Southern Health NHS Foundation Trust

Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Good
Are services safe?	**Good**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Southern Health NHS Foundation Trust is one of the largest providers of mental health, specialist mental health, learning disabilities and community health services in the UK with an annual income of approximately £316 million.

The trust provides these services across Hampshire.

It employs 5,927 staff who work from over 200 sites, including community hospitals, health centres and inpatient units as well as delivering care in the community. The trust has 634 inpatient beds.

The trust received foundation status in April 2009 under the name Hampshire Partnership NHS Foundation Trust.

Southern Health NHS Foundation Trust was formed on 1 April 2011 following the merger of Hampshire Partnership NHS Foundation Trust and Hampshire Community Healthcare NHS Trust.

The trust has a well-publicised history of challenges and regulatory action, culminating in successful prosecutions by CQC and the Health and Safety Executive. The trust has taken action to address the issues that resulted in the prosecutions and have used these to learn and improve the services.

Overall summary

Our rating of this trust improved since our last inspection. We rated it as Good 

What this trust does

Southern Health NHS Foundation Trust provides community health, mental health and specialist mental health and learning disability services for people across the south of England.

Covering Hampshire, the trust is one of the largest providers of these types of services in the UK.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. In addition, we used our information to identify which core services to inspect on this inspection.

On this occasion we inspected four mental health core services:

- Acute wards for adults of working age and psychiatric intensive care units (PICU's)
- Child and adolescent mental health wards

Summary of findings

• Wards for older people with mental health problems

• Mental health crisis services and health based places of safety

Experts by experience (people who have experience of using services or caring for those who use services) and specialist advisors (senior practitioners with specialist knowledge and experience of working in the core services areas) were part of the inspection teams for each core service inspection and so helped us collect high quality evidence and make robust judgements.

We also looked at how well-led the trust was. In order to ensure we have appropriate expertise to make a robust judgement about how well-led the trust is our inspection team comprised an executive reviewer (a board level leader from another organisation rated good or outstanding), a specialist advisor with expertise in governance and a senior leader from NHSI/E with financial expertise as well as CQC inspection team members.

Our last comprehensive inspection of the core services was in May-July 2018, when we inspected all core services.

At this inspection (May/July 2018) we rated community health services as good overall and mental health services were rated as requires improvement. Overall, we rated the trust as requires improvement. Four mental health core services were rated as requires improvement.

Additionally, we undertook an unannounced, focussed inspection of Antelope House in January 2019 due to concerns identified from the information we had collected about the trust and information passed to us from patients, carers and others about staffing levels, assessment of patient risk, cleanliness of the ward environments, staff morale and the leadership of Antelope House. Following the inspection, we told the trust it must make improvements to:

Ensure that there were safe staffing levels on all wards and clinical areas, that staff had access to supervision, team meetings, appraisals and training, that prone restraint should only be used as a last resort, that all patients have a care plan that is person centred, that all wards have a dedicated female only room that male patients do not enter, that staff apply the Mental Capacity Act appropriately, that safeguarding concerns are raised with the local authority, that patients have access to psychological therapies, that patients can access section 17 leave, that patients can meet visitors in private, that medicines management is safe and records are stored securely and that that the trust has clear oversight of all risk issues.

At this most recent inspection we looked at whether improvements had been made.

In rating the trust, we took into account all the ratings from the previous inspection as well as the new ratings from this inspection.

What we found

Overall trust

Our rating of the trust improved. We rated it as good overall because:

- We found that the trust had a highly skilled, strong, stable and experienced senior team, including the chair and non-executive directors. Leaders had the skills, knowledge, integrity and experience to perform their roles and had a good understanding of the services they were responsible for delivering. They were visible in the service and approachable to patients and staff.
- There was a clear vision, underpinned by a set of values that were well understood by staff across the trust. We noted some really clear thoughts and developments around aligning with partners across the health and care economy to further develop services that put patients at the centre of care. The trust was taking a leading role in a number of the system wide developments and the chief executive was leading on progressing mental health services.

Summary of findings

- The leadership team had taken significant steps to improve the culture across the trust and this was paying dividends. Staff across the trust felt valued but there was a real focus on doing what was best for people, both staff, patients and carers and a real commitment to the delivery of good quality patient care at every level. Staff at all levels of the trust were proud to work there and morale amongst staff was good. Both the Council of Governors and the trade union representatives were very positive about how the trust leaders worked with them in an open and transparent way.
- Leaders ensured there were structures and robust systems of accountability for the performance of services. There was a clear focus on delivering high quality care whilst maintaining clear oversight of finances. Some positive work had been done with commissioners to identify the underfunding in mental health services and the trust was working with commissioners to address this in order to ensure the sustainability of services in the future.
- There were some positive developments around succession planning at senior level and thinking to the future in developing the 'rising stars'; including some really good work around equality and diversity to ensure the senior leaders of the future were representative of the population the trust served and the staff group.
- The leadership team had engaged proactively with a number of families who had previously not received the appropriate level of care, consideration and investigation into their loved one's deaths or poor experience of care (under a previous leadership regime). Each family worked with a senior member of the trust's leadership team of their choosing in a partnership arrangement. The trust partners included a member of the executive team and a deputy director of nursing as well as both medical and clinical directors. In late 2018, the trust sought the assistance of NHS Improvement to help address the outstanding concerns of five families which then commissioned an independent review undertaken by an experienced barrister. This report is due to be published in January 2020.
- All in the trust had worked hard to address most of the concerns we raised in the last inspection. Two out of the four services we inspected (acute wards for adults of working age and tier 4 child and adolescent mental health services (inpatients), which were previously rated as requires improvement, have been rated as good following this inspection. Two services (wards for older people with mental health problems and crisis and health based place of safety) remain requires improvement but several improvements have been made.
- Staff put patients at the centre of everything they did. Staff treated all patients with compassion, respect and kindness. The privacy and dignity of patients was maintained. Patients were supported by staff to understand and manage their care and treatment. Staff actively involved families and carers of patients in their care appropriately. For example, families were heavily involved in the development of Austen House, the new child and adolescent low secure inpatient unit.
- Services had enough medical and nursing staff to keep patients safe and meet their needs. Most teams in the organisation had access to a full range of specialists required to meet the needs of patients in their care. Care was planned and provided in a way that met the needs of local people and the communities the trust served. Staff met the needs of patients with a protected characteristic. Staff supported patients with communication, advocacy and cultural and spiritual support.
- The trust had made some really positive steps in implementing quality improvement work across the organisation. The pace of progression had been considerable even though it was still early days but staff at all levels were enthusiastic although there was still much to do to ensure quality improvement work was embedded in all areas. The trust had employed an expert by experience specifically to engage in engage in quality improvement projects. Their role was to ensure co-production at all levels. All the improvement initiatives involved patients and/or carers; there were 250 patient/carers involved in initiatives across the trust.
- The trust managed incidents well and investigated them thoroughly. Staff understood how to report them appropriately. Lessons were learned from incidents and shared with staff across the trust. The trust was also progressing some positive work around learning from deaths.

Summary of findings

- The trust treated concerns and complaints seriously. The organisation investigated concerns and complaints and shared lessons learned with staff. Patients were included in the investigation of their complaint.

However:

- The trust had not yet made all of the improvement that we identified needed to be made at the last inspection in older people and crisis services.

On wards for older people with mental health problems:

- Female patients did not always have a female-only designated area to use as the female-only lounges were accessed by male patients.
- Staff across the services had limited understanding about the use of Mental Capacity Act.
- Patients on five of the seven wards had limited access to a clinical psychologist and psychological therapies.

On crisis and health based place of safety suites:

- Due to recent changes in the way crisis services and health-based places of safety suites were managed both managers and staff of the services were unclear who the senior manager was who held responsibility for the service.
- Staff in the crisis teams did not consistently develop and record holistic, recovery-oriented care and crisis plans informed by a comprehensive assessment and in collaboration with families and carers.
- Senior leaders did not have assurance that the trust was meeting its legal obligation to ensure people did not stay in the health based places of safety longer than 24 hours or had an extension granted by an approved person because staff were not consistently completing the required hourly checks or recording information accurately.

In addition, we found:

- That the board, particularly the non-executive directors were not representative of the community Southern Health served or the staff group. This was known and high on the trust's agenda.
- In older people's services staff did not work in line with the trust policy on handling and disposal of healthcare waste.
- Patients on Beaulieu ward (older people's services) were unable to call for a nurse in the event of an emergency from their bedroom areas. Staff told us that call bells had been removed during refurbishment and had not been replaced by any other means for patients to call for help.

Are services safe?

Our rating of safe improved. We rated it as good because:

- Staffing levels across all services had improved. Staff were available to patients for one to one time. Although staffing issues where still a challenge the trust had a robust, ongoing recruitment and retention programme.
- Staff understood how to protect people who used services from abuse. Staff knew how to make a safeguarding referral.
- The trust had made improvements to minimise ligature risk through its ligature reduction programme. Significant work had been undertaken to reduce fixed ligature points since the last inspection.
- Staff across all services managed patient safety incidents well. Staff knew what to report and reported incidents when they needed to. Serious incidents were thoroughly investigated at a senior level and lessons were learned and shared across teams.

Summary of findings

- The majority of staff had regular supervision, annual appraisal, had completed mandatory training and could access specialist courses to enhance their knowledge and skills to support them in doing their job.

However:

- Staff on the older person's wards did not protect patients from infection control issues adequately when disposing of clinical waste.
- Female patients on the older person's wards did not always have access to a dedicated female-only day room. Male patients regularly used the female only day rooms and staff did not stop them.
- Patients on Beaulieu ward (older people's services) were unable to call for a nurse in the event of an emergency from their bedroom areas. Staff told us that call bells had been removed during refurbishment and had not been replaced by any other means for patients to call for help.

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- The application of the Mental Capacity Act was not robust in older peoples or crisis services. Staff did not always clearly document assessments of capacity and did not always have an acceptable understanding of the guiding principles and how these applied to the patients they cared for.
- The trust had not ensured that patients on the older person's wards all had access to a clinical psychologist or psychological therapies. Only two out of seven wards had psychological therapies available to patients. Nurses told us they had not been trained to deliver psychological therapies.
- The environments in the health-based place of safety suites did not always comply with the Mental Health Act code of practice. Not all suites had clocks and toilets did not have doors to maintain the privacy of people in the suites.
- Care planning was not always person centred or up-to-date on the older person's wards.

However:

- Staff across all services ensured that patients had good access to physical healthcare.
- Staff across all services worked well together to ensure that there was effective clinical handover of information.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. The privacy and dignity of patients was respected and embedded in the work of staff. Staff understood the individual needs of patients. Patients were supported by staff to understand and manage their care, treatment or condition. Staff put patients at the centre of everything they did.
- Staff involved patients in decisions about their care and treatment. Patients were involved in care planning and risk assessment. Managers and staff sought patient feedback on the quality of care received. Patients had access to advocates.
- Staff kept families and carers appropriately updated and involved in the care their family members received. Patients were supported by staff to understand and manage their care and treatment.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

Summary of findings

- The trust planned and provided care in a way that met the needs of local people and the communities served. The trust also worked well with others in the wider system and local organisations to plan care and develop services.
- The trust met the needs of patients including those with a protected characteristic. Staff supported patients with communication, advocacy and cultural and spiritual support.
- The trust treated concerns and complaints seriously. It was easy for people to provide feedback on the services and raise concerns about care received. The organisation investigated concerns and complaints and shared lessons learned with staff. Patients were included in the investigation of their complaint.
- The trust managed beds well. Beds were available when required and patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

However:

- On Elmwood ward it was possible to see into patients' bedrooms from a meeting room used by staff on the first floor of the building. This could compromise the privacy of patients.
- While some older person's wards had shared dormitories and the trust had plans to eradicate these staff were not aware of these plans.

Are services well-led?

Our rating of well-led improved. We rated it as good because:

- Leaders in the organisation had the skills, knowledge, integrity and experience to perform their roles. They had a good understanding of the services they managed. They were visible in the service and approachable to patients and staff. Leaders ensured there were structures, systems of accountability for the performance of services. Staff were clear about their roles and accountabilities.
- Staff throughout the organisation knew and understood the organisations vision and values and applied them to their work. Services within the organisation had a vision for what they wanted to achieve and a strategy to turn it into action. The vision and strategies had been developed with all relevant stakeholders.
- Generally, staff felt respected, supported and valued by the organisation. Staff reported morale was good and were proud to work for the organisation. The organisation promoted equality and diversity throughout. There were opportunities for career progression.
- Staff were familiar with the organisations whistleblowing policy and felt able to raise concerns without fear of retribution.
- Staff working in the services we inspected had access to information they needed to provide safe and effective care and treatment.

However:

- The trust had not addressed all the required improvements that we told it needed to make following the last inspection. The trust had not yet ensured that all patients on older people's wards had access to a clinical psychologist and psychological therapies, it had not ensured that staff understood why there was a need to provide female-only day rooms and had not ensured staff applied the Mental Capacity Act robustly on older people's wards, and in the crisis and health based place of safety teams.
- Due to recent changes in the way crisis services and health-based places of safety suites were managed both managers and staff of the services were unclear who the senior leaders were who held responsibility for the service.

Summary of findings

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all the ratings into account in deciding the overall ratings. Our decision on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

The trust's user involvement facilitator had contacted all patients who were in out of area beds to apologise and provide them with key information such as a named person in the trust to contact. Patients also received a survey to provide feedback on their experience and an action plan had been developed to address the issues raised

Areas for improvement

We found areas for improvement including 8 breaches of legal regulations that the trust must put right. These included concerns about access to psychological therapies in older persons wards, application of the Mental Capacity Act, concerns around infection control on older person's wards and outstanding maintenance issues. We found 15 things that the trust should improve to comply with minor breaches that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality. For more information, see the Areas of Improvement section of this report

Action we have taken

We issued requirement notices to the organisation that meant they had to send us a report saying what action it would take to meet these requirements.For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.We told the trust that it must take action to bring services into line with six legal requirements. This action related to two services.

Action the organisation MUST take to improve.

Wards for older people with mental health problems:

- The trust must ensure that all patients have access to a clinical psychologist and psychological therapies to meet their needs. (Regulation 9)
- The trust must ensure female lounges are not used by male patients and are available for female patients to use throughout day. (Regulation 10)
- The trust must ensure that staff record their decision-making when carrying out mental capacity assessments and ensure staff have a sound understanding of the Mental Capacity Act 2005. (Regulation 11)

Summary of findings

- The trust must ensure there is a patient alarm system on all older person's wards which enables patients and visitors to alert staff to their need for urgent support. (Regulation 12)
- The trust must ensure consistency in the disposal of clinical waste in line with their policy on handling and disposal of healthcare waste, to prevent a breach of the Hazardous Waste Regulations 2005. The trust must ensure that the carpet on Beechwood ward is suitable and meets infection control standards. (Regulation 12)

Mental health crisis services and health based places of safety:

- The trust must ensure that all patients in the crisis service have a holistic, person-centred care and crisis plan within their records. Records must be clear, up-to-date and information recorded consistently in the electronic record. (Regulation 9)
- The trust must ensure that the physical environment of the health-based places of safety are fit for purpose and meet the requirements of the Mental Health Act Code of Practice. (Regulation 15)
- The trust must ensure it meets its legal obligations in the health-based places of safety. (Regulation 17)

Action the organisation SHOULD take to improve

Wards for older people with mental health problems:

- The trust should ensure that patients privacy maintained on Elmwood ward.
- The trust should ensure patients can make phone calls in private.
- The trust should ensure staff know about plans for the eradication of dormitory accommodation.
- The trust should ensure all care plans are patient centred and that patients are given a copy of their care plan should they want it.

Mental health crisis services and health based places of safety:

- The trust should ensure that staff are confident and able to assess and record capacity assessments and best interest decisions for patients who might have impaired mental capacity.
- The trust should ensure that patients have access to physical health checks within the crisis service.
- The trust should ensure that there is clear senior oversight of the service, particularly the health-based places of safety.

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

- The trust should ensure that the furniture at Hawthorns 1 and 2 is fit for purpose.
- The trust should ensure that any maintenance work is completed in a timely manner.
- The trust should ensure that the staff are able to observe and communicate with patients in all areas of Hawthorns 2 seclusion room appropriately whilst maintain the dignity of patients.
- The trust should ensure it continues work to ensure female patients requiring psychiatric intensive care beds are accommodated as close to home as possible.

Child and adolescent mental health wards:

- The trust should ensure there are enough activities for young people throughout the week.
- The trust should ensure that all staff receive regular supervision.

Summary of findings

- The trust should review its procedures for booking carers and families visits to young people on Hill ward to ensure they run smoothly.
- The trust should continue to address the staff morale issues at Bluebird House and should provide support regarding forthcoming changes.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

- We found that the trust had a highly skilled, strong, stable and experienced senior team, including the chair and non-executive directors. Leaders had the skills, knowledge, integrity and experience to perform their roles and had a good understanding of the services they were responsible for delivering. They were visible in the service and approachable to patients and staff. Senior leaders were open and honest, presented and spoke with passion, compassion and authenticity.
- There was a clear vision, underpinned by a set of values that were well understood by staff across the trust. We noted some really clear thoughts and developments around aligning with partners across the health and care economy to further develop services that put patients at the centre of care. The trust was taking a leading role in a number of developments.
- The leadership team had taken significant steps to improve the culture across the trust and this was paying dividends. Staff across the trust felt valued but there was a real focus on doing what is best for people, both staff, patients and carers and a commitment to the delivery of good quality patient care at every level.
- Leaders ensured there were structures, systems of accountability for the performance of services. The board assurance framework was clear and designed for the right audience.
- There was a clear focus on delivering high quality care whilst maintaining clear oversight of finances. Some positive work had been done with to identify the underfunding in mental health services and the trust was working with commissioners to address this in order to ensure the sustainability of services in the future.
- There were some positive developments around succession planning at senior level and thinking to the future in developing the 'rising stars'; including some really good work around equality and diversity to ensure the senior leaders of the future were representative of the population the trust served and the staff group. There was a strong emphasis on recruiting and developing staff at all levels. The trust was utilising innovative ways of developing existing staff members.
- There was good practice and innovation around IT and the digital focus.

However:

- It wasn't always clear how all the risks on the trust risk register were being addressed or if the board had oversight of these some didn't pull through to the board assurance framework which was reviewed during board meetings.
- At the time of the inspection the trust only had one full-time freedom to speak up guardian and we had concerns about the volume of work that might be involved in such a large trust. However, the trust had plans to appoint three part-time deputy freedom to speak up guardians to support the role.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ Feb 2020	Requires improvement ➔➔ Feb 2020	Good ➔➔ Feb 2020	Good ➔➔ Feb 2020	Good ↑ Feb 2020	Good ↑ Feb 2020

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Mental health	Good ↑ Feb 2020	Requires improvement ➔➔ Feb 2020	Good ➔➔ Feb 2020	Good ➔➔ Feb 2020	Good ↑ Feb 2020	Good ↑ Feb 2020
Overall trust	Good ↑ Feb 2020	Requires improvement ➔➔ Feb 2020	Good ➔➔ Feb 2020	Good ➔➔ Feb 2020	Good ↑ Feb 2020	Good ↑ Mar 2020

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community health services for children and young people	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community health inpatient services	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community end of life care	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community urgent care service	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Overall*	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good ↑ Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good ↑ Feb 2020	Good ↑ Feb 2020
Long-stay or rehabilitation mental health wards for working age adults	Good Oct 2018	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018
Forensic inpatient or secure wards	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Child and adolescent mental health wards	Good ↑ Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good ↑ Feb 2020	Good ↑ Feb 2020
Wards for older people with mental health problems	Requires improvement →← Feb 2020	Requires improvement →← Feb 2020	Good →← Feb 2020	Good ↑↑ Feb 2020	Requires improvement →← Feb 2020	Requires improvement →← Feb 2020
Wards for people with a learning disability or autism	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018	Good Oct 2018	Outstanding Oct 2018
Community-based mental health services for adults of working age	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Mental health crisis services and health-based places of safety	Good →← Feb 2020	Requires improvement →← Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Requires improvement →← Feb 2020	Requires improvement →← Feb 2020
Community-based mental health services for older people	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Community mental health services for people with a learning disability or autism	Good Oct 2018	Good Oct 2018	Outstanding Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Overall	Good ↑ Feb 2020	Requires improvement →← Feb 2020	Good →← Feb 2020	Good →← Feb 2020	Good ↑ Feb 2020	Good ↑ Feb 2020

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

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

Good ↑

Key facts and figures

Southern Health NHS Foundation Trust provide acute wards and psychiatric intensive care units for adults of working age. There are seven wards across Hampshire.

Antelope House, based in Southampton, has three wards:

Saxon is a 22-bedded male acute ward.

Trinity a 20-bedded female acute ward.

Hamtun a 10-bedded male only psychiatric intensive care unit.

However, at the time of the inspection bed numbers at Saxon and Trinity had been reduced to ensure patient safety to 18 and 16 respectively.

Elmleigh, based in Havant, has one acute ward which is split into two bays: one 17-bedded male and the second is a 17-bedded female bay.

Melbury Lodge, based in Winchester, has one mixed-sex acute unit with 13 male beds and 12 female beds.

Parklands Hospital, based in Basingstoke, has two wards:

Hawthorns 1 is a 10-bedded male only psychiatric intensive care unit and

Hawthorns 2 is a 23-bedded mixed-sex acute ward with an additional 6-beds allocated to the ministry of defence.

There are currently no female psychiatric intensive care beds within the trust. There are plans to block purchase 10 beds at a local hospital which is currently being built. This will be run by an independent provider. At present all females requiring psychiatric intensive care are accommodated through out of area placements.

We last inspected and rated this core service in July 2018. We rated it requires improvement overall. Safe and well led key questions were rated requires improvement and effective, caring and responsive were rated as good.

Following the inspection in 2018 we told the trust it must make the following improvements:

- ensure that the safer staffing levels are met on all the wards to ensure safe care and treatment of patients. This includes consistent medical cover across the wards.
- ensure that all staff have access to supervision, team meetings and appraisals as is necessary for them to carry out the duties they are employed to perform.

Following concerns raised by staff and patients at Antelope House, we conducted a further inspection of Saxon and Hamtun ward in February 2019 but did not rate. At that inspection we found there were again concerns around staffing levels and also around physical health care. As a result, we told the trust it must make the following improvement:

- ensure that there are sufficient numbers of staff with the appropriate skills and experience on both wards at all times to ensure safe care and treatment of patients.
- ensure patients' risks are assessed and monitored to prevent a deterioration in patients' physical health.

At this inspection (October 2019) we found that all of the improvements we told the trust to make had been made.

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

This inspection was undertaken as part of our comprehensive programme of inspections. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

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?

Before the inspection visit we reviewed information that we held about these services and asked a range of other organisations for information.

During this inspection visit in October 2019, the inspection team:

- visited all seven of the wards at the four hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five ward managers
- Spoke with other staff including 12 registered nurses and a tissue viability nurse
- spoke with a medical director, five junior doctors and a consultant psychiatrist
- spoke with two modern matrons and two psychologists and an advanced nurse practitioner
- spoke with six support workers and a peer specialist worker
- spoke with five occupational therapists and an activity coordinator
- spoke with 23 patients and one carer
- reviewed prescription charts, 26 care records and three seclusion records and
- observed a multidisciplinary team meeting, meal times, two groups and staff interactions.

Summary of this service

Our rating of this service improved. We rated it as good because:

- At this inspection we found that all of the improvements we told the trust to make had been made.
- The trust had responded to staffing problems by reduced bed and increasing staffing levels on wards. It had also increased the senior presence and oversight on each ward, ensuring that there was always senior, experienced nursing staff available on each site every ward. Numbers to ensure safety while stabilising the staffing teams and recruiting more staff. Managers told us that there continued to be challenges with staffing but that the service had been successful in recruiting several newly registered nurses, support workers and block booked agency to ensure the consistency of agency staff. Ward teams were now more stable and staff felt able to deliver safe care and meet patients' needs.

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

- Staff now received regular supervision and regular team meetings were held on all wards to provide staff the forum for raising concerns and sharing learning. Staff told us that they felt supported by their peers, teams and their managers. Regular away days had been introduced. Staff told us that they felt well supported by their peers and by their managers.
- The trust had acted to mitigate ligature risk on the wards. There was a programme of ligature reduction and we found further modifications to fittings such as curtains and doors had been made since the last inspection. Staff managed ligature risks well. All sites visited were clean and well maintained, staff demonstrated knowledge and good practice around infection control. Clinical rooms on all wards were fully equipped with accessible resuscitation equipment and emergency medications which staff checked regularly.
- Patients told us that there were staff available in the ward areas and that there were enough around to ensure that they had regular one to one time. Staff knew what incidents to report and how to report them, we saw evidence of raised concerns and reported incidents and near misses in line with trust policy. Managers debriefed and supported staff after any serious incident.
- Staff completed risk assessments for each patient on admission using a recognised tool and reviewed this regularly, including after any incident. Staff used observations of patients and the ward environment to assess and monitor risks. Staff knew about risks for each patient and acted to prevent or reduce risks. Staff applied restrictions on patient's freedom only when justified.
- Staff spoke to patients about their preferred physical interventions if it became a restraint situation. Staff used restraint as a last resort. There was a culture of using the least restrictive interventions on wards and staff made every effort not to use restraint.
- Staff carried out comprehensive assessments with all patients following their admission. The duty doctor completed physical health assessments for all patients on admission. Staff monitored ongoing physical health conditions requiring care, such as diabetes or epilepsy, by completing national early warning score (NEWS 2) forms.
- Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Patients had access to a range of therapies recommended by National Institute of Health and Care Excellence. Staff used the Health of the Nation Outcome Scale to rate the progress and outcomes of patients. The service had a full range of specialists to meet the needs of the patients on the ward.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Ward managers told us that wherever possible they ensured beds were available for patients living in the catchment area and made every effort to prevent out of area placements. They worked with bed management co-ordinators to review if other patients were ready for move on or discharge to make beds available. Beds were always available when patients returned from leave. Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Discharge was planned for in advance where possible. Each patient had their own ensuite bedroom, which they could personalise.
- Staff made sure patients had access to opportunities outside of the service through activity and signposting to job or volunteer opportunities. Information on patients' rights, local services and how to complain where displayed in each ward and were noted patient welcome packs.

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

- Patients had access to appropriate spiritual support while on the wards. Each ward had visiting chaplains and a multi-faith space for patients to use. Staff understood the policy on complaints and knew how to handle them.
- Leaders within the teams had the skills and abilities to run their wards. They demonstrated passion for patient care and showed they had the knowledge to help run the service. The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Staff felt respected, supported and valued.
- Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. Staff had access to information and technology to support them in their work.
- All staff were committed to continually improving services and had a good understanding of quality improvement methods.

However:

- Staff on Hawthorn 1 and 2 told us that the furniture was not fit for purpose as it was an infection control risk. Although a capital bid had been put to the board to replace it this had been unsuccessful as the trust had other immediate priorities that it needed to fund. Staff said it was difficult to get maintenance work done in a timely manner. For example, the washing machine on Saxon ward had been broken for some time and despite reporting this it had not been fixed.
- It was difficult for staff to observe or communicate with a patient in the seclusion room at Hawthorns 2 when they were using the toilet facilities. Staff had raised this as a potential risk issue, but this had not been addressed by the trust. Staff made every effort to manage patients safely and there had not been any incidents.
- There were no female PICU beds within the trust, so staff needed to refer out of area if a bed was needed. There had been a small number of occasions when patients admitted to Elmleigh ward had needed to be secluded in the health based place of safety suite while they waited for a PICU bed.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The service managed patient risk well. Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff used observations of patients and the ward environment to assess and monitor risks. Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff applied restrictions on patient's freedom only when justified.
- The trust had acted to mitigate ligature risk on the wards. There was a programme of ligature reduction and we found further modifications to fittings such as curtains and sensors on doors had been made since the last inspection. Staff managed ligature risks well.
- All sites visited were clean and well maintained, staff demonstrated knowledge and good practice around infection control. Clinical rooms on all wards were fully equipped with accessible resuscitation equipment and emergency medications which staff checked regularly. Staff followed good practice in medicines management and did it in line with national guidance. All wards had regular input from pharmacists and pharmacy technicians.
- Managers had calculated the number and grade of nurses and healthcare assistants required. There had been a review of staffing which had resulted in increased staffing levels. The review of staffing meant that the site could work to improve safety for the patients in hospital. Ward managers used bank and agency nurses when appropriate.

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

- Patients told us that there were staff available in the ward areas and that there were enough around to ensure that they had regular one to one time. There was adequate medical cover throughout the day and night with junior doctors as well as consultants covering the wards.
- Staff spoke with patients about their preferred physical interventions if it became a restraint situation. Staff used restraint as a last resort. There was a culture of using the least restrictive interventions on wards and staff made every effort not to use restraint. Staff followed the criteria for review and planning of seclusion as per the guidance in the Mental Health Act 1983 Code of Practice.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew what incidents to report and how to report them, we saw evidence of raised concerns and reported incidents and near misses in line with trust policy.
- Managers debriefed and supported staff after any serious incident. We reviewed staff meeting minutes on the wards and saw that discussion had taken place for staff to learn from incidents within the hospital and across the service.

However:

- Staff on Hawthorn 1 and 2 told us that the furniture was not fit for purpose as it was an infection control risk. Although a capital bid had been put to the board to replace it this had been unsuccessful as the trust had other immediate priorities that it needed to fund. The washing machine at Saxon ward at Antelope House had not been replaced despite being out of action for quite some time. Staff felt it was difficult to get the maintenance team to act quickly.
- It was difficult for staff to observe or communicate with a patient in the seclusion room at Hawthorns 2 when they were using the toilet facilities. Staff had raised this as a potential risk issue, but this had not been addressed by the trust. Staff made every effort to manage patients safely and there had not been any incidents.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good because:

- Staff carried out comprehensive assessments with all patients following their admission. These assessments contained information about the patient's safety risks, physical health, mental health, social needs, communication needs and discharge planning details.
- The duty doctor completed physical health assessments for all patients on admission. Staff monitored ongoing physical health conditions requiring care, such as diabetes or epilepsy, by completing National Early Warning Score (NEWS 2) forms.
- Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed 26 care records and found that most care records included a detailed care plan. Staff completed care plans with patients following their admission. Staff worked to develop care plans to help staff and patients focus on recovery. A new recovery focussed care plan was being used and developed, staff focussed on collaboration with the patients and to help them identify own risks and develop and action plan based on these.
- Patients on all wards had input from clinical psychologists. Patients had access to a range of therapies recommended by National Institute of Health and Care Excellence. Clinical psychologist's provided a group programme to help patients develop the emotional coping skills to help them in their recovery. Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

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

- Staff used the Health of the Nation Outcome Scale to rate the progress and outcomes of patients. Clinical psychologists used rating scales and outcome measures such as Mental Health Confidence Scale (MHCS).
- The service had access to a full range of specialists to meet the needs of the patients on the ward. Managers supported staff through regular, constructive appraisals of their work. Staff expressed that they had received a yearly appraisal of their work and had access to a training fund for personal development.
- Staff told us that they felt well supported by their peers and by their managers. The previous inspection had found that staff were not supervised in line with trust policy. Staff told us that they received clinical supervision in line with trust policy.
- There had been an improvement in team meetings provided by each ward. The previous inspection had found that there were not regular team meetings to provide staff the forum for raising concerns and sharing learning.
- Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Handovers were effective in sharing the risk and progress of patients. Ward teams had effective working relationships with external teams and other teams in the organisation.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff were discreet, respectful, and responsive when caring for patients. We observed staff interacting with patients and found them to be caring and compassionate in their interactions. Staff spoke knowledgably about patients care and their risks as well as what the plan for their admission was.
- Staff supported patients to understand and manage their own care.
- Patients we spoke with said that staff treated them well, with respect and dignity. Across the service patients praised the staff for their approach and the time they gave to help them get better in hospital.
- Staff introduced patients to the ward and the services as part of their admission.
- Staff involved patients and gave them access to their care planning and risk assessments. Patients told us that they were a part of ward reviews where changes to treatment was reviewed. Staff involved patients in decisions about the service, you said/we did boards showed actions made at the request of patients.
- Staff supported, informed and involved families or carers. Staff told us that they tried to keep families in the loop around patient care and where possible, providing consent was provided, invited them to ward reviews.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- Ward managers told us that wherever possible they ensured beds were available for patients living in the catchment area. They worked with bed management co-ordinators to review if other patients were ready for move on or discharge to make beds available.

- Staff we spoke with told us that patients were not moved between wards during an admission episode unless it was for a clinical reason, for example requiring more or less intensive nursing care. Ward managers we spoke with told us that patient discharge times were agreed in advance. Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Discharge was planned for in advance where possible.
- Each patient had their own bedroom, which they could personalise. Patients had a secure place to store personal possessions. Staff used a full range of rooms and equipment to support treatment and care. Patients could make their own hot drinks and snacks and were not dependent on staff.
- Staff made sure patients had access to opportunities outside of the service through activity and signposting to job or volunteer opportunities.
- Information on patients' rights, local services and how to complain where displayed in each ward and were noted patient welcome packs. Cultural needs of patients were met and supported across all wards.
- Patients had access to appropriate spiritual support while on the wards. Each ward had visiting chaplains and a multi-faith space for patients to use.
- Staff understood the policy on complaints and knew how to handle them. Patients told us they knew how to make a complaint.

However:

- There were no female PICU beds within the trust, so staff needed to refer out of area if a bed was needed. There had been a small number of occasions when patients admitted to Elmleigh ward had needed to be secluded in the health-based place of safety suite while they waited for a PICU bed.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

- Leaders within the teams had the skills and abilities to run their wards. They demonstrated passion for patient care and showed they had the knowledge to help run the service. Staff knew who the leaders within the teams were. Ward managers were visible and ward staff knew who they were.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They were aligned to local plans and the wider health economy. Managers made sure staff understood and knew how to apply them.
- Staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear.
- Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.
- Staff had access to information and technology to support them in their work. Staff had access to up-to-date information about the work of the trust through the trust's intranet.

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

- Staff and patients were engaged in decision making about the service.
- All staff were committed to continually improving services and had a good understanding of quality improvement methods. There were quality improvement initiatives taking place across the service. Hawthorn's ward had worked to reduce restrictive practice by 55%. The trust's user involvement facilitator carried out an audit every quarter and then worked directly with patients and staff to address any areas for improvement.

Child and adolescent mental health wards

Good ↑

Key facts and figures

The child and adolescent inpatient and forensic services of Southern Health NHS Foundation Trust provide inpatient services to children and young people aged from 12 to 18 years. The service falls under the specialist services division.

The trust has two locations serving young people's mental health needs. These are Bluebird House (situated on the Tatchbury Mount site) and Leigh House.

Bluebird House is a purpose-built, predominantly medium secure inpatient unit. At the time of our inspection only one medium secure ward was open, Stewart ward and this has ten beds. Hill ward at Tatchbury Mount was being used as the temporary placement for the low secure inpatient ward; it has seven beds. This ward was shortly due to move to its new location, Austen House, which is on different part of the Tatchbury Mount site. At the time of our inspection, Moss ward was closed. When Hill ward moves to Austen House, there was a plan to have 14 medium secure beds at Bluebird house: seven at Stewart ward and seven on either Hill ward or Moss ward.

Leigh House is an acute adolescent inpatient unit providing up to 21 beds for children and young people experiencing severe and complex mental health difficulties. The service has specialist expertise in treating young people with eating disorders. Bed numbers at Leigh house were capped at 14 at the time of our inspection due to a lack of consultant provision and the acuity of young people.

We inspected this service in June 2018 and issued a warning notice due to a number of immediate safety concerns. These included insufficient staffing levels, an increase in prone restraint, physical health monitoring not always being conducted as needed, ligature risks at Leigh House not being managed appropriately, the risk register not being used effectively, too few activities for young people, poor staff morale and stress, supervision not being in line with the expected completion rates, varying knowledge of the Mental Capacity Act and Gillick competency. At the time Bluebird House was dealing with some extremely challenging situations which CQC escalated to NHS England as the commissioners of the service. NHS England recognised that it needed to support the service to help resolve and/or deal with the challenges and it made further funding available to increase staffing levels to help the service to deal with the challenges.

The trust responded immediately to the concerns we raised and voluntarily agreed to suspend admissions until it had addressed the safety issues.

We undertook an unannounced, focussed inspection on 18 July 2018 to check that the trust had taken the actions identified in its action plan. We found the trust had reconfigured the wards at Bluebird House and had increased staffing levels on each shift; no shifts were left uncovered and as such there were always sufficient, suitably qualified and competent staff on duty at all times. Observations were being conducted appropriately although some further work was needed to ensure these were always recorded. Environmental work to address the ligature risks at Leigh House was nearing completion and staff had detailed knowledge of the management of the risks. Staff and young people told us that they now felt safe. As such we lifted the warning notice.

Following our inspection In June 2018 we rated the service as requires improvement. We told the service it must make the following improvements:

The trust must ensure the improvements made in response to the warning notice are maintained, that it has clear oversight and assurance of all risk issues and that timely action is taken as needed to ensure that young people using the service are kept safe (Regulation 17)

Child and adolescent mental health wards

The trust must ensure that prone restraint is only used as a last resort and continue work on minimising the use of prone restraint (Regulation 12).

Following our most recent inspection (October 2019) we found the trust had made all the required improvements identified at the previous inspection.

This inspection was undertaken as part of our comprehensive programme of inspections. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

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?

Before the inspection visit we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection, the inspection team:

- visited all three wards at two hospital sites
- spoke to six carers
- spoke to nine young people
- inspected and observed the ward environments
- attended a welcome meeting
- attended a handover meeting
- attended a safer staffing meeting
- attended a multidisciplinary team meeting and
- interviewed 27 staff including matrons, managers, doctors, nurses, health care assistants social workers, and occupational therapists.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The service provided safe care. The ward environments were generally safe. The wards had enough nurses and doctors to keep young people safe and meet their needs. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding. Staff assessed and managed young peoples' risks and followed best practice in anticipating, de-escalating and managing challenging behaviour. There had been a reduction in the use of restraint since our previous inspection.

Child and adolescent mental health wards

- The design, layout, and furnishings of the wards supported young peoples' treatment, privacy and dignity. Staff and young people had a range of rooms and equipment to support treatment and care including clinic rooms, sensory rooms, games rooms, gyms, multifaith rooms, activity and lounge areas. The wards all had gardens that young people could access.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the young people and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of young people on the wards. Managers ensured that these staff received training and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff treated young people with compassion and kindness, respected their privacy and dignity, and understood the individual needs of young people. Young people could feedback and were involved in decisions about the service, including the development of the new unit.
- Young people were encouraged and supported to attend the onsite schools and study for qualifications. Staff actively involved young people and families and carers in care decisions. Staff supported young people in their recovery by involving them in care planning, enabling then to make advanced directives and providing them with information and carefully considered discharge plans. Staff looked after young peoples' physical health with observations and health eating cooking classes.
- Young peoples' families and carers were appropriately involved in their care and could visit, attend ward rounds and receive updates from the ward.
- Staff planned and managed discharge well and liaised well with services that could provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- Staff felt respected, supported and valued and they were committed and felt positive and proud of their work. Staff are involved in the development of the service. They had access to support for their own physical and emotional health needs. Staff met each other regularly to discuss their work and learn from the performance of the service.
- Leaders understood the issues, priorities and challenges the service faced and managed them. They were visible in the service and supported staff to develop their skills and take on more senior roles. Managers monitored risks through appropriate systems such as meetings to discuss their risk register. Leaders had closed one of the wards due to staffing shortages and were working hard to recruit and retain staff. There were systems and processes in place to ensure service developed in response to learning from complaints and untoward incidents. Staff were debriefed and received support after serious incidents.

However:

- Young people and staff told us young people did not have enough to do when they were not at school. Some young people told us they did not like the food at Bluebird house; staff were trying to address this.
- Staff morale was varied at Bluebird house and some staff said they were stressed about forthcoming moves.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

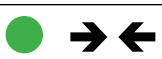
Child and adolescent mental health wards

- Staff generally provided safe care throughout the service. The environments were well maintained
- The wards had enough nurses and doctors to keep young people safe and meet their needs. The trust had an active, ongoing recruitment and retention programme and had closed a ward to ensure they were providing safe care at current staffing levels.
- Staff assessed and managed risk well. Staff assessed and managed young peoples' risks and followed best practice in anticipating, de-escalating and managing challenging behaviour. There had been a reduction in the use of restraint since our previous inspection.
- The trust had made progress with its programme of ligature works to reduce the risk of young people self-harming.
- Staff were managing the practice of placing nasogastric tubes under restraint in the safest way they could, given a lack of national best practice guidance. Staff were continuing to seek guidance from quality networks and other services to develop their practice.

However:

- Door top sensors had been installed to help reduce the ligature risk on Hill ward but these had not been tested to see if they worked effectively.
- There was a maintenance issues with the air conditioning unit leaking small amounts of water at Leigh House. Staff said that getting maintenance done often took some time.
- We found that there were a number of doses of medicine that had not been signed for.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all young people on admission. They developed care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed.
- Staff provided a range of care and treatment interventions suitable for the young people and consistent with national guidance on best practice. They ensured that young people had good access to physical healthcare and supported young people to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward team(s) included or had access to the full range of specialists required to meet the needs of young people on the ward(s). Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit young people. They supported each other to make sure young people had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

However:

- Young people and staff at Bluebird House told us there were not enough activities, especially at weekends on Stewart ward.

Child and adolescent mental health wards

- Care plans did not always include the views of young people and goals were not always written in a way that was meaningful to the young person.
- Some staff on Stewart ward did not always receive regular supervision and supervision was sometimes cancelled.

Is the service caring?

Good 

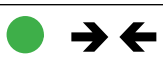
Our rating of caring stayed the same. We rated it as good because:

- Staff treated young people with compassion and kindness. They respected young peoples' privacy and dignity. They understood the individual needs of young people and supported young people to understand and manage their care, treatment or condition.
- Staff involved young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that young people had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

However:

- Carers told us staff did not provide them with information about how to access a carer's assessment.
- Two carers of young people on Hill ward said their visits were shortened or cancelled and one arrived for a visit and was told it was not booked. In forensic service visits need to be booked due to security issues.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, young people did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The design, layout, and furnishings of the ward/service supported young peoples' treatment, privacy and dignity. Each young person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- Staff facilitated young people's access to high quality education throughout their time on the ward.
- Generally, the food was of a good quality and young people could make hot drinks and snacks at any time.
- The wards met the needs of all young people who used the service – including those with a protected characteristic. Staff helped young people with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Some young people told us they did not like the food at Bluebird House; staff were trying to address this.

Child and adolescent mental health wards

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for young people and staff.
- Staff knew and understood the trust's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that the majority of governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However:

- Staff morale was varied at Bluebird House and some staff felt stressed about forthcoming changes.
- Although the service collected friends and family data it was not formally analysed.

Mental health crisis services and health-based places of safety

Requires improvement 

Key facts and figures

Southern Health NHS Foundation Trust's mental health crisis service is known in the trust as the acute mental health teams (AMHT). The teams provide assessment, care and treatment for adults aged 18 and above who are experiencing a mental health crisis. The service is made up of four teams that operate within the crisis care pathway.

The trust has three health-based places of safety. These are based at Parklands Hospital in Basingstoke, Elmleigh Hospital in Havant and Antelope House in Southampton.

The crisis teams are based at the same locations and an additional crisis team is based at Melbury Lodge in Winchester. A health-based place of safety is a room, or suite of rooms, where people are assessed when they have been detained by the police under section 135 or 136 of the Mental Health Act. Health-based places of safety can also be referred to as section 136 suites. People will usually stay in a place of safety for a very short period, and unless an extension is granted by an approved individual should not stay longer than 24 hours.

In all of the health cased places of safety at Southern Health staff from the adjacent acute or psychiatric intensive care wards are responsible for the health-based places of safety during the day. At night, staff from the acute mental health community teams are responsible.

At Elmleigh Hospital there is a health-based place of safety adjacent to the acute ward. There is also an acute mental health team on site which covers east Hampshire.

At Parklands Hospital there is a health-based place of safety adjacent to the psychiatric intensive care unit. There is also an acute mental health team which covers north Hampshire.

At Antelope House there is a health-based place of safety and an acute mental health team, which covers Southampton.

At Melbury Lodge in Winchester there is an acute mental health team, which covers west and mid-Hampshire.

At the last comprehensive inspection in May 2018 we rated Southern Health crisis services and health-based places of safety as requires improvement overall. The key questions safe, responsive and caring were rated good whilst effective and well-led were rated as requires improvement.

Following the inspection in May 2018 we told the trust it must:

- Ensure that senior trust members have full access to information concerning the 24-hour breaches (patients who have been not been given an extension by an approved person must not be detained more than 24 hours in the health-based place of safety) exceeding the maximum detention period in the health-based place of safety. They must ensure there are effective governance systems in place to ensure consistency in standards and work processes across the 136 suites.
- Ensure that all patients have care plans that are up to date and comprehensive. Staff members from the health-based place of safety must ensure the ambulance provider working in the 136 suite has access to up to date, accurate and comprehensive information about patients in their care and treatment plans.

At this inspection we found that the trust still did not have robust governance systems in place to monitor that patients are not detained for longer than 24 hours in the health-based places of safety. Staff were not recording the time of entry and hourly checks appropriately and there was a lack of robust oversight.

Mental health crisis services and health-based places of safety

This inspection was undertaken as part of our comprehensive programme of inspections. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

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?

Before the inspection visit we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit the inspection team:

- visited all crisis teams
- visited all health-based places of safety and looked at the quality of the service environment
- interviewed four team leaders and one manager across each of the crisis teams and two ward managers responsible for the health-based place of safety
- interviewed the police liaison officer for the health-based place of safety and the approved mental health practitioner lead for Hampshire
- spoke with 28 other staff across the acute mental health teams and health-based places of safety including ward managers, support workers, a peer support worker, nurses, a student nurse, consultant psychiatrists, psychologists, a care navigator, senior mental health practitioners, a call handler, team administrator, and social workers
- spoke to three members of staff employed by a private organisation contracted by the trust to transport and monitor individuals in the health-based places of safety
- spoke with five patients, one of which was detained in a health-based place of safety
- reviewed 22 care records across the crisis teams and 13 records across the health-based places of safety
- observed a handover meeting and a multidisciplinary team meeting and;
- reviewed a number of policies and procedures related to the running of the services.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Due to recent changes in the way crisis services and health-based places of safety suites were managed both managers and staff of the services unclear who the senior manager was who held responsibility for the service.
- Staff working for the crisis teams still did not consistently develop and record holistic, recovery-oriented care and crisis plans informed by a comprehensive assessment and in collaboration with families and carers.

Mental health crisis services and health-based places of safety

- Leaders did not have assurance that the trust was meeting its legal obligation to ensure people did not stay in the health-based places of safety for longer than 24 hours or have an extension granted by an approved person because staff were not consistently completing the required hourly checks. There were no systems in place to ensure staff entered correct entry times, completed the hourly checks or to ensure staff would escalate appropriately so action could be taken if people had been in the health-based places of safety nearing the 24 hour time period.
- The physical environment of the health-based places of safety did not fully meet the requirements of the Mental Health Act Code of Practice. For example, two of the three suites did not have a clock (this is important so that people brought into the suites know how long they have been there). There was no toilet door at the Antelope House suite and in the Elmleigh suite the toilet had no walls or door for privacy.
- Staff in the crisis teams did not always record that they had considered a patients capacity to consent to treatment or did not record whether patients had capacity in the patient electronic records. It was therefore not clear to all looking at the records whether a patient had capacity or not to make a particular decision or when best interest decisions had been made.

However:

- The service provided safe care. Clinical premises where patients were seen were safe and clean. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff managed team caseloads well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff provided a range of treatments that were informed by best practice guidance and suitable to the needs of the patients.
- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The crisis services and the health-based places of safety were easy to access. Staff assessed patients promptly. Those who required urgent care were taken onto the caseload of the crisis teams immediately. Staff and managers managed the caseloads of the crisis teams well. The services did not exclude patients who would have benefitted from care.

Is the service safe?

Good ➔➔

Our rating of safe stayed the same. We rated it as good because:

- Clinical premises where patients received care were generally safe, clean, well equipped, well furnished and well maintained.
- The services generally had enough staff, who received basic training to keep people safe from avoidable harm. The number of patients on the team caseload of the mental health crisis teams, was not too high to prevent staff from giving each patient the time they needed.

Mental health crisis services and health-based places of safety

- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans, although this was not consistently recorded as having been done. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service used systems and processes to safely prescribe, administer and record medicines. Staff working for the mental health crisis teams regularly reviewed (or ensured that the GP reviewed) the effects of medications on each patient's mental health and physical health.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Requires improvement  

Our rating of effective stayed the same. We rated it as requires improvement because:

- The physical environment of the health-based places of safety did not fully meet the requirements of the Mental Health Act Code of Practice. For example, two of the three suites did not contain a clock and toilets that did not maintain patients privacy
- Across the service records were not always clear, up-to-date and easily available to all staff providing care, with staff recording information inconsistently in different parts of the electronic record. Some paper records for patients in the health-based places of safety contained recording gaps.
- Staff working for the mental health crisis teams worked with patients and families and carers to gather information but did not always develop individual care plans and update them when needed. Care plan recording was inconsistent, and when plans were produced they were not always personalised and holistic.
- Staff were not consistently completing and recording physical health checks for patients in the crisis teams
- Staff in the crisis teams did not always record that they had considered a patients capacity to consent to treatment or did not record whether patients had capacity in the patient electronic records. It was therefore not clear to all looking at the records whether a patient had capacity or not to make a particular decision or when best interest decisions had been made.

However:

- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care.
- Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Mental health crisis services and health-based places of safety

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Good  

Our rating of responsive stayed the same. We rated it as good because:

- The mental health crisis service was available 24-hours a day and was easy to access, including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated people promptly. Staff followed up with people who missed appointments.
- The health-based places of safety were available when needed and there was an effective local arrangement for young people who were detained under Section 136 of the Mental Health Act. Section 12-approved doctors and approved mental health professionals attended promptly when required.
- The service met the needs of all patients- including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- The design, layout and furnishings of the health-based places of safety did not support patient's treatment, privacy and dignity. For example, there was no toilet door in Antelope House and in Elmleigh the toilet was part of the suite with no walls or door for privacy.

Is the service well-led?

Requires improvement  

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Due to recent changes in the way crisis services and health-based places of safety suites were managed both managers and staff of the services unclear who the senior manager was who held responsibility for the service.

Mental health crisis services and health-based places of safety

- Managers working in the crisis teams told us of a disconnect between each of crisis teams because they were now being managed in different divisions. There was no trust service lead with overarching responsibility for the crisis service or the health-based places of safety. Staff were unclear who had overarching responsibility for the health based places of safety on a day to day basis.
- Leaders did not have assurance that the trust was meeting its legal obligation to ensure people did not stay in the health-based places of safety for longer than 24 hours or have an extension granted by an approved person because staff were not consistently completing the required hourly checks. There were no systems in place to ensure staff completed the hourly checks or to ensure they would escalate appropriately so action could be taken if people had been in the health-based places of safety for nearing the 24 hour time period.

However:

- Leaders had the integrity, skills and abilities to run the service. They understood the priorities, issues and challenges the service faced and managed them.
- Staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear.
- Leaders generally managed performance well using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.
- The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients. The trust's user involvement facilitator had written to every service user that had used the trust's health-based places of safety to understand how they felt about the experience; including the staff that supported them and those that brought them to the suites.
- All staff were committed to continually improving services and had a good understanding of quality improvement methods.

Wards for older people with mental health problems

Requires improvement 

Key facts and figures

The older people's mental health wards within Southern Health NHS Foundation Trust provide care to people with both an organic and functional mental health disorder. Organic mental illness is usually caused by disease affecting the brain, such as Alzheimer's. Functional mental illness has predominantly a psychological cause. It may include conditions such as depression, schizophrenia, mood disorders or anxiety.

The seven wards we inspected are spread over four sites; Gosport War Memorial hospital, Melbury Lodge in Winchester, Parklands hospital in Basingstoke and Western Community hospital in Southampton.

The Stefano Olivieri Unit at Melbury Lodge is a 15-bed acute admission short stay assessment and treatment ward providing care for older people with functional mental health needs.

Beaulieu Ward at Western Community Hospital is a 14-bed acute admission short stay assessment and treatment ward providing care for older people with organic mental health needs. It was refurbished in May after which it re-opened.

Berrywood ward, also at Western Community Hospital is an 18-bed assessment and treatment ward providing care for older people who have functional mental health needs.

Beechwood ward at Parklands Hospital is an 18-bed assessment and treatment ward providing care for older people who have functional mental health needs.

Elmwood ward at Parklands Hospital is an 18-bed ward providing care for older people with an organic mental health needs.

Rose Ward at Gosport War Memorial is a 16-bed acute assessment ward for older persons with functional mental health needs.

Poppy Ward at Gosport War Memorial is a 17-bed acute assessment ward for older persons with an organic mental health needs.

All organic wards will accept patients with early onset dementia if their needs are best met on an organic older person's mental health ward.

All wards are mixed gender.

We last carried out a comprehensive inspection of all the wards between May and July 2018. At this inspection the overall rating of this service was requires improvement. We rated Safe as requires improvement, Effective as requires improvement, Caring as good, Responsive as inadequate and Well-led was requires improvement.

At the previous inspection we said that the trust must do the following to improve:

- The trust must ensure that all wards have a dedicated female-only room which male patients do not enter. (Regulation 10).
- The trust must ensure that staffing is at a safe level on Beaulieu ward at all times. (Regulation 18)
- The trust must ensure that medication is stored at the correct temperature on all wards. (Regulation 12)
- The trust must ensure that staff apply the Mental Capacity Act if there is doubt about a patient's capacity to consent to admission. (Regulation 11)

Wards for older people with mental health problems

- The trust must ensure safeguarding concerns are raised with the local authority. (Regulation 13)
- The trust must ensure patients have access to psychological therapies. (Regulation 9). This remained an area of concern.
- The trust must ensure patients are supported to use their section 17 leave. (Regulation 10)
- The trust must ensure there are rooms available for patients to meet their visitors in private and ensure patients are able to make phone calls in private. (Regulation 10)

At this inspection we found that the trust had made the majority of the required improvements although it still needed to fully address access to a clinical psychologist and psychological therapies across five of the wards, ensuring patients could make phone calls in private, ensuring that men didn't use the female only lounges and ensuring it fully recorded why a patient did not have the capacity to consent to treatment.

This inspection was undertaken as part of our comprehensive programme of inspections. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

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?

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all seven wards
- interviewed the seven ward managers
- checked the clinic rooms and reviewed 19 medicine charts
- spoke with 40 patients
- spoke with 12 visiting carers
- spoke with 43 staff, including doctors, nurses, occupational therapists, physiotherapy assistants, a psychologist, healthcare support workers and recovery workers.
- spoke with one advocate
- reviewed 22 health care records and 10 MHA records
- reviewed several policies, meetings minutes, personnel records and supervision records
- we observed staff meetings on the wards, including multidisciplinary team meetings, ward rounds, staff handover meetings, patient safety at a glance (PSAG) meetings and a staff learning meeting called a comprehend, cope and connect (CCC) meeting that was run by a psychologist and

Wards for older people with mental health problems

- We sat in on patient meetings, including a community meeting, a morning discussion and planning meeting, a 'have your say' group, which included both patients and staff; and a one to one session with a patient and a physiotherapy assistant.

Summary of this service

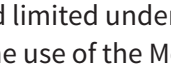
Our rating of this service stayed the same. We rated it as requires improvement because:

- Female patients did not always have a female-only designated area as the female-only lounges were accessed by male patients. The female only lounges were often used for other activities and meetings. We saw male patients wander into female lounges. One was a frequent user of the female lounge because he wanted to use exercise equipment in the room.
- Staff did not protect patients from infection control issues when disposing of clinical waste. Staff did not work in line with the trust policy on handling and disposal of healthcare waste. There was a carpet on Beechwood ward that posed an infection control risk . Staff had escalated this but this had not been addressed. Patients on five of the seven wards had limited access to a clinical psychologist and psychological therapies. Two wards had recruited a psychologist for two days per week, but others had no provision and nursing staff told us that they didn't have the skills to deliver any psychological therapies.
- Staff across the services had limited understanding about the use of Mental Capacity Act. The service did not have a procedure for monitoring the use of the Mental Capacity Act and recording of mental capacity assessments was minimal and variable within the patient records.
- Patients on Beaulieu ward were unable to access a nurse call alarm from their bedroom areas so could not call for help from their bedrooms in an emergency. Staff told us these had been removed during refurbishment.
- Some patients had to sleep in dormitories. While the trust had plans to eradicate dormitories in the future staff had little knowledge of what the plans were and when this might happen.

However:

- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Patients were monitored closely by staff to make sure they were not at risk. Risk assessments for falls, skin problems, pressure ulcers and bone density, as well as those related to their mental health issues were robust and detailed.
- Staff used nationally recognised tools to assess patients and environments were generally dementia friendly
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- Female patients did not have sole use of the designated female-only lounges. Male patients frequently used these.

- The management of infectious waste was not consistent across all wards. We saw paper bin liners in the bins that were designed for clinical waste and on some wards, it was not clear how this waste was being managed safely. The use of paper bin liners was not in line with the trust's policy.
- Patients on Beaulieu ward were unable to access a nurse call alarm from their bedroom areas. Staff told us these had been removed during refurbishment.

However:

- Patients' risk assessments in relation to physical healthcare were updated when risks increased or decreased. Physical risk assessments included falls, skin and pressure ulcers and bone density.
- Staff we spoke with knew how to protect patients from abuse and knew how to make a safeguarding referral using the trust's online system and who to inform if they had concerns.
- Wards had regular fire alarm tests.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- Patients on five of the seven wards did not have access to a clinical psychologist or psychological therapies on most of the wards. Nursing staff told us that they did not have the skills or knowledge to deliver psychological therapies. This was not in line with best practice guidelines from the National Institute for Health and Care Excellence.
- Staff across the services had variable understanding about the use of the Mental Capacity Act. The service did not have a procedure for monitoring the use of the Mental Capacity Act and recording of mental capacity assessments varied within the patient records.
- Care records were not always person centred, up to date or regularly reviewed. Of the 22 care records that we reviewed, we found nine that were not person centred.

However:

- Staff monitored patients' physical health well. Staff used a range of monitoring tools and scales and kept accurate records. The wards had implemented the use of the National Early Warning Score (NEWS 2), which helped staff to check and respond quickly to any signs of an acutely ill patient. Patients' physical observations were regularly monitored and completed by staff.
- Staff referred patients to the independent mental health advocate service. There were leaflets available on all wards about how to access the service and the advocate visited weekly.
- Elmwood ward was nominated for multiple awards for end of life care. It had been nominated in the NHS parliamentary awards for 'the excellence in mental health care award' and had been highly commended at the national older person's mental health and dementia awards 2019 for addressing inequalities. They had developed a good rapport with the local hospice who help provide end of life care.
- Staff shared clear information about patients and any changes in their care, including during handover meetings. We observed handover meetings and review meetings on different wards and saw staff having useful discussions and information sharing.

Wards for older people with mental health problems

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Patients told us that a chaplain had seen them on the wards and they could attend religious services. Patients had a choice in every day decisions such as meals and snacks and personalisation of their bedrooms.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates. We saw advocates talking to patients during our visit.
- Staff informed and involved families and carers appropriately. Carers had been involved in the trust's quality improvement projects and staff told us that carers had helped develop the design for the dementia wards.

However:

- In eight out of the 22 patient records we reviewed, there was no record that patients had been offered a copy of their care plan.

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good because:

- The trust had refurbished the wards and improved signage to make them dementia friendly.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Patients had access to outside space. All wards had enclosed gardens.
- Patients enjoyed the food. There were a range of menu options and drinks and snacks were available throughout the day and night.
- Staff supported patients to engage in the community. Patients could continue their hobbies whilst on the wards and staff supported them to be independent.

However:

- On Elmwood ward it could be possible to see into patients' bedrooms from a meeting room used by staff on the first floor of the building. This could compromise the privacy of patients.
- Patients could not always make a phone call in private, unless they had their own bedroom and a mobile phone. On Beechwood ward staff said patients could make a call from the staff office.
- Whilst the trust had plans to eradicate dormitories in the future staff were unaware when this might happen.

Wards for older people with mental health problems

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Leaders of the service had not made sure all the improvements we told it must make following the last inspection. They had not made sure that staff ensured female designated lounges were only used by females, that patients could make phone calls in private or that all staff understood their responsibilities under the Mental Capacity Act.

However:

- Leaders of the services had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and provided opportunities for career progression. The trust supported staff to access specialist courses such as phlebotomy, dementia training and leadership development. The trust seconded staff to complete their nurse training and there were 'acting up' posts available. Staff felt able to raise concerns without fear of retribution.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. This was communicated through staff meetings, chief executive officer-led 'your voice' staff engagement events, staff bulletins, screensavers on staff computers and posters on the wards.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

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 9 HSCA (RA) Regulations 2014 Person-centred care

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 10 HSCA (RA) Regulations 2014 Dignity and respect

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 11 HSCA (RA) Regulations 2014 Need for consent

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

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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 15 HSCA (RA) Regulations 2014 Premises and equipment
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

Karen Bennett-Wilson, Head of Hospital Inspection for South Mental Health and Community Health Services chaired this inspection and Natalie Southgate, Inspection Manager, led it. Executive reviewers supported our inspection of well-led for the trust overall. The team included inspectors, executive reviewers, specialist advisers and experts by experience. Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.