Solent NHS Trust

Solent NHS Trust

Quality Report

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This report describes our judgement of the quality of care at this location. 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

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Summary of findings

Overall summary

St James' Hospital is the registered location from where Solent NHS Trust provides all its mental health services. The Trust provides mental health services including Child and Adolescent Mental Health Services (CAMHS) for the 220,000 people residing in the City of Portsmouth and some CAMHS services in Southampton.

Overall we found that people received a safe and caring service. People reported feeling well cared for and receiving a compassionate service. People's physical health needs were well managed. We saw positive examples of collaborative working and active engagement with local black minority and ethnic (BME) groups through the community development workers employed by the trust in partnership with Portsmouth City Council. The evidence seen showed us that this had led to an increase in service engagement of these specific groups and demonstrated a pro-active approach to community engagement by the trust.

We found that improvements need to be made in respect of safety at the Kite Unit where there were a lack of specific male and female areas and some fixtures and fittings could present increased risks. In adult community services staffing levels may present risks to safety for people using the services. We also found that staffing levels within the adult community teams were low and improvements were needed to ensure access and safety was maintained.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Most services were safe except we judged that the lack of gender separation on the Kite Unit was not safe and was in breach of Department of Health guidelines and Mental Health Act code of practice. We also found numerous ligature points on the Kite Unit and were concerned that the unit building was not conducive to safe mitigation of the risks associated with these. This is a small unit that did not have any female patients at the time of our inspection and this practice was not reflected elsewhere.

Comprehensive risk assessments were not always carried out in the child and adolescent mental health services and improvements are needed to ensure these are always completed and acted upon.

On the whole, staffing levels were appropriate to the needs of the service, but community services were short staffed at times. Systems were in place to identify and investigate patient safety incidents with an emphasis in the organisation to reduce harm to patients.

We found that people's physical health needs were well managed within all services..

Staffing shortages in adult community services present potential compromises to safety for people needing services in a timely way.

Are services effective?

Most services were effective. The adult community services needs improvement, however. We noted that the Trust amalgamation of the assertive outreach and early intervention psychosis team lacked clear clinical validation. This model had not been evaluated fully by the Trust and yet further trust reconfiguration was due to take place shortly. Whilst we saw some good examples of collaborative partnership working, there was limited multi-disciplinary input into the crisis team.

People were involved in their care treatment and management of their goals.

Are services caring?

The services provided were caring. This was confirmed by our observations of the care and treatment being provided by staff. We noted that staff actively engaged with people. People told us that they were treated with respect and kindness by staff.

Are services responsive to people's needs?

The services provided were responsive. We saw, and people told us, that they received care, treatment and support to meet their needs in a timely way. Complaints were few, but were dealt with in a positive way with an emphasis on resolution.

Are services well-led?

Most services are well led, but improvements are needed in some areas. We found that the current arrangements in the place of safety did not ensure coordinated working with the police around Section 135 and 136 of the Mental Health Act. We also found that some improvements were required in the use and analysis of outcome measures. We noted that improvements were required to ensure a consistent approach across services.

Summary of findings

What we found about each of the main services at this location

Mental Health Act responsibilities

We found that patients were lawfully detained, however there was room for improvement in the recording of procedures required under the Mental Health Act and Code of Practice. This included the recording of conditions associated with section 17 leave.

We were told about delays in the process for Mental Health Act assessment due to the availability of key staff.

Mostly people's rights were being upheld. However we did find some practices that were restrictive within adult mental health services. These included the admittance of people detained under the Mental Health Act directly to psychiatric intensive care even if the individual's risk assessment did not specify this action and routine body searches for people returning from leave.

Care planning and risk assessments were fully completed and usually inclusive of the people's views. People generally felt involved in their care and well supported by staff. Advocacy support was available and community meetings took place.

We found issues regarding the privacy and safety of patients at the Kite Unit. Gender separation was not in line with the Mental Health Act Code of Practice and the environment provided challenges regarding potential self-harm. We also found that the environment within the seclusion facility required improvement.

We found that arrangements with the police regarding the management of places of safety were not clear and the health based place of safety suite was not always used as the preferred place of safety as required by the Mental Health Act Code of Practice.

We found that there was a programme of audit and a governance process in place to consider how well the Mental Health Act is being implemented at the hospital.

Acute admission wards

These services were provided in a safe way. The Trust had ensured that risk assessments had been completed upon initial admission to the service. We saw evidence that showed us the service reviewed, understood and managed the risk to people who used this service. Systems were in place to identify and investigate patient safety incidents with an emphasis in the organisation to reduce harm to patients. Action plans were monitored by local governance groups. The Trust had a risk register as a working document and informed the Trust where to make improvements.

The services were provided in an effective way. People were involved in their care treatment and management of their goals. The care and treatment was holistic and all their mental and physical needs were assessed and supported. The holistic care also applied to their money and benefit concerns and housing needs. Daily support from specialists was available in these areas.

The services provided were caring. This was confirmed by our observations of the care and treatment being provided by staff. We noted that staff actively engaged with people at a local level. Every person we spoke with told us that they were treated with respect and kindness by staff. They told us that they had their privacy and dignity respected and were provided with care or treatment choices wherever possible. Clinicians told us that they felt that people got a 'good service' from the Trust.

The services provided were responsive. We saw, and people told us, that they received care, treatment and support to meet their needs in a timely way. Their concerns were listened to and responded to with at least a verbal response and/or a written response where appropriate.

Summary of findings

The service was well-led. For example the matron had asked people using the service, relatives, carers and staff their thoughts on weekly ward meetings and had responded with changes based on the feedback.

Psychiatric intensive care units and health-based places of safety

PICU

The PICU services were provided in a safe way. The Trust had ensured that risk assessments had been completed upon initial admission to the service. The evidence we saw showed us that the service reviewed, understood and managed the risk to people who used this service. Systems were in place to identify and investigate patient safety incidents with an emphasis in the organisation to reduce harm to patients. Action plans were monitored by local governance groups. The Trust had a risk register as a working document and informed the Trust where to make improvements

The PICU services were provided in an effective way. We saw that people were involved in their care treatment and management of their goals. The care and treatment was holistic with all patients' mental and physical needs assessed and supported. The holistic care also applied to money and benefit concerns and housing needs with daily support from specialists in these areas.

The PICU services were provided in a caring way. This was confirmed by our observations of the care and treatment being provided by staff. Staff actively engaged with people at a local level. Every person we spoke with told us that they were treated with respect and kindness by staff. They told us they had their privacy and dignity respected and were provided with care or treatment choices wherever possible. Clinicians told us they felt that people got a 'good service' from the Trust.

The PICU services were provided in a responsive way. People told us, and we observed that they received care, treatment and support to meet their needs, in a timely way. Their concerns were listened to and responded to with at least a verbal response and/or a written response where appropriate.

We found the PICU service to be robust and well-led at the local level. Previously the matron had asked people who used the service, relatives and carers, and staff their thoughts on weekly ward meetings and had responded with changes based on the feedback.

Place of safety

The environment and location of the section 136 suite meant that there were risks to the safety and dignity of patients and could not ensure that this service was safe.

Whilst the Trust had the capacity to respond appropriately to clinical need there was a lack of joint and collaborative working around the use of the section 136 suite which compromised responsiveness.

We noted that the interface with Hampshire Police was not working as well as it should and was, therefore, not as effective as it could be.

We found that the current arrangements did not ensure coordinated working with the police around Section 135 and 136 of the Mental Health Act and this need to be more robustly led to ensure better liaison.

However, the services provided were caring. The records and other policies seen showed us that there were robust operational protocols in place. This was supported by our discussions with patients and staff. Patients were being made aware of their rights and staff supported people in a caring manner.

Summary of findings

Child and adolescent mental health services

We found that whilst the provision of child and adolescent mental health services was safe some improvements were required. We saw that the service had assessed the mental and physical needs of children who were using these services and provided care accordingly. However, the records seen showed us that the Trust had not always ensured that full risk assessments had been completed upon initial admission to all the services provided.

We saw that children and their parents were involved wherever possible in their care treatment and management of their goals. However, some sites inspected could not demonstrate learning points from audits and were not able to provide action plans which were monitored on a regular basis.This meant that the monitoring of quality of the services provided by the Trust was inconsistent across those services inspected.The evidence we saw showed us that improvements were required to demonstrate fully that the Trust provided an effective service to children and their families.

The service provided by staff was caring. This was confirmed by our observations of the care and treatment being provided by staff. We observed a referral meeting in one team and saw staff accommodated the individual needs of the people referred and that staff worked together to ensure the most appropriate response to individual need. In feedback reports from people who used the service staff were described as caring, helpful and supportive.

Improvements were required by the Trust to ensure that these services were responsive. There were systems in place to monitor the quality of care provided and check it was meeting national standards. There was an effective process in place for responding to complaints. Outcome measures were used to check progress of people using the service. However, there was no evidence of higher levels of analysis to inform service development. Whilst there were arrangements in place for a person's transfer to other services, for example adult mental health services, these arrangements were noted to be varied across sites as a result of different commissioning arrangements.

Staff told us they felt well supported by their manager and could raise any concerns they had and these would be addressed. However, we found that some improvements were required in the use and analysis of outcome measures in these services by the trust. We noted that improvements were required to ensure a consistent approach across all of these services. Staff were concerned about the impact of potential cost improvement plans upon these services, although these had not been finalised.

Services for older people

There were clear incident reporting processes and staff understood their reporting duties. Processes were in place to safeguard people. Risks to people had been assessed upon their admission or referral to community services and on an ongoing basis. Actions had been taken to manage the risk of people falling. There were sufficient staff to provide people's care. There was a significant use of agency staff on The Limes but reasonable steps had been taken to manage the impact of this on people's care.

People's care took account of clinical guidance and best practice. There was close working with other services within the Trust to meet people's needs. People could not currently access a psychologist on The Limes; however, the Trust was in the process of recruiting to this post. The quality of care delivered was monitored through audits, surveys and people's feedback. Staff received a good level of training. We saw adherence to the requirements of the Mental Health Act (MHA) 1983 and the associated Code of Practice (CoP).

People were provided with choices about their care and took part in reviews. Where people lacked the capacity to make specific decisions their capacity had been assessed and best interest decisions made. Staff communicated effectively with people and they were treated with dignity and respect.

Care was tailored to people's individual needs. The Intermediate Care Team (ICT) had been responsive in reducing the need for people to be readmitted. This service did not operate overnight; however, there was a care pathway in place for people who required overnight admission. The complaints policy was readily available to people.

Summary of findings

Staff had an understanding of the governance procedures and processes were in place for risks to be identified and managed. Staff felt well supported by their team managers. Staff received regular supervision and an annual appraisal.

Services for people with learning disabilities or autism

Overall we found that the service was safe. Staff were aware of their responsibility to report incidents and safeguard people. Incidents were reported and learnt from. There were sufficient staff to provide for people's care needs.

People's care took account of clinical guidance and best practice. The quality of care delivered was monitored through audits, surveys and people's feedback. The community team could demonstrate that there had been few admissions to inpatient units required for people with a learning disability.

People were provided with choices about their care and took part in reviews. Where people lacked the capacity to make specific decisions, their capacity had been assessed and best interest decisions made. We observed very positive interaction between staff and people using the service.

Care was tailored to people's individual needs. The complaints policy was readily available to people. Advocacy was proactively promoted and there were a range of activities undertaken to involve people in their care planning and service design.

Staff received a good level of training. Staff had an understanding of the governance procedures and processes in place for risks to be identified and managed. Staff felt well supported by their team managers. Staff received regular supervision and an annual appraisal.

Adult community-based services

We found that whilst the provision of these community services was safe; some improvements were required. The trust had not always ensured that full risk assessments had been completed upon initial admission to the service. Examples were seen of large caseloads and staff shortages within two distinct teams. The evidence seen showed us that improvements were required by the trust to demonstrate that the services reviewed; understood and managed the risk to people who used this service.

Improvements were required to ensure that these services were effective. We noted that the trust amalgamation of the assertive outreach and early intervention psychosis team lacked clear clinical validation. This model had not been evaluated fully by the trust and yet further trust reconfiguration was due to take place shortly. Whilst we saw some good examples of collaborative partnership working, there was a lack of multi-disciplinary input into the crisis team. There was a need to review the levels of the consultant psychiatrist input into the access to intervention service based on the numbers of incoming referrals noted. These identified concerns meant that improvements were required by the trust to fully ensure the effective delivery of care and treatment to some patients.

The services provided were caring. This was confirmed by our observations of the care and treatment being provided by front line staff. We noted that staff actively engaged with people at a local level. Almost every person spoken with told us that they were treated with respect and kindness by staff. They told us that they had their privacy and dignity respected and were provided with care or treatment choices wherever possible. Clinicians told us that they felt that people got a 'good service' from the trust.

Improvements were required to ensure that these services were fully responsive to people's needs. This was because we noted that the trust needed to review the evidence it had used to plan their services based on the needs of the local population. The trust was meeting the individual needs of people who used this service and we reviewed some good examples of responsive and patient centred care during the inspection. Examples were seen of effective complaints management. Some patients spoke highly of their own involvement and participation in their transition from hospital in-patient care to recovery in the community.

Summary of findings

Whilst we found robust and well led local service provision; improvements were required to ensure that trust wide leadership was more visible and responsive to front line staff. Some staff told us that they didn't feel listened to at the organisational level and that they felt the trust's risk register did not reflect the potential risks to the organisation. This showed us that improvements were required by the trust in order to review the existing trust risk register in the light of these concerns.

Specialist eating disorders services

There were systems and processes in place to ensure the safety of people using the service and staff, although some improvements were required.

The service had not always ensured full risk assessments had been completed upon initial admission to the service. We saw that improvements were required to fully demonstrate the services understood and managed the risk to people who used this service.

People who used the service reported feeling safe and understood the approach used by staff. They told us staff were caring and responsive to their needs.

In feedback reports from people who used the service, staff were described as caring, helpful and supportive. Staff told us there had been no formal complaints and if an individual raised any concern it would be dealt with as part of their therapeutic intervention and recorded in their clinical record.

There were sufficient transfer arrangements for young people coming in to the service. For example we looked at records for a young person who was in the process of transferring and saw there was communication between both services.

However, there was poor communication between adult mental health and this service. For example the electronic system did not show the involvement of the eating disorder service for a person open to adult mental health services.

The record keeping required improvement, we found the care records did not contain all relevant information which staff retained; there was discrepancy between what was recorded on the electronic system and what was in the paper record.

Staff could not show us a record of when the equipment, for example weighing scales, had been checked and calibrated and there was no label on the equipment to show when this was last done. There were labels to show when the equipment had been tested for electrical safety. We later received assurance from the Trust the equipment had been calibrated. Improvement was required in local systems to monitor this.

There were effective processes in place for appraisal of staff and regular supervision to ensure safe and effective provision of care. Staff we spoke with told us they felt well supported by their manager and could raise any concerns they had and these would be addressed.

Some improvements were required to ensure safe record keeping which identified risk, care planning and in recording communication with other services. Improvement was required in the local monitoring of equipment checks.

Other specialist services inspected

Overall we found that the service was safe but improvements are required in respect of the environment and the risks that this poses to patients, in particular female patients. Staff were aware of their responsibility to report incidents and safeguard patients. Incidents were reported and learnt from. There were sufficient staff to provide for people's care needs. We judged that the lack of gender separation on the Kite Unit was not safe and was in breach of Department of Health guidelines and Mental Health Act code of practice.

Summary of findings

Care was provided with account of clinical guidance and best practice. We saw adherence to the requirements of the Mental Health Act, however some improvement is required to deliver care in line with the Code of Practice. The quality of care delivered was monitored through audits, surveys and people's feedback. Staff received a good level of training.

People were provided with choices about their care and took part in reviews. Where people lacked the capacity to make specific decisions, their capacity had been assessed and best interest decisions made. We observed very positive interaction between staff and patients.

Care was tailored to people's individual needs. The complaints policy was readily available to people. Advocacy was proactively promoted at the service.

Staff had an understanding of the governance procedures and processes in place for risks to be identified and managed. Staff felt well supported by their team managers. Staff received regular supervision and an annual appraisal.

Summary of findings

What people who use the location say

People reported feeling cared for by staff and that they felt they received a good service that met their needs in a compassionate manner. We spoke with patients on wards and also telephoned people who use community services as well as hosting engagement events. All the people we spoke with were complimentary about the staff they dealt with and felt the services were caring. The Trust undertakes a friends and family test and this was positive, but has rather low response rates.

Areas for improvement

Action the provider MUST take to improve

- The Trust must reconsider the environment of the Kite Unit as it does not provide adequate protection to people and does not reflect the requirements of published expert guidance.
- The Trust must ensure the case loads of each mental health community team are supported by adequate numbers of skilled and experienced staff including consultant psychiatrist input.

Action the provider SHOULD take to improve

- The Trust should ensure risk assessment and management is embedded in practice.
- The Trust should ensure analysis of outcome measures across CAMHS to inform service development.
- The Trust should ensure a high standard of record keeping across all CAMHS sites and ensure consistency.
- The Trust should ensure that all clinical decisions were based upon a robust and documented assessment process that includes multi-disciplinary involvement.
- The Trust should ensure effective clinically based treatment provision was available to all patients who use these services.
- The Trust should ensure staffing levels and skills in each community based team were sufficient so that patients received the appropriate level of care and treatment from front line staff.
- The Trust should ensure the environment and location of the Section 136 suite (Place of Safety) are reviewed to promote fully the safety and dignity of patients.
- The Trust should review arrangements (delivery and commissioning) for the reception and assessment of young people detained under Section 136 of the mental health act.
- The Trust should ensure that coordinated working arrangements were in place with Hampshire Police around Section 135 and 136 of the Mental Health Act.
- The Trust should demonstrate further that it listened to all staff at the organisational level.

Good practice

Our inspection team highlighted the following areas of good practice:

- Overall we found that there was a positive working culture, demonstrated by staff talking with pride in working for the Trust and patients praising staff for their caring, compassion and dedication.
- Staff across the Trust demonstrated a clear understanding of the organisation's vision and values, and these were well-embedded in practice.
- Across the Trust's services, staff demonstrated excellent commitment to providing the best care they could and putting the patient at the centre of their care.

Learning disability

- We saw the trust was able to demonstrate that people who used this service received care and treatment in line with the current best clinical practice guidance and this had resulted in very few admissions to inpatient units

Summary of findings

Community Services

- We saw two examples of positive recovery care models as evidenced by the Solent recovery college and the day treatment centre. Both were an innovative development in recovery and in maintaining people's recovery in the community.
- We saw the customer recovery outcome scores (CROS) had been introduced by the trust following extensive consultation and the subsequent audits seen showed us that clinical outcomes were being monitored effectively.
- We saw positive examples of collaborative working and active engagement with local black minority and ethnic (BME) groups through the community development workers employed by the trust in partnership with Portsmouth City Council. The evidence seen showed us that this had led to an increase in service engagement of these specific groups and demonstrated a pro-active approach to community engagement by the trust.
- We saw the homeless service in action and were impressed by the high standards of care being provided to this 'difficult to reach' population group. Evidence was seen that demonstrated to us that people's long term health conditions were being met effectively by this service. We saw that the trust worked collaboratively and in partnership with a number of other providers including general practitioners (GP) as part of this service.

PICU

- We saw that any identified risks had a clear and relevant care plan in place that showed the involvement of the person themselves. Practices consistently reflect the principle of least restriction, including when people were admitted to the service. All use of these interventions complied with national guidelines, the Mental Health Act Code of Practice and local policies and their use was recorded and monitored.

Solent NHS Trust

Detailed Findings

Services we looked at:
Mental Health Act responsibilities; Acute admission wards; Psychiatric intensive care units and health-based places of safety; Child and adolescent mental health services; Services for older people; Services for people with learning disabilities or autism; Adult community-based services; Community-based crisis services; Specialist eating disorder services; Other specialist services inspected (neuro-psychiatry ward)

Our inspection team

Our inspection team was led by:

Chair: Stephen Dalton, Chief Executive Mental Health Network, NHS Confederation

Head of Inspection: Julie Meikle

The teams included CQC inspectors, a variety of specialists and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Specialists included: Consultant Psychiatrists, registered mental nurses specialising in learning disability, adult services and older peoples services, social workers and a GP.

Background to Solent NHS Trust

St James' Hospital is the registered location from where all the mental health services for the Tust are provided. The Trusts provides mental health services for the 220,000 people residing in City of Portsmouth and some CAMHS services in Southampton.

The location has been compliant on previous inspections undertaken on 27 September 2012 and on 21 February (published on 6 June 2013). However, on 3 June 2013, the mental health act commissioners reported that the Kite Unit, which had been opened that year subsequent to the February inspection so had not been inspected, did not meet requirement for gender separation. A report was sent to the Trust following the menatl health act commissioner's vist and replied to by the Trust in July 2013.

St James Hospital

Core Service provided: Older persons mental health

Male/female/mixed: mixed

30 Brookvale Road, Southampton

Core service provided: CAMHS Community Service for 14-18 year olds

Male/female/mixed: Mixed

Falcon House, St James Hospital, Portsmouth

Core service provided: CAMHS Community Service 0-18 year olds

Male/female/mixed: mixed

The Orchard Centre, Southampton

Core service provided: CAMHS Community Service 0-14 year olds

Male/female/mixed: mixed

Detailed Findings

Bluebell Rooms, Kingston Crescent, Portsmouth
Core service provided: Specialist Eating Disorder Service

Male/female/mixed: mixed

Hawthorn Ward
Core service provided: Adult Mental Health acute ward

Male/female/mixed:mixed

Capacity: 24 beds

Oakdene Ward
Core service provided: Adult Mental Health rehabilitation ward

Male/female/mixed:mixed

Capacity: 14 beds

The Kite Unit
Core service provided: Specialist service - acquired brain injury unit

Male/female/mixed:mixed

Capacity: 8 beds

Section 136 Suite
Core service provided: Place of Safety

Male/female/mixed:mixed

Capacity: One person

St Mary's Hospital
Core service provided: Two community recovery teams.The Intensive Engagement Team (IET). The access to intervention service (a2i).

Male/female/mixed:mixed

Capacity: N/A

St John's Hospital
Core service provided: Crisis Resolution Team

Male/female/mixed:mixed

Capacity: N/A

Core service provided: Community Development Workers

Male/female/mixed:mixed

Capacity: N/A

Queen Alexandra Hospital Portsmouth
Core service provided: Liaison Psychiatry

Male/female/mixed:mixed

Capacity: N/A

Why we carried out this inspection

We inspected this provider as part of our in-depth mental health inspection programme. One reason for choosing this provider is because they are a trust that has applied to Monitor to have Foundation Trust status. Our assessment of the quality and safety of their services will inform this process.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

- Mental Health Act responsibilities
- Acute admission wards
- Psychiatric intensive care units and health-based places of safety
- Child and adolescent mental health services
- Services for older people
- Services for people with learning disabilities or autism
- Adult community-based services
- Community-based crisis services
- Specialist eating disorder services
- Other specialist services inspected (this was a neuro-psychiatric ward)

Before visiting, we reviewed a range of information we hold about the location and asked other organisations to share what they knew about the location. We carried out announced visits on 18, 19 and 20 March 2014. During our visit we held focus groups with a range of staff at the

location (these included nurses, doctors, managers, support staff, allied health professionals, mental health act managers and clinical governance staff). We talked with people who use services and staff from all areas of the location. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences

Mental Health Act responsibilities

Information about the service

During our inspection we looked at how the Mental Health Act was operated at all of the wards at St James Hospital where the Mental Health Act is used to detain patients. These included the following services:

- Older people mental health services: the Limes is a 36 bedded unit including three wards. Appleby, Kitwood and Booker wards provide care for people with organic and functional mental illness.
- Adult mental health wards: Maples ward is a 10 bedded psychiatric intensive care unit. Hawthorne is a 24 bedded acute admission ward. Oakdene is a 14 bedded rehabilitation unit.
- The Kite unit is an eight bedded neuropsychiatric rehabilitation service for people with a brain injury. It provides treatment and intensive support to patients with cognitive impairment and additional psychiatric needs but does not facilitate crisis/emergency admission.
- We also looked that the section 136 place of safety facilities based at St James Hospital and the seclusion facility based on Maples ward. We considered how Mental Health Act assessments are undertaken in the community and for existing inpatients. We looked at how community treatment orders (CTO) are managed. We also considered the provision of electro-convulsive therapy (ECT) at the hospital.

During our visit we reviewed Mental Health Act (MHA) paperwork, policies, protocols and patient electronic records. We reviewed the detention and care of 22 patients who were detained under the MHA and met with 14 detained patients. We spoke to front line staff including ward based nurses and support workers, responsible clinicians and staff grade doctors, several community nurses, social workers, psychologists, approved mental health professionals and a security guard. We spoke with individual ward and team managers and met with clinical leads at the trust. We met with the lead for the MHA, MHA administrators and the hospital managers.

Summary of findings

We found that patients were lawfully detained however there was room for improvement in the recording of procedures required under the Mental Health Act and Code of Practice. This included the recording of conditions associated with section 17 leave, how decisions about people's best interests had been made and the authority to treat.

We were told about delays in the process for Mental Health Act assessment due to key staffs' availability.

Generally people's rights were being upheld. However we did find some practices that were restrictive within adult mental health services. These included the admittance of patients directly to the psychiatric intensive care and routine body searched for patients returning from leave.

Care planning and risk assessments were fully completed and usually inclusive of the patient's views. Patients generally felt involved in their care and well supported by staff. Advocacy support was in available and community meetings took place.

We found issues regarding the privacy and safety of patients at the Kite Unit. Gender separation was not in line with the Mental Health Act Code of Practice and the environment provided challenges regarding potential self-harm. We also found that the environment within the seclusion facility required improvement.

We found that arrangements with the police regarding the management of places of safety were not clear and the health based place of safety suite is not always being used as the preferred place of safety as required by the Mental Health Act Code of Practice.

We found that there was a programme of audit and a governance process in place to consider how well the Mental Health Act is being implemented at the hospital.

Mental Health Act responsibilities

Are Mental Health Act responsibilities safe?

There have been no deaths of patients subject to the Mental Health Act at the trust since 2011.

On most wards we found that that risk assessments were comprehensive and supported by care plans which were regularly updated. Many risk assessments included the views of the patients.

There were systems and processes in place to enable community and crisis team staff to supervise community treatment and to facilitate assessment in the community under the Mental Health Act. We saw evidence that comprehensive multidisciplinary risk assessments took place. We saw evidence that decisions about the continuance and conditions of community treatment orders were undertaken in collaboration with service users, their nearest relatives, the responsible clinician and other team members.

Physical healthcare observations were carried out on admission, and were part of daily care and recorded appropriately. Care plans examined included details of people's specific healthcare needs.

Patients generally had good levels of section 17 leave and risk plans for the management of section 17 leave were in place on the wards. One patient on Kitwood ward showed us her section 17 leave form and told us that she needed an escort to leave the ward. Informal patients were generally aware of their right to leave the ward in discussion with staff. In all wards there was a notice by the door explaining the process. However we found on the adult wards that for those patients receiving section 17 leave there was a lack of clarity from the approved clinician on the conditions of the leave. For one patient whose risk had increased we found an entry in the patient's records system to cancel all current unescorted leave however we found that this had not resulted in the individual's section 17 leave ceasing.

For people receiving unescorted leave from the psychiatric intensive care unit there was a blanket practice to conduct both personal and body searches when the patient returned from leave. We were informed by staff that there had been frequent occurrences of patients returning from leave under the influence of drugs or found in possession of contraband items.

Staff demonstrated on all wards that they were aware of their safeguarding responsibilities. We saw evidence of staff awareness training in the Mental Capacity Act . Copies of the Codes of Practice to both the Mental Health Act and The Mental Capacity Act were kept in the ward offices. We were told that the Mental Health Act was the usual procedure for treating incapacitated patients refusing treatment. However several patients on Kite Unit who were admitted under best interests decisions contained insufficient evidence of how the decision had been made.

We found that staff were trained in strategies for the prevention of crisis intervention and in de-escalation techniques.

Generally the wards were well-staffed with a mix of RMN (registered mental health nurses) and RGN (registered general nurses) as well as healthcare support workers as required. We were told that the staffing levels on most wards were adjusted to reflect the changing dependency needs of patients. However, there was a high use of agency staff on some units. It was unclear whether the use of agency staff always enabled safe practice and we were told that Kitwood ward sometimes struggled to meet the staffing requirements.

Generally the ward environments were well designed and fit for purpose. All wards were clean and nicely decorated. However we found a number of issues with the environment on Kite Unit. These include a lack of gender separation within bedrooms and bathrooms, potential ligature points and poor lines of sight for the purpose of staff observing patients.

The location and environment of the section 136 place of safety suite were not ideal. Whilst this was a purpose built unit, it was some distance away from the admission wards. We were told that this means there is a risk of absconsion and physical harm to staff if patients are transferred from the suite to the ward at night. We observed there to be two items in the toilet of the 136 suite that were potential self-harm risks.

Are Mental Health Act responsibilities effective?
(for example, treatment is effective)

We reviewed the care records and legal documentation of 22 patients who were or had been detained under the

Mental Health Act responsibilities

Mental Health Act and found that all patients appeared to be legally detained. AMHP (approved mental health act professional) reports were available on the electronic record system. Renewal processes were adequately recorded and we were shown a document entitled "improving service user engagement with managers' hearings" designed to help patients understand the renewal and appeals process and the benefits to them of attending managers hearings.

A Mental Health Act assessment took place on Kite Unit while we were there and we met with the approved mental health professional (AMHP), the patient, his responsible clinician and the section 12 approved' doctor. We were told that there were effective lines of communication between the ward and the AMHP service. We saw clear written evidence of the protocol for accessing AMHPs and saw this working in practice.

We were informed, however, that staff with an AMPH qualification have been told to let their warrants lapse and also that there is no provision within the trust for social work or other professionals to work towards or use an AMHP qualification within the current structure. We were also told that financial constraints had reduced the number of AMHPs in the Crisis Team. On Kitwood ward there was evidence that section 5 holding powers were used quite regularly. Staff told us that there were sometimes problems in getting an assessment team together on weekends to conduct a full MHA assessment for the conversion of holding powers to a formal detention. We met with The Mental Health Act administration team who endorsed the views expressed about the out of hours service. We were also told that patients recalled on community treatment orders were also affected.

Although no Deprivation of Liberty Safeguards (DOLS) application had been made on any ward visited staff demonstrated that they were aware of the process for making an application and considered whether there was a possible deprivation of liberty when informal incapacitated patients tried to leave the ward.

On Kite Unit capacity assessments were being completed on admission and were regularly reviewed. However we found that the part of the form for recording the assessment of capacity for administering medication did not include the patient's own view on any of the forms we inspected. We also noted that a similar part of the best interest assessment form was not completed on any of the documents we examined. This is contrary to the guidance stated in the Code of Practice to the Mental Capacity Act. The best interest assessment form was not completed on admission but was only used for decisions that arose after admission.

We reviewed the legal and treatment documentation for six people who had received electroconvulsive therapy (ECT). All were legally detained and had received the treatment under required legal authority. One patient on Appleby ward was being considered for ECT. There was a very good record of discussion with the patient and their nearest relative, and a SOAD (second opinion appointed doctor) opinion had been requested. In all relevant cases the procedure for second opinions had been followed. Discussions with statutory consultees were recorded.

We reviewed the medication records and certificates of authority to treat for all patients were this was relevant. On Kite Unit we found that while treatment was lawful there was some confusion regarding people's legal status and therefore the requirement to consent to treatment.

On Oakdene unit there was a temporary change of the responsible clinician to a locum consultant psychiatrist and where applicable new capacity assessments had been carried out. On Hawthorns unit there was clear documented evidence that the 'least restrictive principles' of the act were considered, when a service user who was assessed under the Mental Health Act in the community had then agreed to informal admission.

We asked about advance decisions. No patients had made these but there was evidence that patients were being asked at discharge meetings, how they would like to be treated for future episodes of care. Capacity assessments and consent were recorded from admission and regularly addressed and recorded at ward round.

Section 132 rights were given to patients on admission and regularly repeated, and recorded accordingly. IMHAs (independent mental health advocates) were available by referral and an IMHA told us that they regularly visit the wards. Notices about the IMHA service were on all wards.

We saw written evidence of collaborative working between team members within community services around community treatment orders (CTO) and arranging assessments for admission. We saw that there is clear guidance for community staff around reviewing CTOs and working with service users subject to CTOs.

Mental Health Act responsibilities

Partnership arrangements around section 136 place of safety were not working well. We were told by some staff that the suite is not always used due to lack of staffing. We were told by other staff that the section 136 suite is used and that staffing is not an issue but that police frequently bring service users who are inappropriate for admission. We reviewed statistical information about the use of the suite. Over 50% of admissions had led to discharge. We were told that there is no provision to review section 136 cases at the local general hospital so the police bring people to the suite instead. We met with clinical leads regarding the health based places of safety. We asked for a copy of the jointly agreed local policy regarding section 136. We reviewed the operational policy for the 136 suite. It was dated February 2010 but had no review date.

Are Mental Health Act responsibilities caring?

Overall we found the service at the hospital to be delivered in a caring, supportive and enabling way. We observed many examples of staff treating patients with kindness, respect and dignity. We observed that staff and patient interaction was caring and responsive to the specific needs of patients. The advocacy services manager told us that staff were committed and caring.

However we did find examples of restrictive practice and 'blanket rules' within the adult services. These included the admission of most detained patients directly into the intensive care unit in the first instance, the searching of all patients returning from unescorted section 17 leave on the intensive care unit and the lack of clear information for patients receiving both escorted and unescorted leave on the conditions of their leave. On Kite Unit there was a notice by the exit door to explain the procedure for informal patients to leave the ward, but patients interviewed felt that they were unable to leave. The advocacy provider also told us that they were of the view that it was not explained sufficiently to patients as to why the door was locked.

We found that care plans were in place for most patients and there were sufficient details to demonstrate or reflect patient's participation. Care plans were holistic and very detailed, covering all aspects of patient care. They were regularly reviewed and updated to meet changing needs. There was evidence in care plans of consideration of people's spiritual needs. Staff described the arrangements in place to meet identified spiritual needs. There was evidence found in care planning records of clearly outlined section 117 discharge planning.

We attended a care planning meeting on Kitwood ward for one patient about to be discharged to a care home. The relative attended together with the responsible clinician, the community nurse, the social worker, and the staff nurse. The patient attended towards the end. Discussion included the placement, physical and mental health needs, medication and future care. Agreement was reached to send the patient on section 17 leave to enable her to settle in. We were impressed with the carer involvement and the multi-agency approach to enable safe and effective discharge.

Community meetings take place on all wards on a regular basis providing patients with a means to express their needs and wishes. They are minuted and available for patients. We were invited to attend the weekly patient forum which included patients' relatives, and observed very good interaction. Matters discussed were recorded and taken forward and the outcome reported back at the following meeting. Patients and their relatives told us they valued this opportunity to discuss any concerns they may have.

We noted that information about the advocacy service was prominently displayed within the wards visited. We spoke with the Advocacy services provider for St. James' Hospital. We were told that a good relationship existed with all wards and that a working protocol was in place. Patients who qualified for support from an independent mental health advocate (IMHA) were automatically referred to the service. The service also offered independent mental capacity advocacy (IMCA) which had been taken up on occasion. They service also provided generic advocacy for informal patients. We found that the independent mental health advocacy (IMHA) service was available but did not attend all wards frequently and was mostly available when a specific referral to their service was made.

We were also informed that there were limited psychological or specific structured therapeutic activities available for service users on the adult mental health units and older peoples units visited.

Mental Health Act responsibilities

We found that incidents of seclusion use were rare and documents examined demonstrated that the Code of Practice and the trust policy and procedure on its use was being adhered to.

There were issues identified concerning patients' privacy and dignity on the Kite unit. We looked at minutes of a Kite Unit community meeting which took place on 31 January 2014 when patients expressed concerns about invasion of privacy from other patients entering bedrooms and bathrooms and disinhibited behaviour in communal areas. This was supported by incident reports which recorded episodes in which patients had removed their clothes in public areas.

Generally gender separation is achieved on wards. However on Kite Unit the arrangements in place are inadequate and do not comply with the requirements of the Mental Health Act Code of Practice or Department of Health guidance.

We saw evidence in clinical records that service users are informed of their rights when on community treatment orders (CTO). We saw evidence in service users' CTO care plans and progress notes that they are involved in and central to care planning. We saw evidence in progress notes that nearest relatives are supported by community staff. In our discussions with community staff it was apparent that detention under the Mental Health Act is viewed as a last resort and that least restrictive options are explored.

We saw evidence in the section 136 records that service users are informed of their rights. We saw that the section 136 suite facilities enable a degree of privacy and dignity for service users. We were told, however, that there is poor sound proofing in the building and that the observation window does not work well. There is also no clock in the suite.

Are Mental Health Act responsibilities responsive to people's needs? (for example, to feedback?)

We were told that there can be delays in completing assessments under the Mental Health Act because of a lack of availability of medical staff during working hours and due to lack of staff to facilitate the section 136 suite. We were also told that that there were sometimes problems in getting an assessment team together on weekends to conduct a full MHA assessment for the conversion of holding powers to a formal detention.

We found that the majority of patients detained under the Mental Health Act were initially admitted into the intensive care unit in the first instance and where applicable were then considered for transfer out into the adjoining acute admission ward.

Arrangements between the trust and the police regarding section136 are unclear and not effective. There is confusion about when to use the facility and whether it is in use. A review of the section 136 records suggests police are not bringing appropriate referrals. The location and physical environment present safety risks and risks to the dignity of patients.

Are Mental Health Act responsibilities well-led?

We found that there was a programme of audit in place to consider how well the Mental Health Act is being implemented at the hospital. Audits undertaken included the recording of consent to treatment, information on rights, section 17 leave arrangements, discharge arrangements and use of the place of safety.

We spoke with the manager with lead responsibility for Mental Health Act administration at the trust and met with the Mental Health Act administration team and the hospital managers. We reviewed the minutes of the Mental Health Act scrutiny committee. The committee reports to the trust Board and meets quarterly. We found that there were robust processes in place for the receipt of statutory documentation and medical scrutiny. We found that the trust has a governance process in place for looking at the use of the Mental Health Act. Inpatient audits undertaken at hospital level are aggregated and presented at the hospital managers meeting along with information about how frequently different sections of the Mental Health Act are used. Through this meeting the hospital managers also look at any findings from CQC and other external reviews about how the Mental Health Act is operated. Any areas of concern found are referred to the trust's assurance committee for taking forward at hospital level.

Mental Health Act responsibilities

However we found that the infrastructure did not ensure coordinated working with the police around sections 135 and 136. We were told that police bring service users to the suite even when they have been told the suite is not in use. We did not see clear evidence of cooperation with other agencies regarding the place of safety.

Staff told us that board members regularly visit the wards to engage with patients and staff and listen to their views and concerns. A patient confirmed that this happens.

We found that some of the trust designed Mental Health Act forms, particularly relating to urgent treatment, leave and rights, are ambiguous and could lead to staff misunderstanding the process. This was confirmed when we asked staff to explain to us some of the specifics of these forms.

The Mental Health Act administration team also provide training on both the Mental Health and Mental Capacity Acts. A one day MHA /MCA mandatory training course is provided by the Mental Health Act Manager and updates are available through e-learning and drop in sessions.

Acute admission wards

Information about the service

The trust has two services for working age adults, Oakdene is a recovery rehabilitation unit with 14 beds and Hawthorne is an acute inpatient unit for 24 people.

Summary of findings

The provision of this service was safe. The trust had ensured that risk assessments had been completed upon initial admission to the service. The evidence seen showed us that the service reviewed, understood and managed the risk to people who used this service. Systems were in place to identify and investigate patient safety incidents with an emphasis in the organisation to reduce harm to patients. Action plans were monitored by local governance groups. The trust had a risk register as a working document and informed the trust where to make improvements.

The provision of these services was effective. People were involved in their care treatment and management of their goals. The care and treatment was holistic and all their mental and physical needs were assessed and supported. The holistic care also applied to their money and benefit concerns and housing needs with daily support from specialists in these areas.

The services provided were caring. This was confirmed by our observations of the care and treatment being provided by staff. We noted that staff actively engaged with people at a local level. Every person spoken with told us that they were treated with respect and kindness by staff. They told us that they had their privacy and dignity respected and were provided with care or treatment choices wherever possible. Clinicians told us that they felt that people got a 'good service' from the trust.

The services provided were responsive. We saw and people told us that they received care, treatment and support to meet their needs in a timely way. Their concerns were listened to and responded to with at least a verbal response and/or a written response where appropriate.

The service was well led for example the matron had asked people using the service, relatives and carers and staff their thoughts on weekly ward meetings. Feedback from people using the service was that they felt intimidated, patronised and ignored. The changes made were from weekly to daily meetings and named staff advocated for the person/people they cared for.

Acute admission wards

Are acute admission wards safe?

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How well does the provider learn from incidents and improve standards of safety for people who use services?

Staff reported a positive and inclusive culture within their particular team. For example, they told us that individual concerns were discussed at their team meetings. They confirmed that they knew how to report incidents and 'near misses'. People told us that they felt comfortable in raising any specific concerns with any of the staff.

Staff confirmed that the trust had an on-line reporting system to report and record incidents and near misses. Staff had access to this system via 'password' protected computers. The trust wide evidence provided showed us that the trust were reporting concerns through the National Reporting and Learning System (NRLS). The levels of reporting were within expectations for a trust of this size.

The trust's serious incident data showed us that trust wide learning from 'Serious Incidents that Required Investigation' (SIRI) had been reviewed and disseminated throughout the trust. Staff confirmed this and reported that the lessons learnt from these incidents had been discussed within their specific team and disseminated through the trust. We saw copies of the trusts on line safety magazine 'RisQy business'. This provided information and guidance for staff to follow. Most members of staff spoken with were aware of this publication. Further trust wide learning was evidenced through the trust's on line newsletter. This included updates and 'key messages' for staff.

Systems were in place to review incidents and near misses. This included the monthly 'quality and risk report' for the Adult Mental Health (AMH) directorate. Included also was information on complaints, incidents, feedback from the patients' experience desk and feedback about staff experience. Staff confirmed that they had received risk assessment training and told us that they felt well supported by their line manager following any safety incidents.

The evidence seen demonstrated to us that these services had learnt from any incidents that had happened. We saw that trust wide learning from these had been recorded and disseminated. Staff had undertaken refresher courses in de-escalation of behaviour and assessments of risk.

Are behaviours, processes and systems reliable, safe and proportionate for people who use services?

We noted that the trust had recently distributed a safeguarding vulnerable adults' handbook to staff. This generic handbook also included a specific reminder of the trust's safeguarding procedures and local contact numbers. This meant that staff had been given the required guidance in order to support them to raise concerns when these were identified.

Staff were aware of the trust's safeguarding and other polices. They told us that they knew how to raise any safeguarding concerns. This was demonstrated by individual treatment records seen. These showed us that identified safeguarding concerns had been reported appropriately and pro-actively by staff.

Staff were aware of the trust's whistle blowing policy and confirmed that they felt able to raise concerns with their direct line manager or within an open forum such as the ward staff meeting. Staff told us they felt listened to and this included issues as well as ideas for improvement.

We noted that staff were aware of the risks associated with their specific role and they were aware of the expectations of their role which was also guided by their experience. Evidence was seen of staff taking proactive risk management strategies. For example, assessing people for Section 17 leave (leave granted when a person is detained under the Mental Health Act 1983) whether this was escorted or accompanied and ensuring if the person was accompanied by family or relatives then they also had a copy of the leave agreement.

Medicines were handled safely within the adult mental health in-patient units. All medicines were stored safely and prescriptions were reviewed in a timely manner by

pharmacy staff. People were allowed to self-administer their medicines where appropriate on a risk- assessed basis. Medicines incidents were reviewed and learning from those incidents was disseminated.

How do services understand and manage risk to the person using services and others with whom they may live with?

There were good examples of risk assessments and subsequent care plans linked to them. Risk assessments were seen in records reviewed and these included assessments of the person's physical health and their risks to self or others where appropriate. Evidence was seen of the active involvement of the person in assessing risks for themselves, linked to their discussions with their care co-ordinator/named nurse. These assessed identified risks had a clear and relevant care plan in place that showed the involvement of the person themselves.

How does the provider ensure that staffing levels and quality of staffing enables safe practice?

Staff told us they had received induction and training to prepare them for their role and felt well supported by their line manager. Each member of staff spoken with told us they received supervisions and annual appraisals from their line manager as required. Staff told us about the quality 'wheel' which outlined the Trust's vision for service provision being used by the trust. They said they felt their appraisal was more meaningful now it was linked to the Trust's quality vision.

Managers told us recruitment took place in line with the trust's human resources policy and procedures. This was confirmed by some front line staff who told us that they knew that active recruitment was taking place within these services. The manager had assessed the needs of people using the service and ensured there were sufficient numbers of skilled nursing and care staff in addition to other support, for example occupational therapists to support people.

Staff confirmed that systems were in place to monitor staff sickness and that they had access to occupational health support. Staff confirmed that systems were in place to monitor staff sickness and that they had access to occupational health support. Staff were tested and appropriate occupational health ensured physiotherapy was provided so they would be fit enough to work in an area where people may need to be restrained. Staff spoke highly of the individualised support and 'return to work' programmes provided by the trust. Staff told us they felt well supported by their line manager.

Are acute admission wards effective? (for example, treatment is effective)

The provision of these services was effective. People were involved in their care treatment and management of their goals. The care and treatment was holistic and all their mental and physical needs were assessed and supported. The holistic care also applied to their money and benefit concerns and housing needs with daily support from specialists in these areas.

Can the provider demonstrate that nationally/ internationally recognised clinical guidelines and standards, other recognised guidance and standards and current recognised best practice are used to deliver care and treatment that meets the needs of people who use services and delivers positive outcomes?

From the evidence inspected and discussions with managers and front line staff, we saw the trust was able to demonstrate that people who used this service received care and treatment in line with the current best practice guidance.

The trust had recently commenced a peer review system to review a selected number of assessments and care plans. This was seen to be a collaborative approach and involved lead clinicians and the relevant care co-ordinator. This process covered the salient points and identified areas where improvements could be made. Evidence was seen that staff had responded positively to these meetings. This demonstrated a good example of 'bridging the gap' between care recorded and management support and guidance provided for staff.

The evidence seen and discussed with staff showed us that they were aware of national guidance, policies, enquiries and clinical guidance. There were care plans that referenced NICE (National Institute of Clinical Excellence) guidelines.

The Solent quality cycle was known to most staff that we questioned and was available in those clinical areas visited. This showed us how the trust monitored and reviewed their

existing quality systems. We also saw a physical and mental health 'wheel' being used in the areas we inspected. Staff were aware of these and said they helped them ensure that all needs of people were addressed.

Can the provider demonstrate collaborative multi-disciplinary working across all services and in partnership with other providers, support networks and organisations

The trust worked collaboratively and in partnership with a number of other providers within this service. Staff were knowledgeable about their key roles and responsibilities. We saw examples of collaborative working effectively with staff employed by other trusts and with third sector providers.

Good examples were noted of patient and carer involvement in the drawing up of their care plans. One person told us of the support they had received from trust staff regarding accessing housing and other benefits.

How is the quality of care measured and managed in a manner to deliver the best outcomes for people?

Clinical audits and other reporting mechanisms to the trust board were in place. This was via the Adult Mental Health directorate's monthly 'quality and clinical risks' reports.

Feedback systems were in place for people using the service for example daily coffee mornings, weekly ward meetings which were often facilitated by a person who had used the service who worked on one of the wards during the week..

Do people who use services receive treatment and care from suitably qualified and competent staff, supported in their role and service delivery?

Staff spoken with confirmed that they had received adequate training and support to prepare them for their role. Staff told us that they received support from other members of their team. They gave us examples of team meetings and line management supervisions as opportunities for receiving appropriate support.

Staff gave us examples of trust wide training undertaken. Mental Health Act and Mental Capacity Act, safeguarding, health and safety, equality and diversity training had been received. New staff told us that they had received induction to the trust and their specific service.

Ensuring that staff training was embedded into individual practice was assessed through a variety of methods. These included case load reviews, staff supervision and weekly team meetings. Staff told us that they could ask for additional support if this was needed.

Staff told us there was always a minimum staffing level that was maintained and that only staff that had access to the electronic records system and who had been assessed as fit to work on these wards were used from the agency and bank lists. This ensured where possible continuity of staff and that staff were trained to work in these areas.

Are acute admission wards caring?

The services provided were caring. This was confirmed by our observations of the care and treatment being provided by staff. We noted that staff actively engaged with people at a local level. Every person spoken with told us that they were treated with respect and kindness by staff. They told us that they had their privacy and dignity respected and were provided with care or treatment choices wherever possible. Clinicians told us that they felt that people got a 'good service' from the trust.

Do people who use services have choice in decisions affecting their care and support and are enabled to participate at each level?

People we spoke with felt that they were involved with their care and informed about their treatment. Most people we spoke with described their care as good to excellent and said that staff were caring, even when busy, they made time for them. The only negative comments were about the time some staff spent on the office on the computers.

We looked at care plan documents and found they were individualised, with evidence of people's involvement. We saw examples of advocacy being used throughout the trust. However, although advocacy was available the advocacy service did not attend regularly only when requested.

We received some positive comments from people who told us that staff worked with them in a way that they felt "equal" and that they had developed positive working relationships with staff. We saw that staff had a person centred approach to care planning and risk assessment with people contributing their views and perspective of people's needs.

Acute admission wards

Do staff develop trusting relationships and communicate effectively so that people who use services understand what is happening to them and why?

The majority of people we spoke with told us they good relationships with staff. Only one person told us that a member of staff could be "strict". People told us of the changes that had taken place with daily 'ward rounds'. They told us they speak with their named nurse who goes into the meeting for them and advocates on their behalf. They told us this worked better than the weekly meetings when they would often have to wait for a week to resolve concerns or get answers. The daily meetings meant they could get responses quickly which may include changes to medicines. We asked staff how they ensured that the needs of the people using the service were relayed without change at these meetings. We were told "Verbatim, verbatim, verbatim", the staff did not alter or judge what they were asked to take to these meetings on behalf of people. The staff told us they gave feedback after the meeting to people so they were informed in a timely manner so they could decide if they needed to do or ask anything else.

Do people who use services receive the support they need?

People`s needs were assessed and care was delivered in line with their individual care plan. Records showed that risks to mental and physical health were identified and managed. Observation, physical monitoring and goals were agreed according to individual need. Staff and people who use the service told us that care plans were regularly reviewed with individuals.

People who use the service were offered a range of treatment options on the units. Therapeutic options included, talking therapies, group and individual therapy, and occupational activities. Staff told us that they also supported people`s recovery by accompanying them to community activities, such as going to local shopping areas.

We spoke with staff at each service about the care needs of individual people. We wanted to see if staff supported people adequately. Interaction between staff and people on the wards was good. Staff gave explanations and reassurance to people. Staff knew people well and they were able to describe individual support that people needed. Staff told us that if temporary staff were needed they ensured they had staff who had worked on the wards before to enable people to be looked after by staff who knew them. This meant the care was delivered in a consistent and personal manner.

Recovery and rehabilitation services

Oakdene used the recovery approach to work with people. Staff worked with the person collaboratively, providing care and treatment in the least restrictive way. The service also had a bedsit which could provide accommodation for one person. This was generally used for people to regain independent living skills when preparing for discharge from the unit. There was also access to a kitchen where people could be supported to prepare their own meals.

Is the privacy and dignity of people who use services respected?

People`s privacy and dignity were respected. People who use the service told us they felt staff treated them with respect, even when there were restrictions in place. All bedroom doors had a screen the size of a window in the door, which offered additional privacy in the event that staff had to remain close to the person. Several people told us that staff always knocked and waited before entering their room.

We found different examples within the acute admission ward and the rehabilitation and recovery unit, with regard to respecting people's individual privacy and dignity. People had single bedrooms with en-suite facilities where they could go when they wanted to have some time alone. However, at Oakdene the rehabilitation and recovery service people told us that they were checked throughout the night with lights sometimes being left on and the door blind left open. People also told us that the communal areas were locked at night. Senior staff were not aware of these issues.

Staff told us they took account of people`s cultural and religious needs. People had access to local community facilities, such as banking and were supported to access these. There were a number of rooms on the ward which were available for private consultations. People`s confidentiality was respected and care records were stored securely on the Trust's electronic system.

Are acute admission wards responsive to people's needs?

Acute admission wards

(for example, to feedback?)

The services provided were responsive. We saw and people told us that they received care, treatment and support to meet their needs in a timely way. Their concerns were listened to and responded to with at least a verbal response and/or a written response where appropriate.

How are the individual needs of people who use services met at each stage of their care?

People were involved daily in the planning of their care working with their named nurse and others as needed. This included advice from specialists regarding housing and benefits, college and university courses and help getting back into work. One person was attending university working on a degree; others attended employment whilst being supported from the service.

People could ask about medicines, request changes to their treatment and were offered access to the pharmacy team at the hospital to explain about their medicines and side effects. There was support from physiotherapy with people saying it was accessible through a referral system. Staff said whilst not ideal there had not been any detrimental impact for people using the service. Psychological therapies and support has been identified as a need across the two services and psychological therapies will be offered at these services from June 2014.

Arrangements for admission and discharge were discussed and planned with other care providers. Appropriate information was shared in order to agree the treatment plan. There were regular Care Programme Approach (CPA) (an individualised approach to giving care and treatment), meetings. These included attendance from other professionals to discuss the person`s treatment, progress and discharge planning. The unit ensured that professionals who were unable to attend were kept informed through telephone and e-mail.

How does the provider act on and learn from concerns and complaints from people who use services and use this information to improve quality and plan services?

The service had a system in place to learn from any complaints made. Information about the complaints process was clearly displayed. People who used the service told us that they knew how to make a complaint and felt able to do so if they needed to. There was information about how to access advocacy clearly displayed. Staff knew the process for receiving complaints and told us that learning took place in their staff meetings. The manager gave us an example of a recent complaint and how this had been resolved. A person using the service confirmed that they had been satisfied with the outcome of a complaint that they had made.

Managers we spoke with were clear about their role and that of their staff in managing issues at the earliest opportunity before they could develop to a formal complaint. Managers told us they would not directly investigate complaints that were linked to their team but would undertake investigations for other teams. We saw information displayed on notice boards in the services, that provided information on how to make a complaint. Information was primarily in English, but we were told other languages and formats could be accessed as required in addition to a translation service if needed. The Patient Advice and Liaison service played a good part in ensuring that complaints were locally resolved.

Are acute admission wards well-led?

The service was well led for example the matron had asked people using the service, relatives and carers and staff their thoughts on weekly ward meetings. Feedback from people using the service was that they felt intimidated, patronised and ignored. The changes made were from weekly to daily meetings and named staff advocated for the person/ people they cared for.

Is the governance framework coherent, complete, clear, well understood and functioning to support delivery of high quality care? How does the provider make sure that the organisations vision and culture for services is focused on good and effective care?

We found that staff's understanding of the trust's governance framework function was consistent in the services we inspected. Staff told us they regularly received information via email with updates on issues in the service. Staff reported described the systems to give feedback centrally on trust issues and how they received feedback.

Staff reported positive leadership in their service and from direct line managers. They were aware of the new lines of operation across the trust and could explain about the one that was relevant to them.

Acute admission wards

The managers told us there were regular random audit of the quality of (CPA) documentation was undertaken by managers and we saw examples of the audits that had been undertaken. Senior managers told us concerns regarding documentation were discussed with staff in supervision.

There were also local systems in place on to check care and safety. Medicines were checked to ensure there was sufficient stock, there were no errors in the records and that medicines were in date weekly.

How are staff concerns dealt with; risks identified, managed and mitigated in a manner that ensures quality care and promotes innovation and learning; and what assurances are sought and provided?

There was a positive and open culture within the teams. Staff told us that they felt well supported by their manager and the wider multi-disciplinary team. Debrief sessions were provided following any incident on the ward. There was a regular nurses meeting, during which the manager told us they also held teaching sessions. There was also an informal weekly staff peer support meeting. Staff told us that this was a good opportunity to "take time out".

Staff told us they felt able to report incidents and raise concerns and that they would be listened to. The manager had introduced a number of measures that ensured staff felt supported and respected in their roles. The manager told us that they felt senior managers in the trust listened to concerns that they raised and acted.

Psychiatric intensive care units and health-based places of safety

Information about the service

PICU

The trust provides one psychiatric intensive care (PICU) ward the Maples, which offers ten beds. On the day we inspected there were six people using the service.

We examined three treatment plans and spoke with senior clinicians and other staff during the inspection. We met with three people who used these services and observed the care and treatment being provided. With permission, we attended a ward meeting.

We also used information provided by the trust and information that we requested, which included some trust policies and other information for example training records and numbers of staff appraisals.

Place of safety

The crisis resolution team was based at St James' Hospital. This team was responsible for management of the 'section 136 suite' in the grounds of the hospital, which was the designated health based place of safety.

During our visit we inspected the section 136 suite. We also reviewed the statutory Mental Health Act paperwork, policies, protocols and electronic patient records. We spoke to front line staff with different roles within this service and with patients.

Summary of findings

PICU

The provision of the PICU service was safe. The trust had ensured that risk assessments had been completed upon initial admission to the service. The evidence seen showed us that the service reviewed, understood and managed the risk to people who used this service. Systems were in place to identify and investigate patient safety incidents with an emphasis in the organisation to reduce harm to patients. Action plans were monitored by local governance groups. The trust had a risk register as a working document and informed the trust where to make improvements

The provision of the PICU service was effective. We saw that people were involved in their care treatment and management of their goals. The care and treatment was holistic and all their mental and physical needs were assessed and supported. The holistic care also applied to their money and benefit concerns and housing needs with daily support from specialists in these areas.

The service provided by staff on the PICU was caring. This was confirmed by our observations of the care and treatment being provided by staff. Staff actively engaged with people at a local level. Every person spoken with told us that they were treated with respect and kindness by staff. They told us they had their privacy and dignity respected and were provided with care or treatment choices wherever possible. Clinicians told us they felt that people got a 'good service' from the trust.

The services provided by the PICU were responsive. People told us, and we observed, that they received care, treatment and support to meet their needs, in a timely way. Their concerns were listened to and responded to with at least a verbal response and/or a written response where appropriate.

We found the PICU service to be robust and well led at the local level. Previously the matron had asked people who used the service, relatives and carers, and staff their thoughts on weekly ward meetings. Feedback from people using the service was that they felt intimidated, patronised and ignored. The changes made were from weekly to daily meetings and named staff advocate for the person/people they care for.

Psychiatric intensive care units and health-based places of safety

Place of safety

Improvements were required by the trust to ensure that this service was safe. The environment and location of the section 136 suite meant that there were risks to the safety and dignity of patients.

Improvements were required by the trust to ensure that these services were effective. We noted that the interface between Hampshire Police and the trust was not working as well as it should.

Improvements were required by the trust to ensure that these services were responsive. Whilst the trust had the capacity to respond appropriately to clinical need there was a lack of joint and collaborative working around the use of the section 136 suite.

The services provided were however caring. The records and other policies seen showed us that there were robust operational protocols in place. This was supported by our discussions with patients and staff. Patients were being made aware of their rights and staff supported people in a caring manner.

Improvements were required by the trust to ensure these services were well led. We found that the current arrangements did not ensure coordinated working with the police around Section 135 and 136 of the Mental Health Act.

Are psychiatric intensive care units safe?

How well does the provider learn from incidents and improve standards of safety for people who use services?

PICU

Staff on PICU reported a positive and inclusive culture within their particular team. For example, they told us that individual concerns were discussed at their team meetings. They confirmed that they knew how to report incidents and 'near misses'. People told us they felt comfortable in raising any specific concerns with any of the staff.

Staff confirmed that the trust had an on-line reporting system to report and record incidents and near misses. Staff had access to this system via 'password' protected computers. The trust wide evidence provided showed us that the trust were reporting concerns through the National Reporting and Learning System (NRLS). The levels of reporting were within expectations for a trust of this size.

The trust's serious incident data showed us that trust wide learning from 'Serious Incidents that Required Investigation' (SIRI) had been reviewed and disseminated throughout the trust. Staff confirmed this and reported that the lessons learnt from these incidents had been discussed within their specific team and disseminated through the trust. For example, we saw copies of the trusts on line safety magazine 'RisQy business'. This provided information and guidance for staff to follow. Most members of staff spoken with were aware of this publication. Further trust wide learning was evidenced through the trust's on line newsletter. This included updates and 'key messages' for staff.

Systems were in place to review every time the seclusion room was used. We saw that this included an investigation and action plan where changes had been identified to improve the process and assessment of people. We also saw that these plans were reviewed and signed off as completed. Staff confirmed that they had received risk assessment training and told us that they felt well supported by their line manager following any safety incidents.

The evidence seen demonstrated to us that these services had learnt from any incidents that had happened. We saw that trust wide learning from these had been recorded and disseminated.

Psychiatric intensive care units and health-based places of safety

Place of Safety

The location of the Section 136 suite was some distance away from the admission wards. We were informed that this meant there was a risk of potential patient abscondments and physical harm to staff during patient transfers to the main ward areas. We noted there were two items in the suite's toilet that were potentially self-harm risks. These were brought to the attention of staff during our visit.

Are behaviours, processes and systems reliable, safe and proportionate for people who use services?

PICU

Staff on PICU showed the safeguarding vulnerable adults' handbook which had been distributed to staff. This generic handbook also included a specific reminder of the trust's safeguarding procedures and local contact numbers. This meant that staff had been given the required guidance in order to support them to raise concerns when these were identified.

Staff were aware of the trust's safeguarding and other polices. They told us that they knew how to raise any safeguarding concerns. This was demonstrated by individual treatment records seen. These showed us that identified safeguarding concerns had been reported appropriately and pro-actively by staff.

Staff were aware of the trust's whistleblowing policy and confirmed that they felt able to raise concerns with their direct line manager or within an open forum such as the ward staff meeting. Staff told us they felt listened to and this included issues as well as ideas for improvement.

Staff were aware of the risks associated with their specific role and they were aware of the expectations of their role which was also guided by their experience. Evidence was seen of staff taking proactive risk management strategies. For example, assessing people for section 17 leave (leave granted when a person who is detained under the Mental Health Act) whether this was escorted or accompanied and ensuring if the person was accompanied by family or relatives then they also had a copy of the leave agreement.

Medicines were handled safely within the psychiatric intensive care unit. All medicines were stored safely and prescriptions were reviewed in a timely manner by pharmacy staff. People were allowed to self-administer their medicines where appropriate on a risk assessed basis. Medicine related incidents were reviewed and learning from those incidents was disseminated.

We found that restraint was sometimes required. The manager told us that all staff were trained in the use of physical intervention. We saw training records which showed that staff were up to date with their training. Records showed that no restraint had been needed in the last twelve months. This meant that people who use the service were protected against the risk of unlawful or excessive restraint because the provider had made suitable arrangements.

Place of Safety

Protocols were in place for the safe management of people once they were admitted to the section 136 suite.

How do services understand and manage risk to the person using services and others with whom they may live with?

PICU

On the PICU we saw good examples of risk assessments and subsequent care plans linked to them during our inspection. Risk assessments were seen in records reviewed and these included assessments of the person's physical health and their risks to self or others where appropriate. Evidence was seen of the active involvement of the person in assessing risks for themselves. For example, linked to their discussions with their care co-ordinator/named nurse. These assessed identified risks had a clear and relevant care plan in place that showed the involvement of the person themselves.

Practices consistently reflect the principle of least restriction, including when people were admitted to the service. The use of restrictive practices was minimised, coercion and blanket restrictions were avoided so that people felt safe, whilst having the maximum freedom possible. Rapid tranquilisation, physical restraint and seclusion were only used as a last resort and once de-escalation and other strategies had been employed. All use of these interventions complied with national guidelines, the Mental Health Act Code of Practice and local policies and their use was recorded and monitored. The level of use of these interventions was low. We saw that the seclusion room had been used three times in January 2014 for different people and the previous record related to a person in August 2013.

Psychiatric intensive care units and health-based places of safety

Place of Safety

We saw protocols and other evidence to show us that systems were in place to assess and manage the potential risks to people who used this service. However, improvements were required to ensure that these risks were being appropriately managed by front line staff in collaboration with other stakeholders. For example, with the Hampshire Police force.

How does the provider ensure that staffing levels and quality of staffing enables safe practice?

PICU

Staff on PICU told us that they had received induction and training to prepare them for their role and felt well supported by their line manager. Each member of staff spoken with told us that they received supervision and annual appraisal from their line manager as required. Staff told us about the quality 'wheel' which outlined the vision for service provision being used by the trust. They said they felt their appraisal was more meaningful now it was linked to the trust's quality vision.

Managers told us recruitment took place in line with the trust's human resources policy and procedures. This was confirmed by some front line staff who told us that they knew that active recruitment was taking place within these services. The manager had assessed the needs of people using the service and ensured there were sufficient numbers of skilled nursing and care staff in addition to other support, for example occupational therapists to support people.

Staff confirmed that systems were in place to monitor staff sickness and that they had access to occupational health support. Staff were health assessed if required and appropriate occupational health support ensured physiotherapy was provided so they would be fit enough to work in an area where people may need to be restrained. Staff spoke highly of the individualised support and 'return to work' programmes provided by the trust. Staff told us they felt well supported by their line manager.

Place of Safety

Staff informed us there were delays in completing assessments under the Mental Health Act because of lack of availability of medical staff during working hours. There were also potential staffing shortages at times to fully support the opening of this suite.

The evidence seen for this domain demonstrated to us that improvements were required by the trust to ensure the safe delivery of care and treatment to people using the Section 136 suite.

Safe environment

PICU

The Maples (PICU) was a safe and secure environment. Main risks to people's safety were known and monitored on an on-going basis. However, we noted that there were 'blind spots' in the seclusion room which meant that clear all round observation to ensure a person's safety was not always possible. The layout of the building could present risks as it does not always allow staff to have a clear line of sight so they can observe all areas of the ward. The staff told us that CCTV had been fitted in communal areas and corridors to assist with this risk. We observed that safety measures were followed. A visitor explained to us the routine for coming into the building which included signing in and staff signed keys and safety alarms out to themselves via reception. There were clear routes of safe entry and exit in the event of an emergency and emergency exits were clearly signed.

Place of Safety

The location and environment of the section 136 place of safety suite were not ideal. Whilst this was a purpose built unit, it was some distance away from the admission wards. We were told that this means there is a risk of absconsion and physical harm to staff if patients are transferred from the suite to the ward at night. We observed there to be two items in the toilet of the 136 suite that were potential self-harm risks.

Psychiatric intensive care units and health-based places of safety

Are psychiatric intensive care units effective?
(for example, treatment is effective)

Can the provider demonstrate that nationally/ internationally recognised clinical guidelines and standards, other recognised guidance and standards and current recognised best practice are used to deliver care and treatment that meets the needs of people who use services and delivers positive outcomes?

PICU

From the evidence inspected and discussions with managers and front line staff on the PICU, we saw the trust was able to demonstrate that people who used this service received care and treatment in line with the current best practice guidance.

We saw that the trust had recently commenced a peer review system to review a selected number of assessments and care plans. This was seen to be a collaborative approach and involved lead clinicians and the relevant care co-ordinator. We saw that this process covered the salient points and identified areas where improvements could be made. Evidence was seen that staff had responded positively to these meetings. This demonstrated a good example of 'bridging the gap' between care recorded and management support and guidance provided for staff.

The evidence seen and discussed with staff showed us that they were aware of national guidance, policies, enquiries and clinical guidance. We saw examples of care plans that referenced NICE (National Institute for Health and Care Excellence) guidelines.

The Solent quality cycle was known to most staff that we questioned and was available in those clinical areas visited. This showed us how the trust monitored and reviewed their existing quality systems. We saw a poster describing the qualities for staff to achieve to ensure people received a good service for physical and mental health needs in the areas we inspected. Staff were aware of these and said they helped them ensure that all needs of people were addressed.

Place of Safety

We reviewed the available copy of the trust's section 136 suite operational policy and noted that this was dated February 2010 but had no review date. This meant that frontline staff did not have access to up to date guidance regarding this facility.

Can the provider demonstrate collaborative multi-disciplinary working across all services and in partnership with other providers, support networks and organisations?

PICU

The trust worked collaboratively and in partnership with a number of other providers within this service. PICU Staff were knowledgeable about their key roles and responsibilities. We saw examples of collaborative working effectively with staff employed by other trusts and with third sector providers. They worked with the community teams to ensure a smooth transition from inpatient services to the community.

Good examples were noted of patient and carer involvement in the drawing up of their care plans. One person told us of the support they had received from trust staff regarding accessing housing and other benefits.

Place of Safety

Staff told us that the professionals working for the trust with the AMPH (approved mental health proffessional) qualification have been told to let their warrants lapse. They confirmed that there was no provision within the trust for social work or other professionals to work towards or to use this qualification within the current structure.

We found that partnership working around section136 place of safety was not effective. Staff reported some concerns about how the jointly agreed local policy was being interpreted by the local police force. For example some referrals were inappropriate.

We saw that there was no provision to accept section 136 cases in the local acute NHS hospital trust and that this had been agreed with senior managers in Hampshire Police. This impacted upon the acute service and the trust's own liaison psychiatry service based at the Queen Alexandra Hospital.

Psychiatric intensive care units and health-based places of safety

How is the quality of care measured and managed in a manner to deliver the best outcomes for people?

PICU

The managers of the PICU ensured there were clinical audits and other reporting mechanisms to the trust board in place. This was via the adult mental health directorate's monthly 'quality and clinical risks' reports.

Feedback systems were in place for people using the service. For example daily coffee mornings and weekly ward meetings which were often facilitated by a person who had used the service and who worked on one of the wards during the week.

Place of Safety

We reviewed statistical information about the use of the suite. Over 50% of admissions there had led to direct discharge from this service. This showed us that improvements were required by the trust to develop a clear protocol around the use of this facility.

Do people who use services receive treatment and care from suitably qualified and competent staff, supported in their role and service delivery?

PICU

Staff on the PICU confirmed that they had received adequate training and support to prepare them for their role. Staff told us they received support from other members of their team. They gave us examples of team meetings and line management supervision as opportunities for receiving appropriate support.

Staff gave us examples of trust wide training undertaken. For example, Mental Health Act and Mental Capacity Act, safeguarding, health and safety, equality and diversity training had been received. New staff told us they had received induction to the trust and their specific service.

Ensuring that staff training was embedded into individual practice was assessed through a variety of methods. These included case load reviews, staff supervision and weekly team meetings. Staff told us that they could ask for additional support if this was needed.

Staff told us there was always a minimum staffing level that was maintained and that only staff that had access to the electronic records system, and who had been assessed as fit to work on these wards, were used from the agency and bank lists. This ensured where possible continuity of staff and that staff were trained to work in these areas.

Are psychiatric intensive care units caring?

Do people who use services have choice in decisions affecting their care and support and are enabled to participate at each level?

PICU

People on the PICU told us they felt involved with their care and informed about their treatment. Most people we spoke with described their care as good to excellent and said that staff were caring, even when busy, they made time for them. The only negative comments were about the time some staff spent in the office on the computers.

We looked at care plan documents and found they were individualised, with evidence of people's involvement. Advocacy was being used throughout the trust. However, although advocacy was available the advocacy service did not attend regularly, only when requested.

We received some positive comments from people who told us that staff worked with them in a way that they felt "equal" and that they had developed positive working relationships with staff. Staff had a person centred approach to care planning and risk assessment with people contributing their views and perspective of people's needs.

Place of Safety

The care and treatment records reviewed showed us that patients were informed of their rights whilst on the Section 136 suite. We saw that the environment enabled a degree of privacy and dignity for people.

Do staff develop trusting relationships and communicate effectively so that people who use services understand what is happening to them and why?

PICU

The majority of people we spoke with on the PICU told us they good relationships with staff. Only one person told us that a member of staff could be strict. People spoke about the changes that had taken place with daily 'ward rounds'. They told us they spoke with their named nurse who goes into the meeting for them and advocates on their behalf. They told us that this worked better than the weekly meetings when they would often have to wait for a week to resolve concerns or get answers. The daily meetings meant they could get responses quickly which may include

changes to medicines. We asked staff how they ensured that the needs of the people using the service were relayed without change at these meetings. We were told the staff did not alter or judge what they were asked to take to these meetings on behalf of people. The staff told us they gave feedback after the meeting to people. This meant people were informed in a timely manner and could decide if they needed to do or ask anything else.

Place of Safety
Staff told us that detention under the Act was viewed as a last resort and that least restrictive options were explored with people and their families. This was supported by those patients spoken with.

Do people who use services receive the support they need?

PICU
We spoke with staff about the care needs of individual people. We wanted to see if staff supported people adequately. Interaction between staff and people on the wards was good. Staff gave explanations and reassurance to people. Staff knew people well and they were able to describe individual support that people needed. Staff told us that if temporary staff were needed they ensured they had staff who had worked on the wards before to enable people to be looked after by staff who knew them this meant the care was delivered in a consistent and personal manner.

The needs of people on the PICU were assessed and care was delivered in line with their individual care plan. Records showed that risks to mental and physical health were identified and managed. Observation, physical monitoring and goals were agreed according to individual need. Staff and people who used the service told us that care plans were regularly reviewed with individuals.

People who used the service were offered a range of treatment options on the units. Therapeutic options included, talking therapies, group and individual therapy, and occupational activities. Staff told us they also supported people`s recovery by accompanying them to community activities, for example, going to a local shopping areas.

Place of Safety
People told us they felt well supported by community staff and received adequate explanations from both medical and nursing staff regarding their care and treatment.

Is the privacy and dignity of people who use services respected?

PICU
People's privacy and dignity were respected on the PICU. People who used the service told us they felt staff treated them with respect, even when there were restrictions in place. We saw that all vision panles in bedroom doors had a screen, which offered additional privacy in the event that staff had to remain close to the person. Several people told us staff always knocked and waited before entering their room. One person reported to us that a maintenance worker had knocked and then entered their room without waiting. They were very distressed by this. We followed this up with the ward manager who told us that this had been addressed with the worker concerned and their company and they were not allowed around the ward unaccompanied.

Staff told us that they took account of people`s cultural and religious needs. People had access to local community facilities, such as banking and were supported to access these. We saw a number of rooms on the ward which were available for private consultations. People`s confidentiality was respected and care records were stored securely on the trust electronic system.

Place of Safety
We saw the environment enabled a degree of privacy and dignity for people. However staff expressed some concerns about poor sound proofing in the building and reported that the observation window does not work well. We observed that there was no clock in the suite.

Are psychiatric intensive care units responsive to people's needs?
(for example, to feedback?)

How are the individual needs of people who use services met at each stage of their care?

PICU
People on PICU were involved daily in the planning of their care working with their named nurse and others as needed. People could ask about medicines, request changes to their treatment and were offered access to the pharmacy team at the hospital to explain about medicines and side effects. There was support from physiotherapy with people

saying it was accessible however, a referral had to be made. Psychological therapies and support had been identified as a need across the two services and psychological therapies will be offered at these services from June 2014.

Arrangements for admission and discharge were discussed and planned with other care providers. Appropriate information was shared in order to agree the treatment plan. There were regular care planning meetings which included attendance from other professionals to discuss the person`s treatment, progress and discharge planning. The unit ensured that professionals who were unable to attend were kept informed through telephone and e-mail.

Place of Safety

The care and treatment records reviewed showed us front line staff were working hard to meet the individual need of the people who used this service. However the location of the section 136 suite made it difficult for staff to transfer people from it to the main ward areas if required by patient assessed needs.

How well do providers work together when people who use services during periods of transition?

Place of Safety

We found that collaborative working with other agencies around this service was incomplete. For example, the jointly agreed local policy was not always being followed by front line police officers. Staff informed us that some referrals to this service were inappropriate and this was supported by evidence that 50% of people were being discharged directly from the section 136 suite.

How does the provider act on and learn from concerns and complaints from people who use services and use this information to improve quality and plan services?

PICU

The managers of the PICU had a system in place to learn from any complaints made. Information about the complaints process was clearly displayed. People who use the service told us that they knew how to make a complaint and felt able to do so if they needed to. There was information about how to access advocacy clearly displayed. Staff knew the process for receiving complaints and told us that learning took place in their staff meetings. The manager gave us an example of a recent complaint and how this had been resolved. A person using the service confirmed that they had been satisfied with the outcome of a complaint that they had made.

Managers we spoke with were clear about their role and that of their staff in managing issues at the earliest opportunity before they could develop to a formal complaint. Managers told us they would not directly investigate complaints that were linked to their team but would undertake investigations for other teams. We saw information displayed on notice boards in the services on how to make a complaint. Information was primarily in English, but we were told other languages and formats could be accessed as required in addition to a translation service if needed. The Patient Advice and Liaison service played a good part in ensuring that complaints were locally resolved.

Staff were aware of the trust's complaints policy and confirmed that any complaints are addressed through the trust's complaint procedure as required. Staff told us that they welcomed any complaints that people may have as a way of developing local services. The records seen showed us that the adult mental health directorate had received six formal complaints between January 2014 and the date of the inspection. These were being addressed through the trust's complaint procedures.

Are psychiatric intensive care units well-led?

Is the governance framework coherent, complete, clear, well understood and functioning to support delivery of high quality care? How does the provider make sure that the organisations vision and culture for services is focused on good and effective care?

PICU

We found the staff on PICU had a good understanding of the trust's governance framework. This function was consistent in the services we inspected. Staff told us they regularly received information via email with updates on issues in the service. Staff described the systems to give feedback centrally on trust issues and how they received feedback.

Staff reported positive leadership in their service and from direct line managers. They were aware of the new lines of operation across the trust and could explain about the one that was relevant to them.

We were told that regular random audit of the quality of care programme approach (CPA) documentation was

undertaken by managers and we saw examples of the audits that had been undertaken. Senior managers told us that concerns regarding documentation were discussed with the staff in supervision.

We found that there were also local systems in place on to check care and safety. For example, medicines were checked weekly.

Place of Safety

There was guidance in the crisis team office around use of the section136 suite. We saw that clear guidance was provided to staff about arranging a Mental Health Act assessment in the community.

The current service configuration did not ensure coordinated working with the police around sections 135 and 136. We were told that some police officers brought people to the suite even when they were informed that the suite was not available for use. We did not see clear evidence of co-operation with Hampshire Police.

How are staff concerns dealt with; risks identified, managed and mitigated in a manner that ensures quality care and promotes innovation and learning; and what assurances are sought and provided?

PICU

There was a positive and open culture within the teams. Staff told us they felt well supported by their manager and the wider multi-disciplinary team. Debrief sessions were provided following any incident on the ward. There was a regular nurses meeting, during which the manager told us they also held teaching sessions. There was also an informal weekly staff peer support meeting. Staff told us this was a good opportunity to "take time out".

Staff told us they felt able to report incidents and raise concerns and that they would be listened to. The manager had introduced a number of measures that ensured staff felt supported and respected in their roles. The manager told us that they felt senior managers in the trust listened to concerns that they raised and acted.

Most staff told us that they felt well supported at a local team level. However they expressed some concerns that the trust's board was not fully responsive to staff concerns.

We reviewed the trust's risk register and noted some non-alignment between the risks highlighted on this document and the potential risks to the organisation as identified by staff. This showed us that improvements were required by the trust in order to review the existing trust risk register in the light of these concerns.

Are there high levels of staff engagement; cooperation and integration; responsibility and accountability; and do HR practices reinforce the vision and values of the organisation?

The records seen showed us that weekly team meetings were held. Staff told us that they felt well supported by their line manager.

Child and adolescent mental health services

Information about the service

The specialist Child Adolescent Mental Health Service (CAMHS) is a multi-disciplinary service providing a range of assessments, treatment and support for children and young people in the community where there are concerns about their mental health. Types of conditions include depression, psychosis, eating disorders, self-harm, obsessive compulsive disorder and neuro-developmental disorders. There is a strong focus on partnership working with the children and young people, their family, primary care, education services, social care, adult services and the third sector.

There are four sites where the CAMHS teams are based:

- 30 Brookvale Road Southampton,
- The Orchard Centre, Southampton
- Behavioural Resource Centre Southampton
- Falcon House, St James Hospital, Portsmouth.

The trust provided this as part of their mental health services. We reviewed and inspected the services being provided from all four sites.

We examined twenty-three care records and spoke with senior clinicians and other staff over the course of a four-day inspection. We attended a referral meeting and two review meetings.

We met with three people who used these services and with two parents.

We also used information provided by the trust and information that we requested, which included some trust policies and other information.

Summary of findings

We found that whilst the provision of these services was safe. Some improvements were required by the trust to fully ensure that these services were safe for children and their families. We noted that the trust was reporting concerns through the National Reporting and Learning System (NRLS). However, the levels of reporting were lower than expected for a CAMHS service of similar size and this was discussed with senior staff during the inspection. Processes were in place for the appraisal of staff and regular staff supervisions took place in order to monitor the safe and effective provision of care. Staff told us they were concerned there were no facilities for young people under the age of 18 who needed a place of safety under the 1983 Mental Health Act. This meant young people were sometimes reviewed by the team in police cells when they required a place of safety, although staff told us that they sought alternatives, such as residential units or the accident and emergency department wherever possible. We saw that the service had assessed the mental and physical needs of children who were using these services and provided care accordingly. However, the records seen showed us that the trust had not always ensured that full risk assessments had been completed upon initial admission to all the services provided.

We saw that children and their parents were involved wherever possible in their care treatment and management of their goals. However, some sites inspected could not demonstrate learning points from audits and were not able to provide action plans which were monitored on a regular basis.This meant that the monitoring of quality of the services provided by the trust was inconsistent across those services inspected.The evidence seen showed us that improvements were required to demonstrate fully that the trust provided an effective service to children and their families.

The service provided by staff in these services was caring. This was confirmed by our observations of the care and treatment being provided by staff. We observed a referral meeting in one team and saw staff accommodated the individual needs of the people

Child and adolescent mental health services

referred and staff worked together to ensure the most appropriate response to individual need. In feedback reports from people who used the service staff were described as caring, helpful and supportive.

Improvements were required by the trust to ensure that these services were responsive. There were systems in place to monitor the quality of care provided and check it was meeting national standards. There was an effective process in place for responding to complaints. Outcome measures were used to check progress of people using the service. However, higher level of analysis to inform service development was not evident. Whilst there were arrangements in place for a person's transfer to other services, for example adult mental health services. These arrangements were noted to be varied across sites as a result of different commissioning arrangements.

Staff told us they felt well supported by their manager and could raise any concerns they had and these would be addressed. However, we found that some improvements were required in the use and analysis of outcome measures in these services by the trust. We noted that improvements were required to ensure a consistent approach across all of these services. Staff were concerned about the impact of potential cost improvement plans upon these services, although these had not been finalised.

Are child and adolescent mental health services safe?

How well does the provider learn from incidents and improve standards of safety for people who use services?

A lower number than expected of incidents were reported by this service. At one site we were shown minutes of meetings where feedback and lessons learnt from incidents were fed back to the staff team. The matron attended the governance meeting to feedback to the team. Staff at other sites could describe how learning was shared but could not provide an example.

Are behaviours, processes and systems reliable, safe and proportionate for people who use services?

One team had effective measures in place to record incidents and report them according to the trust policy. We were shown an example of how an incident was recorded.

We were told that incidents were reported through to the risk department using an electronic system; from this system any incidents requiring external notification were reported. We saw that staff had access to this system via 'password' protected computers. The trust wide evidence provided showed us that the trust was reporting concerns through the National Reporting and Learning System (NRLS). The levels of reporting were lower than expected for a CAMHS service of similar size. This was brought to the attention of senior staff during our inspection.

We saw, by looking at emails, how incidents were monitored by the trust board and were shown an example of feedback to one team about a concern around the potential lack of reported incidents and how reported incidents increased following this discussion.

At one site there were processes in place to ensure monitoring of the maintenance and cleanliness of the environment. We saw the records of how this was monitored. For example there was a record of the regular cleaning of toys which were in the waiting room and clinic rooms for children to use when being see at clinic. We saw the record of the calibration of weighing machines to ensure they were accurate. Staff wore personal alarms and there was a protocol in place for what to do if the alarm was activated. We noted that the monitoring systems in place were less robust at the other trust sites inspected.

Child and adolescent mental health services

Staff said they could raise any concerns with their manager and felt their concerns would be addressed. They all said their manager was approachable and kept them informed. They told us they were aware of the trust's whistleblowing policy and their responsibilities in relation to reporting concerns. Some staff were not aware they could also contact the Care Quality Commission directly with any concerns.

The trust had a lone working policy and staff told us that they followed this wherever applicable. This meant the safety of staff was seen a priority by the trust.

How do services understand and manage risk to the person using services and others with whom they may live?

At one site we visited the care records showed us that the care plans included any identified risk. Staff told us it was a challenge using the trust risk assessment because this was designed for use in adult services not children's. There were plans about what people needed to do in a crisis, for example who to contact. Care plans were signed by the young people. We saw a risk plan which had been copied to the person's GP.

There were records of consultation with other professionals, documentation about medication regimes, prescriptions and discussion with the young person. The assessments seen included physical health and well as mental health. We saw an example template which was used at one site for the initial assessment with the child and their family.

At another site we reviewed six care records, the records at this site showed us that identified risks were recorded as part of the narrative report rather than separately. Although there was a template form to use for risk assessment the records we looked at did not have completed risk assessment forms. Care plans were recorded as part of a narrative not separately, this could make it difficult for staff to identify risk and care plan accordingly.

At one site we saw the safeguarding children flowchart. It was noted this had no action for when a manager was not available. Each member of staff had a copy of the flow chart and knew how to escalate concerns to senior managers if their line manager was not available.

Staff at different sites appeared to have different safeguarding children guidance. For example, at a second site they had produced local guidance. We saw that this local guidance was written informally and it was not clear whether this had received trust approval. This could mean there was inconsistency in how children were safeguarded.

There was a joint 'out of hours' duty rota in place for doctors to review any young person under 16 years of age who may have self-harmed. One of the doctors showed us the form used to let other services know if one of their patients was seen 'out of hours'. The adult mental health liaison team saw people aged 16-17 and CAMHS were notified the following day.

Staff told us they were concerned there were no facilities for young people under the age of 18 who needed a place of safety under the 1983 Mental Health Act. This meant young people were sometimes reviewed by the team in police cells when they required a place of safety, although staff told us they sought alternatives, such as residential units or the accident and emergency department wherever possible

How does the provider ensure that staffing levels and quality of staffing enables safe practice?

We saw that the teams consisted of nurses, psychologists, psychiatrists, occupational therapists, art therapists, social worker and a support worker. This showed us that there was a range of skills and seniority within the team. We met with staff from across all professions. There were processes in place for staff appraisal and regular supervision of staff in order to monitor the safe and effective provision of care.

There were two non-medical prescribers in the team and they looked after people with Attention Deficit and Hyperactivity Disorder (ADHD), they said they had good support from medical staff and a good relationship with other professionals in the team. Senior staff told us that there was a CAMHS worker in the youth offending service and in the diabetes service, plus CAMHS input into the Children's Community Team. There was a community learning disability team and staff who worked in the 'Looked After Children' (LAC) team which tried to maintain stability of placements for children in care.

Senior staff told us they could raise any issues about staffing with their line manager and would be listened to, but they accepted the need for budget restraint. We were told if this became an issue for service provision it would be placed on the trust's risk register. Staff in one team told us

Child and adolescent mental health services

they were looking at new ways of working to improve service capacity for the increase in unscheduled care. This included identifying a duty worker to deal with crisis appointments or emergencies during working hours.

Senior managers told us they relied on clinical judgement and team discussions to agree the staffing level required. We were told by staff there had recently been a review of CAMHS in Portsmouth by the commissioners and they were waiting for this report to come through.

Are child and adolescent mental health services effective?
(for example, treatment is effective)

Can the provider demonstrate that nationally/ internationally recognised clinical guidelines and standards, other recognised guidance and standards and current recognised best practice are used to deliver care and treatment that meets the needs of people who use services and delivers positive outcomes?

From the evidence inspected and discussions with managers and front line staff, we saw the trust was able to demonstrate that people who used this service received care and treatment in line with the current best practice guidance.

There was a trust audit programme in place to audit against NICE (National Institue for Health and Care Excellence) standards. In one team there was a local audit programme in place also with identified leads for each audit. We were shown copies of audit reports and action plans. However, some sites inspected could not demonstrate learning points from audits and were not able to provide action plans which were monitored on a regular basis.

This meant that the monitoring of quality of the services provided by the trust was inconsistent across those services inspected.

Can the provider demonstrate collaborative multi-disciplinary working across all services and in partnership with other providers, support networks and organisations

When we looked at care records an one of the sites, we saw care plans were comprehensive and included input from all professionals involved. Information was shared with the person's GP in the form of a letter. We saw an example of a crisis plan which was shared with the person's GP.

Staff told us there was a particular challenge because the records were part electronic and part paper which meant there was a potential risk that information could be in the paper record but not on the electronic system. However, staff informed us that they ensured that all the information that should be on the electronic system was being scanned.as required.

How is the quality of care measured and managed in a manner to deliver the best outcomes for people?

We saw regular feedback from people who used the service was obtained in the form of surveys, thank you letters or emails. We were given a copy of the Infant Mental Health Service Annual report 202/13. This report included analysis of where referrals came from, the ethnicity make up and feedback from mothers who had used the service. The report did not included information regarding any changes to practice as a result of this feedback. However the results were positive. We saw that some outcome measures were used in these services but were not consistently in place throughout the service.

This meant that the measuring of the quality of the care provided by the service was inconsistent across those sites inspected.

One relative told they were very impressed with the service and said that the care plan was working for their child. Another relative told us they had had a quick response to a referral and an appointment had been made within 24 hours of referral. Staff had ensured that they received the appointment letter in time.

Child and adolescent mental health services

Do people who use services receive treatment and care from suitably qualified and competent staff, supported in their role and service delivery?

Staff gave us examples of trust wide training undertaken. For example, mandatory safeguarding training for children and adults, health and safety, equality and diversity training had been provided.

All staff reported that they had specific training to meet their role. We spoke with non-medical prescribers who told us they were well supported to carry out their role and always had access to specialist advice if needed. There had been the development of specific roles within the service, for example the diabetes specialist role with in CAMHS. We were shown a programme for a training day planned which included training on the Mental Capacity Act (2005) and safeguarding adults training. We saw the draft report from a recent review by the Royal College of Psychiatrists for a national accreditation of this service. This provided information on staffing and training and supported the evidence that was seen during our inspection.

Are child and adolescent mental health services caring?

Do people who use services have choice in decisions affecting their care and support and are enabled to participate at each level?

The care plans we looked at showed the young person and or parent were involved in reviewing their own care and progress. The young person had signed their care plan which showed us that they had seen and agreed with it.

We observed a treatment consultation appointment at one site with parental consent. We saw the member of staff was responsive to the young person's distress and gave clear explanations about the treatment available. The member of staff explained the medication and side effects and answered questions put by the young person sensitively.

The evidence seen showed us that people and their families were involved in making decisions about their care and support wherever possible.

Do people who use services participate, in a review of their needs and preferences when their circumstances change?

The records showed that care was responsive to individual need and any changes in need.

There was communication between CAMHS and adult mental health (AMH) services when a young person required transition and a six month lead in to transfer with joint working between CAMHS and AMH. We were told there could be an issue when the young person did not meet the criteria for adult services because of thresholds or when the adult services were provided by a different trust. Some staff were not sure if there was a transition protocol for young people needing further support from the adult eating disorder services.

Do staff develop trusting relationships and communicate effectively so that people who use services understand what is happening to them and why?

The feedback reports we saw showed positive feedback about the services provided at one location. We saw staff communicated effectively with patients and their families. People told us that the service was caring and that the staff were supportive.

Do people who use services receive the support they need?

We observed a referral meeting in one team and saw staff accommodated the individual needs of the people referred and staff worked together to ensure the most appropriate response. Staff agreed joint appointments where needed. The team also provided consultation to other professionals.

Staff told us they worked hard to prevent admissions because there were no in-patient beds in Portsmouth so people would be required to travel if they needed admission. This showed us that the service attempted to ensure that people received the appropriate levels of support wherever possible.

Is the privacy and dignity of people who use services respected?

We did not observe direct care but we saw that staff discussed potential referrals in private. Staff spoke about patients respectfully. A relative told us they felt staff had respected their privacy by ensuring they could discuss things confidentially in private. This showed us that the service maintained and promoted the privacy of people and their families.

Are child and adolescent mental health services responsive to people's needs?

(for example, to feedback?)

How are the individual needs of people who use services met at each stage of their care?

The care plan records seen showed us that people and their families were involved in their care. We saw that care plans were reviewed with the involvement of people and their family. The assessments seen took into account the individual needs of people.

One of the teams operated an intensive support team, or outreach, for people with complex needs, the other teams provided this from within the team as needed. Another team had a worker who worked specifically with people from ethnic minority groups and liaised with the adult services community development worker. The evidence seen showed us that this service was responsive to the individual needs of patients.

However, higher level of trust analysis to inform consistent service development was not evident.

How well do providers work together when people who use services during periods of transition?

We were told there was a transition protocol in place for young people who needed to transfer to adult services. Staff at one site told us there was generally no problem with this as adult mental health (AMH) services in Portsmouth were provided by the same trust. Staff told us of a case where they had worked jointly with AMH services where a parent had mental health needs and the child was being supported by this service.

Staff told us the team provided referrals to other agencies and professionals when requested to ensure the person's needs were met. We saw examples of these in those care and treratment records reviewed.

We noted that some staff were not aware if there was a transition protocol to adult eating disorder services. However, we observed a review meeting in one team where there was a good discussion about transition to adult eating disorder services. Staff at this review meeting also discussed the possible renewal of detention under the 1983 Mental Health Act and use of a Community Treatment Order (CTO). The young person and family members also attended the review meeting.

The evidence seen showed us some good examples of the trust working collaboratively within teams and externally with other providers.However, these arrangements were noted to be varied across sites as a result of different commissioning arrangements.

How does the provider act on and learn from concerns and complaints from people who use services and use this information to improve quality and plan services?

There was a trust complaints policy in place and we saw an example of how a complaint was resolved. We saw minutes from a staff meeting detailing the learning from a complaint. The reports we saw showed positive feedback from people who used the services. Senior staff told us there were very few formal complaints but that all concerns were taken seriously and responded to appropriately.

The evidence seen showed us examples of where the service had used complaints to improve professional practice within the team.

Are child and adolescent mental health services well-led?

Is the governance framework coherent, complete, clear, well understood and functioning to support delivery of high quality care? How does the provider make sure that the organisations vision and culture for services is focused on good and effective care?

There were effective systems in place locally to monitor quality of care. Information was fed into the trust governance meetings through the matron. We saw posters up throughout the unit showing the Solent quality wheel. We also saw this was included in the annual appraisal of staff, as part of the trust's documentation used for appraisal. Each member of staff spoken with told us they had received an annual appraisal and that their next year's appraisal was already set up. We were told the team had an away day in January 2014 where objectives were set. There were seen to be linked to the Solent quality wheel and this was monitored through the appraisal process.

Staff told us that said they felt well led by their senior manager and staff. We were told about board to service walkabouts where a director visited a team and spent time with the staff. An example was given to us when a director had commented on the low number of incidents reported

by CAMHS and we saw minutes of a meeting where this had been shared with staff and staff reminded what needed to be reported. We were told by the manager concerned that this had led to an increase in reporting.

We found that some improvements were required by the trust in the use and analysis of outcome measures in these services by the trust.

How are staff concerns dealt with; risks identified ,managed and mitigated in a manner that ensures quality care and promotes innovation and learning; and what assurances are sought and provided?

Staff we spoke with told us they could raise any concerns with their manager and they would listen to them and address the concerns. They also told us they would escalate any concerns if they felt anything was not being addressed.

The manager told us about the risk register and the process for escalating any risk from a local level to directorate or trust level. They said they would feel able to raise anything in this way. There were no risks on the trust register relating to this service recorded at the time of our inspection. The manager said they used to get a quarterly risk update from the trust's risk team but they had not received this since October 2013. The Matron told us they attend the trust's governance meetings and then fed back accordingly to local staff. This was supported by those team meeting minutes seen.

We noted that improvements were required by the trust to ensure a consistent approach towards quality across all of these services.

Are there high levels of staff engagement; cooperation and integration; responsibility and accountability; and do HR practices reinforce the vision and values of the organisation?

Staff told us they received regular supervision both individually and in peer (multi-disciplinary) groups. There was a strong emphasis on promoting staff well-being within the team and we saw staff were respectful and supportive of each other.

Staff training and professional was well supported by the trust. For example we were told that some staff had completed the trust leadership programme and had found it to be professionally helpful. Furthermore, some staff had also completed the NHS England leadership programme and had reported this had been very beneficial.

However, staff were concerned about the impact of potential cost improvement plans upon these services, although these had not yet been finalised by the trust.

Services for older people

Information about the service

The older person's mental health (OPMH) service serves the Solent East locality, which is co-terminus with the geographical area served by Portsmouth City Council Social Services. The OPMH service in Portsmouth is part of the Solent NHS Trust and provides care for older people who are registered with GP practices within this area and whom require specialist secondary care mental health services.

The acute admission wards are designed to provide care for older people who require assessment and treatment for an acute phase of a mental illness. The wards are provided in a modern, purpose built unit, The Limes at St James Hospital. The unit can accommodate up to 36 people on three wards. Appleby ward provides 14 beds for older people experiencing functional mental illness, Kitwood ward provides 14 beds for older people who have dementia and Brooker ward has eight beds for older people with high care needs and challenging behaviour. Brooker ward is currently used to accommodate five older people with advanced dementia and its future purpose is under review by the Trust and the Portsmouth Clinical Commissioning Group (CCG). The Limes provides care primarily for older people, however, it does accommodate people with early onset dementia who are under age 65. The unit is managed by a modern matron and there is a senior nurse who manages Kitwood and Brooker wards, a second senior nurse manages Appleby ward.

There is a day hospital based in the Lowry Treatment Centre at St James Hospital. The future of the day hospital is currently under review with the CCG. There is a memory clinic which is based at the Langstone Centre at St James Hospital.

Older people's community mental health services are provided via three community psychiatric nurse (CPN) teams and there is an intermediate care team (ICT) that operates between 8am and 10pm for 365 days per year.

Summary of findings

Services were seen to be safe.There were clear incident reporting processes and staff understood their reporting duties. Processes were in place to safeguard people. Risks to people had been assessed upon their admission or referral to community services and on an ongoing basis. Actions had been taken to manage the risk of people falling. There were sufficient staff to provide people's care. There was a significant use of agency staff by The Limes but reasonable steps had been taken to manage the impact of this on people's care.

People said they were cared for. People's care took account of clinical guidance and best practice. There was close working with other services within the Trust to meet people's needs. People could not currently access a psychologist on The Limes; however, the Trust was in the process of recruiting to this post. The quality of care delivered was monitored through audits, surveys and people's feedback. Staff received a good level of training. We saw adherence to the requirements of the Mental Health Act (MHA) 1983 and the associated Code of Practice (CoP).

People were provided with choices about their care and took part in reviews. Where people lacked the capacity to make specific decisions, their capacity had been assessed and best interest decisions made. Staff communicated effectively with people and they were treated with dignity and respect.

The service was responsive as care was tailored to people's individual needs. The ICT had been responsive in reducing the need for people to be readmitted. This service did not operate overnight; however, there was a care pathway in place for people who required overnight admission. The complaints policy was readily available to people.

Staff had an understanding of the governance procedures and processes were in place for risks to be identified and managed. Staff felt well supported by their team managers. Staff received regular supervision and an annual appraisal.

Services for older people

Are services for older people safe?

Incidents are learnt from and used to improve standards of safety for people who use services

We spoke with staff who told us about the electronic incident reporting system and their role and responsibilities to report incidents which impacted upon people's safety. We reviewed incidents that had been reported and staff told us there was a high level of reporting of incidents. Medical and clinical staff told us that reflection and learning from incidents took place both in the community teams and amongst ward staff. For example, community staff described a multi-agency review that had taken place following an incident to learn lessons about how to improve the co-ordination of people's care. Ward staff told us of an accident that had occurred and that following a review of the incident; a particular item of equipment had been removed from The Limes in order to reduce the future risk to people. We reviewed written evidence of a ward reflective review that had taken place in December 2013 and the resulting action plan. This meant that staff understood their incident reporting responsibilities, and there was a culture of reporting incidents.

Behaviours, processes and systems are reliable, safe and proportionate for people who use services

We were told that people had been fully involved in designing the environment of The Limes. Staff told us that Kitwood ward which accommodated people with dementia was not fully anti-ligature. Each person was assessed on an individual basis and if they were assessed as at higher risk of self-harm then they were moved to Appleby ward. We saw written evidence that Appleby ward was anti-ligature in all areas. This meant that there was individualised management of the environmental risk for people with dementia.

Medicines were handled safely within The Limes. All medicines were stored safely and prescriptions were reviewed in a timely manner by pharmacy staff. Medicines incidents were reviewed and learning from those incidents was disseminated. Covert administration of medicines was undertaken with due regard for people's mental capacity and the properties of the medicines concerned. Processes were in place to ensure people received their medicines safely.

The Limes cleaning schedules were displayed and we saw staff cleaning the unit throughout the inspection. Staff were seen carrying out maintenance tasks. People were cared for in a clean and well maintained environment.

Ward staff carried personal alarms and there was a rapid response team in operation. We spoke with community staff and they told us they used the Skyguard personal safety system. At night community staff worked in pairs in accordance with the lone working policy. This ensured that there were processes in place to ensure staff safety on the wards and in the community.

Safeguarding information was displayed in The Limes for people who used the service to access and staff had access to the Trust safeguarding policy. We saw written evidence that staff training in safeguarding and the Mental Capacity Act (MCA) 2005 was mandatory. Staff reported that they had received good quality safeguarding training. Community staff told us they carried a safeguarding pocket notebook which contained essential safeguarding information. We saw written evidence that safeguarding alerts were reported via the Trust incident reporting system. Community nursing staff told us they contacted the Trust safeguarding team if risks to people were identified. Staff at The Limes told us there were regular link meetings with the Trust safeguarding team to discuss risks to people. Safeguarding concerns were also highlighted at clinical leads meetings. This meant that there were processes in place to ensure people were safeguarded effectively.

Locked door policies were in operation but we did not find evidence of restrictive practices. Risk assessments in relation to the locked door policy were visible on each ward. We saw written evidence that a MCA and Deprivation of Liberty Safeguards (DoLs) compliance audit of The Limes was completed in Jan 2013. It documented the actions taken to ensure people were not unlawfully deprived of their liberty. Although no-one was subject to DoLs staff understood the process. Therefore the use of restrictive practices had been minimised.

The Trust understands and manages risk to the person using services and others with whom they may live with

We saw evidence that when people were admitted to The Limes their needs had been assessed and they had received a multi-disciplinary team (MDT) assessment. There was an admission checklist for people which covered – physical observations, advance directives, Do Not

Attempt Resuscitation (DNAR) forms, venous thromboembolism (VTE) assessment, mental capacity assessment to agree to admission, whether the person had a social worker or if a referral was required, Mental Health Act 1983 (MHA) rights read, risk assessments completed, falls care pathway and tissue viability. People had a completed life history form that recorded their personal biography to inform their care planning. Community staff told us that once a referral was received it was prioritised and a risk assessment completed for the person. Risk assessments were comprehensive, regularly reviewed and aligned to people's care plans. Therefore risks to people were identified and care plans were in place to address identified risks.

Staff told us that people were assessed individually upon admission to the Limes and then a decision was made with regards to which was the best ward to suit their needs. For example, if they had early onset dementia they might have been better placed on Appleby ward rather than Kitwood ward. This meant that people's needs were individually determined rather than them being automatically placed on Kitwood ward due to their diagnosis.

Our analysis of data from our 'Intelligent Monitoring' before the inspection showed that older people experienced a high level of falls with harm within the Trust. We saw that there was a falls pathway in use at The Limes. We spoke with the physiotherapists who told us that all people received a physiotherapy assessment within 48 hours of arrival; and the results were then used to devise their care plan. They told us that people's medicines were reviewed via the ward round to identify any side effects that could increase the risk of the person falling. Any falls experienced by people were recorded as incidents and within the following 24 hours the person was re-assessed by a physiotherapist. We were told that some people wore hip protectors and there were bed beams to detect when people had got out of bed. People were on one to one observations if required, to manage the risk of them falling. The number of falls people experienced was monitored via the incident reporting system and the falls link staff from each ward attended the falls meetings. Measures had been taken to actively manage the risk of people falling.

Staffing levels and quality of staffing enables safe practice

There was an agreed staffing level for each ward on The Limes and this was increased in response to fluctuating clinical need. We saw written evidence that a staffing review took place in October 2013. As a result Kitwood and Appleby wards were in the process of increasing their level of nurses by two for each ward, the two additional nurses for Kitwood ward were due to commence the week after the inspection. Staff told us that there was a daily assessment of the staffing requirements for each ward and that staff were deployed across the unit as required. We observed and saw from the staff rosters that a number of people were on one to one observations and there were sufficient staff to provide this level of care. A person's relative told us there were good staffing levels. There was a system in place to ensure there were sufficient staff for the unit on a daily basis and there was flexibility in the use of staff.

We noted however, that there was no allowance in the staffing level for staff sickness and training for example, therefore any shortfall had to be addressed with the use of NHS professionals or agency staff. We examined the rosters and found there was a significant reliance on agency staff in order to maintain safe staffing levels. We spoke with senior nursing staff who told us that to ensure continuity of care for people they used NHS professionals and staff from one other agency. They told us that they also ensured continuity in the staff booked; we reviewed the staff rosters which confirmed this. Staff told us that consideration was given to how agency staff were deployed within the unit and we noted that on Brooker ward there was a lower use of agency staff. We spoke with agency staff who told us that they worked regularly at the unit and one told us they had been working at the unit for the past two years. The Trust board and staff told us that they were in the process of setting up their own internal bank system, which was expected to be operational within the next six weeks. There was a reliance on agency staff in order to maintain safe staffing levels however; the Trust had taken reasonable measures to manage the use of agency staff to ensure that people received continuity in their care.

Staff told us that the rate of staff sickness on The Limes was generally 6% We spoke to the Clinical Director who told us that sickness rates were monitored monthly and that although there was some long-term sickness rates of short term sickness were not high. Staff sickness rates and their causes were being monitored by the Trust.

Are services for older people effective?

(for example, treatment is effective)

Evidence-based clinical guidance, standards and best practice

We saw evidence that clinical interventions were informed by the trust clinical policies and national guidance. For example, the Trust had introduced a pilot of the National Early Warning Score (NEWS) to enable them to identify if a person's physical condition was deteriorating. All staff had received training in the use of NEWS and people's observational charts were seen to be fully completed. The Trust had replaced the Liverpool care pathway with a nursing care plan for the deteriorating and dying person. Medical staff told us that guidance was followed as much as possible for example; they told us people's cognition was assessed upon their admission to the Limes then further tests were completed as required. We saw written evidence of dementia care maps that had been completed on Kitwood ward to assess the quality of care from people's perspective and to develop person centred care.

Risk assessment screening tools were used for example, the Malnutrition Universal Screening Tool (MUST) and Waterlow. Risks to people had been assessed using falls and choking screening tools. People were screened for MRSA within 24 hours of their admission. We observed that people had protected mealtimes to ensure they could eat their meals uninterrupted. People's treatment followed relevant guidance.

Demonstrate collaborative multi-disciplinary working across all services

There was evidence on people's records that when they had been admitted to The Limes relevant information had been sought from their GP and Social Services. People's care plans were comprehensive and regularly reviewed. Care and treatment was shared with family members via ward rounds and Care Programme Approach (CPA) meetings. Community staff told us there were weekly MDT meetings to discuss new referrals to the teams. People's needs were assessed promptly.

Care pathways existed throughout the trust which ensured people could access the services they required for example, tissue viability and end of life care. Staff from both The Limes and the community teams told us that they could readily access a range of specialists including occupational therapy (OT), speech and language therapy (SALT), dietician, physiotherapy, tissue viability nurses and the approved mental health professional (AMHP) service as required. There was joint working with other agencies for example, staff told us that electro-convulsive therapy (ECT) and the lithium clinic were managed by another provider on-site, so staff worked with them to meet people's needs. We observed various professionals worked with people on The Limes across the course of the inspection for example OT technicians, physiotherapists, SALT and social workers. This meant that there was collaborative working across a range of disciplines to ensure that people's needs were met effectively.

We spoke with both community and ward staff about people's access to psychology. Community staff told us that the team psychologist and social worker had left and not been replaced. Instead older people were referred to the Improving Access to Psychological Therapies (IAPT) team if they were assessed as requiring psychological intervention. Representatives from the IAPT service told us that there was a special interest group looking at how to involve more older people with the service. People in the community could access psychological therapy.

At the time of the inspection a psychologist was not based at The Limes. Staff told us that cognitive assessments of people with dementia were completed by the OT's or SALT. The Clinical Director told us that neuropsychological assessments were provided by a psychologist based at the acute hospital. We had seen evidence that the use of antipsychotics was being audited regularly and their use gradually reduced as recommended in the Banerjee report. However, there was a lack of a psychologist on the ward to support this work. We spoke with the Clinical Director who informed us that psycho-social interventions were provided by the OT's and two nurses were trained in cognitive behavioural therapy (CBT). They informed us that the trust was in the process of recruiting a part-time psychologist for The Limes. Therefore people were currently unable to access a psychologist at The Limes, however, interim measures were in place to manage this and a psychologist was being recruited.

Staff told us that some of the five people on Brooker ward could not be moved from The Limes to other placements at the request of the CCG and that staff had been instructed not to accept any new admissions to this ward currently. The Clinical Director informed us that a service plan had been submitted to the CCG in relation to the future use of

this ward and they were awaiting their decision. People accommodated on this ward received good quality care however, the resource was underutilised whilst negotiations took place in relation to its future use.

Quality of care measured and managed

We saw evidence that the quality of care people experienced was measured in a number of ways. The 2013 in-patient survey showed that 36 people completed the survey and there was a satisfaction rate of 82.23%. The survey had also been provided in a pictorial form to enable people with dementia to complete it. The Limes had been running a pilot patient forum group for the previous six weeks which involved people and their relatives, in order to seek people's views about their care and to identify what issues needed to be addressed. Staff told us that the trust used the 'Friends and Family' test to measure quality of people's experience. There were a number of mechanisms in place for people and their relatives to provide their feedback on the service.

Staff told us that they did not formally audit the care plans but they completed a compliance weekly checklist, which covered 13 aspects of the care planning documentation. We saw evidence from a completed checklist that following completion of the checklist actions had been identified and passed to the ward staff to complete. We saw evidence of audits that had been completed for example, in relation to staff hand washing and the environment. Consultants told us that they had access to information on clinical performance through Health of the Nation Outcome Scales (HONOS). The quality of care delivered was being monitored.

The trust supplied us with data that indicated there were no delayed discharges for The Limes. However, we found that it was unlikely that all delayed transfers of care were being captured. Staff told us that the discharge co-ordinator used to record delayed discharges but this had not happened for some months, as they had left and not been replaced, this was confirmed by the Clinical Director. Staff told us that since the discharge co-ordinator had left it had created a high burden for ward staff completing the paperwork and that people's discharges took longer to facilitate. There were processes in place to monitor the rate of delayed discharges; however they were not being implemented to capture the data.

Suitably qualified and competent staff

Community and ward staff all reported that they had received relevant training. We saw that staff were required to complete a range of mandatory training. This included for example, hand hygiene, health wrap, equality, diversity and human rights. In addition to health and safety, infection control, information governance, MCA, moving and handling, safeguarding of adults and children and resuscitation. We saw evidence that staff had attended additional relevant training. Staff told us that there was no mandatory training for health care support workers (HCSW) on dementia; however an eLearning package had been introduced on The Limes that staff were completing. We observed qualified staff being assessed for their competency in relation to medicines administration. Clinical and medical staff all reported that they received regular supervision and an annual appraisal of their work. Staff told us that they were supported to undertake further professional qualifications. People were cared for by staff that were suitably trained and supported.

Adhere with the Mental Health Act and have regard to the Code of Practice

Mental health act processes were in accordance with the requirements of the MHA 1983, CoP. People had risk assessments and risk management care plans were in place. People's Section 17 leave was in accordance with the requirements of the CoP. We saw evidence from staff meeting minutes that staff had been reminded of the importance of making people aware of their Section132 rights under the MHA 1983 (Hospital managers are required to provide detained people with information about the MHA 1983 and their rights). We found that people's Section 132 rights were well documented in their notes. Staff told us that people were automatically referred to an independent mental health act advocate (IMHA) provided by South of England Advocacy Projects (SEAP).

The SEAP advocate told us that they attended meetings with the Trust on the use of the MHA 1983 and that the Trust welcomed feedback and challenge. We saw evidence of regular MHA 1983 and MCA link meetings that were held to review practice issues. This meant that when people were subject to the MHA 1983 their care adhered to the statutory requirements.

Services for older people

Are services for older people caring?

There is choice and are people enabled to participate

We spoke with two people who told us they had been involved in making decisions about their care. A person's relative we spoke with told us they were consulted about changes to their relative's medicines and asked for their views; they had also been invited in to The Limes to discuss their views. One person wrote on their comment card that they always received answers to their questions. We noted there was limited evidence of one person's views in their care plan but their views were captured in their progress notes. People and their relatives had been asked for their views about their care.

We saw that where people lacked the capacity to make a specific decision a mental capacity assessment and best interest decisions had been made and recorded in all cases. Family involvement in these decisions had been recorded. Therefore, where people lacked capacity, relevant guidance had been followed.

There were leaflets available both at The Limes and in the community services about the services, treatments, advocacy and support available. There was information for people displayed on the wards, for example, about the staff group, who was on duty, infection control processes and the activities timetable. On Kitwood ward there was orientation information displayed for people in relation to the day, date and season. We noted that the information on Kitwood ward about leaving the ward could have been made clearer for people. We observed staff in the memory clinic whilst they reviewed a person. We saw that they were provided with both verbal and written information. People could access a variety of relevant information in a format to meet their needs.

We spoke with hostess staff on The Limes who described to us the range of options and choices for people with regards to meals. People had a range of choices and soft, pureed and cultural diets were catered for. There was a range of meals and snacks provided throughout the day and night if people needed this. Therefore choices were available to people with regards to their meals.

People participate in a review of their needs

Two people told us that they had been involved in reviews of their care. We attended a person's CPA meeting and saw evidence of their involvement and their carer's in all aspects of their care as far as their capacity allowed. We spoke with the SEAP advocate who told us that they supported people in mental health review tribunals (MHRT), MDT meetings and best interest decision meetings. People were appropriately supported to participate in reviews of their care.

Staff communicate effectively

We used our Short Observational Tool for Intervention (SOFI) on Kitwood ward over the lunchtime period to assess the quality of interactions that people experienced from staff. We found that staff spoke with people respectfully and supported them appropriately. People were verbally encouraged to come for lunch and were provided with choices. To support people to make choices about their meal staff used 'show' plates so that people had a visual aid to making their decision. Staff were observant and responsive to people's needs. For example, a person spilt their drink and staff immediately provided them with reassurance and discreetly offered a change of clothing. Staff were seen to ensure that they were on the person's level when they spoke with them and maintained eye contact whilst talking with them. Touch was also used as a method of communication. Staff communicated positively and meaningfully with people.

People receive the support they need

Staff on Brooker ward told us that they had formed strong bonds with people on this ward and their relatives. We observed that people on this ward required a high level of stimulation as their communication was very limited and several were nursed in bed. We noted that staff moved people from their room to the lounge for stimulation. We saw staff completed activities with people such as art. We spoke with staff who demonstrated a good understanding of people's needs. Staff told us that they responded to people's individual interests for example, by reading poetry to them, playing classical music and they used aromatherapy oils. Staff told us they interacted with people regularly throughout the day. They brought the 'Pat dog' who visited weekly into people's rooms to ensure their inclusion in this ward activity. We saw people's rooms were highly personalised with their belongings. People had ceiling tracks in their room to enable staff to hoist them safely. People had televisions in their room in addition to the lounge. Staff on Brooker understood people's needs and responded appropriately.

Services for older people

When we used SOFI on Kitwood ward we saw that staff knew who needed thickener for their drinks and that they offered people assistance with their meal as required. We saw that staff ensured that people had appropriate equipment to eat their meal, for example, a plate guard. We saw that staff promoted people's independence by encouraging them to undertake tasks for themselves where they were able to. People were provided with appropriate assistance.

We spoke with the OT technicians who explained that a range of activities were provided across six days of the week, and that they utilised the OT room, kitchen and hairdressing room to provide a range of activities in addition to community based activities. Staff told us that the OT's completed activities of daily living (ADL) assessments with people initially on the ward and then in people's homes as part of their rehabilitation. People were able to access a comprehensive OT service across the week.

Staff from the CPN team told us they followed patients up in the community within seven days of their discharge from The Limes. Staff from the ICT said that their discharge planning commenced once the referral was accepted. We spoke with the Clinical Director who told us the ICT had been very successful at reducing the rate of re-admissions. People received prompt follow-up in the community and systems were in place to reduce their risk of readmission.

Staff told us that the early onset dementia team was disbanded in December 2013. People with early onset dementia were now seen by the community CPN teams and the OT's also ran an early onset dementia group. This meant that people with early onset dementia were no longer able to access a specific service and their needs were now met by the generic CPN team.

People's privacy and dignity is respected

We found that there was a staff culture of speaking to people with dignity and respect. Feedback from people who completed comment cards was positive about the way staff treated them. We heard staff speak with people respectfully and care was provided in private. Staff were observed to speak to people sensitively and reassuringly. People had their own bedrooms with en-suite facilities. People's bedrooms were located in gender separated areas. People had a lockable drawer in their room for their possessions. Electronic notes could only be accessed by authorised staff and paper records were stored within the nursing station. People were treated with dignity by staff and their privacy was respected.

We found that restrictive practices were minimised. Staff told us that physical restraint was rarely used however staff received annual training in restraint.

Are services for older people responsive to people's needs?

(for example, to feedback?)

People's individual needs were met

We saw evidence from the operational policy for The Limes that there had been analysis of the local demographic to determine the required level of service provision. We spoke with the Clinical Director, Service Manager and Modern Matron for The Limes who told us work was ongoing with the Portsmouth CCG to review aspects of the service to ensure they met the needs of the population.

Age appropriate visual aids and visual information was displayed in The Limes. For example, pictures on people's doors on Kitwood ward, braille signage, pictorial signage and easy read surveys. Menus were displayed in a written and pictorial form on Kitwood and Brooker wards and there were pictures of the pureed meals to show people what they looked like. Staff told us that MHA Section 132 leaflets were available in other languages for people if required. Staff told us that an interpreter service was available as required by people. We saw that there was a church on-site at St James and staff told us that a minister visited The Limes fortnightly. We observed OT technicians as they facilitated people's attendance at the church. People's individual needs had been taken into account in the provision of their care.

Providers work together during periods of transition

Staff from the CPN team told us that they attended CPA meetings on the wards and discharge meetings. We saw written evidence from people's CPA paperwork that discharge plans were commenced upon people's admission and that other agencies had been involved. However, staff reported that attendance at CPA meetings by social care staff was poor. The Clinical Director confirmed to us that a Social Worker was no longer based

with the community teams. Community staff from the ICT told us that that GP's were able to make urgent referrals via the single point of access. Referrals to the community teams were received from other Solent teams, primary and secondary care. Staff from the CPN team told us that from the point of referral people were seen within seven to 14 days. There were good links between the GP's, community services and The Limes however, access to social work was not as responsive as it had been previously.

Staff at The Limes told us that one of the consultants worked with the general hospital. They gave us an example of where a person had been transferred to an acute hospital and they had deployed a member of staff to support the person during their acute hospital admission. The service was responsive to people's needs as they moved between providers.

The Clinical Director told us that they saw a strength of the service was that they had retained the traditional one consultant model for both community services and The Limes. This meant that people received continuity of medical care when they transferred between these services.

We reviewed re-admission data provided by the Trust which indicated there was a high rate of re-admissions to the Limes. We spoke with staff and the Clinical Director who showed us written evidence that the figures were incorrect and the rate of re-admissions of people from the community was actually low. The Clinical Director informed us that since the formation of the ICT the rate of re-admissions to The Limes had reduced. We found that the ICT were responsive in preventing admissions and supporting early discharge when people returned to home.

We were informed that the ICT finished at 10pm until 8am and the care pathway for people overnight to access The Limes was via the staff ward bleep holder. Staff cited a recent example of a person who had been admitted overnight in response to their need for admission. The Clinical Director told us that older people were unable to use the Crisis Resolution Home Treatment Team (CRHT) for support overnight unless they were previously known to adult services and the Portsmouth CCG had not commissioned the ICT to operate overnight. Processes were in place to ensure that people could access The Limes overnight, however older people could not access the CRHT provided by adult services.

Provider acts on and learns from concerns and complaints

We reviewed a copy of the complaints policy and saw that the complaints leaflet was available. Staff on The Limes told us that four verbal complaints had been received in the past six months but these had been managed at the ward level and the complainants had not felt the need to make a formal written complaint. Processes were in place to ensure that people or their representatives could make a complaint; however, they had not done so recently.

Are services for older people well-led?

The governance framework is coherent, complete, clear, well understood and functioning

The objectives and values of the organisation were explicit within the 'Solent Wheel.' We found that staff were aware of the wheel. We spoke with the Health and Social Care Partnership lead who told us that the organisations visions and values were embedded at all levels of the organisation and that staff individual objectives were cross referenced to the Trust's strategic objectives. We spoke with staff who confirmed this and we were shown written evidence from staff appraisals. Staff understood the organisations operational objectives.

The Health and Social Care Partnership lead told us there were rigorous governance arrangements in place to monitor the quality of the service and risks to people and a high level of joint working with partners'. We spoke with nurses at a focus group and they demonstrated that they were familiar with the governance structure and lines of accountability. We saw written evidence of the older person's mental health governance meetings and saw that safety alerts, incident reports, serious incidents requiring investigation (SIRI's) and quality improvement plans had been reviewed. Processes were in place to monitor the delivery of the service.

Staff told us that communication from the Trust board came via newsletters, staff meetings, emails and handover. They said board members were seen every four to six months for a walk round and they could escalate issues as required. Staff in the CPN team told us there were regular surveys of people's experiences. A person on The Limes said the patient forum was a good place to speak up. A SALT told us how they had captured people's stories and

presented these to the Trust, so the board could understand people's and carers' views. There were processes in place to ensure that the voices of people and staff were heard.

Staff concerns were dealt with; risks identified, managed and mitigated

Staff were able to describe the processes whereby risks were captured using the incident reporting system. Incidents were then discussed at ward meetings and the risk manager might request further information. We reviewed the risk register and saw that risks within the service had been identified. There were monthly risk link meetings where feedback on incidents was provided from the risk manager and for sharing resulting changes to practice. Nurses and junior doctors told us they were aware of how to escalate issues and that they were encouraged to speak up. Consultants told us they had regular one to ones with the Clinical Director and attended risk panel meetings.

The Health and Social Care Partnership lead told us there were weekly staff meetings to cascade information to staff. Staff told us that they attended risk meetings. We saw that the Trust had a newsletter 'RISQy business' that was used to communicate information to staff on risk, infection prevention & control, safeguarding and quality. We saw evidence that a patient safety survey was circulated to all staff in the Trust. There were processes in place to capture and address risks.

Leadership within the organisation is effective, maintained and developed

Staff within the OPMH service both within The Limes and the community teams told us that there was good location level leadership; they felt well supported by senior nursing staff and the Modern Matron. Staff said that there was good professional line management. Consultants told us that senior management were visible and accessible. Staff felt supported by their line management.

There were high levels of staff engagement; cooperation and integration; responsibility and accountability

Staff told us they had received a good level of support when they were off sick. We saw evidence that two staff were on long-term sick and they had received appropriate support.

Junior doctors told us there was good induction for new staff. Staff from the ICT told us they had spent time shadowing staff from their main referral agencies. We saw written evidence that staff received clinical supervision and an annual appraisal, this was confirmed by staff.

Nurses at a focus group said that there could be issues accessing e-learning in relation to having the time to complete this. However, they reported that they were supported in their continuing professional development (CPD). Staff had been supported to undertake further qualifications for example, degrees. Community staff were required to 'hotdesk' and they told us that they found this disruptive. Staff told us that they did not find that the IT systems always supported them in their work. The Clinical Director informed us that the IT systems were under review. Overall, staff received appropriate support to undertake their role.

Functioning Governance Framework for Mental Health Act duties

Hospital managers were found to have improved people's engagement with manager's hearings. Link meetings had taken place regularly to discuss issues relating to the functioning of the MHA 1983 within OPMH services. Processes were in place to monitor the provider's duties.

Services for people with learning disabilities or autism

Information about the service

The Trust has a specialist learning disability community team for Portsmouth who work in partnership with the local authority. The Trust does not have any specialist beds for people with a learning disability who are in crisis. Instead beds are made available where required within adult mental health services at St James Hospital or they are sourced from within the independent sector. Referrals can also be made to the Trust's Kite Unit, a neuro-psychiatric rehabilitation service for people with cognitive impairment and additional psychiatric needs, which provides treatment and intensive support although it does not facilitate crisis/emergency admission.

The learning disability team works with approximately 160 individuals at any one time. The service works as an integrated service which is delivered in four specific teams. These are the community learning disability healthcare team, the learning disability acute liaison team, the complex healthcare team and the intensive support team.

During this inspection we spoke with people who use the service and their carers. We met with the management and staff of the service and representatives of partner agencies including the local authority, advocacy and a local independent provider. We reviewed the care and treatment records of people who use the service and we also observed an assessment and service user appointment.

Summary of findings

Overall we found that the service was safe. Staff were aware of their responsibility to report incidents and safeguard people. Incidents were reported and learnt from. There were sufficient staff to provide for people's care needs.

People's care took account of clinical guidance and best practice. The quality of care delivered was monitored through audits, surveys and people's feedback. The community team could demonstrate that there had been few admissions to inpatient units required for people with a learning disability.

People were provided with choices about their care and took part in reviews. Where people lacked the capacity to make specific decisions, their capacity had been assessed and best interest decisions made. We observed very positive interaction between staff and people using the service.

Care was tailored to people's individual needs. The complaints policy was readily available to people. Advocacy was proactively promoted and there were a range of activities undertaken to involve people in their care planning and service design.

Staff received a good level of training. Staff had an understanding of the governance procedures and processes in place for risks to be identified and managed. Staff felt well supported by their team managers. Staff received regular supervision and an annual appraisal.

Services for people with learning disabilities or autism

Are services for people with learning disabilities or autism safe?

Learn from incidents and improve standards of safety for people who use services

Staff confirmed that the trust had an on-line reporting system to report and record incidents and near misses. The trust wide evidence provided showed us that the trust was reporting concerns through the National Reporting and Learning System (NRLS). The levels of reporting were within expectations for a trust of this size.

We spoke with staff who told us about the electronic incident reporting system and their role and responsibilities to report incidents which impacted upon people's safety. Staff told us that they were comfortable reporting incidents and felt that their concerns would be responded to and confirmed that they were well supported by their line manager following any safety incidents.

We were told that there had been no serious incidents involving the learning disability service in the previous 12 months. Records supplied by the trust confirmed this. Staff told us that reflection and learning from incidents occurring elsewhere in the trust and externally took place within team and directorate meetings, and that debrief sessions would be used where appropriate. We reviewed team meeting minutes and saw discussion about incidents, and actions undertaken in response to these.

The trust's serious incident data showed us that trust wide learning from 'Serious Incidents that Required Investigation' (SIRI) had been reviewed and disseminated throughout the trust. Staff confirmed this and reported that the lessons learnt from these incidents had been discussed within their specific team and disseminated through the trust. The evidence seen showed us that the trust had embedded learning from incidents within the organisation.

Systems were in place to review incidents and near misses. This included the monthly 'quality and risk report'. This included information on complaints, incidents, feedback from the patients' experience and feedback about staff experience.

The evidence seen during our inspection demonstrated to us that the service had a process in place to learn from any incidents that had happened. We saw that trust wide learning from these had been recorded and disseminated.

Are behaviours, processes and systems reliable, safe and proportionate for people who use services

We noted that the trust had recently distributed a safeguarding vulnerable adults' handbook to staff. This generic handbook also included a specific reminder of the trust's safeguarding procedures and local contact numbers. This meant that staff had been given the required guidance in order to support them to raise concerns when these were identified. The trust had identified safeguarding vulnerable adults and safeguarding children leads and staff told us that they were aware of their roles within the trust. Staff were aware of the trust's safeguarding and other polices. They told us that they knew how to raise any safeguarding concerns.

Staff were aware of the trust's whistleblowing policy and confirmed that they felt able to raise concerns with their direct line manager. Staff told us they felt listened to and this included issues as well as ideas for improvement. Staff were also aware of how to raise concerns outside of their direct management line should this be needed.

We noted that staff were aware of the risks associated with their specific role and they were aware of the expectations of their role. Evidence was seen of staff taking proactive risk management strategies. For example, when planning their home visits and other treatment interventions with patients.

Understand and manage risk to the person using services and others with whom they may live with

A risk management policy is in place for the learning disability service which was updated following the opening of the Kite Unit in 2013. Staff told us about the process for assessment and risk management. We attended an assessment of a person who had been referred to the team by a local independent provider. This assessment was observed to be thorough and consider all aspects of the person's needs and any risks to their health and well-being.

We saw evidence that when people were referred to the service their needs had been assessed and they had received a multi-disciplinary team assessment. Risk assessments were seen in those records reviewed and these included assessments of the person's physical health and their risks to self or others where appropriate. Risk assessments reviewed were comprehensive, regularly reviewed and aligned to people's care plans. Evidence was

seen of the active involvement of the person in assessing their needs and risks for themselves. Identified risks had a clear and relevant care plan in place that showed the involvement of the patient themselves.

We were provided with a protocol for managing people with a learning disability who are in crisis. This clearly set out the process to be followed to manage risk in an emergency and set out referral routes to inpatient services.

Staffing levels and quality of staffing enables safe practice

We reviewed the numbers of staff in their respective teams and their relevant caseloads during our inspection. We were provided with performance data for the period April to December 2013. We noted that staff have manageable workloads and there is not a substantial waiting list for people who need support from the team.

Staff told us that they had received induction and training to prepare them for their role and felt well supported by their line manager. Each member of staff spoken with told us that they received supervisions and annual appraisals from their line manager as required. This meant that staff received the appropriate levels of support from their immediate manager.

Managers told us that recruitment took place in line with the trust's human resources policy and procedures. This was confirmed by some front line staff who told us that they knew that active recruitment was taking place within these services. Management confirmed that previous vacancies within the team had recently been filled.

Staff confirmed that systems were in place to monitor staff sickness and that they had access to occupational health support. At the time of our visit the sickness rate for the service had improved significantly over the previous 12 months and stood at 1.5%, the lowest level across trust services. Staff told us that morale was very good and that they felt well supported by their line manager.

Are services for people with learning disabilities or autism effective?

(for example, treatment is effective)

Evidence-based clinical guidance, standards and best practice

From the evidence inspected and discussions with managers and staff, we saw the trust was able to demonstrate that people who used this service received care and treatment in line with the current best clinical practice guidance.The community team could demonstrate that there had been few admissions to inpatient units required for people with a learning disability.

Staff showed us that they were aware of national guidance, policies, enquiries and clinical guidance. We saw care plans, risk assessments and policies that referenced NICE (National Institute for Health and Care Excellence) and other relevant clinical guidelines.

The manager of the service provided us with copies of evaluation reports and action plans developed in response to learning from the Winterbourne Enquiry and commissioning guidance updated in 2013.

The Solent quality cycle was known to most staff that we spoke with. This showed us how the trust monitored and reviewed their existing quality systems. We also saw a physical and mental health 'wheel' being used in the areas we inspected. Staff were aware of this and said they helped them ensure that all needs of people were addressed.

Demonstrate collaborative multi-disciplinary working across all services

The community learning disability team is delivered in partnership with the local authority. A section 75 agreement is in place to ensure the effective governance and delivery of the partnership. The team is part of the adult services directorate within the trust however the staff demonstrated their close working with colleagues in the adult mental health directorate. We also saw examples of effective collaborative working with staff in the Kite Unit, with GPs and with those employed by other providers such as care homes, supported living and advocacy services. We were also provided with details of the local learning disability partnership board which includes active participation from the team.

Services for people with learning disabilities or autism

We spoke with the local advocacy service during this inspection. The advocacy lead spoke highly of the cooperation experienced with the community learning disability team and stated that staff were pro-active about making advocacy referrals.

Quality of care measured and managed

Clinical audits and other reporting mechanisms were in place. This was reported via the adult services directorate's monthly 'quality and clinical risks' reports to the learning disability governance group, that assurance committee and to the trust board. Measures considered include incidents, complaints, patient experience, medication compliance, staffing measures and treatment outcomes.

We were provided with a service user involvement strategy and protocol for the service. Feedback systems were in place for people using the service through a wide range of initiatives. These include accessible service user satisfaction surveys, service user and carer groups, active involvement of advocates, and pro-active involvement of service users' families and carers.

Suitably qualified and competent staff

Staffing with the community learning disability team includes a skills mix designed to meet the complex needs of the client group. The staff team includes nurses and social care employees from a learning disability speciality, as well as a consultant psychiatrist, psychologists, occupational therapists, speech and language therapists and dieticians.

Staff confirmed that they are provided with a wide range of mandatory and specialist training to undertake their role. We saw that staff were required to complete a range of mandatory training. This included hand hygiene, equality, diversity and human rights. In addition to health and safety, infection control, information governance, MCA, MHA, moving and handling, safeguarding of adults and children. We saw evidence that staff had attended additional relevant training and staff told us that they were supported to undertake further professional qualifications.

Clinical staff all reported that they received regular supervision and an annual appraisal of their work. We were provided with data regarding levels and supervision and appraisal and these indicated all staff were up to date.

Are services for people with learning disabilities or autism caring?

Is there choice and are people enabled to participate

We met with three people who were receiving care from the community learning disability team at the time of our visit. People we spoke with felt that they were involved with their care and informed about their treatment. We also spoke to person's relative who also spoke very highly of the service and confirmed that they were engaged in planning for their loved ones' care where appropriate. We spoke with independent providers about the work of the team and they spoke highly of the engagement between staff and the service users in their care.

The service has a range of information available for people about the service and its objectives, the wider trust's services, advocacy and making complaints. These are all designed as 'easy read' documents.

We looked at care plan documents and found they were holistic and individualised. We found evidence of people's involvement in care planning and we observed staff actively encouraging participation with a group of people who are not always easily engaged in their care. The people who use the service we spoke with told us they had copies of their care plan and understood what the team needed to do to support them.

We were provided with a service user involvement strategy and protocol for the service. Feedback systems were in place for people using the service through a wide range of initiatives. These included accessible service user satisfaction surveys, service user and carer groups, active involvement of advocates, and pro-active involvement of service users' families and carers. Staff told us about an employment scheme the trust had developed to include people with a learning disability in the delivery of services, including the administration of outpatient appointments. We were also provided with information about a project to involve people with a learning disability as trainers.

Staff communicate effectively

We observed that staff communicated effectively with people who use the service. Patients told us that staff are good and make time for them. One person told us that someone in the team will respond if their worker was not available.

Services for people with learning disabilities or autism

Staff told us that people were kept informed of any changes to their care and treatment. Evidence was seen in records reviewed of effective communication between staff and the people they were caring for. For example preferred communication methods were listed in individual care records.

We found that staff in the team communicate effectively with colleagues within the wider trust, the local authority, and in external bodies as relevant.

People receive the support they need

The learning disability service aims to support people within the community without the requirement for inpatient care. The staff told us that they now manage people within the community, with at times very challenging behaviour, who previously would have been long stay hospital patients. We were provided with details of inpatient admissions for people with a learning disability from Portsmouth. These indicated that there were seven people receiving out of county specialist hospital placements and that there have been five people admitted to the trust's own inpatient services in the last 12 months.

People`s needs were assessed and care was delivered in line with their individual care plan. Records showed that risks to mental and physical health were identified and managed. 'My plan' was in place for all people whose records we reviewed. This included areas to set out people's needs in relation to their physical health, their personal goals, their cultural and spiritual needs, their capacity and consent and their communication needs. Staff and people who use the service told us that care plans were regularly reviewed with individuals.

We spoke with staff in the team about the care needs of individual people. Interaction between staff and people who use the service was good. Staff gave explanations and reassurance to people. Staff knew people well and they were able to describe individual support that people needed.

The records seen showed us that people received the correct level of care and treatment required by them. We saw that close working relations were in place with local authority staff and other relevant organisations. Sign posting arrangements were in place with leaflets and other information about local services and support groups being available for people.

Privacy and dignity respected

People who had used the team's services told us that their privacy and dignity were respected. We observed clinical and administrative staff communicating positively and respectfully with people.

During our visits to people's homes we saw that individual's privacy and dignity were being promoted as far as possible by front line staff. We saw that private rooms were available for consultations at the team's base if required.

Are services for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Individual needs met

People who use the service were involved in the planning of their care. People told us that they felt involved in their care planning and had copies of their care plans. We observed staff encouraging patients to consider their care goals and make individual choices. People told us that their religious, spiritual and cultural needs are met and respected by staff.

Mechanisms were in place to ensure that people who use the service are involved in the design and delivery of the future service. These include These included accessible service user satisfaction surveys, service user and carer groups, active involvement of advocates, and pro-active involvement of service users' families and carers.

Arrangements for treatment and discharge were discussed and planned with other care providers. Appropriate information was shared in order to agree the treatment plan. There were regular care planning meetings which included attendance from other professionals to discuss the person`s treatment, progress and discharge planning.

The team has a wide multi-disciplinary team including medical staff from psychiatry, as well as occupational therapy, psychology, speech and language therapy and dieticians. People told us that their treatment needs are met and that they are well supported.

Services for people with learning disabilities or autism

Providers work together during periods of transition

The evidence seen showed us that people were well supported when and if they underwent a transition from one provider to another.

We saw evidence of close working relationships between the community team and other providers such as the local authority and independent providers. We saw examples of the team identifying different community support mechanisms for people and their carers. We saw effective communication and information sharing with staff at the Kite Unit where an inpatient stay was required. The records seen showed us that referrals to other services had been discussed with people prior to this taking place.

Provider act on and learn from concerns and complaints

A system was in place to learn from any complaints made. Information about the complaints process was clearly displayed around the unit. The Patient Advice and Liaison Service (PALS) is in place to ensure early learning from complaints and to support patients in making their complaints. Patients told us that they knew how to make a complaint and felt able to do so if they needed to.

Staff knew the process for receiving complaints and told us that learning would take place in their staff meetings. The numbers of complaints and their outcomes were reported to the governance committee, the assurance committee and the board through the 'quality and clinical risks' report. There had been no formal complaints about the service in the previous 12 months.

Mechanisms were in place to ensure that people who use the service could feed back about the service. These included accessible service user satisfaction surveys, service user and carer groups, active involvement of advocates, and pro-active involvement of service users' families and carers.

Are services for people with learning disabilities or autism well-led?

The governance framework is coherent, complete, clear, well understood and functioning

The objectives and values of the organisation were explicit within the 'Solent Wheel.' We found that staff were aware of the wheel. We spoke with the Health and Social Care Partnership lead who told us that the organisations visions and values were embedded at all levels of the organisation and that staff individual objectives were cross referenced to the trust's strategic objectives. We spoke with staff who confirmed this. Staff understood the organisations operational objectives.

The Health and Social Care Partnership lead told us there were rigorous governance arrangements in place to monitor the quality of the service and risks to people and a high level of joint working with partners. We spoke with nurses and care workers at focus groups and they demonstrated that they were familiar with the governance structure and lines of accountability. We saw written evidence of the governance meetings and saw that safety alerts, incident reports, serious incidents requiring investigation (SIRI's) and quality improvement plans had been reviewed. Processes were in place to monitor the delivery of the service. We found that there were also local systems in place on to check care and safety.

We found the staff had a good understanding of the trust's governance framework. Staff told us they regularly received information and described the systems to give feedback centrally on trust issues and how they received feedback. Staff told us that communication from the trust board came via newsletters, staff meetings, emails and handover. Staff told us there were regular surveys of people's experiences.

Staff concerns dealt with; risks identified, managed and mitigated

There was a positive and open culture within the team. Staff told us they felt well supported by their manager and the wider multi-disciplinary team. Debrief sessions were provided following any relevant incident at the trust. There was a regular team meeting, which included a focus on learning.

Staff told us they felt able to report incidents and raise concerns and that they would be listened to. The manager told us that they felt senior managers in the trust listened to concerns that they raised and acted on these.

Staff were able to describe the processes whereby risks were captured using the incident reporting system. Incidents would then be discussed at ward meetings and the risk manager might request further information. There were monthly risk link meetings where feedback on incidents was provided from the risk manager and for

sharing resulting in changes to practice. Staff told us they were aware of how to escalate issues and that they were encouraged to speak up. Consultants told us they had regular one to ones with the Clinical Director and attended risk panel meetings.

The Health and Social Care Partnership lead told us there were weekly staff meetings to cascade information to staff. Staff told us that they attended risk meetings. We saw that the trust had a newsletter that was used to communicate information to staff on risk, infection prevention and control, safeguarding and quality. We saw evidence that a patient safety survey was circulated to all staff in the trust. There were processes in place to capture and address risks.

Leadership within the organisation is effective, maintained and developed

Staff within the team told us that there was good local leadership and they felt well supported by senior nursing staff. Staff said that there was good professional line management. Consultants told us that senior management were visible and accessible. Staff felt supported by their line management.

Nurses and support workers at a focus group said that there could be issues accessing e-learning in relation to having the time to complete this. However, they reported that they were supported in their continuing professional development (CPD). Staff including support workers had been supported to undertake further qualifications.

Currently staff from the trust use different IT systems from their colleagues employed by the local authority. The manager of the service did not feel that this impinged on the teams work. Staff within focus groups told us that they did not find that the IT systems always supported them in their work. The Clinical Director informed us that the IT systems were under review.

Adult community-based services

Information about the service

The trust provided this as part of their mental health services. We reviewed and inspected the community services being provided and managed from St James Hospital and also provided from St Mary's Hospital.

The services located at St Mary's Hospital were the following:-

Two community recovery teams (geographically divided into South and North)

The Intensive Engagement Team (IET) (which was an amalgamation of two previous teams: early intervention in psychosis and the assertive outreach team).

The access to intervention service (a2i), which was the point of referral into community and crisis services during the day.

The crisis resolution team was based at St James Hospital. This service offered crisis care in the community, arranged and managed hospital admissions and was responsible for the management of the section 136 suite. This was located in the grounds of the hospital and was the designated healthcare based place of safety.

We were informed that these services were due for further reconfiguration. Staff told us that they expected confirmation of the trust's plans during the week following our inspection.

We also reviewed and inspected the liaison psychiatry service being provided by the trust at the Queen Alexandra Hospital Portsmouth and the parts of the homeless service being provided by the trust at the Royal Southampton Hospital.

We met with the community development workers (CDW) who were employed by the trust in partnership with Portsmouth City Council.

We examined nine treatment plans and spoke with senior clinicians and other staff over the course of a four-day inspection. We accompanied a front line clinician from the trust's crisis team on two visits to clients with their prior permission and observed the direct care and treatment being provided.

We met with 15 people who used these services and with three carers who were accompanying them. We conducted nine telephone interviews with people who had given their prior permission.

We also used information provided by the trust and information that we requested, which included some trust policies and other information.

Adult community-based services

Summary of findings

We found that whilst the provision of these community services was safe, some improvements were required. The trust had not always ensured that full risk assessments had been completed upon initial admission to the service. Examples were seen of large caseloads and staff shortages within two distinct teams. The evidence seen showed us that improvements were required by the trust to demonstrate that the services reviewed; understood and managed the risk to people who used this service.

Improvements were required to ensure that these services were effective. We noted that the trust amalgamation of the assertive outreach and early intervention psychosis team lacked clear clinical validation. This model had not been evaluated fully by the trust and yet further trust reconfiguration was due to take place shortly. Whilst we saw some good examples of collaborative partnership working, there was a lack of multi-disciplinary input into the crisis team. There was a need to review the levels of the consultant psychiatrist input into the access to intervention service based on the numbers of incoming referrals noted. These identified concerns meant that improvements were required by the trust to fully ensure the effective delivery of care and treatment to some patients.

The services provided were caring. This was confirmed by our observations of the care and treatment being provided by front line staff. We noted that staff actively engaged with people at a local level. Almost every person spoken with told us that they were treated with respect and kindness by staff. They told us that they had their privacy and dignity respected and were provided with care or treatment choices wherever possible. Clinicians told us that they felt that people got a 'good service' from the trust.

Improvements were required to ensure that these services were fully responsive to people's needs. This was because we noted that the trust needed to review the evidence it had used to plan their services based on the needs of the local population. The trust was meeting the individual needs of people who used this service and we reviewed some good examples of responsive and patient centred care during the inspection.

Examples were seen of effective complaints management. Some patients spoke highly of their own involvement and participation in their transition from hospital in-patient care to recovery in the community.

Whilst we found robust and well led local service provision; improvements were required to ensure that trust wide leadership was more visible and responsive to front line staff. Some staff told us that they didn't feel listened to at the organisational level and that they felt the trust's risk register did not reflect the potential risks to the organisation. This showed us that improvements were required by the trust in order to review the existing trust risk register in the light of these concerns.

Adult community-based services

Are adult community-based services safe?

How well does the provider learn from incidents and improve standards of safety for people who use services?

Staff reported a positive and inclusive culture within their particular team. For example, they told us that individual concerns were discussed at their team meetings. They confirmed that they knew how to report incidents and 'near misses'. Patients told us that they felt comfortable in raising any specific concerns with staff.

Staff confirmed that the trust had an on-line reporting system to report and record incidents and near misses. We saw that staff had access to this system via 'password' protected computers. The trust wide evidence provided showed us that the trust were reporting concerns through the National Reporting and Learning System (NRLS). The levels of reporting were within expectations for a trust of this size.

The trust's serious incident data showed us that trust wide learning from 'Serious Incidents that Required Investigation' (SIRI) had been reviewed and disseminated throughout the trust Staff confirmed this and reported that the lessons learnt from these incidents had been discussed within their specific team and disseminated through the trust. For example, we saw copies of the trusts on line safety magazine 'RisQy business'. This provided information and guidance for staff to follow. Most members of staff spoken with were aware of this publication. Further trust wide learning was evidenced through the trust's on line newsletter. This included updates and 'key messages' for staff. The evidence seen showed us that the trust had embedded learning from incidents within the organisation.

Systems were in place to review incidents and near misses. This included the monthly 'quality and risk report' for the Adult Mental Health (AMH) directorate. This included information on complaints, incidents, feedback from the patients' experience desk and feedback about staff experience. Staff confirmed that they had received risk assessment training and told us that they felt well supported by their line manager following any safety incidents.

The evidence seen during our inspection demonstrated to us that these services had learnt from any incidents that had happened. We saw that trust wide learning from these had been recorded and disseminated.

Are behaviours, processes and systems reliable, safe and proportionate for people who use services?

We noted that the trust had recently distributed a safeguarding vulnerable adults' handbook to staff. This generic handbook also included a specific reminder of the trust's safeguarding procedures and local contact numbers. This meant that staff had been given the required guidance in order to support them to raise concerns when these were identified.

The trust had identified safeguarding vulnerable adults and safeguarding children leads and staff told us that they were aware of their roles within the trust.

Staff were aware of the trust's safeguarding and other polices. They told us that they knew how to raise any safeguarding concerns. This was demonstrated by some of those individual treatment records seen. These showed us that some identified safeguarding concerns had been reported appropriately and pro-actively by staff. However, we noted that two potential safeguarding children risks had not been clearly identified, assessed or managed appropriately by front line staff. This was brought to the attention of senior staff during our visit and subsequently addressed.

Staff were aware of the trust's whistleblowing policy and confirmed that they felt able to raise concerns with their direct line manager. Some staff told us that they had raised concerns through their line manager. For example, in relation to their individual work load and recent managerial and other staff changes linked to service transformation. Staff informed us they felt that a number of these issues had not yet been resolved satisfactorily by the trust.

We noted that staff were aware of the risks associated with their specific role and that specific concerns had been raised within caseload management discussion. Evidence was seen of staff taking proactive risk management strategies. For example, when planning their home visits and other treatment interventions with patients.

Adult community-based services

The evidence seen showed us that trust wide behaviours, processes and systems required some improvements to ensure that these were reliable, safe and proportionate for patients who used this service.

How do services understand and manage risk to the person using services and others with whom they may live with?

The care and treatment records seen showed us that three people who had recently been seen by the 'assessment to intervention' service did not have a documented individual risk assessment in place and this included any specific safeguarding concerns. We noted gaps in some of the other risk assessments reviewed within this service. This meant that some clinical decisions were being made without the basis of a robust documented assessment process. This showed us that improvements were required to ensure that patient's care and treatment needs were met fully by this service.

Risk assessments were seen in those other records reviewed and these included assessments of the person's physical health and their risks to self or others where appropriate. Evidence was seen of the active involvement of the person in assessing risks for themselves. For example, linked to their discussions with their care co-ordinator. These assessed identified risks had a clear and relevant care plan in place that showed the involvement of the patient themselves.

We saw good examples of risk assessments and subsequent care plans linked to those community treatment orders (CTO) reviewed during our inspection.

The evidence seen showed us that improvements were required to demonstrate fully that the services reviewed, understood and managed the risk to people who used this service.

How does the provider ensure that staffing levels and quality of staffing enables safe practice?

We reviewed the numbers of staff in their respective teams and their relevant caseloads during our inspection. We noted that that 'access to intervention' service and the intensive engagement team were adversely affected by large individual caseloads linked to staff shortages. Further evidence of the impact was the delay in responding to some referrals received from General Practitioners (GP). This had led to the trust not meeting the agreed time scales for assessing some referrals as agreed with these stakeholders.

We saw that a number of staff had recently left the intensive engagement team as a result of further proposed trust changes to service provision. This demonstrated to us that improvements were required to ensure that staff numbers met the needs of the population served by the trust.

Staff told us that they had received induction and training to prepare them for their role and felt well supported by their line manager. Each member of staff spoken with told us that they received supervisions and annual appraisals from their line manager as required. This meant that staff received the appropriate levels of support from their immediate manager.

Managers told us that recruitment took place in line with the trust's human resources policy and procedures. This was confirmed by some front line staff who told us that they knew that active recruitment was taking place within these services.

Staff confirmed that systems were in place to monitor staff sickness and that they had access to occupational health support. Some staff told us that they had concerns about the effectiveness of this service. Whilst others spoke highly of the individualised support and 'return to work' programmes provided by the trust. Most staff told us that they felt well supported by their line manager.

The evidence seen showed us that improvements were required by the trust to identify and address staffing levels in some teams and the individual concerns of some staff regarding the further proposed changes.

Are adult community-based services effective?

(for example, treatment is effective)

Can the provider demonstrate that nationally/ internationally recognised clinical guidelines and standards, other recognised guidance and

standards and current recognised best practice are used to deliver care and treatment that meets the needs of people who use services and delivers positive outcomes?

From the evidence inspected and discussions with managers and front line staff, we saw the trust was able to demonstrate that most of the patients who used this service received care and treatment in line with the current best practice guidance.

We saw that the trust had recently commenced a peer review system to review a selected number of assessments and care plans. This was seen to be a collaborative approach and involved lead clinicians and the relevant care co-ordinator. We saw that this process covered the salient points and identified areas where improvements could be made. Evidence was seen that staff had responded positively to these meetings. This demonstrated a good example of 'bridging the gap' between care recorded and management support and guidance provided for staff.

The evidence seen and discussed with staff showed us that they were aware of national guidance, policies, enquiries and clinical guidance. We saw examples of care plans that referenced NICE (National Institute for Health and Care Excellence) guidelines.

The Solent quality cycle was known to most staff that we questioned and was available in those clinical areas visited. This showed us how the trust monitored and reviewed their existing quality systems. However, we noted that the trust amalgamation of the assertive outreach and early intervention psychosis team lacked clear clinical validation. This model had not been evaluated fully by the trust and was being subjected to further changes shortly after the inspection. This meant that improvements were required by the trust to demonstrate effective clinically based treatment provision to patients who used these services.

Can the provider demonstrate collaborative multi-disciplinary working across all services and in partnership with other providers, support networks and organisations?

We saw that the trust worked collaboratively and in partnership with a number of other providers within this service. For example, with Portsmouth City Council and the local NHS acute trust via the Queen Alexandra Hospital. Staff spoken with were knowledgeable about their individual roles and responsibilities.

We saw that the liaison psychiatry service offered a nurse led service that worked effectively across a complex arena. We saw examples of effective collaborative working with staff employed by other trusts and with third sector providers.

When we visited the homeless service we were impressed by the high standards of care being provided to this 'difficult to reach' population group. Evidence was seen that demonstrated to us that people's long term health conditions were being met effectively by this service. We saw that the trust worked collaboratively and in partnership with a number of other providers including General Practitioners (GP) as part of this service.

The evidence seen showed us that trust was working effectively and in collaboration within a number of community and trust based settings to try and ensure that the care and treatment needs of patients were being met.

However, the trust may find it useful to note that we observed a lack of multi-disciplinary involvement in the crisis team and a need to review the levels of the consultant psychiatrist input into the access to intervention service based on the numbers of incoming referrals noted. These identified concerns meant that there were improvements required to fully ensure the effective delivery of care and treatment to some patients.

Good examples were noted of patient and carer involvement in the drawing up of some care plans seen. Carers told us that they had been involved in discussions regarding their relatives' care and treatment. One carer spoke highly of the support they had received from trust staff regarding accessing housing and other benefits for their relative.

Examples were seen of collaborative working and active engagement with local Black Minority and Ethnic (BME) groups through the community development workers employed by the trust in partnership with Portsmouth City Council. The evidence seen showed us that this had led to an increase in service engagement of these specific groups and demonstrated a pro-active approach to community engagement by the trust.

The trust should be aware that some people told us that it was difficult for them to access community general health services if they had physical long term care needs. There were some concerns expressed about how the 'single point

of contact' worked for this group of patients. This showed us that improvements were required by the trust to promote collaborative working within this area of patient need.

How is the quality of care measured and managed in a manner to deliver the best outcomes for people?

Clinical audits and other reporting mechanisms to the trust board were in place. This was via the Adult Mental Health directorate's monthly 'quality and clinical risks' reports.

Patient feedback systems were in place for example, we noted that individual evaluation took place following attendance at therapeutic groups. For example, there was entirely positive feedback from people who had attended the day treatment centre. Positive comments received from people included, "Everyone was very kind to me" and, "A hundred percent service."

We saw that the trust had effectively piloted three systems for measuring outcomes for patients who used their services. Examples were seen of a recent audit of the system chosen by the trust following extensive consultation with patients, carers and staff. This demonstrated an increase in completed Consumer Recovery Outcome System (CROS) forms and a corresponding increase in completed recovery focused care plans.

The evidence seen showed us that the trust had robust systems in place to measure the quality of care and treatment being provided by front line staff.

Do people who use services receive treatment and care from suitably qualified and competent staff, supported in their role and service delivery?

Most staff spoken with confirmed that they had received adequate training and support to prepare them for their role. Staff told us that they received support from other members of their team. They gave us examples of team meetings and line management supervisions as opportunities for receiving appropriate support.

Staff gave us examples of trust wide training undertaken. For example, mandatory safeguarding, health and safety, equality and diversity training had been received. New staff told us that they had received induction to the trust and to their specific service.

However, the trust should note that the introduction of the electronic staff record had led to managers being unable to review all of their team's current training status. This showed us that improvements were required to ensure that managers could effectively identify any gaps in training provision and attendance.

Ensuring that staff training was embedded into individual practice was assessed through a variety of methods. These included case load reviews, staff supervision and weekly team meetings. Staff told us that they could ask for additional support if this was needed.

Some staff told us that their team was short staffed and they felt that their case loads were correspondingly too large. This view was particularly prevalent in the access to intervention and the intensive engagement teams and compounded by additional trust plans to further transform community services. Staff confirmed that they had raised these concerns with the trust but had yet to receive a satisfactory response. This showed us that improvements were required by the trust to ensure that all members of staff had enough time to provide responsive and appropriate care to people who use services.

Senior staff confirmed some on-going concerns but reported that individual and team caseloads were monitored through clinical leadership and supervision. They also confirmed that caseloads varied as a result of ongoing changes in specific needs of people who used the service.

The evidence reviewed showed us that whilst systems were in place locally to support and train staff in their role. Some improvements were required by the trust to ensure that staffing levels and skills in each team was sufficient to ensure that patients received the appropriate level of care and treatment from front line staff.

Are adult community-based services caring?

Do people who use services have choice in decisions affecting their care and support and are enabled to participate at each level?

The evidence seen showed us that people who use services had a reasonable choice in decisions affecting their care and support and were encouraged to participate in this.

We noted a wide range of information available for people at those locations visited. Whilst this was mostly in the form of literature we were informed that people with literacy

problems would be assisted wherever possible by their care co-ordinator or main carer. We were told that staff had access to literature in other languages. Some staff members were fluent in languages other than English and senior staff confirmed that translation and interpreting services were available if required.

The treatment records seen demonstrated a person centred approach to individual care but that where applicable; some carer involvement was recorded if people who used the service wanted this. We noted that some peer group support was available. For example through peer workers providing and assisting with therapy sessions at the day treatment centre.

Staff reported good links with advocacy services and other support services. For example we saw information about independent advocacy providers at each location we visited. We saw that appointments had been made to provide people with benefits and housing support. People and their carers were positive about this support and told us that they appreciated this individualised help. Examples were seen of people being supported by their third sector residential provider to attend the blood testing clinics required by their prescribed medication, by the provision of transport and accompanying staff members. People were supported to obtain 'bus passes' if eligible, so they could attend the day treatment centre.

The records seen showed us that people who used these services had the opportunity to discuss their care, support and any treatment received with their care co-ordinator and other staff where applicable. This was supported by our observations of the front line delivery of care and treatment visits by staff.

Most people who spoke highly of the support that they had received from the service. For example, ensuring that they received choices and individualised support. People told us that, "My nurse is excellent." And, "I feel well supported by the team."

People spoken with were aware of the available advocacy services and one person told us that they understood their rights as a 'Community Treatment Order' (CTO) patient. A number of people told us that they were fully involved in discussions about their care and treatment and was aware of their care plan.

Clinicians interviewed told us that they considered that patients were receiving 'good care' from this service. When asked about what could be done to improve the services provided, they told us that more staff and time was needed.

Evidence was seen that the trust had actively engaged with a carers' group. This was held at Portsmouth Carer Centre in January 2014. A letter had subsequently been sent to each attendee listing an action plan to address the individual concerns raised. We were told that a further meeting would be held in approximately six months to assess progress with this.

We spoke with three carers and they told us that they were actively involved with the care and treatment being provided for their relative with their permission. For example we saw carers attended appointments with trust staff and were able to act as an advocate for their relative where required. However the trust may wish to note that some carers expressed frustration with the lack of consistency regarding not seeing the same psychiatrist or other clinicians on a regular basis.

The records seen showed us that mental capacity issues were assessed where appropriate and discussed with the person concerned. Some records seen identified and documented individual support mechanisms. Evidence was seen of a focus on the recovery model for patients. For example via therapy groups run by the day treatment centre and courses run by the Solent Recovery College.

The evidence seen showed us that the trust were good at enabling active participation in care and promoting individual choices for patients.

Do people who use services participate, in a review of their needs and preferences when their circumstances change?

We saw some good examples of how people who used these services were involved in discussions around their care and that encouragement and support was given by staff where appropriate. Staff informed us that the choices people made were discussed with them by their key worker and the effects of these on any potential treatment outlined to them.

The records seen showed us that people were involved in the decisions around their care and treatment wherever possible. For example, we noted that people were referred to this service by their GP or had self-referred when they

realised that they required assistance. Systems and procedures were in place that enabled people to be supported and assessed in their own home. Staff gave us examples of where this had been beneficial in the identification of further risks or concerns.

We saw that the care given was as responsive as possible. Staff confirmed their flexibility around making appointments with people. This included making appointments around people's work patterns.

We saw good evidence of people being supported to attend recovery services following their discharge from acute care. We saw examples of close and collaborative working between the acute admission ward and the day treatment centre based on assessment of individual needs and strengths.

The evidence seen showed us that the trust were good at involving individuals in all aspects of their care and treatment.

Do staff develop trusting relationships and communicate effectively so that people who use services understand what is happening to them and why?

People told us that they were able to ask questions around their care options and that staff always attempted to answer these if possible.

Staff told us that they welcomed any complaints that people may have. The records seen showed us that the adult mental health directorate had received six formal complaints between January 2014 and the date of the inspection. These were being addressed through the trust's complaint procedures. Senior staff told us that people were kept informed of the progress of any complaint made.

Staff told us that people were kept informed of any changes to their care and treatment. Evidence was seen in most of the records reviewed of effective communication between staff and the people they were caring for. For example contact numbers and preferred communication methods were listed in individual care records.

One person told us that staff were nearly always on time for their appointment and that individualised care and treatment had been provided in a supportive and non-judgemental manner. This was supported in those episodes of front line care that we observed with the patient's prior permission.

The records seen showed us that effective communication took place within this service. For example through weekly team meetings and the trust's newsletter.

Do people who use services receive the support they need?

Most of the records seen showed us that people received the correct level of care and treatment required by them. We saw that close working relations were in place with other statutory bodies including Portsmouth City Council, the local NHS acute trust and independent advocacy organisations. Sign posting arrangements were in place with leaflets and other information about local services and support groups being available for people. Staff informed us that key workers would advocate on behalf of people where this was appropriate.

Most people spoken with told us that they felt well supported by the services provided. One person told us, "I am happy with my care co-ordinator." Some-one else said, "I feel that I am well supported by staff." Another person told us, "My questions are always answered." Some people expressed concerns around staff continuity and staff seemingly short of time and being overworked.

We saw two examples of positive recovery care models as evidenced by the Solent Recovery College and the Day Treatment Centre. Both were an innovative development in recovery and in maintaining people's recovery in the community.

Audits and other systems to monitor and measure the care being provided were in place. For example we saw examples of how the Customer Recovery Outcome Scores (CROS) were being audited to demonstrate improved clinical outcomes. We saw positive feedback from other services visited. This included very positive feedback from people who were accessing the Homeless Service

Is the privacy and dignity of people who use services respected?

Staff told us that they had received 'equality diversity and human rights' training. They confirmed that the trust had a 'zero tolerance' to any unlawful discriminatory behaviour. They confirmed that any disrespectful or abusive attitudes towards people were not tolerated.

From the interactions that we observed staff were seen to be communicating positively with people. For example, we saw people being welcomed politely to the service and being given clear guidance about their appointment.

Adult community-based services

People told us that their privacy and dignity were respected. For example, during consultation and meetings. We saw that therapy groups were provided with clear ground rules around privacy and respect for the contribution of others.

During our visits to people's houses we saw that individual's privacy and dignity were being promoted as far as possible by front line staff. The day treatment centre was able to give us clear examples of how they set up and managed groups and individual therapy sessions within this service. This promoted individual access and choices for people where this was needed.

We saw that private rooms were available for consultations if required and that these were used for 'one to one' therapy sessions where applicable.

The evidence seen and discussions with people showed us that the privacy and dignity of the people who used this service was being respected by the trust.

Are adult community-based services responsive to people's needs?
(for example, to feedback?)

How are the individual needs of people who use services met at each stage of their care?

The evidence seen did not provide us with enough evidence that the trust had robustly planned its services on the basis of the needs of the local population. Improvements were required to enable the trust to demonstrate the evidence it had used to plan their services based on the needs of the local population. However we noted that future reconfiguration of these services were due in the near future.

We saw evidence of information about locally available services and self-help support groups being available to people. The geographical configuration of the recovery teams assisted in developing relationships with General Practitioners and other health professionals. Some patients spoke highly of their own involvement and participation in their transition from hospital in-patient care to recovery in the community.

We met with the community development workers' (CDW) team. They were able to give us good examples of how they were working with the local population to try and break down the stigma associated with mental health issues within some 'difficult to reach' groups.

The homeless team provided robust examples of the work that they did to assist people with urgent and long standing health needs. Examples were seen of a collaborative approach with local General Practitioners and other health professionals.

We visited a clinic for people who required regular blood tests as a result of the medication they were receiving. People also received the required physical health checks to monitor for any potential side effects to their medication. This was an example of where the trust had provided an effective service to people based on 'open access' principles and according to individual need. People spoke highly of the convenience and accessibility of this service.

Good examples were seen of where the trust worked as advocates for people where changing needs had been identified. For example in supporting people with access to housing, employment and other benefits

Evidence was seen in some care plans of cultural needs having been assessed and discussed with the individual. Staff told us that they had received 'equality diversity and human rights' training. Staff had access to a translating and interpreting service where this was required.

How well do providers work together when people who use services during periods of transition?

The evidence seen showed us that people were well supported when and if they underwent a transition from one provider to another. For example we saw that people who used the day treatment centre had received an assessment for this service whilst they were on the acute admission ward in preparation for their discharge.

We saw evidence of close working between the various community teams. For example in identifying different community support mechanisms for people and carers. The records seen showed us that referrals to other services had been discussed with people prior to this taking place.

Adult community-based services

How does the provider act on and learn from concerns and complaints from people who use services and use this information to improve quality and plan services?

Staff were aware of the trust's complaints policy and confirmed that any complaints are addressed through the trust's complaint procedure as required. Staff told us that they welcomed any complaints that people may have as a way of developing local services. The records seen showed us that the adult mental health directorate had received six formal complaints between January 2014 and the date of the inspection. These were being addressed through the trust's complaint procedures. Senior staff told us that people were kept informed of the progress of any complaint made.

Complaints were recorded on the trust's incident system. Staff confirmed that complaints handling was part of the trust's 'customer care training'. They told us that local actions were taken to address any informal complaints in a prompt manner. For example if a person wanted to change their therapist or care co-ordinator this would be discussed within the team.

We saw a number of posters around the services visited seeking the views of people and referring them to the trust's patient's experience desk. Staff explained how they worked closer with independent advocacy services to try and support people. Some members of staff told us that they had advocated on behalf of people with housing and other welfare services issues.

Staff told us that people were kept informed of the progress of any complaint made and that an independent investigator would be appointed by the trust to ensure that the correct procedures were being followed.

Evidence of trust wide learning from complaints and incidents was demonstrated through the Trust's staff briefing emails, team meeting minutes and the 'RisQy business' bulletins. These included updates and 'key messages' for staff.

The evidence seen showed us that the trust was responsive to the concerns raised by the people who used their services.

Are adult community-based services well-led?

Is the governance framework coherent, complete, clear, well understood and functioning to support delivery of high quality care? How does the provider make sure that the organisations vision and culture for services is focused on good and effective care?

Evidence was seen of monthly senior managers' meetings within the adult mental health directorate. Senior staff confirmed that a number of items for example incidents, complaints and staff related matters were standard agenda items.

We saw good evidence of trust consultation with patients and staff. For example prior to the introduction of the Customer Recovery Outcome Score (CROS) recovery audit system, the trust had piloted three potential audit tools in order to evaluate their effectiveness.

We saw that the trust used people as peer workers. For example in the day treatment centre and this demonstrated a positive attitude to ensuring that people were well supported through their recovery.

Staff told us that they felt well supported by their line manager. Each member of staff spoken with told us that they received supervisions and appraisals as required. Staff attended weekly team meetings and where appropriate multi-disciplinary team meetings.

Some staff told us that they didn't feel listened to at the organisational level. This showed us that improvements were required by the trust to fully engage with staff in this service.

How are staff concerns dealt with; risks identified, managed and mitigated in a manner that ensures quality care and promotes innovation and learning; and what assurances are sought and provided?

Some staff told us that they felt that staff morale was quite low at this time and that they was a lack of visibility of senior trust leaders at front line services.

Staff told us that they were aware of the trust's whistleblowing policy and that they felt able to report incidents and raise concerns through this avenue.

Adult community-based services

Most staff told us that they felt well supported at a local team level. Although we identified some staff concerns about the variability of leadership across the different teams visited.

Some staff told us that they felt the trust's risk register did not reflect the potential risks to the organisation. This showed us that improvements were required by the trust in order to review the existing trust risk register in the light of these concerns.

Are there high levels of staff engagement; cooperation and integration; responsibility and accountability; and do HR practices reinforce the vision and values of the organisation?

The trust should be aware that some staff expressed concerns about the previous service reconfiguration about the imminent changes.

Some staff told us that they had been well supported by the trust following periods of ill health and enabled to return to work. For example in a different role if required.

Newly recruited staff told us that they had received induction to the trust and to their specific service'. We saw that staff engaged well with people using services at a local level. They felt that they were doing the best they could for people. They told us that they felt that people got a 'good service'.

Specialist eating disorder services

Information about the service

Portsmouth Eating Disorder Service provides a range of interventions for people over 17 with an eating disorder who are registered with a Portsmouth GP.

The trust provided this as part of their mental health services. We reviewed and inspected the services being provided from Kingston Crescent, Portsmouth.

We examined six care records and spoke with clinicians over the course of the inspection. We attended a group session with five people who used the service to ask for their feedback on their experience.

We also used information provided by the trust and information we requested, which included some trust policies and other information.

Summary of findings

There were systems and processes in place to ensure the safety of people using the service and staff. Some improvements were required.

The service had not always ensured full risk assessments had been completed upon initial admission to the service. The evidence seen showed us improvements were required to demonstrate fully the services reviewed understood and managed the risk to people who used this service.

People who used the service reported feeling safe and understood the approach used by staff. They told us staff were caring and responsive to their needs.

In feedback reports, from people who used the service, staff were described as caring, helpful and supportive. Staff told us there had been no formal complaints and if an individual raised any concern it would be dealt with as part of their therapeutic intervention and recorded in their clinical record.

There were sufficient transfer arrangements for young people coming in to the service. For example we looked records for a young person who was in the process of transferring and saw there was communication between both services. There was poor communication between adult mental health and this service. For example the electronic system did not show the involvement of the eating disorder service for a person open to adult mental health services.

The record keeping required improvement, we found the care records did not contain all relevant information which staff retained; there was discrepancy between what was recorded on the electronic system and what was in the paper record.

Staff could not show us a record of when the equipment had been checked and calibrated and there was no label on the equipment to show when it was last calibrated, for example a weighing scales. There were labels to show when the equipment had been tested for electrical safety. We later received assurance from the trust the equipment had been calibrated. Improvement was required in local systems to monitor this.

Specialist eating disorder services

There were effective processes in place for appraisal of staff and regular supervision to ensure safe and effective provision of care. Staff we spoke with told us they felt well supported by their manager and could raise any concerns they had and these would be addressed.

Some improvements were required to ensure safe record keeping which identified risk, care planning and in recording communication with other services. Improvement was required in the local monitoring of equipment checks.

Are specialist eating disorders services safe?

How well does the provider learn from incidents and improve standards of safety for people who use services?

We saw minutes from a team meeting in this service where the Solent quality and standards lead attended and gave an overview of learning from incidents. Staff told us there were very few incident in the eating disorder service. The main themes identified trust wide were: communication breakdown between services, risk management, clinical standards not met and lack of family involvement.

Are behaviours, processes and systems reliable, safe and proportionate for people who use services?

We were told incidents were reported through to the risk department using an electronic system; from this system any incidents requiring external notification were reported. The trust wide evidence provided showed us the trust was reporting concerns through the National Reporting and Learning System (NRLS). There had been no incidents reported in the eating disorder service.

There was no local record of monitoring the environment or equipment such as calibration of weighing scales, although we received trust assurance equipment was calibrated. We saw a label for electrical testing on equipment. Improvement was required in local monitoring systems for equipment and environment.

Staff we spoke with said they could raise any concerns with their manager and said they felt the concerns would be addressed. They all said their manager was approachable and kept them informed. They told us they were aware of the trust's whistleblowing policy and their responsibilities in relation to reporting concerns. Some staff were not aware they could also contact the Care Quality Commission directly with any concerns.

We were told about the arrangements for the imminent transfer of this service to another provider and were assured by senior managers this transfer would have minimal impact on the people who used the service and the staff. We were told the service was to be transferred with no change from its current service provision. Most staff were to be transferred to the new provider. Staff had been

spoken with as a group with the opportunity to have individual meetings if needed. The people who used the service had all been informed. People we spoke with confirmed this.

How do services understand and manage risk to the person using services and others with whom they may live?

In the records we reviewed there was no formal risk assessment or risk documentation. There was no evidence of ongoing risk assessment other than in the day to day narrative and in correspondence. Not all information from the paper record had been input to the electronic system. This meant for people open to adult mental health services, adult mental health staff would not be aware of the level of risk or plans in place which had been put in place by the eating disorder service.

In one record we saw there was a plan in place for if the person BMI (Basic Metabolic Index) fell below a safe level. The paper records were not organised in a way which made it clear to staff outside of the service what was happening.

There was evidence to show the person's involvement in decisions about their care. Staff told us a person's family were not routinely involved but the person could request this at any time. People we spoke with said they were aware family could be involved and told us there had been family days set up for family to meet with staff. One person said, "I think staff would see my boyfriend if I wanted them to."

Staff told us there was team discussion about caseload and we saw minutes from the weekly team meeting where any clinical concern could be discussed and advice sought. This included risk level of people seen by the team.

How does the provider ensure that staffing levels and quality of staffing enables safe practice?

Staff we spoke with told us there was sufficient staff for the service provided. The team consisted of a clinical consultant psychologist, clinical psychologist, psychotherapist, psychology assistant and a therapy assistant. There was administrative support provided to the team. The active caseload was 40 people being seen by the service at the time of our inspection. It was not clear how staffing had been determined.

Are specialist eating disorders services effective?

(for example, treatment is effective)

Can the provider demonstrate that nationally/ internationally recognised clinical guidelines and standards, other recognised guidance and standards and current recognised best practice are used to deliver care and treatment that meets the needs of people who use services and delivers positive outcomes?

From the evidence reviewed, discussions with managers and front line staff, we saw the trust was able to demonstrate people who used this service received care and treatment in line with the current best practice guidance.

There was a Trust audit programme in place to audit against NICE (National Institute for Health and Care Excellence) standards. The annual report produced by the eating disorder service (2012/13) showed interventions provided according to NICE guidance for people with eating disorders. Staff described to us what NICE guidance for eating disorders contained and reported they provided these interventions. For example staff were trained in Cognitive Behavioural Therapy (Enhanced) (CBTE) which is supported by NICE guidance.

Can the provider demonstrate collaborative multi-disciplinary working across all services and in partnership with other providers, support networks and organisations?

The team consisted solely of psychology staff. Staff we spoke with told us they would work with staff in other services during transition in or out of the service. We had attended a review meeting in Child and Adolescent mental health Services (CAMHS) where transition to the eating disorder service was discussed. Records showed communication with the person's GP but did not always show communication with adult mental health services. We were told a dietician visited the team weekly to provide advice and input to people who used the service, and to anyone with an eating disorder on an adult mental health ward.

Specialist eating disorder services

How is the quality of care measured and managed in a manner to deliver the best outcomes for people?

The annual report produced by the eating disorder team showed analysis of the outcome measures used in the service, plus analysis of number and type of referrals. Questionnaires were used to obtain feedback from people on what they found most helpful or what could be improved. The report detailed what was done to accommodate suggestions on improvements. For example arranging a workshop for people about a specific eating disorder.

Do people who use services receive treatment and care from suitably qualified and competent staff, supported in their role and service delivery?

Staff gave us examples of trust wide training undertaken. For example, mandatory safeguarding training for children and adults, health and safety, equality and diversity training had been received.

All staff reported they had specific training to meet their role. For example staff had received training in CBTE, and had attended relevant conferences during the year.

Are specialist eating disorders services caring?

Do people who use services have choice in decisions affecting their care and support and are enabled to participate at each level?

People we spoke with told us staff discussed with them what would happen. One person said, "They challenge you even though you may hate it. They care and support us."

Another said, "We receive letters explaining our targets and include what was discussed at sessions." People told us they discuss their targets and agree them with staff.

Do people who use services participate, in a review of their needs and preferences when their circumstances change?

The records showed care was responsive to individual need. People told us they were involved in reviewing progress. One person told us they were seen earlier than planned and was offered extra time when they needed it.

Do staff develop trusting relationships and communicate effectively so that people who use services understand what is happening to them and why?

People told us they were involved in planning their care and staff explained to them what was available. They said they understood the approach used by staff and staff encouraged them to be independent.

Do people who use services receive the support they need?

People told us they were supported by staff and staff were flexible in agreeing what they needed and when.

Staff told us they work hard to prevent admissions because there were no specialist eating disorder inpatient beds in Portsmouth so people would need to travel out of area if they needed admission.

Is the privacy and dignity of people who use services respected?

We did not observe direct care but staff we spoke with talked respectfully about people who used the service.

Are specialist eating disorders services responsive to people's needs?

(for example, to feedback?)

How are the individual needs of people who use services met at each stage of their care?

The care plan records we saw showed people were involved in their care. People told us they were involved in discussion about their care and staff were flexible in meeting their needs.

The team provided an integrated treatment programme to help people improve or maintain their psychological and physical help, strengthen healthy eating and reduce the impact of the eating disorder on their daily life. We saw the information given to people about this service and saw people were helped with their eating at a meal time.

One person said, "I was offered extra time and had a very detailed assessment."

How well do providers work together when people who use services during periods of transition?

Staff told us there was a transition protocol in place for people coming in to the service from CAMHS and Talking Change. People told us they were made to feel welcome

during their first appointment. Records did not always show communication between adult mental health services and the eating disorder service. Improvement was required in the recording of transition arrangements and communication between services.

How does the provider act on and learn from concerns and complaints from people who use services and use this information to improve quality and plan services?

There was a trust complaints policy in place. The manager told us there were very few formal complaints. Staff told us they would address any concerns raised with the person as part of their therapeutic intervention. People told us they could raise any concerns they had with staff.

Are specialist eating disorders services well-led?

Is the governance framework coherent, complete, clear, well understood and functioning to support delivery of high quality care? How does the provider make sure that the organisations vision and culture for services is focused on good and effective care?

All staff we spoke with told us they had received an annual appraisal and received regular clinical and managerial supervision. The team manager told us they received managerial supervision from within the trust and clinical supervision externally when required.

All staff said they felt well led by their manager. Improvement was required in how the trust values were incorporated into the team culture and how the eating disorder service was involved in the wider trust agenda.

How are staff concerns dealt with; risks identified ,managed and mitigated in a manner that ensures quality care and promotes innovation and learning; and what assurances are sought and provided?

Staff we spoke with told us they could raise any concerns with their manager and they would listen to them and address the concerns. They also told us they would escalate any concerns if they felt anything was not being addressed.

Are there high levels of staff engagement; cooperation and integration; responsibility and accountability; and do HR practices reinforce the vision and values of the organisation?

There was a strong emphasis on promoting staff well-being within the team and we saw staff were respectful and supportive of each other. The service was in the process of transferring to a new provider and HR policy had been followed in the transfer of the staff to the new provider.

Other specialist services

Information about the service

The Kite Unit is a neuro-psychiatric rehabilitation service for people with a brain injury. The unit which opened in 2013 provides neurological rehabilitation for people with cognitive impairment and additional psychiatric needs. It provides treatment and intensive support but does not facilitate crisis/emergency admission.The unit has eight beds, all of which were occupied on the day of our visit. The unit admitted both male and female patients, although only male patients were present during our visit. Two patients were detained under the Mental Health Act during our visit and further patients had recently had their detention removed.

Summary of findings

Overall we found that the service was safe but improvements are required in respect of the environment and the risks that this poses to patients, and particularly female patients. Staff were aware of their responsibility to report incidents and safeguard patients. Incidents were reported and learnt from. There were sufficient staff to provide for people's care needs. We judged that the lack of gender separation on the Kite Unit was not safe and was in breach of Department of Health guidelines and Mental Health Act code of practice. We also found numerous ligature points on the Kite Unit and were concerned that the unit building was not conducive to safe mitigation of the risks associated with these.

People's care took account of clinical guidance and best practice. We saw adherence to the requirements of the Mental Health Act however some improvement is required to deliver care in line with the Code of Practice. The quality of care delivered was monitored through audits, surveys and people's feedback. Staff received a good level of training.

People were provided with choices about their care and took part in reviews. Where people lacked the capacity to make specific decisions, their capacity had been assessed and best interest decisions made. We observed very positive interaction between staff and patients.

Care was tailored to people's individual needs. The complaints policy was readily available to people. Advocacy was proactively promoted at the service.

Staff had an understanding of the governance procedures and processes in place for risks to be identified and managed. Staff felt well supported by their team managers. Staff received regular supervision and an annual appraisal.

Other specialist services

Are other specialist services safe?

Learn from incidents and improve standards of safety for people who use services

Staff confirmed that the trust had an on-line reporting system to report and record incidents and near misses. The trust wide evidence provided showed us that the trust was reporting concerns through the National Reporting and Learning System (NRLS). The levels of reporting were within expectations for a trust of this size.

We spoke with staff who told us about the electronic incident reporting system and their role and responsibilities to report incidents which impacted upon people's safety. Staff told us that they were comfortable reporting incidents and felt that their concerns would be responded to and confirmed that they were well supported by their line manager following any safety incidents.

We reviewed incidents that had been reported and staff told us there was a high level of reporting of incidents. Staff told us that reflection and learning from incidents took place within team and directorate meetings, and that debrief sessions would be used where appropriate. We reviewed team meeting minutes and saw discussion about incidents, and actions undertaken in response to these.

The trust's serious incident data showed us that trust wide learning from 'Serious Incidents that Required Investigation' (SIRI) had been reviewed and disseminated throughout the trust. Staff confirmed this and reported that the lessons learnt from these incidents had been discussed within their specific team and disseminated through the trust. The evidence seen showed us that the trust had embedded learning from incidents within the organisation.

Systems were in place to review incidents and near misses. This included the monthly 'quality and risk report'. This included information on complaints, incidents, feedback from the patients' experience and feedback about staff experience.

The evidence seen during our inspection demonstrated to us that the service had a process in place to learn from any incidents that had happened. We saw that trust wide learning from these had been recorded and disseminated.

Are behaviours, processes and systems reliable, safe and proportionate for people who use services

We found the Kite Unit to be clean, nicely decorated and well maintained. Staff reported that any maintenance issues where attended to appropriately. Due to the physical difficulties experienced by some patients with an acquired brain injury the ward has been fitted with a range of disability aids and facilities. The ward was physically designed to enable wheelchair users' access to all areas and the kitchen was equipped with aids for people with mobility and stability problems. Due to this we found that the unit contained many fittings that could be used as a potential ligature point. Staff confirmed that these had been highlighted in an audit undertaken in November 2011 but considered as a low risk. Staff told us that no one would be admitted to the unit if they had a recent history of self-harm and that they manage any risks through appropriate staffing, robust risk assessment and locking off rooms where required.

While there have been no significant safety incidents on the ward we did note that some patients had a history of self-harm behaviour. In addition during our visit the staff were not immediately able to find a tool used to cut ligatures should an incident of this nature occur. We also found that the layout of the unit does not facilitate easy observation of patients as the bedroom corridor and activities corridor are discreet from the nursing offices.

The unit provides treatment for both male and female patients. We found that the layout of the unit does not provide separate bedroom and bathroom facilities for men and women as required by the Mental Health Code of Practice and Department of Health guidance. Although there were no females on the ward at the time of our visit, there was evidence that there had been instances when female patients had forgotten to lock the bathroom door and male patients had entered. We also noted a number of incidents were patients had been sexually disinhibited, sexually inappropriate or entered other people rooms. Staff told us that they manage this risk by placing male and female patients at either end of the bedroom corridor and through staffing. We noted that there is not a specific risk assessment policy or tool for the safe management of men and women sharing this unit. We judged that the lack of gender separation on the Kite Unit was not safe and was in breach of Department of Health guidelines and Mental Health Act code of practice.

Other specialist services

We noted that the trust had recently distributed a safeguarding vulnerable adults' handbook to staff. This generic handbook also included a specific reminder of the trust's safeguarding procedures and local contact numbers. This meant that staff had been given the required guidance in order to support them to raise concerns when these were identified. The trust had identified safeguarding vulnerable adults and safeguarding children leads and staff told us that they were aware of their roles within the trust. Staff were aware of the trust's safeguarding and other polices. They told us that they knew how to raise any safeguarding concerns.

Staff were aware of the trust's whistleblowing policy and confirmed that they felt able to raise concerns with their direct line manager. Staff told us they felt listened to and this included issues as well as ideas for improvement. Staff were also aware of how to raise concerns outside of their direct management line should this be needed.

We noted that staff were aware of the risks associated with their specific role and they were aware of the expectations of their role. Evidence was seen of staff taking proactive risk management strategies. This was particularly evident in relation to leave planning.

Medicines were handled safely within the Kite Unit. All medicines were stored safely and prescriptions were reviewed in a timely manner by pharmacy staff. People were allowed to self-administer their medicines where appropriate on a risk-assessed basis. Medicines incidents were reviewed and learning from those incidents was disseminated. However information about individual people's medicines was not always updated in a timely manner.

The main door to the unit was locked throughout our visit but we did not find evidence of restrictive practices. Risk assessments in relation to the locked door policy were visible on the ward. Most informal patients told us that they were able to leave the ward when required. Although no Deprivation of Liberty Safeguards (DOLS) application had been made, staff demonstrated that they were aware of the process for making an application and considered whether there was a possible deprivation of liberty when informal incapacitated patients tried to leave the ward. Capacity assessments were being completed on admission and were regularly reviewed although they did not always include patients' own views.

Understand and manage risk to the person using services and others with whom they may live with

We saw evidence that when people were admitted to the unit their needs had been assessed and they had received a multi-disciplinary team assessment. There is a specific policy for managing risk for people with a learning disability or acquired brain injury which was reviewed following the creation of the Kite Unit in 2013. There was an admission checklist for people which covered – physical observations, advance directives, venous thromboembolism assessment, mental capacity assessment to agree to admission, whether the person had a social worker or if a referral was required, Mental Health Act (MHA) adherance, risk assessments completed, falls care pathway and tissue viability.

Staff told us that the unit does not take people in crisis and that admission was always planned. Once a referral was received a risk assessment was completed for the person. We noted that there is not a specific risk assessment policy or tool for the safe management of men and women sharing this unit. Otherwise risk assessments were comprehensive, regularly reviewed and aligned to people's care plans. Physical assessments were undertaken as required and recorded in detail in care plans, including healthcare needs specific to individuals.

Staffing levels and quality of staffing enables safe practice

There was an agreed staffing level for the unit and we were told that the staffing levels were adjusted to reflect the changing dependency needs of patients. Staffing levels on Kite were observed to be good with a skills mix in place to meet the complex needs of the patient group, including the needs of patients with a learning disability. The staff team also includes medical staff from neurology and psychiatry, occupational therapy, behavioural therapy, psychology, speech and language therapy and physiotherapy. While there is a process in place to bring in extra staff if required we were told that there is limited use of agency staff at the unit and this was confirmed by records reviewed.

Other specialist services

Are other specialist services effective? (for example, treatment is effective)

Evidence-based clinical guidance, standards and best practice

From the evidence inspected and discussions with managers and unit staff, we saw the trust was able to demonstrate that people who used this service received care and treatment in line with the current best clinical practice guidance. However we found that compliance with the Mental Health Act Code of Practice requires some improvement. This includes meeting guidance in respect of gender separation and clearer recording of patient's capacity, consent and the authority to treat.

Currently the Kite Unit does not participate in an accreditation scheme with external bodies such as the Royal College of Psychiatry.

Staff showed us that they were aware of national guidance, policies, enquiries and clinical guidance. We saw care plans, risk assessments and policies that referenced NICE (National Institute for Health and Care Excellence) and other relevant clinical guidelines.

The Solent quality cycle was known to most staff that we spoke with and was available in those clinical areas visited. This showed us how the trust monitored and reviewed their existing quality systems. We also saw a physical and mental health 'wheel' being used in the areas we inspected. Staff were aware of this and said they helped them ensure that all needs of people were addressed.

Demonstrate collaborative multi-disciplinary working across all services

The Kite Unit is part of the adult services directorate however the staff demonstrated their close working with colleagues in the adult mental health directorate. We also saw examples of effective collaborative working with staff in the learning disability community team and those employed by other providers and the local authority.

We spoke with the local advocacy service during this inspection. The advocacy lead spoke highly of the cooperation experienced with the Kite Unit team and stated that staff were pro-active about making advocacy referrals.

A Mental Health Act assessment took place on Kite unit while we were there and we met with the approved mental health professional (AMHP) and the section 12 approved doctor. We were told that there were effective lines of communication between the ward and the AMHP service.

Quality of care measured and managed

Clinical audits and other reporting mechanisms were in place. This was reported via the adult services directorate's monthly 'quality and clinical risks' reports to the assurance committee and to the trust board. Measures considered include incidents, complaints, patient experience, medication compliance, falls and PLACE (patient led assessments of the care environment) outcomes.

Feedback systems were in place for people using the service through weekly ward community meetings, active involvement of advocates, and pro-active involvement of patient's families and carers.

Suitably qualified and competent staff

Staffing at the Kite Unit includes a skills mix designed to meet the complex needs of the patient group, including the needs of patients with a learning disability. The ward is managed by a unit manager, a ward manager and a clinical nurse specialist, who respectively come from a neurology, mental health and learning disability nursing background. This is also reflected within the wider nursing team. The staff team also includes medical staff from both neurology and psychiatry, as well as occupational therapy, psychology, speech and language therapy and physiotherapy.

Staff confirmed that they are provided with a wide range of mandatory and specialist training to undertake their role. We saw that staff were required to complete a range of mandatory training. This included hand hygiene, equality, diversity and human rights. In addition to health and safety, infection control, information governance, MCA, MHA, moving and handling, safeguarding of adults and resuscitation. We saw evidence that staff had attended additional relevant training. However some staff told us that they had not undertaken specific risk management training.

Clinical staff all reported that they received regular supervision and an annual appraisal of their work. Staff told us that they were supported to undertake further professional qualifications.

Other specialist services

Are other specialist services caring?

Is there choice and are people enabled to participate

We met with the majority of the patients on the unit at the time of our visit. People we spoke with felt that they were involved with their care and informed about their treatment. Most people we spoke with described their care as excellent, and said that staff were caring and made time for them. We also spoke to patient's relatives who also spoke very highly of the service and confirmed that they were engaged in planning for their loved ones' care where appropriate.

We received some positive comments from people who told us that staff were "extremely supportive" and took "time to explain". One person told us that the team had brought him "back from the dead".

The unit has a range of information available for people about the running of the ward, the trust's services, advocacy and making complaints. These are available in a range of formats including 'easy read' documents.

We looked at care plan documents and found they were holistic and individualised. We found evidence of people's involvement in care planning and we observed staff actively encouraging participation with a group of people who are not always easily engaged in their care. The majority of patients we spoke with told us they had copies of their care plan and understood what the team needed to do to support them.

There are regular community meetings on the ward, which are recorded, and we saw examples of advocacy being used pro-actively.

Although no Deprivation of Liberty Safeguards (DOLS) application had been made, staff demonstrated that they were aware of the process for making an application and considered whether there was a possible deprivation of liberty when informal incapacitated patients tried to leave the ward. Capacity assessments were being completed on admission and were regularly reviewed although they did not always include patients' own views.

Staff communicate effectively

Patients and carers we spoke with stated that staff communicate effectively with them. Patients told us that staff "take time out to talk to me" and that staff "talk to me until I understand". We observed very positive relationships between patients and their named workers.

We found that staff at the unit communicate effectively with colleagues within the wider trust and in external bodies as relevant.

People receive the support they need

People`s needs were assessed and care was delivered in line with their individual care plan. Records showed that risks to mental and physical health were identified and managed. Observation, physical monitoring and goals were agreed according to individual need. Staff and patients told us that care plans were regularly reviewed with individuals. People who use the service were offered a range of activities and treatment options on the unit.

We spoke with staff at the unit about the care needs of individual people. Interaction between staff and people on the unit was good. Staff gave explanations and reassurance to people. Staff knew people well and they were able to describe individual support that people needed.

Privacy and dignity respected

Patients told us they felt staff treated them with respect, even when there were restrictions in place. One patient we spoke with told us that staff were always respectful and would make sure when he spoke with them that this was done in private. We found records of situations where patient's dignity may have been compromised but these appear to have been well managed by staff in most instances.

The unit provides treatment for both male and female patients. We found that the layout of the unit does not provide separate bedroom and bathroom facilities for men and women as required by the Mental Health Code of Practice and Department of Health guidance. Although there were no females on the ward at the time of our visit, there was evidence that there had been instances when female patients had forgotten to lock the bathroom door and male patients had entered. We also noted a number of incidents were patients had been sexually disinhibited, sexually inappropriate or entered other people rooms.

Patients and staff told that the use of restraint is minimised and there have been few incidents at the unit that have

required physical intervention. The manager told us that all staff were trained in the use of physical intervention. We saw training records which showed that staff were up to date with their training.

Seclusion is not practiced at the unit. Staff told us that in the event a person needed this level of intervention they would be moved to an adult mental health unit. Staff stated that in the interim they would manage the person's challenging behaviour by clearing bedrooms and communal areas of objects that pose a risk, whenever the need arises.

Are other specialist services responsive to people's needs?
(for example, to feedback?)

Individual needs met
Patients were involved in the planning of their care. Patients told us that they felt involved in their care planning and a number had copies of their care plans. Ward rounds occur weekly and patients and their carers' are encouraged to actively participate. We observed staff encouraging patients to consider their care goals and make individual choices.

Arrangements for admission and discharge were discussed and planned with other care providers. Appropriate information was shared in order to agree the treatment plan. There were regular care planning meetings which included attendance from other professionals to discuss the person`s treatment, progress and discharge planning.

The unit has access to a wide multi-disciplinary team including medical staff from both neurology and psychiatry, as well as occupational therapy, psychology, speech and language therapy and physiotherapy. Patients told us that their treatment needs are met and that they have access to a wide range of activities.

Patients told us that their religious, spiritual and cultural needs are met and respected by staff. The unit is designed to meet the mobility needs of people with a physical disability.

We found that the environment does not promote the safety, privacy or dignity of female patients.

Providers work together during periods of transition
The Kite Unit is part of the adult services directorate however the staff demonstrated their close working with colleagues in the adult mental health directorate. We also saw examples of effective collaborative working with staff in the learning disability community team and those employed by other providers and the local authority.

A Mental Health Act assessment took place on Kite unit while we were there and we met with the approved mental health professional (AMHP) and the section 12 approved doctor. We were told that there were effective lines of communication between the ward and the AMHP service.

Arrangements for admission and discharge were discussed and planned with other care providers. Appropriate information was shared in order to agree the treatment plan. There were regular care planning meetings which included attendance from other professionals to discuss the person`s treatment, progress and discharge planning.

Provider act on and learn from concerns and complaints
A system was in place to learn from any complaints made. Information about the complaints process was clearly displayed around the unit. The Patient Advice and Liaison Service (PALS) is in place to ensure early learning from complaints and to support patients in making their complaints. Patients told us that they knew how to make a complaint and felt able to do so if they needed to. Two patients told us that they had raised their concerns with the unit manager and that these had been acted upon. Staff knew the process for receiving complaints and told us that learning took place in their staff meetings. The numbers of complaints and their outcomes are reported to the assurance committee and the board through the 'quality and clinical risks' report.

Are other specialist services well-led?

The governance framework is coherent, complete, clear, well understood and functioning
The objectives and values of the organisation were explicit within the 'Solent Wheel.' We found that staff were aware of the wheel. We spoke with the Health and Social Care Partnership lead who told us that the organisations visions and values were embedded at all levels of the organisation

and that staff individual objectives were cross referenced to the trust's strategic objectives. We spoke with staff who confirmed this. Staff understood the organisations operational objectives.

The Health and Social Care Partnership lead told us there were rigorous governance arrangements in place to monitor the quality of the service and risks to people and a high level of joint working with partners. We spoke with nurses and care workers at focus groups and they demonstrated that they were familiar with the governance structure and lines of accountability. We saw written evidence of the governance meetings and saw that safety alerts, incident reports, serious incidents requiring investigation (SIRI's) and quality improvement plans had been reviewed. Processes were in place to monitor the delivery of the service. We found that there were also local systems in place on to check care and safety. For example, medicines were checked weekly and Mental Health Act documentation is checked quarterly.

We found the staff had a good understanding of the trust's governance framework. Staff told us they regularly received information and described the systems to give feedback centrally on trust issues and how they received feedback. Staff told us that communication from the trust board came via newsletters, staff meetings, emails and handover. They said board members were seen frequently for a walk round and they could escalate issues as required. Staff told us there were regular surveys of people's experiences.

Staff concerns dealt with; risks identified, managed and mitigated

There was a positive and open culture within the team. Staff told us they felt well supported by their manager and the wider multi-disciplinary team. Debrief sessions were provided following any incident on the unit. There was a regular nurses meeting, during which they also held teaching sessions.

Staff told us they felt able to report incidents and raise concerns and that they would be listened to. The manager told us that they felt senior managers in the trust listened to concerns that they raised and acted on these.

Staff were able to describe the processes whereby risks were captured using the incident reporting system. Incidents were then discussed at ward meetings and the risk manager might request further information. There were monthly risk link meetings where feedback on incidents was provided from the risk manager and for sharing resulting in changes to practice. Staff told us they were aware of how to escalate issues and that they were encouraged to speak up. Consultants told us they had regular one to ones with the Clinical Director and attended risk panel meetings.

The Health and Social Care Partnership lead told us there were weekly staff meetings to cascade information to staff. Staff told us that they attended risk meetings. We saw that the trust had a newsletter that was used to communicate information to staff on risk, infection prevention and control, safeguarding and quality. We saw evidence that a patient safety survey was circulated to all staff in the trust. There were processes in place to capture and address risks.

Leadership within the organisation is effective, maintained and developed

Staff within the team told us that there was good local leadership and they felt well supported by senior nursing staff. Staff said that there was good professional line management. Consultants told us that senior management were visible and accessible. Staff felt supported by their line management.

Nurses and support workers at a focus group said that there could be issues accessing e-learning in relation to having the time to complete this. However, they reported that they were supported in their continuing professional development (CPD). Staff including support workers had been supported to undertake further qualifications. Staff told us that they did not find that the IT systems always supported them in their work. The Clinical Director informed us that the IT systems were under review. Overall, staff received appropriate support to undertake their role.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**The environment of Kite Unit does not provide adequate protection to people against the risks of receiving treatment that is inappropriate or unsafe and does not reflect the requirements of published expert guidance:** • There is not clear gender separation within bedroom and bathroom areas as required by the Mental Health Act Code of Practice and Department of Health Guidance. Regulation 9 (1) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**The Kite Unit is not of a suitable design and layout:** • There are areas of the ward that do not provide clear lines of sight to staff observing patients. • There are fixtures and fittings that pose a risk to patients who wish to self-harm that have not been reviewed, removed or mitigated. Regulation 15 (1) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Staff shortages were identified within the access to intervention and the intensive engagement community adult mental health teams.** • These shortages had an adverse impact on individual case load size and subsequently on direct patient care interventions. • Delays were identified in responding to some referrals received from General Practitioners (GP). This had led to the trust not meeting the agreed time scales for the completion of some community based assessments. Regulation 22