed us that one of the wards had been identified as requiring additional intensive support as part of a planned improvement programme to address a number of serious concerns related to service quality and safety at the ward, and that some staff had found this process challenging. Some staff at Southfield told us that they felt less connected with the senior management team.
- Several senior managers and consultants we spoke with acknowledged there had previously been a `disconnect` between the board and services, that they hoped would now improve. A description of being “cautiously optimistic” that the newly restructured leadership team would bring an open,

listening culture was given. The interim chief executive officer recognised that some mental health and learning disabilities teams had felt isolated from the wider trust. Accordingly, one of their priorities was to re-engage those staff, as well as ensure consistency and accountability across services.

- The trust action plan stated there would be ‘improved senior leadership visibility at the frontline (including executives and non-executive directors) and increased focus on patient safety’. We were told that the executive ‘back to the floor’ programme and new listening events had been place from the previous month. Staff in several services told us that senior managers or members of the executive team had visited their services, including the new interim chief executive officer who had also attended a band 6 development day. Staff told us that patient safety had become a much higher priority within the trust. The senior team had recently introduced `back to the floor`, where senior clinicians and nursing staff worked shifts within services each week, then provided feedback and guidance. This was in the process of being rolled out, and while some staff were not yet aware of it, other staff we met had experienced it happening and were positive about it.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was inconsistency in the quality and detail of risk assessments across the wards The risk assessments at Ravenswood House were not reviewed and updated following incidents. The premises at several locations, identified in this report, were subject to plans to improve and make them safe. This work had not yet been completed Reg 12(1)(2)(a)12(2)(d)12(2)(c)
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Whilst a number of new processes had been introduced and strengthened, the trust had not embedded systems and processes to ensure quality and safety of services. Reg 17 (1)(2)(b)