Care Quality Commission

Southern Health NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWI46	Trust Headquarters	South Hampton Community Mental Health Teams	SO40 2RZ

This report describes our judgement of the quality of care provided within this core service by Southern Health NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement 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.

Where applicable, we have reported on each core service provided by Southern Health NHS Foundation Trust and these are brought together to inform our overall judgement of Southern Health NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

- The adult community mental health services provided a range of mental health services for people in Southampton. Patients and carers had raised concerns that there was disjointed provision of crisis services across the area and some people waited a long time for an appointment with the community teams following a referral. The trust and local clinical commissioning group had identified that there were a number of key performance indicators of safety and quality. For example, the trust had benchmarked these indicators and found that there were higher than average complaints and serious incidents, which showed mental health services for people in Southampton were not being performing well.
- We had a number of continued concerns. These included inconsistent recording in care records in relation to risk assessment and plans, and a failure to follow up patients who did not attend appointments. These were all aspects of care that have been identified as key risk issues in a number of serious incidents that had occurred but had not been addressed, at the time of the inspection, by the trust. We also found that supervision structures were not consistently embedded across the teams and as a result, staff did not always manage their caseloads effectively or monitor the quality of record-keeping.

However,

- The area manager and team managers all demonstrated a good understanding of the challenges and risks within the service and were committed to continuing with the implementation of the improvement plan. Staff we met were reflective and supportive of the changes being implemented.
- The trust board recognised that significant work was required at Southampton in order to ensure safe and effective services were provided. As such, an improvement team had been put in place by the trust, which developed a plan of action to achieve a number of changes. Staff had been consulted on the improvement plan in July 2015 and the first phase of the improvement plan had been implemented in November 2015. The main components of the first phase had been implemented at the time of inspection:
- A redesigned community pathway had been introduced. The community teams were based across three hubs, central, east and west, delivering all functions of community mental health care, undertaking mental health assessments and, where allocation within the team was appropriate, a range of more specialist assessments and interventions.
- A redesigned crisis care pathway had been implemented. One 24 hour team had been established, to be available seven days a week to support people who were acutely unwell, and either work with people at home or arrange admission and discharge from hospital where indicated. There was a plan to increase the psychiatric liaison service at Southampton General hospital by March 2016.
- The plan included a focus on improving the pathway for people who were in hospital, ensuring people did not remain in hospital any longer than they need to and that local beds were available when people need admission
- The implementation of the improvement plan was being overseen by an area manager who was well respected by all staff we met. It was the first permanent area manager in post for two years. Most staff felt consulted and engaged with the improvement plan and felt it would improve services. While it was clear there were still a number of improvements to be made and changes to be evaluated and embedded, we saw how proposed improvements to the care pathway would reduce the experience of multiple transitions between different teams for patients and had improved communication and joint working between the teams. Weekly project meetings monitored actions.

Summary of findings

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

Are services safe?

- Staff did not always assess risks for individual patients well. They did not always record risks in care plans or update care plans to take account of changes in risk. Staff did not develop crisis plans for all patients.
- The trust had benchmarked performance indicators and found there was a higher than national average number of serious incidents. It was not clear how trust-wide learning was being implemented, particularly in relation to risk assessment processes and patients who `do not attend` appointments. For example, whilst the trust had identified through thematic review of incidents that improvements needed to be made in relation to risk assessment and management of patients who 'do not attend' appointments and these two topics were included in the Southampton improvement plan, at the time of our inspection it was not clear how these were being implemented.
- A new trust-wide process for recording, reporting and investigating deaths had been implemented from December 2015. Whilst the process was in place, the quality and detail of the incident reports and initial management reviews varied and did not always accurately represent the information available in the care records, which meant that appropriate and detailed information was not always available for decisions to be made as to whether further investigation might be needed.

However,

- Each team held daily meetings to discuss referrals and patients that may be presenting with increased support requirements or risks. The acute mental health team held daily telephone conferences with the community mental health teams to discuss patients on their caseload and potential transfers between the teams.

Are services effective?

- We found a variation in quality and detail of care records. Investigations undertaken by the trust into serious incidents had highlighted that poor recording had been noted in a number of serious incident investigations in Southampton and other parts of the trust. There were inconsistencies across teams in relation to where they recorded patient information on the electronic care record system. The teams informed us

Summary of findings

that they did not currently have a written standard of what was expected and where it should be recorded. The trust stated there was a standard operating procedure as well as quick reference guides, although they recognised that more work was required to standardise where on the electronic care system entries were required.

However,

- The teams facilitated health and wellbeing clinics and identified clinicians who focused on the physical health and wellbeing of patients. A range of psychological therapies and social support was available to patients. The acute mental health team was using crisis workbooks with people to help manage emotional distress.
- The acute mental health team had recently started to undertake the bed gatekeeping role and managed most admissions and discharges from the local in-patient unit.
- There was a specialist assertive outreach team to work with patients with severe and enduring complex mental health needs.
- The teams were multidisciplinary and included psychiatrists, nurses, psychologists, support workers, occupational therapists and social workers. All staff attended weekly team meetings.

Are services caring?

We did not assess this key question as part of this inspection

Are services responsive to people's needs?

- The teams had capacity and systems in place to respond to urgent and routine referrals within the community mental health teams and the acute mental health team. The service had established referral pathways and monitored the time from referral to appointment.
- There were systems in place for people to complain. The trust had recently implemented a change to this process to ensure all concerns and complaints were recorded on the Ulysses incident reporting system. It was too early to gauge how effective this would be.

However,

Summary of findings

- There was no clear process for actively engaging patients who did not attend their appointments, even within the acute mental health team who worked with people who were in crisis or acutely mentally unwell.

Are services well-led?

- All staff we met said that the major redesign of Southampton mental health services had been managed very effectively. Staff said they felt genuinely listened to and valued by their team managers and the area manager This was a real achievement given that all the staff in Southampton said that the previous redesign process four years previously had been very badly planned and managed, resulting in poor staff morale and a poor model of care.
- Overall staff morale was good and staff were positive about the potential benefits of the new model. The area manager and team managers all demonstrated a good understanding of the challenges and risks within the service and were committed to continuing with the implementation of the improvement plan. Staff we met were reflective and supportive of the changes being implemented.

Summary of findings

Information about the service

Southern Health NHS Foundation Trust's adult community mental health services provide a range of services for people in Southampton. Three community mental health teams (CMHTs) cover the east, central and west areas of the city. All referrals into services come to these three teams from Monday to Friday between 9am and 5pm. The trust passes urgent out-of-hours referrals to the 24-hour acute care mental health team. The acute care mental health team works with patients when they are most mentally unwell, or experiencing significant levels of emotional distress. The team supports people to stay at home if possible, through providing an intensive period of care. There are two practitioners providing crisis support at night in addition to the psychiatric liaison team at Southampton General Hospital which is available at weekends and evenings.

Southern Health NHS Foundation Trust's adult community mental health services provide a range of specialist services for people in Southampton as well as the community mental health services, including:

- early intervention in psychosis team
- assertive outreach team
- custody liaison and diversion team
- psychiatric liaison team at Southampton General Hospital
- rehabilitation services at Crowlin House and Forest Lodge.

Our inspection team

The inspection team was led by:

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

The team that inspected this core service comprised of an inspection manager, and two specialist advisors. A specialist advisor is someone who has specific expertise in relation to health services we visited.

Why we carried out this inspection

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

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

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

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

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

In addition, we wanted to check whether the trust had made the improvements that we had told it to make

Summary of findings

following the comprehensive inspection in October 2014 and the focussed inspection of the inpatient learning disability services at the Ridgeway Centre, High Wycombe and the forensic services, which we had carried out in August 2015. We had also received a number of complaints about some of the trust services, had contact from a number of whistle-blowers (people who expose activity or information of alleged wrong doing in a private or public organisation) and had identified the suicide rate was higher than expected in similar cities in the Southampton area.

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

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

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

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

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

Community mental health services in Southampton

During our inspection, we reviewed the community mental health pathway in Southampton. We visited the central and east community mental health teams and the acute mental health community team based at Antelope House.

This aspect of the inspection was to check on the progress of an improvement plan implemented in the Southampton community mental health services. The trust had identified that a number of key performance indicators of safety and quality were identifying issues of concern. For example, it had a higher than average number of complaints and serious incidents. This showed that community mental health services for people in Southampton were not performing well. The local clinical commissioning group had also raised concern about the quality of community mental health services across Southampton. In addition, patients and carers had raised concerns that there was disjointed provision of crisis services across the area and some people were waiting a long time to be seen by the community teams, following a referral. An improvement team had been put in place by the trust, which developed a plan of action to achieve a number of changes.

How we carried out this inspection

To fully understand the experience of people who use services, 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?

On this inspection, we focused on the progress of an improvement plan implemented in the Southampton community mental health services. However, as this was a focused inspection our emphasis was on following up on the improvement plan and on specific governance arrangements. As such, some key questions have received more focus than others.

During the inspection visit the inspection team:

- visited the Southampton acute mental health community team who work 24 hours a day, 7 days a week

Summary of findings

- visited two of the community mental health teams, the central team and the east team
- spoke with the team managers of each of the teams
- interviewed the area manager for Southampton community mental health services
- spoke with 20 staff members, including doctors, nurses, administrative staff, allied health professionals and support workers
- observed a handover meeting
- reviewed the serious incident tracking system
- reviewed 23 individual patient care and treatment records
- reviewed seven incident reports, initial management reports, and one full investigation report
- reviewed a range of documents related to the running of the service.

What people who use the provider's services say

We did not have the opportunity to speak with people who used the service as part of this inspection. We asked the teams to speak with their patients about whether they wanted to share their experiences with us and if they did share contact details with us. We did not receive any contacts.

Areas for improvement

Action the provider MUST take to improve

The trust must ensure that staff undertake risk assessments for all patients that use the service and that patients' care plans include the risks that have been identified and the actions required to manage these.

The trust must ensure that staff follow a consistent procedure for following up on patients who do not attend their appointments, especially those identified as posing a high risk of harm to themselves and/or to others.

Action the provider SHOULD take to improve

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

Southern Health NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Southampton Community Mental Health Teams	Trust Headquarters

Are services safe?

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

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

Our findings

Safe and clean environment

- Staff saw most patients at venues within the community, for example a café, or at the patient's home. The teams had recently moved into new bases. These were clean and had alarm systems in place. Staff had access to meeting rooms, although the east team had limited space to see patients on site and had submitted plans to gain more space. In the meantime, they were negotiating the use of additional facilities at GP surgeries and could also see patients at the central team building.

Safe staffing

- At the time of inspection, 9% of all staff posts across community mental health services were vacant. The sickness absence rate was 3.5%. The central team had the highest vacancies at four full time practitioners. However, at the time of the inspection, the area manager told us they had recruited new staff and expected them to be in post by April 2016. There was one full time practitioner post vacant in the acute mental health team.
- The size of caseloads varied depending on each clinician's working hours and commitments. However, most carried a caseload of between 25 and 40 patients. The east community team was still in the process of reviewing caseloads and some clinicians had more than 65 patients, some of whom were not receiving active treatment and review at the time of our inspection.
- Staff told us that they were able to access a psychiatrist and management support if required.

Assessing and managing risk to patients and staff

- We reviewed 22 care records. The risk assessments we looked at varied in detail and quality. Six patient records either had no risk assessment, or one that was not up-to-date. Staff were inconsistent in how they used the risk assessment field on the RIO electronic care record system. In the acute mental health team and psychiatric liaison teams in particular, it was common practice to put the risk assessment in a progress note only. This meant that a staff member who did not know the patient would have to search through the progress notes to find potentially important information about risk. This also meant that staff would not have access to a historical overview of risks or how these might affect the patient's current state of health. The trust confirmed that inconsistencies on where staff recorded certain information on RiO had been identified as a problem across the trust and a work stream had been established to identify and address the main issues.
- The trust was developing a 'borderline personality disorder pathway'. This was designed to provide support to patients who had been identified as high users of emergency services. The focus of the pathway was risk management and crisis planning. A weekly meeting to discuss and develop shared plans to assess and manage risks with patients who met these criteria had just been established at the time of our inspection.
- Each community mental health team had two members of staff allocated daily to `shared care`. The purpose was to provide additional support to patients identified as being at increased risk by their care co-ordinator. The shared care workers had protected time to undertake this role and would also work weekends and evenings to meet the needs of patients. The community mental health teams held shared care meetings each morning to discuss any patients who may require additional support, or who were felt to be at increased risk. All members of the team attended these meetings. The acute mental health team shift co-ordinator contacted the allocated shared care practitioner each morning for an update and discussion. The community mental health teams also had daily meetings at 2pm to discuss new referrals made to the team and any significant concerns. These were attended by the team manager, the psychiatrist and the staff member who was allocated to the role of 'shared care'.
- Each community mental health team allocated a duty manager daily, to whom serious concerns could be escalated. The community mental health teams operated a buddy system so that patients would continue to be supported in the event of annual leave or other absence.

Are services safe?

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

- The acute mental health team had three handover meetings a day, including a daily multidisciplinary one, which the medical staff and psychologist attended. The patient caseload was then allocated a risk rating using five different gradings dependent on risk. Not all patients were discussed with the multidisciplinary team on a daily basis, although each patient was discussed during the team handovers.

Track record on safety

- The trust had benchmarked Southampton adult mental health services and shared information which showed it had a higher than the national average of reported serious incidents. There were 110 incidents that required investigation by the trust during 2015. Forty-seven of these were patients who had died, 17 of those deaths were confirmed suicides. Southampton has a higher rate of suicide per head of population than the national average of comparative cities, although not all of the people who commit suicide have had any contact with mental health services. The trust was working with other agencies to develop a suicide prevention strategy for Southampton.
- As of 23 December 2015, there were 16 serious incidents open to Southampton mental health services. Healthcare providers have investigation times targets within which they are expected to complete investigations into serious incidents. Nine of the current investigations were overdue.

Reporting incidents and learning from when things go wrong

- The area manager had undertaken a review of serious incidents to help inform the improvement plan. Common themes from the serious incidents that had happened whilst patients were in receipt of care from the Southampton community mental health team included:

- multiple transitions between teams
- delay in accessing treatment
- lack of joined up working
- lack of risk assessment
- lack of support when leaving hospital
- lack of crisis planning
- poor management of patients who failed to attend appointments

- The improvement team met weekly to review actions, such as reducing the number of transitions a person might have to make between teams. In addition, the team monitored progress against key performance indicators such as themes from serious incidents. There was significant work to do to continue embedding learning and changes across the community mental health services in Southampton and also across the trust.
- All staff we spoke with knew about the Ulysses electronic incident reporting system and all staff could explain escalation processes to be used if they had concerns. One member of staff undertaking investigations had not yet received formal training but felt supported by the trust serious incident department. The area manager had identified that incidents were not always reported appropriately within the acute mental health team. The team have introduced a process where the senior practitioner or team manager would review whether there were any incidents that had not been reported following the daily multidisciplinary handover. We observed that this took place. We saw an example where a patient had brought a knife on to the premises at Antelope House and this had not been reported as an incident by the acute mental health team. The area manager had requested that this was reported retrospectively and investigated to ensure the team reflected fully on the incident and considered what could be learnt from the incident. However, when we reviewed the initial management assessment (IMA) report, this did not include all the relevant information about risks to staff, for example, a previous recent incident of threat with a knife. The purpose of the IMA was to assess whether there were any concerns about care, identify issues and risks and to determine if further investigation was required.
- We reviewed seven incident reports and IMA reports relating to recent serious incidents. Whilst we observed the updated process was in place, the quality and detail of the incident reports and IMAs varied. Three reports did not accurately represent all of the information available in the care records. This had the potential to influence the decision made whether or not to investigate further, although in these examples the decision to investigate further had been made correctly. We shared the three reports with the area manager who recognised our concerns.

Are services safe?

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

- The area manager informed us that a new head of nursing was due to take up post imminently for the Southampton area. The head of nursing would lead on complaints and incidents in order to have the complete overview, develop effective implementation systems, to take the lead on involving families and ensure there was learning from incidents across the teams. This would include implementing the learning networks. These networks would generate the topics for the new monthly learning hotspots bulletin so learning was driven from bottom to top of the organisation. Currently, incidents were discussed at team meetings and also at the weekly divisional meetings with the clinical director. We saw an example of the first learning hotspots bulletin, which gave an overview of key themes and learning from incidents throughout 2015.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- Patients were offered an assessment carried out by a clinician to understand their needs and agree a plan. The community mental health teams delivered all aspects of community mental health care, undertaking mental health assessments, and where allocation within the team was appropriate, a range of more specialist assessments and interventions.
- We found a wide variation in quality and detail of records. We saw some comprehensive and detailed records and assessments. However, we also saw six care records that had serious omissions. For example, where there were no care plans, risk summary or relapse management plan in place. There were inconsistencies across teams in relation to where they recorded patient information on the electronic care record system. The teams informed us that they did not currently have a written standard of what was expected and where it should be recorded. The trust stated there was a standard operating procedure as well as quick reference guides, although they recognised that more work was required to standardise where on the electronic care system entries were required. There was inconsistent practice of using the care plan and risk assessment field on the electronic care note system. There was a common practice to have both in a progress note only. Therefore, for a staff member to review and understand a care plan or risk issues, they would need to search the progress notes.
- From the care records we reviewed, it was not always clear what was the outcome of assessments, what were the agreed actions or the contact details of those involved in the care plan. For example, an individual on the acute mental health team caseload was noted to have suicidal plans for a specified date but the care record contained no clear plan to monitor this risk on the specified date. We saw some examples of records that had no record of recent contact with the patient. It was not possible to know if this was because the records had not been updated or if the patient had not been seen. For example, the acute mental health team had noted that they had been unable to make contact with an individual for three days, and at the point of inspection, there was no further information in the records (two days after the last failed attempt to contact the person), there was no plan of action in place. We asked the team managers to follow up on three people, because there had been no recent contact or follow up from failed contacts. The improvement plan, team managers and area manager all identified that care records was an area that still needed urgent focus to ensure consistency and effective records were kept. There was a trust wide care records work stream, although this was still in the process of assessing the key issues and developing strategies with the divisions to address and monitor this issue.

Best practice in treatment and care

- In line with National Institute for Health and Care Excellence (NICE) guidance, a range of psychological therapies and social support was available to patients. There was a specialised assertive outreach team to work with patients with severe and enduring complex mental health needs. In addition, a specialised early intervention team worked with young people aged between 14 and 35 years old at their first presentation of psychosis. The teams facilitated health and wellbeing clinics and identified clinicians who focused on the physical health and wellbeing of patients.
- The acute mental health team performed the bed gatekeeping role (to acute inpatient beds) and managed all admissions and discharges from the local inpatient unit, with the acute care transfer co-ordinator. The acute care transfer coordinator was a protected role dedicated to bed management and supporting the gatekeeping function. They monitored the progress of in-patients by visiting the wards daily. They used a risk rating system to highlight when patients may be ready for discharge. The acute care transfer coordinator kept a tracking spreadsheet to monitor bed usage and had daily telephone conferences with the other co-ordinators in the trust. Staff told us that they could usually access a bed when they needed one and that the use of out of area beds was rare, information provided by the trust reflected this.

Skilled staff to deliver care

- The teams were multidisciplinary and included psychiatrists, nurses, psychologists, support workers, occupational therapists and social workers. All staff attended weekly team meetings. Staff in all the teams

Are services effective?

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

we spoke with identified that communication across the teams had improved and that it was easier to transfer patients between the community mental health teams, shared care, acute mental health and the in-patient services. The community teams could access sessions facilitated by the ward for patients they felt would benefit. Staff were hopeful that once the improvement plan was embedded they could focus on increasing the therapeutic work they undertook. For example, they hoped to provide dialectical behavioural therapy sessions to help patients to manage emotional distress.

- Effective staff supervision was not consistently in place across the teams. New systems were being developed to ensure that staff were supported and that caseload management and performance was managed more effectively. However, all staff we spoke with felt well supported and received regular support from their managers or clinical team leaders. Staff also valued peer supervision and the recent reflective practice sessions that had been established. Development days had just been commenced and the teams had all been on `away` days to agree team values and actions. Staff who had been involved in serious incidents told us that they were well supported throughout the investigation process.

Are services caring?

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

Our findings

We did not assess this key question as part of this inspection.

Are services responsive to people's needs?

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

Our findings

Access and discharge

- The information provided by the trust for the central, east and west community mental health teams waiting times, showed that 75% of patients were seen within the agreed timelines for assessment. Information from the trust showed that 81 people across the three community mental health teams were still waiting for assessment seven weeks or over from referral. The teams had introduced assessment slots each week and the team managers reported this was more effective in managing the waiting lists and they were continuing to reduce the length of time people were waiting. The trust timelines standards for seeing new patients referred to the service were as follows:
- **Emergency** – within 24 hours, normally within four hours. This assessment was usually undertaken by the acute mental health team
- **Urgent** – Within 10 days
- **Routine** – within seven weeks

The frequent transfer of patients between teams had been highlighted as a causative factor in serious incidents. To address this, the teams were now able to transfer care between teams without the need for additional assessments. Whilst GPs referred most patients to the teams, the service also operated a rapid access referral system for patients who had received a service within the previous year. Patients could self-refer and get an appointment quickly. New referrals were discussed within the daily referrals meetings to identify how quickly an assessment needed to take place.

- The trust reported that it received approximately 400 referrals a month across the whole of the Southampton mental health service. There was a high `did not attend` rate for the Southampton services, recorded at 21% in the performance report ending November 2015. There was no clear process for following up on patients who did not attend their appointments, even within the acute mental health team. We found that teams appeared to rely on leaving telephone messages for patients who did not engage with the service or who were difficult to engage with, without clear plans for who to contact if they could not locate an individual. We reviewed three patients on the acute mental health team caseload who were rated red (or high) risk. One had stated a clear plan of intent to attempt to commit suicide and had not responded to contacts made by the team. The team had no clear plan of action in place. In one of the serious incident reports we reviewed, despite the patient`s risks being clearly documented in care records, there was no active attempt to contact them or their next of kin when they did not attend an arranged appointment. The Southampton learning hotspots bulletin highlighted poor management of patients who failed to attend appointments as a factor when looking at key themes and learning from all incidents. A task and finish group has been set up to review the `did not attend` policy, however, there were no clear plans to understand the extent of the issue and ensure action is taken to address and monitor within the services actually delivering the care. The trust informed us that following our feedback from this inspection, all patients who `did not attend` would be discussed in the multi-disciplinary team meetings. This was not in place at the time of inspection, therefore we cannot comment on the effectiveness of this system to improve awareness, response and management of risks to patients who `did not attend`.

Listening to and learning from concerns and complaints

- All staff were aware of supporting patients to raise concerns and complaints. Team managers had systems in place to monitor informal complaints. There were systems in place for people to complain. The trust had recently implemented a change to this process to ensure that staff recorded all concerns and complaints on the Ulysses incident reporting system. The Southampton community mental health service had received a higher than the trust average number of complaints prior to the improvement plan according to information from the trust. The improvement team were using complaints as part of their key performance indicators to monitor progress. It was too early to gauge the effectiveness of this development.

Are services well-led?

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

Our findings

Good governance

- The Southampton area community mental health teams had a dedicated performance manager who monitored the performance of the division, in relation to its commissioning for quality and innovation (CQUIN) objectives, as well as other local and national targets relating to the services. The trusts' new business intelligence tool (Tableau) has been installed and rolled out to clinical and corporate teams, this contained clinical, governance and staffing data. The area manager had undertaken local reviews of incidents and complaints and compiled clear, detailed reports outlining key issues.
- Meeting structures were in place to monitor safety and quality. For example, monthly integrated governance meetings where the range of performance and governance issues were discussed. We reviewed a sample of meeting minutes, safeguarding and performance reports. There was a service improvement action plan, which contained targets and clear indicators to monitor progress.
- We reviewed the local systems that were in place to track serious incidents, investigation processes and complaints. This was led by an administrative staff member who had a protected role to manage this and a clear understanding of the systems. The area manager informed us that a new head of nursing was due to take up post imminently in the Southampton mental health division and that they will lead on complaints and incidents, to have the complete overview, develop systems and to take the lead on involving families and learning from incidents. Team managers and the area manager recognised the importance of embedding an open reporting and learning culture in addition to effective risk management and incident investigation systems. They all recognised that there was still significant work required in this area as part of the wider trust improvements.

Leadership, morale and staff engagement

- All staff we met said that the major redesign of Southampton community services had been managed very effectively. Some staff were not happy to have left their previous teams and admitted that they were still adapting to the change. However, they said they felt genuinely listened to and valued by their team managers and the area manager. Team managers had weekly meetings with the area manager and were currently attending reflective practice sessions led by the psychology team to build on leadership skills and supporting teams through change. Overall staff morale was good and staff were positive about the potential benefits of the new model. Staff told us that the area manager was `inspirational`, approachable and highly visible. Staff were keen to reflect and continue implementing the improvement plan. This was seen as a real achievement given that all the staff in Southampton that we spoke with said that the previous redesign process, four years previously, had been very badly planned and managed, resulting in poor staff morale and a poor model of care.

The area manager was extremely positive during discussion and talked enthusiastically about improving processes and systems of the service for the benefit of patients. They acknowledged and responded openly and constructively to feedback from inspectors during inspection visit. It was clear that they would take a key role in making necessary changes to drive wider long-term improvement in the quality of service provision.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was not consistent use of risk assessment processes. Crisis plans were not used consistently. There was no clear process for following up on patients who did not attend their appointments, even when a person was identified as high risk of harm to themselves and/or others. This is a breach of regulation 12(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)