

Southern Health NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Wards for older people with mental health problems	Gosport War Memorial Hospital – Daedalus Ward	RW158
	Gosport War Memorial Hospital – Dryad Ward	RW158
	Melbury Lodge – Stefano Olivieri	RW119
	Parklands Hospital – Beechwood Ward	RW1AC
	Parklands Hospital – Elmwood Ward	RW1AC
	Western Community Hospital – Berrywood Ward	RW155
	Western Community Hospital – Beaulieu Ward	RW155
	Community-based mental health services for adults of working age	Hewat Centre
Petersfield CMHT		RW146
West Community Mental Health Team		RW146
Andover CMHT		RW146

Summary of findings

	Eastleigh CMHT	RW146
	Romsey CMHT	RW146
Community mental health services for older people	Trust Headquarters	RW146
Community health inpatient services	Alton Community Hospital	RW194
	Fordingbridge Hospital	RW178
	Gosport War Memorial Hospital	RW158
	Lymington New Forest Hospital	RW1YM
	Petersfield Hospital	RW170
	Romsey Hospital	RW1FY
Community end of life care	Alton Community Hospital	RW194
	Fordingbridge Hospital	RW178
	Gosport War Memorial Hospital	RW158
	Lymington New Forest Hospital	RW1YM
	Petersfield Hospital	RW170
	Parklands Hospital	RW1AC
	Romsey Hospital	RW1FY
Community health services for adults	Trust Headquarters	RW146
	Alton Community Hospital	RW194
	Fordingbridge Hospital	RW178
	Gosport War Memorial Hospital	RW158
	Hythe Hospital	RW1Q6
	Lymington New Forest Hospital	RW1YM
	Petersfield Hospital	RW170
	Romsey Hospital	RW1FY
	Havant Integrated Community Team	
	Basingstoke Enhanced Recovery and Support at Home	
	Avalon House Winchester	

Summary of findings

Urgent Care Services	Lymington New Forest Hospital	RW1YM
	Petersfield Hospital	RW170

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

Summary of findings

Ratings

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

Overall rating for 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.

Summary of findings

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Summary of findings

Overall summary

We did not re rate the core services inspected or the overall provider following this inspection.

At the time of our inspection, the trust was going through a significant period of change. The recently appointed interim chair and interim chief executive were implementing a considerable change programme. This included a change in leadership at board level and at service level (particularly in mental health) and changes that were intended to bring about improvements across all services. The trust recognised that there was still much work to do and that whilst we found it had made some significant improvements across the trust we found concerns in a number of areas.

During the comprehensive inspection of the trust in 2014 we told the trust it must make improvements in a number of areas but during this inspection we found that some of the required improvements had not been made. For example, at the previous inspection we found there had been delays in provision of special mattresses and beds for patients approaching the end of their life in both the community hospitals and at home. On this inspection we found that there were still delays in this provision although the trust was continuing to work with commissioners to try and address the issues.

Within the community health service for adults, there were still significant delays in the provision and repair of wheelchairs. This affected the safety and well-being of a large number of patients.

The requirement to review and amend the management of FP10 prescriptions had not been met. On the trust intranet, there was guidance on how to order and store FP10 prescriptions but there was no guidance on how staff should record receipt of, issue and undertake checks of FP10s. Hence, there was variability across the trust on how staff managed FP10s. In addition, we found that medicines management and reconciliation in the community hospitals was not robust or managed in line with best practice guidelines and therefore compromised patients' safety.

There was still inconsistent and varied practice in both community health services and older people's mental health services in the completion of do not attempt cardiopulmonary resuscitation records and sharing of information.

During our previous inspections in the mental health and learning disabilities services, we had identified inconsistencies in the completion and updating of risk assessments. During this inspection, we found this continued to be an issue, particularly in the community adult mental health teams. The trust had introduced a number of measures to continue to address this, such as training, changes to the electronic record templates and supervision tools.

At this inspection we had concerns about some aspects of care at Gosport War Memorial hospital. In some areas, there was insufficient staff to meet the assessed needs of patients. Staff did not always store or administer medicines in line with manufacturer's guidelines, staff did not consistently adhere to the trust's infection control policy and not all staff had a good understanding of mental capacity assessments.

Patients, families, partner agencies and CQC had previously expressed significant concerns about the trust's complaints processes, quality of responses and learning from complaints. The trust had implemented several changes to address this. Overall, the complaints governance systems in the trust had improved over the past 12 months but further improvements were still required. However, some members of staff, patients and families told us that they believed that the trust needed to do more and that they would like to see swifter action and much more effective communication related to complaints and investigations into incidents when things had gone wrong.

The trust recognised that there remained significant concerns and still much work to do in the way it communicated with, and involved, patients and families. It had formed a family engagement action task and finish group and recently established a 'families first' group. Members of the families first group were very positive that the trust had a commitment to driving this work forward and engaging more effectively with the patients, families

Summary of findings

and members of the public. A family liaison officer had been appointed and the interim chief executive was meeting regularly with a number of families to address their concerns.

However, we concluded that the trust had turned a corner. The interim chair and chief executive had a clear vision and understanding of what was required to bring about improvements and were committed to ensuring that improvement was made in a timely manner.

In October 2016, the trust initiated a review of how it provided services. This resulted in the development of a clinical services strategy. This had three key components: i. the development of a clinical strategy for mental health and learning disabilities services; ii. a review of the trust's multi-speciality community provider work to make sure it was aligned with the mental health and learning disabilities strategy and iii. a review of how the organisation would be best structured to deliver the mental health and learning disabilities services for the new models of care. The majority of the trust governors told us that there had been a very open and inclusive approach to the development of the strategy.

Members of the council of governors and the majority of staff that we spoke with told us that they believed that the interim chair and interim chief executive were making a positive difference in changing the culture. They reported that there was now a clearer focus on quality, and that the trust leaders were improving governance processes and supporting improvements in service delivery. They also told us that trust leaders were more open and approachable than they had previously experienced.

Since our last inspection (September 2016) the senior leaders of the trust were a more visible to the frontline staff. This had been achieved through the implementation of an executive 'back to the floor' programme and listening events.

Overall, staff morale was good in the mental health teams we visited, although was more varied in the adults of working age community mental health teams. Staff morale in community health services on the whole had improved.

Staff in all areas of the trust responded to patients in a kind, caring and compassionate manner and treated them with dignity and respect.

There was a greater focus on ensuring that the trust implemented the actions in the improvement action plans arising from previous CQC inspections and from the review of serious incidents and mortality undertaken by Mazars. Managers monitored progress weekly and reported progress to the trust board.

There had been a notable improvement in the timeliness and quality of investigation reports following serious incidents, including deaths. In January 2017, the trust had completed 97% of the required mortality reviews within 48 hours of the death occurring (the figure was 78% in June 2016). Work had progressed to improve learning from these incidents but there was still work do to ensure learning from incidents that did not meet the serious incident threshold. In addition, we found that there was variable reporting and learning from incidents within the community health services that we inspected.

We will continue to monitor the trust closely and will undertake focussed inspections as needed. At some point in the future (in line with our methodology) we will undertake an inspection that will result in a review of the ratings across the trust.

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?

We looked at most aspects of this key question across all services inspected.

- There were continued deficiencies with the quality and consistency in how staff updated risk assessments. This was a particular problem in adult community mental health teams. The trust has introduced changes to the electronic record templates, supervision tools and training to address this.
- The trust recognised that there was still work to do in relation to the learning from incidents that did not meet the serious incident threshold. There was variable reporting and learning from incidents within the community health services that we inspected.
- In the community health services staff did not always recognise and escalate safeguarding concerns.
- There were still delays in the provision of mattresses for patients receiving end of life care although the trust was working with commissioners to address this.
- Although equipment used in the care of patients was available in the community hospitals, we found some equipment was not serviced in accordance with any maintenance programme.
- Within the community health service for adults, there were significant delays in the provision and repair of wheelchairs. This service was provided by an external provider. The problem affected the safety and well-being of a number of patients.
- Staffing levels and the number of vacant posts varied considerably between all of the community mental health teams. Although staffing levels had been adjusted following a demand and capacity review staff felt that extra responsibilities, such as running clinics, were not taken into account when allocating their caseloads. Some staff held very high caseloads.
- Staff working in the community hospitals did not regularly use an acuity and dependency assessment tools to assess staffing requirements as this was carried out at six monthly intervals. There were not always adequate numbers of staff available to meet the needs of all patients in community inpatient wards. Data provided by the trust showed a high percentage of substantive posts filled by bank and agency staff. Data also reflected a high proportion of shifts that were not filled.
- We had concerns about the quality of medicines optimisation. In the community hospitals medicines were not always managed in line with best practice. There was inadequate

Summary of findings

pharmacy support to some clinical areas due to staff shortages. Some areas did not receive regular visits from a pharmacist/ pharmacy technician and when a member of pharmacy staff was absent or on leave, their role would not always be covered. As a result staff did not complete proper medicine reconciliation for all patients. This had not improved since our inspection in 2014. The trust was in the process of recruiting 5.5 WTE pharmacists and pharmacy technicians.

- Staff did not always record the next of kin on patient records so impacting on the trust's ability to meet its obligations under the Duty of Candour in a timely and effective manner.
- Environmental work within mental health and learning disabilities wards had been completed. Older people's mental health wards had a separate environmental plan as these sat within the integrated services unit. However, work had not yet been completed at the time of the inspection and some wards still contained ligature risks with limited mitigation of those risks.
- We had concerns about how incident reports were completed and then subsequently signed off relating to the seclusion of patients at Elmleigh. We are continuing to investigate this issue and will produce a separate report detailing our findings at a later date.
- Staff reported incidents via the trust electronic incident reporting system and these were summarised in a monthly board integrated performance report. This included a narrative about any identified trends or themes. All ward managers and team leaders could explain how they used this information to help monitor the safety aspects of their services.
- There were notable improvements in the timeliness and quality of investigation reports following serious incidents, including deaths. The trust now completed 97% of mortality reviews within 48 hours which were assessed by a panel to decide on further investigation that might be required.
- The trust had established monthly 'evidence for improvement' panels to review how learning had been embedded following an investigation into a serious incident.

Are services effective?

We looked at most aspects of this key question across community health services but focussed on records relating to risk assessment and treatment under the Mental Health Act in community mental health services.

Summary of findings

- The trust used individualised end of life care plans in the community hospitals; these had not yet been implemented for patients who were cared for in their homes.
- Within the community hospitals and community adults services the trust used National Institute for Health and Care Excellence and Royal College of Nursing policies and best practice guidelines to support the care and treatment provided for patients.
- The trust monitored the average length of stay for patients in community hospitals and benchmarked the inpatient wards against each other.
- All community health services used the trust's electronic monitoring tool which measured and compared outcomes for patients across the services.
- Patients who attend the minor injuries unit received care, treatment and support that achieved good outcomes.
- Staff in the community hospitals and community adults' services reported high levels of satisfaction with appraisals. All staff reported good access to training and development opportunities.
- In mental health services the trust had established a clinical care records work stream to support effective record keeping. Changes had been made to templates and frontline `champions` had been introduced to support implementation. The mental health division had implemented a new risk summary and crisis/safety plan in January 2017 but there was inconsistency in how these were being used at the time of the inspection.
- There were significant problems with the care records of patients under the care of some of the community health services. Staff that provided end of life care did not have access to a single patient record that contained all of the necessary information in one place. Staff had to work with a mix of paper and electronic records and were sometimes slow and inconsistent in updating patient records.
- Staff did not always keep patients' care plans and risk assessments up to date. In the community adults service, care plans held at patients' homes were not current and patients' records were not sufficiently managed to keep patients safe. In community hospitals inpatients records were not fully completed and did not consistently accurately reflect the needs of patients.
- There was a lack of a clear escalation pathway for patients on community treatment orders when there was no bed available for a patient that needed to be recalled due to deterioration in their mental health.

Summary of findings

- Within the community hospitals and community adults service there was inconsistent practice in the application of Mental Capacity Act assessments and Deprivation of Liberty Safeguards.
- There was inconsistent and varied practice in both community health services and older people's mental health services in the completion of do not attempt cardiopulmonary resuscitation records and sharing of information.

Are services caring?

We looked at all aspects of this key question across community health services and although did not specifically look at 'caring' in mental health services we noted areas of good practice and specific developments.

- Staff in all areas of the trust responded to patients in a kind, caring and compassionate manner and treated them with dignity and respect.
- Across all areas we saw staff focussed on doing their very best for patients and their families; despite challenges posed in some areas due to staffing shortages.
- The trust had established a patient engagement and experience work stream, led by an executive director and was developing a strategy for patient engagement, experience and involvement which was at final draft stage.
- The trust had established a 'caring' sub group of the board to help build relationships with families, improve listening to patients and being open and honest when things went wrong.
- In community health services, patients and their families were fully involved in planning their care and treatment.
- A family liaison officer had been in post since December 2016. At the time of inspection, 25 families had been referred to the family liaison officer and there were seven families receiving on-going support.

Are services responsive to people's needs?

We looked at most aspects of this key question across community health services and focussed on learning from concerns and complaints across the trust.

- The trust worked with the local commissioning groups to develop services to meet the needs of the local population.
- Patients who attended the minor injuries unit had timely access to diagnosis and treatment, although X-ray services were limited.

Summary of findings

- Specialist nurses were available to support staff to care for patients living with dementia.
- Community services hospital wards had clear admission criteria for the service they provided. Patients who lived in the catchment areas, as defined by local commissioning groups, were admitted if their conditions would benefit from the treatment and care provided by the hospital.
- The trust's governance processes for managing complaints and the overall approach to handling and responding to complaints had improved over the past 12 months.
- Although some considerable improvements have been made to the process the trust used in managing complaints further, significant improvements was still required, particularly to the procedure for obtaining feedback from complainants, how learning from complaints was shared trust-wide and how the trust demonstrated that change and improvement to practice had taken place. The current timescales for responding to complaints continued to be unacceptable for a number of complainants.
- The support for patients in vulnerable circumstances varied between the minor injuries units (MIUs). In Petersfield MIU there were no dedicated facilities for children to ensure they were cared for in an environment suitable to meet their needs.
- Service delivery did not always support patients to access care in a timely manner. In some areas, shortages of staff meant that the single point of access and triage processes in the community adults service were not fully effective.
- There were delays for some patients accessing outpatient clinics and services, with between 11% and 14% not having an appointment within the trust target of two weeks from time of referral.

Are services well-led?

We looked at all aspects of this key question that we had previously identified as requiring improvement and where we had questions and concerns identified from our ongoing monitoring of the trust.

- At the time of our inspection, the trust was going through a significant period of change with several changes taking place within the senior leadership team and leaders at service level, particularly within mental health. The interim chief executive had been in post since September 2016 and the interim chair since November 2016. The trust had announced the resignation of all the non-executive directors. There were vacancies on the council of governors and several senior manager vacancies, particularly within mental health services.

Summary of findings

- Some members of staff, patients and families told us that they believed that the trust needed to do more and that they would like to see swifter action and much more effective communication related to complaints and investigations into incidents when things had gone wrong.
- The trust's three year corporate safeguarding strategy was awaiting sign off at the time of inspection. The trust's annual 'safeguarding children and adults' report 2015/16 had been significantly delayed (it should have been available in June 2016) it did not provide analysis of the impact on patients and staff.
- Some staff in mental health services raised concerns about how changes had been introduced and that staff concerns about the implications for the quality of care and patient and staff safety and well-being were not always listened to.
- The trust had developed a clinical services strategy that set out how services across the trust would best be structured and delivered in the future.
- There was an improved focus on ensuring the actions from the CQC improvement action plans and the serious incident and mortality (Mazars's) improvement action plans were being implemented and effectively monitoring on a weekly basis which was reported to the trust board.
- Outcomes related to the serious incident and mortality improvement action plan had also been chosen as a patient safety priority to be included in the quality accounts priorities 2017/18, to ensure that processes had effectively been embedded and learning led to improvements.
- The trust had made improvements to its board assurance framework and how it recorded these. This gave clearer oversight of the risks and actions being taken.
- The trust had made significant investment in the development of its own electronic data collection and reporting system (Tableau). This had led to improvements in 'ward to board' governance in the form of a monthly performance report – although this was reliant on the accuracy of the information on the other systems which pull through into Tableau. All staff and managers we met were positive about the on-going development and continued extended implementation of Tableau.
- The trust had developed a cycle of 'deep dive' activity, to enable it to focus in detail on specific areas to understand issues and risks. This had led to changes such as increased staffing numbers on some wards and development of specific risk training modules.

Summary of findings

- The trust had combined serious incident and complex complaint investigations into a single process. Although this change was in its infancy, we did see evidence of improvements in responding effectively to complex complaints that had arisen from serious incidents.
- The trust recognised there were significant concerns and still much work to do in the way it communicated with, and involved, patients and families. It had formed a family engagement action task and finish group and recently established a families first group. Members of the families first group were very positive that the trust had a commitment to driving this work forward and engaging more effectively with the patients, families and members of the public.
- The trust had appointed a freedom to speak up guardian who dedicated three days per week to this role.
- The executive team and senior leaders undertook a regular 'back to the floor' programme and listening events and were now seen as more visible.
- Overall, staff morale was good in the mental health teams we visited, although was more varied in the adults of working age community mental health teams. Staff morale in community health services on the whole had improved.

Summary of findings

Our inspection team

Our inspection team was led by:

Karen Bennett- Wilson, Head of Hospital Inspection.

The team included:

- CQC managers
- Inspectors
- An assistant inspector
- A Pharmacist specialist
- Mental Health Act reviewers
- A variety of specialist advisors including approved mental health practitioners, mental health nurses and governance specialists.
- Senior community nurses

- An occupational therapist
- A general practitioner
- A surgical team manager
- Specialist nurses for minor injury units and end of life care
- Inspection planners.

The community health services team also included Experts by Experience who had personal experience of using or caring for someone using services that we inspected. One Expert by Experience was involved in inspecting the community inpatients service and one was involved in inspecting the community health services for adults.

Why we carried out this inspection

We carried out this short notice inspection of Southern Health Foundation NHS Trust to follow up on areas that we had previously identified as requiring improvement or, particularly in mental health, where we had questions and concerns that we had identified from our ongoing monitoring of the trust.

We undertook a comprehensive inspection of the whole trust in October 2014. We rated the trust as `requires improvement` overall. We have re-inspected some of the mental health and learning disabilities services since that time.

We served a warning notice 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 using mental health and learning disabilities services. We told the trust that its governance arrangements did not facilitate effective, proactive, timely management of the risks in the environment.

At our inspection in January 2016, we also found that the trust was not always undertaking effective investigations and learning from serious incidents. 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.

We undertook an inspection of the trust's mental health and learning disabilities inpatient units in September 2016. This 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 found that the trust had made significant improvements and met the requirements of the warning notice; as such we lifted the warning notice.

During this most recent inspection (March 2017), we wanted to look again in detail at how the trust carried out investigations, including those into serious incidents and deaths, how it responded to and monitored complaints and how it was involving patients. We also looked at how the trust was implementing the Duty of Candour. Our inspection focused on community mental health services for adults and older people and the inpatient wards for older people with mental health needs to check that learning from serious incidents had been embedded. We focused on aspects of the `safe` and `well led` in these services.

Summary of findings

In addition, we looked at the community health services delivered by the trust to follow up our comprehensive inspection in 2014 where some services had required improvement.

How we carried out this inspection

During a comprehensive inspection, we ask the following five questions of every service and provider:

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

This was a focussed inspection during which we assessed specific aspects of care and care provision.

We used the findings of previous inspections plus ongoing monitoring information to decide which services to inspect. Prior to the inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included clinical commissioning groups, NHS Improvement, NHS England and Healthwatch.

We gave the trust a week's notice of our inspection (announced) of community health and community mental health services and trust wide leadership. However, we also carried out a number of unannounced inspections of wards in community health inpatient and older people's mental health inpatient services.

We assessed aspects of the 'well led' key question. These included: senior oversight, complaints and investigations. We interviewed a small number of the executive team, including the interim chair and interim chief executive; we spoke to several members of the council of governors; we looked at some of the governance systems and processes at ward/service level and checked how the data/information was then used by the trust to assess and manage safety and quality. We will continue to monitor these closely.

We undertook a focused inspection of community mental health services for adults and older people, as well as the

inpatient wards for older people with mental health needs to check that learning from serious incidents had been embedded. We focused on the 'safe' and 'well led' key questions in these services.

The team focussing on mental health services at the trust inspected the following mental health services:

- Wards for older people with mental health problems
- Community-based mental health services for working age adults
- Community mental health services for older people

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

- Community health inpatient services
- Community health services for adults
- Urgent care services
- Community end of life care.

During this inspection, the inspection team:

- visited 44 locations, including community health services, and mental health services
- spoke with 265 staff members (including head of nursing, ward managers and deputy managers, allied healthcare professionals, matrons, team leaders, physiotherapists, occupational therapists, physiotherapy assistants, occupational therapy assistants, psychologists, mental health nurses, social workers, medical staff, specialist nurses and healthcare support workers)
- spoke with two volunteers
- spoke with 149 people who used the service and 54 carers of service users
- reviewed 252 patient care records, 49 patient ligature plans and 40 patient records relating to observation
- reviewed 12 staff supervision records
- reviewed comment cards left in boxes distributed at various sites
- carried out a focus group with four staff members

Summary of findings

- observed six handover meetings, and four multidisciplinary team meetings
- carried out specific checks of the service dashboards used to manage performance in services

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment provided by Southern Health Foundation NHS Trust.

Information about the provider

Southern Health Foundation NHS Trust provides community health, specialist mental health and learning disability services for people across the south of England. Covering Hampshire and Oxfordshire it is one of the largest providers of these types of services in the UK, with an annual income in excess of £330 million.

The trust received foundation status in April 2009 under the name Hampshire Partnership NHS Foundation Trust. Southern Health NHS Foundation Trust was formed on 1

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.

The trust employs approximately 6000 staff. Between April 2016 and March 2017, it supported more than 238,800 patients and service users to receive care and treatment.

What people who use the provider's services say

Within the mental health services, the feedback was generally positive. Patients spoke fondly of the staff, and felt services were responsive to their needs. Some patients said that their views were taken into account and they felt empowered to make their own decisions. Most patients and carers told us that staff responded quickly and were very caring. Carers in one service told us they had been helped to find additional support and had been able to attend a psycho education course that they found

beneficial. With the exception of Stefano Olivieri ward, where three patients commented on feeling vulnerable due to lack of adequate security arrangements, most patients felt well-cared for.

Within the community health services, the feedback was overwhelmingly positive. Patients thought the staff were kind, compassionate and listened to them. Patients reported that they had received an excellent level of attention from wonderful staff. They also said that although staff were always very busy, they never felt rushed and that staff treated them with dignity and respected their privacy.

Good practice

Areas for improvement

Action the provider MUST take to improve

Wards for older people with mental health problems

- The trust must ensure that where patients are on one to one nursing observations, staff maintain and review these in line with organisational policy and they do not change them in order to manage low staffing levels.

- The trust must ensure that all do not attempt cardiopulmonary resuscitation (DNACPR) records and sharing of DNACPR information are correct and consistent at all times.
- The trust must ensure that the privacy and dignity of the patients on Stefano Olivieri ward is adequately protected.

Summary of findings

- The trust must ensure that it continues with and completes all outstanding ligature works
- The trust must ensure that staff use covert medication in a manner that is in line with organisation's policy and procedure.

Community-based mental health services for older people

- The trust must assess staff caseloads in the Gosport team and ensure there is sufficient staff capacity to manage allocated caseloads.
- The trust must ensure that next of kin details are clearly recorded on the patient care records.

Community-based mental health services for adults of working age

- The trust must ensure that staff update relevant care records fully and in a timely manner when changes to a patients' risks are identified.
- The provider must ensure that there are crisis plans in place for patients accessing the service, where risk assessments indicate this is required.
- The trust must ensure that next of kin details are clearly recorded on the patient care records
- The trust must ensure there are sufficient numbers of suitably qualified/trained and competent staff to meet the needs of the numbers of patients on their caseloads.

End of life care

- The trust must ensure that do not attempt cardiopulmonary resuscitation (DNACPR) forms are completed in line with national guidance.
- The trust must improve appraisal rates for community nursing staff.
- The trust must ensure that individualised care for patients at end of life is planned and delivered for patients cared for at home.
- The trust must ensure that community staff have access to up to date information in the record of patients at end of life who are cared for at home.
- The trust must ensure that appropriate support is available to community hospital staff to respond to end of life care patients who deteriorate.

Community Inpatient services

- The trust must have appropriate measures in place to ensure that staffing levels are safe for every shift and in particular at Gosport War Memorial hospital
- The trust must ensure that staff complete mandatory training, including basic and advanced life support, to safeguard patients receiving care.
- The trust must ensure that all medicines are managed in line with manufacturers guidelines, and that when opened they are labelled with the patient's name and administered accordingly.
- The trust must ensure that staff adhere to policies and procedures for the safe management of medicines at all times to protect patients from the risk of harm.
- The trust must ensure that all staff follow effective infection control procedures when dealing with and disposing of infected materials. In particular, at Gosport War Memorial Hospital.
- The trust must ensure that all equipment used for providing care or treatment is safe for use at all times and meets the needs of the patients.

Community health services for adults

- The trust must ensure that all staff understand and recognise safeguarding concerns
- The trust must ensure that all staff escalate safeguarding concerns following the trust and local authority safeguarding procedures.
- The trust must ensure that staff store medicines at the Alton intravenous clinic securely and that only staff that need to access the medicines are able to access them.
- The trust must work with the commissioners to improve wheelchair provision for community service patients.
- The trust must ensure that all staff understand their responsibilities in respect of the Mental Capacity Act.
- The trust must ensure that patient records are accurate and up to date

Action the provider SHOULD take to improve Wards for older people with mental health problems

Summary of findings

- The trust should review the ligature risk care plans to ensure that they are individualised to patients needs and risks.
- The trust should consider including, in all induction packs for all new starters and agency staff, information relating ligature risks on all wards.
- The trust should review the trust mitigation plans for areas that are considered locked and inaccessible to patients.

Community-based mental health services for older people

- The trust should review the provision of psychology in Chase/Petersfield.
- Staff should record all multidisciplinary discussions in patient records at Chase/Petersfield and Gosport.
- The trust should review the caseloads across the service to ensure that there is equity of safe workloads and that the CPA framework is consistently applied

Community-based mental health services for adults of working age

- The trust should complete its review to ensure that the CPA framework is consistently applied and ensure that caseloads are allocated equally

Urgent care services

- The trust should ensure that all staff report all incidents that occur.
- The trust should implement, across both MIUs, an audit plan on the use of national guidance's locally.
- The trust should develop children's waiting area at Petersfield MIU to provide visual and audible separation from the adult waiting areas.
- The trust should continue to embed its complaints systems to ensure complainants are responded to in a timely manner.
- The trust should ensure staff across the urgent care provision are informed of the trust plans for the service, including those arising from discussions with the CCGs
- The trust should review the governance reporting framework for the MIU in Petersfield.

- The trust should ensure there is clear support structure in place with clear lines of accountability for the MIU in Petersfield.
- The trust should review the staffing levels at the MIU in Petersfield to ensure they are able to offer a safe service at all times.
- The trust should ensure there are sufficient numbers of staff trained in the care of a sick child, on duty at all times in MIUs.

End of life care

- The trust should consider analysing themes of incidents in relation to the provision of end of life care for all patients cared for in the community and in patient settings to ensure lessons are learnt.
- The trust should work to improve the provision of beds to end of life patients.
- The trust should collate and monitor locally held data on the uptake of staff training on end of life care and syringe driver competency assessment.
- The trust should evaluate the provision of end of life care.

Community inpatient services

- The trust should ensure that all staff are fully trained in the assessment and competent in the use of the Mental Capacity Act.
- The trust should ensure that all staff complete and sign all patient clinical records with all relevant information.
- The trust should ensure that all staff follow the process for identifying and managing clean and dirty equipment in line with the trust policy.
- The trust should ensure that staff review the ward environment taking into account the needs of people living with dementia.
- The trust should review the washing and toilet facilities at Gosport hospital to ensure that they promote the privacy and dignity of patients.
- The trust should ensure that there is appropriate pharmacy support for medicines reconciliation.'
- The trust should ensure that staff support and enable patients to administer their medicines as part of the discharge process in the rehabilitation wards.

Summary of findings

Community health services for adults

- The trust should ensure that staff report incidents in a timely manner
- The trust should ensure that staff follow infection prevention best practice guidelines while providing care in patients' homes.
- The trust should introduce an appropriate tool to monitor and detect deterioration in the condition of patients, receiving care and treatment in their own homes, who have long term conditions who may routinely have abnormal physical signs.
- The trust should review whether there is a need for a night nursing service across all areas.
- The trust should ensure all medicines are in date.

Southern Health NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Please provide information about the Provider's adherence to the MHA Act. This will be used as a determiner in the overall rating for this core service.

This should be informed by evidence gathered using the Mental Health Act Module Lines of Enquiry and prompts.

Mental Capacity Act and Deprivation of Liberty Safeguards

Please provide information about the Provider's adherence to the MCA and DoLS.

This should be informed by evidence gathered using the MCA Module which includes prompts. Please avoid statements such as 'all staff had attended training', evidence would be that all staff we met had a clear (or not) understanding of their responsibilities; how many DoLS applications had been made.

CQC have made a public commitment to reviewing provider adherence to MCA and DoLS.

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

Reporting and investigation of incidents

Staff reported incidents via the trust electronic incident reporting system. Managers collated these into a detailed monthly board integrated performance report. This included a narrative about any identified trends or themes. The incidents were reported on in key areas, for example, ligature incidents and medicines management incidents. The report included data reported in the previous two financial years to enable easier comparison and oversight. In addition, there were a number of different Tableau data reports that monitored a range of safety information. All ward managers and team leaders that we spoke with in mental health services showed us how they used this information to help monitor the safety aspects of their services. For example, how many incidents had occurred and what type to enable them to identify potential trends.

We found variable reporting of and learning from incidents within the community health services we inspected. Within the end of life service none of the staff we spoke with could confirm if incidents relating to the care of end of life patients had been reported. There was no overall analysis of end of life care incidents. We found that staff at Petersfield MIU did not report incidents and there were delays in incident reporting in the community adults' service.

Quality governance business partners provided a direct link between the governance team and the clinical divisions. One person had successfully been appointed for the community division and had been in post since January 2017. The substantive mental health business partner was due to take up post in April 2017. The role of the division business partner was to ensure that trends and/or specific issues highlighted in incidents were identified and actions taken. At this inspection, we identified concerns in relation to how incident reports were completed and then

subsequently signed off relating to the seclusion of patients at Elmleigh. We reviewed 16 incidents involving seclusion facilities on Elmleigh ward and found that none of them had been completed appropriately with the details required for sign off. We are continuing to investigate this issue.

NHS England told us that there had been a notable improvement in the timeliness and quality of the investigation reports following serious incidents. Trust data showed that all investigation reports had been submitted within national serious incident reporting timelines of 60 days, since June 2016. The number of new serious incident investigation reports being presented to the clinical commissioning groups serious incident panel and agreed at the first presentation had improved. Few were now being returned for major issues, and of those that were these were usually associated with the quality of the action plans, needing to reflect a more specific and measurable approach. We reviewed seven serious incident investigation reports and there were consistent improvements in the quality, compared with our review of investigation reports during our January 2016 inspection.

We reviewed 18 investigations, including a sample of deaths and serious incidents from across different parts of the trust, between June 2016 and January 2017. For deaths that had occurred, we checked that the trust had followed its 'mortality' review process. We found that this was the case in all incidents of deaths that we looked at. The timeliness of completing initial mortality reviews within 48 hours to agree next actions and/or if further investigation was reported as improved from June 2016. This was reflected in data supplied by the trust from April 2016, when 78% complied with the 48 hour panel, to January 2017 when 97% were completed within 48 hours. During our January 2016 inspection, we identified a number of concerns with the quality and accuracy of the initial management reports (IMAs). During this inspection, we saw that checklists were completed at the 48 hour panel to record a view of the timeliness, quality and accuracy of the initial management report. We saw evidence that the trust was undertaking monthly audits of 50% of the IMAs submitted, with reports being sent back for additional

Are services safe?

information if the panel did not feel there was enough to make a decision. The decision-making about whether to investigate further was recorded as part of this process and the grading of the incident agreed in line with the trust policy. At the time of inspection the trust was subject to an external audit of the serious incident and mortality action plan; it was anticipated the report would be completed in Autumn 2017. The action plans continued to receive oversight and scrutiny at the monthly quality oversight group, chaired by NHS Improvement.

The trust told us that there were 79 recorded inquests held by the coroner for patients between June 2016 and February 2017. The trust had not received any regulation 28 `prevention of further deaths` notifications, although there had been one narrative verdict where the coroner found that the team had not followed trust policy in relation to risk assessments, care plans and contingency arrangements.

Learning from incidents

The trust had established monthly `evidence for improvement` panels in September 2016. The focus of these was to review evidence and how learning has been embedded from action plans agreed at corporate panel following an investigation into a serious incident. Presentations and evidence were kept in individual files electronically attached to the serious incident documentation, as well as in paper copies at the site and/or team that are responsible for implementing the actions. We saw two examples of these and found that they were comprehensive and clearly demonstrated actions taken, with evidence to support this. Local teams we visited were able to describe this process to us and give examples of changes made to practice following learning from serious incidents.

All the mental health teams we visited were able to describe various systems to ensure learning. These included discussions during team meetings, `hotspots` bulletins, trust immediate action alerts, learning networks and investigation outcomes. Staff gave examples of learning from incidents and we saw some examples of how these had been implemented. For example, the monitoring and follow up of patients who failed to attend appointments with the community mental health teams.

An appointed medicine safety officer was responsible for analysing medicines incidents and sharing learning. We saw the most recent medicine incident report and the associated shared learning bulletin.

The trust recognised that there was still work to do in relation to the learning from incidents that did not meet the serious incident threshold. Work was underway to ensure actions from incidents (and where applicable, their investigations) were followed up to ensure lessons are learnt. This was due to take place once the new action tracking module was made available on the electronic incident system at the end of March 2017. The incident team in the governance office would take on this role from April 2017. We saw how data in relation to outstanding actions were reported via Tableau, this meant the incident team could identify teams with outstanding actions in order to progress this work. We will continue to monitor progress made in relation to learning from incidents.

Safeguarding

NHS England confirmed that the trust's annual `safeguarding children and adults` report 2015/16 had been significantly delayed and was only presented at the February 2017 contract quality reporting meeting. The trust acknowledged that the report should have been presented to the trust board for June 2016 and was late. Whilst the CCGs agreed there were some notable key achievements in the report, it identified that the report listed activity but had little analysis of the impact on patients and staff. The CCGs requested that future reports were provided to the CQRM promptly in the month following presentation to the trust board.

The Southampton and West Hampshire local authority safeguarding lead told us that they were keen to ensure a more robust safeguarding meeting structure was established with the trust. The local authority were continuing to secure a section 75 agreement that would set out monitoring arrangements for safeguarding within the trust. A section 75 agreement sets out a framework for the provisions of services to a local authority by a health authority.

The trust three year corporate safeguarding strategy was awaiting sign off at the time of inspection. A number of additional processes had been introduced to improve the corporate oversight of safeguarding. For example, a serious case review tracker was maintained with details of

Are services safe?

communications to staff, a monthly corporate safeguarding report had now been established and the safeguarding lead described good access to the board. In addition, they attended the weekly trust executive committee meetings.

Within the community adults service, staff did not always recognise and escalate safeguarding concerns. We found areas of practice within several services that indicated staff did not fully consider the need to safeguard vulnerable patients. In some community multidisciplinary team meetings we observed, staff discussed patients whose circumstances should have prompted a safeguarding alert or action to protect the patient.

Environment and Equipment

At the previous inspection of end of life care in 2014 we found there had been delays in provision of special mattresses and beds for patients who needed them when receiving care at the end of their life in both community hospitals or at home. On this inspection we found that while this requirement was not wholly met the trust was working with commissioners to address the issues. Delays in the provision of equipment were recorded on the divisional risk register and measures and monitoring of the risk identified to mitigate the risk to patients and staff. Equipment was available in the community hospitals to care for people but we found that some equipment was not serviced in accordance with any maintenance program.

Within the community health service for adults, there were significant delays in the provision and repair of wheelchairs. This service was provided by an external provider. The problem affected the safety and well-being of a number of patients. Staff told us that some vulnerable patients were kept in bed at home because of a lack of appropriate seating. When we spoke with staff they were unsure what action the trust was taking to facilitate improved access to wheelchair services for these patients. The trust provided evidence that they had raised these issues with commissioners. However, staff could not identify any improvements being made in the wheelchair service for their patients.

Equipment provision was variable across the trust. Winchester community teams reported the lack of equipment was documented on the team risk register.

Staff in Lymington New Forest hospital did not use safety signs in the ophthalmic laser clinic to identify when staff were using the laser equipment. There was a risk that people could enter the room be subject to injury caused by a laser.

Environmental work within mental health and learning disabilities wards had been completed. Older people's mental health wards had a separate environmental plan as these services sat within the integrated services unit. However, work had not yet been completed at the time of the inspection and some wards still contained ligature risks. All wards provided an up to date ligature risk assessment but some did not cover all areas of the wards. The wards for older people with mental health problems wards had potential ligature anchor points. However, all wards included the local fire procedure in the induction information. Daedalus, Dryad and Stefano Olivieri ward induction paperwork included ligature risk awareness; Berrywood, Beechwood and Beaulieu wards induction paperwork did not contain ligature risk information. The security arrangements and exit and entrance facilities to Stefano Olivieri were inadequate and there were privacy and dignity issues relating to the bathroom facilities. We brought the latter concern to the attention of the trust and action was taken to immediately rectify this.

Assessing and monitoring safety and risk

The draft quality account priorities for 2017/18, included risk assessments and crisis contingency plans as priorities for patient safety. The trust reported that when reviewing underlying factors in serious incident reviews, 75% of investigation reports identified poor risk assessments and/or crisis plans. However, a further review was conducted in November 2016 which showed an improvement with this figure now being at 57%. During previous inspections of the mental health and learning disabilities services, we had identified inconsistency in the completion and updating of risk assessments. We also found that there was no consistent place to record crisis plan information and this meant that there were continued to be clear risks that important patient information was not easily available to staff, particularly in the event that patients presented in crisis outside of working hours. During this inspection, we found this continued to be an issue, particularly in the community adult mental health teams.

The trust had introduced new risk assessment training and tools. The content for the risk assessment e-learning

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training package was piloted in adult mental health teams through face to face team sessions. At the time of inspection, the project team was finalising the training content based on the pilot feedback. The completion date for the new e-learning was planned to go live to staff in May 2017. An additional workshop was taking place in May 2017 to look specifically at risk assessments and crisis plans. The mental health division was implementing a new supervision tool, following a serious incident. The tool was intended to be used in caseload management supervision with clinicians to focus on the quality and completion of risk assessments. We found variation in how embedded this was in the community mental health teams we visited.

At the time of inspection, there were twelve teams across the trust that were identified as currently have staffing issues - seven mental health units and five community teams. All had workforce action plans in place. The trust had undertaken a safer staffing review of all the wards. This had created additional vacancies due to the trust identifying the need to increase staff numbers. The trust had set safe agency use at 50%. Anything above this was flagged as a risk. The most recent board meeting held in March 2017 identified Dryad, Daedalus and Beechwood wards as all having used in excess of 50% agency staff. We were concerned to learn that on Beaulieu ward, there had been occasions where staff reduced patients' observation levels to manage low staff numbers.

Staffing levels and vacancies varied considerably between all of the community mental health teams. Following a review of the demand and capacity of the community mental health teams, the trust had adjusted staffing levels. There was inconsistency with whether teams placed staffing issues on the divisional risk register. Many staff told us that although they were busy they felt able to manage the demands of their workload. However, we found examples in some teams where, due to the pressures on workloads, staff had taken work home with them. Staff felt that managers did not take account of extra responsibilities, such as running clinics, when allocating their caseloads. We found that it was not always possible to keep caseloads down and that if a patient needed allocating then they would be given to the person with the least pressure on their caseload as well as the best skill match to support. Some staff held very high caseloads.

Within the community hospitals, staff did not regularly use acuity and dependency assessment tools to assess staffing

requirements as this was carried out at six monthly intervals. There were not always adequate staffing levels to meet the needs of patients in the community inpatient wards. Data provided by the trust showed a high percentage of substantive posts filled by bank and agency staff. Data also reflected a high proportion of shifts which were not filled. Senior staff told us this was on the trust's risk register and that staffing remained a challenge for them. Community staffing for both nurses and therapists was a challenge for the trust with a number of areas having vacant posts. Overall vacancies for community adults' services were 5%. Due to some shortages in staff some patient visits were referred to the GP out of hour's service. The trust and individual staff teams were undertaking work to improve staff retention.

Within the community adults team, the tool that staff used to monitor and identify if a patient's condition was deteriorating was not appropriate for some patients living at home with long term health conditions. The tool did not provide appropriate guidance for staff. Discussions to improve the escalation process for community patients were taking place.

Within the minor injury units, safety was a priority at all levels. Staff took an active role in delivering and promoting safety, learning and improvement. Safety performance included waiting times for assessment and treatment, adverse incidents, complaints and compliments, which were monitored continuously and were reported to the board.

The requirement from the 2014 comprehensive inspection, to review and amend the management of FP10 prescriptions had not been met. On the trust intranet, there was guidance on how to order and store FP10 prescriptions. There was no guidance on how staff should record receipt of, issue of and checks of FP10s. Hence, there was variability across the trust on how staff managed FP10s. The system at present was not auditable at departmental level. We were shown a draft FP10 management process dated March 2017 that was going through the review process. However, the trust had a governance structure to support the safe management of medicines, with a monthly medicine management committee and medicines reporting.

At our last inspection in October 2014, we found that medicines management in the community hospitals was not robust and compromised patients' safety. On this

Are services safe?

inspection, we noted that there were areas of improvement still to be made and medicines were not always managed safely and in line with best practice and manufacturers guidelines. For example, storage of medicines in the intravenous clinic and Alton Hospital was not secure and some medicines had passed their expiry date.

Within end of life care, inpatient and community staff had good access to support from the local hospice. However, at Romsey hospital, staff raised concerns that in cases where a patient deteriorated out of hours, they could not always obtain timely support from medical staff. Consequently, the patient may have been transferred to an acute hospital.

The trust had an infection control policy which was current and available for staff to view. We found the policy was not consistently adhered to at Gosport hospital. We observed infection control practices posed a risk of transfer of infection to patients.

Staff told us that they were unclear how best to restrain an older patient that required injectable medication; thus harm could be caused to the patient. The trust was currently reviewing its policy to ensure that this intervention could be delivered safely. This issue was on the trust risk register.

Potential risks

The trust had contributed to plans that had been finalised with all local health providers, NHS England and the CCGs in relation to the trust's responsibilities as part of the local health economy response to a major casualty incident. In addition, the trust had plans in place to support and respond to other major business continuity events, such as wide spread transport or weather disruption.

The trust pharmaceutical supply was managed through five separate service level agreements (SLAs). A service level agreement is a contract that defines the level of service expected from the service provider to the customer (in this instance the different pharmacy's and the trust). Our pharmacy specialist inspector was not assured of the governance of the SLAs and the trust's chief pharmacist agreed this was a substantial risk for business continuity. The trust was in the process of recruiting a band 8c pharmacist to review the contracts and medicine supply at the time of inspection.

Mandatory training

The trust's current training compliance for community health services was variable and some services were falling short of the trust target of 95%,

Duty of Candour

The Duty of Candour (DOC) became a statutory requirement for all CQC registered trusts in November 2014. The DOC places a requirement on providers of health and adult social care to be open with patients when things go wrong, ensuring that honesty and transparency is standard practice. The trust's DOC policy and 'being open' procedure, were ratified in June 2016. Patients, families, partner agencies and CQC have had significant concerns in relation to the trust's implementation of the DOC. We reported on this in our January 2016 inspection and told the trust it needed to make improvements.

At the time of this inspection, the trust was developing a DOC training package. The clinical commissioning group quality contracts for the trust specified that the trust must report on Duty of Candour. An audit of DOC was undertaken as part trust internal audit plan for 2016/17. This found a number of areas that the trust needed to work on, including how they accurately monitored and reported on compliance with DOC. A follow up audit to check on progress of these recommendations completed in March 2017 showed that the trust was progressing, or had completed many of these actions. However, the trust had not achieved sustained improvement on recording next of kin details on the electronic record system. Whilst progress was monitored in each division, using Tableau, there remained a significant gap in recording and assurance. At the time of inspection, the learning disabilities division was reported at 56% of records containing next of kin, adult mental health 46%, older person's mental health 47% and adult (community health) 22%. This failure to record next of kin impacted on the trust's ability to meet their obligations under the Duty of Candour in a timely and effective manner. In the family liaison officer report to board, they had highlighted that they were unable to offer support to nine families as the trust has not been able to identify next of kin details.

We wrote to 60 people identified as having been involved in an incident that was reportable under DOC between June 2016 and January 2017. In addition, the trust included CQC's direct contact details in 15 letters sent to 11 families. We received responses from two relatives; both of whom reported that they had been satisfied with the

Are services safe?

communication and information that they had received from the trust in relation to the incident. We were aware of three on-going complaints in relation to the quality and openness of investigations undertaken prior to June 2016.

The family liaison officer had been in post at the trust since December 2016 and advised that a family engagement

review would continue to be undertaken on a quarterly basis, in line with recommendations from the review of family involvement in investigations carried out in September 2016. The family liaison officer provided a quarterly report to the executive team.

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

Our findings

Evidence based care and treatment

While the trust used individualised end of life care plans in the community hospitals, these had not been implemented for patients who were cared for in their homes.

Within the community hospitals and community adults services the trust used National Institute for Health and Care Excellence (NICE) and Royal College of Nursing (RCN) policies and best practice guidelines to support the care and treatment provided for patients. We saw evidence of references to the use of national guidelines within a number of the trust's policies. The endoscopy service adhered to best practice guidelines and had recently acquired JAG accreditation.

The community MIUs met the minimum requirements set out in "Unscheduled Care Facilities: minimum requirements for units which see the less seriously ill or injured" (Royal College of Emergency Medicine, 2009)

Outcomes for people using services

The end of life care service had not participated in any national audits or benchmarking exercises. However, staff used the Gold Standard Framework to plan the right care for people as they neared the end of their life.

The trust monitored the average length of stay for patients in community hospitals and benchmarked the inpatient wards against each other. The average length of stay exceeded the rehabilitation wards criteria. Patients at Alton, Gosport and Petersfield community hospitals had the longest length of stays (over 30 days).

All services used the trust's electronic monitoring tool; which measured and compared outcomes for patients across the services.

Patients who attend the MIU received care, treatment and support that achieved good outcomes

Skilled staff to deliver care

Appraisal rates for community nurses were lower than the trust target; 65% against 90%. Staff in the community hospitals and community adult's services reported high levels of satisfaction with appraisals although not all hospital staff had met the 90% target. All staff reported good access to training and development opportunities.

Managers identified the learning needs of staff and provided training to meet those learning needs. They supported staff across all MIUs to maintain and develop their professional skills and experience.

There was limited resilience in the pharmacy department. For example, when a member of staff was absent or on leave, their role could not be covered. This meant that some weeks the community hospitals went without a clinical pharmacist visit. The lack of resilience was evidenced in the variable medicine reconciliation rates and in the reports from ward managers that some weeks they did not receive a pharmacy visit. . The resource issue was being addressed. The board approved a business case in February 2017 for an uplift of 5.5 WTE pharmacists and pharmacy technicians. Recruitment was in progress at the time of inspection.

In 2014 we identified the trust was not achieving the National Institute for Health and Care Excellence (NICE) recommendations for medicines reconciliation. During this inspection, we found that the medicines reconciliation process had not improved. Staff told us this was not carried out consistently as they did not have adequate pharmacy support.

Multi-disciplinary working

We found a positive culture of multidisciplinary working was embedded throughout the community hospitals. Multidisciplinary team meetings were effective and involved a variety of clinical disciplines which ensured all the care needs of patients were discussed.

Are services effective?

Community services were managed within integrated teams. This meant, that in these teams, there were staff of differing care disciplines, such as physiotherapists, occupational therapists, nurses and medical staff who could support the wide range of needs of patients.

Information and Records Systems

The trust had established a clinical care records workstream led by a senior member of the trust who clearly understood where changes were required to support effective record keeping and reduce over burdening staff with unnecessary processes. The workstream had implemented a number of changes in practice and to the templates on the electronic care record. In wards and teams 'team champions' had been identified who were available to identify risks and propose changes, as well as support the implementation of actions. Evaluation panels had also recently been established to review how effective the actions had been. A new risk summary and crisis/safety plan on the electronic record system was implemented for the mental health division in January 2017. We found that few teams had started using the new crisis/safety plans and there was inconsistent use of the new risk summary. The trust governance system monitored whether risk assessments and crisis plans had been completed on the system. Team managers told us they used this in caseload supervision to work with staff. However, there was recognition that just because a summary had been completed the quality also needed to be acceptable. These areas require the full focus of the trust.

At the last inspection of community services in 2014, the trust had identified that not all staff used the electronic recording system efficiently and effectively. The trust attributed staff self-management issues, staff reluctance to use laptops in patients' homes, difficulties with connectivity in the community and the use of temporary staff as reasons why staff did not use the electronic record system effectively. While the trust had attempted to address some of the difficulties raised by staff on this inspection we found staff still did not use the electronic record system effectively.

Community staff, specialist nurses and GPs that provided end of life care all used separate records which meant that not all the information about patients was kept in the same place and as such staff did not have access to all the information about each individual patient.

Within end of life care there was a delay in updating records and inconsistency in paper and electronic records. This meant an accurate and contemporaneous record of the patient visit was not always available for staff to access. We saw care plans and risk assessments were not always up to date.

Within community health services for adults not all records were complete, available or contemporaneous and the overall standard of documentation was variable. The management of records and delays in completing records meant there was a risk that patients would not receive care and treatment which fully met their needs. As part of its quality assurance the trust undertook a documentation audit in the autumn of 2016. After our inspection we requested a copy of the audit; this was not provided by the trust.

When reviewing the system for recording care programme approach, we noted that there were low levels of patients allocated to the care programme approach framework across the whole of the community mental health service. The care programme approach (CPA) is a national framework for way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs. However, all records that we looked at identified that staff had assessed and managed patients' needs appropriately. We raised the low levels with the trust and were informed that it was undertaking a review of caseloads and how the CPA framework was applied.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

The requirement from our 2014 inspection to ensure do not attempt cardiopulmonary resuscitation (DNACPR) records were completed in line with national guidance had not been met. There were trust wide guidelines for do not attempt cardiopulmonary resuscitation (DNACPR) and forms were completed for appropriate patients. However we found there were inconsistencies and varied practice in the completion of DNACPR forms.

Within the community hospitals and community adults service there was inconsistent practice with regards to the application of Mental Capacity Act (MCA) assessments and Deprivation of Liberty Safeguards.

Assessment and treatment in line with Mental Health Act

Are services effective?

Concerns had been raised with us about the timeliness of patients being placed on community treatment orders, particularly in the Basingstoke area. We looked at 37 records of patients who we were told were on a community treatment order (CTO) across the whole trust. There appeared to be historic delays in putting someone on a CTO in 11 cases. Some were short delays, others longer than a month. The approved mental health practitioner (AMHP) lead acknowledged that there had been some delays in responding to CTO requests the previous year due to capacity issues within the AMHP team to keep up with all the requests. There were also occasions patients were referred for a CTO and the 'responsible clinician' (consultant psychiatrist responsible for their care) had not completed the necessary up to date care plan, risk assessment or spoken to the patient or their nearest relative, which also contributed to delays. The AMHP lead reported that there were now more AMHPs in the team and they were developing a CTO referral pathway, which would hopefully make it clear (for responsible clinicians) what their responsibilities were.

Concerns had been raised with us prior to inspection that it was not always easy to find beds for people who had been recalled from a CTO. We looked at four notes in relation to incidents raised where a patient had been recalled from a CTO and no bed was available. Two of these incidents had significant consequences for the patients. We identified, from reviewing the patient records, that there was not a clear escalation pathway if there is no bed available and a patient needed to be recalled to hospital due to deterioration in their mental health.

We looked at 11 notes of patients who we were told were on long-term Section 17 leave and/or patients potentially

waiting to go on a CTO. When a patient is on leave from the wards, there should be clear communication with the inpatient and community teams as to who is following up the patient, in particular, who is responsible for ensuring the patient has their required medication. There was evidence in some of the notes that we looked at that there was confusion about who was responsible.

A person admitted to hospital and detained under the relevant sections of the Mental Health Act, who then ceases to be detained, is eligible for provision of after-care services in the community under Section 117. The Mental Health Act Code of Practice identifies that it is important that all patients who are subject to Section 117 are clearly identified and that up to date records are kept of what after-care is provided to them under section. During our inspection in January 2016, we looked at nine files in relation to section 117 and did not find any section 117 assessments or considerations in any of the files. During this inspection (March 2017), we looked at seven files and found that only one file had any mention that Section 117 assessment was required, suggesting that the trust still needed to do more work in relation to clear recording and discharge planning for patients who meet the criteria for section 117 support. In addition, we looked at 15 patient records in relation to safeguarding. In 13 files, there was evidence that safeguarding was considered appropriately.

We received two whistleblowing contacts during the inspection period. These related to patient safety concerns about staffing and use of restrictive practices (including governance and use of seclusion) at two of the trust's acute mental health units. We are continuing to review these concerns and will report separately on these.

Are services caring?

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

Summary of findings

Our findings

Dignity, respect and compassion

During our inspection visit, we observed that staff in all areas of the community health services responded to patients in a kind and compassionate manner. We also reviewed feedback from 50 patients in the endoscopy unit. This was overwhelmingly positive.

Across all services, we saw that staff focussed on doing their very best for patients and their families, despite challenges posed in some areas due to staffing shortages.

Involvement of people using services

The trust had established a patient engagement and experience work stream. A member of the executive team led this. Its work plan included the development of a trust strategy for patient engagement, experience and involvement. This was at final draft stage at the time of inspection. The patient engagement and experience group reported to the recently formed `caring` group; which was led by the interim director of nursing. The group was within the safety and quality committee structure. The `caring` group was a sub-group of the quality and safety committee. Its aim was to undertake work and give assurance on all areas relating to the caring domain. We

saw the `caring` sub group board report. This included details about work being undertaken in relation to complaints. It detailed themes for improvement that had been identified during engagement work undertaken by the trust in December 2016 and January 2017 that involved people who used services in the development of the patient experience strategy. The themes included: effective signposting, clear information and involvement of families in an individual`s care, listening and involving people with openness and honesty. The trust recognised that there was still a significant amount of work to do to build relationships although there had been some improvements since the last inspection.

Emotional support for people

A family liaison officer had been in post since December 2016. Their role was to support families and ensure they had the information they needed and to support, develop and influence the trust to improve their interaction with families. At the time of inspection, 25 families had been referred to the family liaison officer and there were seven families receiving on-going support from them.

All patients we spoke with across the community health services told us that they received emotional support from staff. Many of the services provided by the trust resulted in social and emotional support for patients. Group education, as in the diabetic education programmes and the balance and safety classes, gave opportunity for patients to socialise and provide peer support to each other.

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

Our findings

Planning and delivery of services

When we reviewed data from the trust, we noted that there a low proportion of patients were allocated to the care programme approach framework across the whole of the community mental health service. The Care Programme Approach (CPA) is a national framework for way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. We did not find any evidence from the records we looked at that staff had not assessed and managed patients' needs appropriately. However, we raised it with the trust and were informed that it was undertaking a review of caseloads and how the CPA framework was applied.

The trust worked with the local clinical commissioning groups to develop services to meet the needs of the local population. Individual community adults' teams developed initiatives to meet the needs of their local population, for example, collaborative working with social services to prevent hospital admissions from care homes. Patients who attended MIU had timely access to diagnosis and treatment but X-ray services were limited. However, we found there was no evidence of an urgent care delivery or review group to support the development of urgent and emergency care at the trust.

Diversity of needs

Adequate provision was made for people with diverse needs. Specialist nurses were available to support staff to care for patients living with dementia. While information was printed in English staff had access to an interpreter or written information in other languages if required.

All community adults' services we visited were accessible to patients using mobility aids by the use of ramps or lifts. Disabled parking was available at hospital and clinic sites.

The support for patients in vulnerable circumstances varied between the MIUs. In Petersfield MIU there was no dedicated facilities for children to ensure there were cared for in an environment suitable to meet their needs.

Right care at the right time

Individual wards had clear admission criteria for the service they provided. Patients, who lived in the catchment areas, as defined by local commissioning arrangements, were admitted if their conditions would benefit from the treatment and care provided by the hospital.

Service delivery did not always support patients to access care in a timely manner. The single point of access and triage process in the community adults' service did not always operate effectively and in some areas was adversely affected by availability of staff. In some areas staff shortages meant they could not always visit all their patients. In these situations, patients were referred to the out of hours doctor service.

There were delays for some patients accessing outpatient clinics and services, with between 11% and 14% not having an appointment within the trust target of two weeks from time of referral.

Learning from concerns and complaints

Patients, families, partner agencies and CQC have had significant concerns about the trust's complaints processes, quality of responses and learning from complaints. We looked at this in detail and reported on it in the January 2016 inspection report. In order to review how the trust had progressed with this, we undertook a review of the trust complaints process during this inspection. We reviewed a range of data and policies. We also questioned a number of senior staff across the trust about complaints and patient experience. These included the interim chief executive, the acting director of nursing, the head of patient engagement and experience, the trust programme manager and the interim customer experience manager. We also conducted a telephone interview with a current complainant who had experience of how the trust dealt with their complex complaint and looked at a sample of responses to complaints.

Are services responsive to people's needs?

We found that, overall, the complaints governance process in the trust had improved over the past 12 months but that further improvements were required. Specifically, we found improvements on the trust's focus on the need to improve timeliness and quality of response and the requirement to improve the quality of documents that guide practice. The interim chief executive demonstrated more involvement and interest in pushing through learning from complaints and improvements for patients and families. There was an improved, formal governance committee structure, new methods of corporate review and the trust was introducing oversight of complex complaints through integrated panels reviewing serious incidents. The e-training module for complaints had been revised and the trust was re-designing the training provided for investigating officers for complaints and serious incidents. The trust had introduced supervision for the complaints team and this was valued by the staff. Complaints process risks has been added to the governance risk register to ensure that there was continued senior oversight of the on-going requirements and work.

While there was improved engagement of local staff, staff in the divisions did not always respond promptly to communications from or requests for information by, the complaints team. There was a focussed effort to close outstanding cases.

We selected six complaint files at random and reviewed them. On the basis of the trust's complaints process flow chart information, a non-complex complaint has a target of 42 days for response and a complex complaint has 52 days (working days). Standard practice within the NHS is 25 working days. Of the six files that we looked at, none were considered complex, one was withdrawn by the complainant, two were responded to within the trust's policy target of 42 working days and the remaining three took: 59, 73 and 115 working days to make a formal response.

The final response letters were all signed by the interim chief executive in line with the policy and mostly answered the complaint. There were two examples where the letter did not fully answer the complaint; one about race and one about mental health service provision. Compared with letters we reviewed in Autumn 2016, the language used in more recent letters was considerably more compassionate and caring and there were sincere apologies and offers of further contact, in addition to information about how to access PHSO. However, the trust still needed to ensure

consistency in the final response letters and to achieving an acceptable outcome for the families; some of whom continued to have outstanding issues due to previous poor experiences with the way investigations and complaints were managed. The complainant we spoke with was very unhappy with the way the trust had dealt with their complaint and felt the complaints process was not fit for purpose and that trust staff did not listen to the complainant.

If a complainant was not happy with the outcome of an investigation, they could request an external investigator and this would be discussed on an individual basis with the interim chief executive's office. This had happened in the past but was considered to be a rare event. There were no apparent criteria for determining what independent meant or for identifying if there was a conflict of interest. For example, if and when the prospective investigating officer was an employee of the trust (past, or present). These discussions would take place between the interim CEO, quality governance team, customer experience lead and divisional commissioning manager. Two families raised concerns about the independence of investigations and said they had not had a satisfactory resolution of their concerns about this.

There had been improvement in the involvement of complainants and families earlier on in the complaints process and the interim chief executive had been meeting regularly with several families who have had very poor experiences with the trust in the past. The interim chief executive and interim chair assured us that the meetings were continuing and it was a focus for the trust's executive to achieve an acceptable outcome for all involved.

An example of how the trust was working to improve the relationship and learning with families was through the establishment of the 'families first' group. The "families first" group was where families previously involved in incidents and now complaints (since February 2017) were co-producing action plans and policies. The group had met four times, had three regular family members and two new members were about to join. We spoke with two members of the group who were very positive about the trust commitment to driving this forward and seeking genuine involvement from families to bring about change.

The interim chief executive described further improvements that were planned for the complaints governance framework. These would be informed by an

Are services responsive to people's needs?

extensive audit and review of complaints which was due to be undertaken in June 2017. It will also take account of the recommendations from the outgoing interim complaints manager and the views of the new substantive manager, who was due to take up post in April 2017. The outgoing interim complaints manager had submitted a report to the interim CEO summarising the current position of the complaints improvement plan, actions to date, governance, team development and required actions. Therefore, what was in place at the time of inspection was the existing system and while that was considerably more embedded than a year ago, it would change again during 2017.

Although some considerable improvements have been made to the process the trust used in managing complaints further, significant improvements was still required, particularly to the procedure for obtaining feedback from complainants, how learning from complaints was shared trust-wide and how the trust demonstrated that change and improvement to practice had taken place. The current timescales for responding to complaints continued to be unacceptable for a number of complainants.

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

Vision, values and strategy

The interim chair and chief executive had a clear vision of what was required to bring about improvements and were committed to ensuring improvement.

In October 2016, the trust initiated a review of how it provided services. This resulted in the development of a clinical services strategy. This had three key components: i. the development of a clinical strategy for mental health and learning disabilities services; ii. a review of the trust's multi-speciality community provider work to make sure it was aligned with the mental health and learning disabilities strategy and iii. a review of how the organisation would be best structured to deliver the mental health and learning disabilities services for the new models of care. The majority of the trust governors told us that there had been a very open and inclusive approach to the development of the strategy.

Good governance

There was a greater focus on ensuring that the trust implemented the actions in the improvement action plans arising from previous CQC inspections and from the review of serious incidents and mortality undertaken by Mazars. Managers monitored progress weekly and reported progress to the trust board.

External partner agencies (NHS Improvement, NHS England and CCGs) continued to monitor the plans monthly at the quality oversight committee. Outcomes related to the serious incident and mortality improvement action plan has also been chosen as a patient safety priority to be included in the quality accounts priorities 2017/18, to ensure that processes have effectively been embedded and learning has led to improvements.

The trust had continued to work on its board assurance framework and how it recorded corporate risks and used risk registers at local and divisional level. We reviewed some of the risks on the risk register and the trust were able to describe why they were on there and actions to date.

Project managers within the governance team oversaw the implementation of the CQC and serious incident trust-wide plans. In addition, there were validation processes to agree completed actions. Exception reports were presented where there were any delays or significant changes required. These include reasons for delay, proposed remedial actions and any identified risks. In February 2017, an external auditor commenced the second part of the review and assurance of the serious incident and mortality plan. The report was due for completion in Autumn 2017. The same validation process had been applied to the health and safety work plan 2017/18 and there was much more direct executive oversight of this plan and executive involvement with the health and safety team. NHS Improvement recently undertook a review of the trust governance processes.

The trust had made significant investment in continuing the development of its own electronic data collection and reporting system. This contained a range of quality and safety data. The system extracts the information directly from the electronic clinical records and incident system. This had led to improvements in 'ward to board' governance in the form of a monthly performance report – although was reliant on the accuracy of the information on the other systems. Teams could request their own specific reports (for example, incident data) to help local services have easily accessible information tailored to the services, as well as for the corporate team. Reports could be available in a range of different formats depending on what information was required (for example, through graphs or by individual breakdown of numbers) and could give comparisons with other teams. At the time of inspection, there were 3,000 users within the trust. The trust emailed Tableau workforce data reports to the commissioners and were looking at how it could provide other reports. The divisions and corporate teams used Tableau to monitor action plans through the quality improvement plans.

Are services well-led?

Each clinical business unit had an analyst and worked with the quality and governance business partners to try to ensure that staff understood and used data in a way to improve quality and safety on the frontline. All staff and managers we met were positive about the on-going development and continued extended implementation of Tableau. We were shown how it was used at local level to help teams with a range of quality and safety requirements such as staffing, incidents and complaints. There was still work required in relation to ensuring that data were accurate and used in a consistent manner, specifically in relation to how effectively supervision and training was captured from the learning and development system. There were 68 Tableau champions across the trust at the time of inspection; all of whom give feedback and got involved with the development and design of reports generated by the system.

Quality business partners provided a direct link between governance and the clinical divisions. One person had successfully been appointed for the community division and had been in post since January 2017. The mental health business partner role was being filled with an interim and the substantive member of staff was due to take up post in the forthcoming month.

The trust had developed a cycle of `deep dive` activity, to enable them to focus in detail on specific areas to understand issues and risks. Examples of deep dives that had been undertaken in the previous six months were safer staffing, learning from serious incidents, and acuity and dependency in community mental health teams. This had led to changes such as increased staffing numbers on some wards and development of specific risk training modules.

Leadership and culture

At the time of inspection, there was continued uncertainty about the future of the trust and several significant changes taking place within the trust. The interim chief executive had been in post since September 2016 and the interim chair since November 2016. The trust had announced the resignation of all the non-executive directors and there were a number of vacancies on the board of governors. In addition, there were also a number of senior management vacancies or senior managers due to leave post, particularly in mental health services.

Members of the board of governors and the majority of staff that we spoke with felt that the interim chair and interim

chief executive were making a positive difference. They thought that they were changing the culture, introducing a clear focus on quality, improving governance processes, supporting improvements in service delivery and that they were more open and approachable than they had previously experienced. However, all those we spoke with recognised that there was still much to do. Some members of staff, patients and families said that things had not changed enough and they would like to see swifter action and much more effective communication related to complaints and investigations into incidents when things had gone wrong.

The trust executive committee meeting was held weekly. Clinical and support staff presented reports and attended parts of the meeting as requested. Some staff we spoke with reported that this meant that they felt there was a much more direct line of communication with the executive team.

The freedom to speak up guardian has been in post three days a week since January 2017. They worked in an independent capacity to support and help drive the trust towards becoming a more open and supportive place to work. They had direct access to the interim chief executive and prepared a monthly report of issues arising from front line meetings that need decisions by the trust executive. They had not had any patient safety incidents raised with them at the time of inspection.

We informed them about two whistleblowing contacts we had received during the inspection period. These related to patient safety concerns about staffing and restrictive practices (including use of seclusion) at two of the trust`s acute mental health units. We are continuing to investigate these concerns.

Most team leaders and ward managers we met were supportive of their team and provided good oversight and decision-making. However, there were a number of significant gaps in the senior mental health leadership team. Three experienced senior managers had recently resigned or retired within the mental health division and there was still a significant gap in nursing leadership due to the continued absence of a head of nursing for mental health and learning disabilities. Most managers in the mental health division we met felt the trust executive were

Are services well-led?

more open and supportive, although felt it was early days still. We had some concerns raised with us in relation to how some changes have been introduced and that staff concerns were not always listened to.

The trust had recently reconfigured the management and business structure of its community health services. The community health services were part of the integrated services division, along with older people's mental health service and children's services. A director led the division; supported by healthcare professionals, a clinical lead, transformation lead plus deputy directors. The division was separated into four business units. Most staff spoke highly of their local leadership. They felt they were supportive and were receptive to new ideas from staff but were fearful that the new clinical service strategy would be a step backwards if all services for older people weren't part of an integrated service.

At our last inspection (September 2016), the interim chief executive told us there would be 'improved senior leadership visibility at the frontline (including executives and non-executive directors) and increased focus on patient safety'. During this inspection, many staff confirmed that the executive 'back to the floor' programme was taking place (where senior managers and the executive team undertook shifts with frontline staff every Thursday morning). This included the interim director of nursing and finance director going 'back to the tools' with the health and safety and estates teams. Listening events had been taking place with the interim chief executive and one psychiatrist said that a 'question and answer' session with the executive team had been very helpful. Those staff who had attended a listening event, told us they had confidence that the interim chief executive listened to their views and concerns and considered them in the development of the service.

Most staff told us that executive members of the board now more visible to frontline staff. The interim chief executive and the divisional directors provided the staff with regular updates and many staff commented that their service had received visits from these senior leaders.

Overall, staff morale was good in the mental health teams we visited, although was more varied in the adults of working age community mental health teams.

Engaging with the public and with people who use services

The trust recognised that there were significant concerns about how it had communicated with, and involved, patients and families although improvements had been made since our last inspection. It had formed a family engagement action task and finish group and recently established a families first group. These groups had been involved in reviewing policy changes and providing feedback on a draft patient engagement strategy. Members of the group we spoke with were very positive that the trust had a commitment to driving this work forward and engaging more effectively with the public and people who used services.

The interim chief executive had been meeting regularly with several families who had had very poor and difficult experiences with the trust. The interim chief executive and interim chair assured us that a key focus for the trust's executive was to achieve an acceptable outcome for all involved.

All areas of the community adults' service had patient experience champions whose role was to put the spotlight on patient experiences, to help inform and influence the development of services.

Quality improvement, innovation and sustainability

The trust had published a quality improvement strategy and an organisational learning strategy in January 2017. The trust were meeting with another trust to understand how it had implemented quality improvement methods and embedded this throughout the organisation. The clinical services strategy had reported on themes from patient and service user interviews to contribute to the design the services in the future.

Every team had a quality improvement plan that was team based and included actions from their incidents and complaints. Teams we visited were able to describe these to us. The new evidence of improvement panels that assessed learning from serious incidents was about to be used to assess complex complaints (April 2017). Since February 2017, the trust had combined serious incident and complex complaint investigations; it believed this would lead to improvements in responding effectively to complex complaints that had arisen from serious incidents.

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
Treatment of disease, disorder or injury	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p>End of Life care</p> <p>The trust did not always provide care and treatment of patients with the consent of the relevant person because:</p> <p>All of the do not attempt cardio-pulmonary resuscitation (DNACPR) forms we reviewed were not completed in line with national guidance.</p> <p>Community Health Services for Adults.</p> <p>Not all staff demonstrated a full understanding of the mental capacity act or their responsibility towards it.</p> <p>This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014</p>

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>End of life Care</p> <p>Care was not always provided person centred because:</p> <p>The trust did not use individualised end of life care plans for patients cared for at home.</p>

This section is primarily information for the provider

Requirement notices

This is a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
Community Health Services for Adults

Staff did not always recognise and escalate safeguarding concerns.

This is a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Regulation

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Community Health Inpatients Service

The governance process to assess, monitor and improve the quality of the service was not robust. Risks were not consistently assessed in order to mitigate these. There was a lack of oversight where services were not performing.

Community Health Services for Adults

Delays in staff making entries in patients' records increased the risk of incorrect information being recorded.

Care plans held at patients home were not up to date.

This section is primarily information for the provider

Requirement notices

Systems were not in place to ensure equipment (wheelchairs) was supplied by the service provider, ensuring that there were sufficient quantities to ensure the safety of the service user and to meet their needs.

Trust wide

There was inconsistent completion of next of kin details in care records

This is a breach of Regulation 17 (1) and (2) (b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 older people with mental health problems

Service users must be treated with dignity and respect. The trust must ensure the privacy of the service user.

There were privacy and dignity issues relating to the bathroom facilities on Stefano Olivieri. Patients from the adjoining acute admissions ward were able to see into the toilet and bathrooms on Stefano Olivieri ward.

This is a breach of Regulation 10 (1) and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

End of Life Care

This section is primarily information for the provider

Requirement notices

Systems were not in place to assess the risks to the health and safety of service users of receiving care and treatment because:

All community staff did not have access to up to date information in the record of patients at the end of life.

Staff at Romsey Hospital did not have access to timely support to respond to end of life care patients who deteriorated.

Community Health Inpatient Service

Staff did not follow policies and procedures about managing medicines. Medicines were not stored safely and systems were not effective to ensure medicines were used within the recommended timescale once opened. Patients were put at risk of receiving medicines that had expired.

Equipment was not maintained safely and the drug fridge which was in use had not been serviced in line with recommendations and the trust policy.

Some staff did not follow effective infection control procedures in particular when dealing with and disposing of infected materials at Gosport War Memorial Hospital

Community Health Services for Adults

Storage of medicines in the intravenous clinic and Alton Hospital was not secure and some medicines had passed their expiry date

Wards for older people with mental health problems

This section is primarily information for the provider

Requirement notices

Care and treatment must be provided in a safe way for service users.

Beaulieu ward staff reduced patient observation levels to manage low staff numbers.

We found on Stefano Olivieri, Berrywood and Beaulieu ward issues relating to best interest meetings and covert medication practices and the sharing of correct information amongst staff related to DNACPR procedures.

Providers must make sure that premises are safe. All wards were subject to the trust environmental improvement plan that included minimising ligature risks. Although progressing, the improvement plan was not yet complete.

Community-based mental health services for adults of working age

Regulation 12 Health and Social Care Act (Regulated Activities) Regulations Safe Care and Treatment

There was poor completion of crisis plans and there was risk information missing from care records we reviewed for people accessing the service.

This is a breach of regulation 12 (1) and (2)(a)(b)(d)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

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

Diagnostic and screening procedures

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Community-based mental health services for older people

The provider had not ensured there were sufficient members of staff at Gosport to meet the numbers of patients on the caseload.

Community-based mental health services for adults of working age

There were insufficient members of staff to meet the numbers of patients on the caseload in some of the teams.

End of Life Care

All staff had not received appropriate training and appraisal to ensure compliance with the requirements of the regulation because:

Appraisal rates for community nursing staff were low

Community Health Inpatients Service

There was not always adequate staffing to meet the assessed needs of people receiving care and treatment. This included patients who required 1:1 support and on night duty.

All clinical staff had not completed basic life support training which could impact of the welfare and safety of patients receiving care at the service.

This is a breach of Regulation 18 (1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.