

Southern Health NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RW1GE	Antelope House	Saxon Ward Trinity Ward Hamtun Psychiatric intensive care unit	SO14 0YG
RW1AM	Elmleigh	Blue bay Green Bay Red Bay Yellow Bay	PO9 2JJ

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

Summary of findings

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We found the following areas of good practice:

- The trust had taken significant steps to address the serious concerns raised at the last inspection to address the issues within the seclusion room at Antelope House. The trust had invested considerable resources to re-design the seclusion room and high care area and bring it in line with the requirements of the Mental Health Act code of practice. The layout and décor of the seclusion room and the high care area had been well considered and constructed to be as non-threatening an environment as possible for unwell patients.
- Patients were very complimentary with regard to the level of care they received from the staff and the atmosphere on the wards at the time of our inspection was calm and we saw very positive interactions between staff and patients.
- The staff we spoke with were knowledgeable about the patients on the ward and the staff team were passionate about achieving positive outcomes for the patients.
- The senior management team had committed resources to analysing the issues of concern on the ward and there was clear planning with regard to driving improvements across the hospital, this included increasing the numbers of restraint trained staff on the wards, increasing staffing levels and skill mix across the wards too.
- The trust was adopting innovative ways to attract new staff into the service and was also offering developmental opportunities to existing staff.
- The ward environments were clean and well presented.

However, we also found the following issues that the service provider needs to improve:

- There were some concerns with regard to examples of poor communication between the senior management team and staff on the wards; this included a lack of clarity with regard to the number of restraint trained staff that should be present within the hospital, and a significant change of plan with regards to the re-opening of Hamtun ward following the redesign of the seclusion room. Staff told us that they felt the trust had been dishonest in its behaviour around the re-opening of Hamtun ward and that their concerns for staff and patient safety had not been heard by the senior management team. Despite the lack of understanding by staff of the number of restraint trained staff considered by the trust to be safe on the wards; the trust was working within the policy by having five PRISS trained staff on duty across the site.
- The seclusion records at Elmleigh were not completed correctly, the rationale for the seclusion was not always in line with the Mental Health Act (MHA) code of practice and where patients had been secluded more than once in a short time period it was difficult to follow the processes and to be sure that reviews had taken place appropriately. The records did not always state the legal status of the patient, the trust initially told us that where there was no information with regard to the status of the patient on the form then the patient was an informal patient and not detained under the MHA. However at a later visit to the trust we were told this was a recording error and staff had not completed the forms appropriately.
- The trust was using the place of safety 136 suite at Elmleigh for seclusion of patients. This is contrary to the MHA code of practice and is contrary to the trust seclusion policy.

Summary of findings

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

Are services safe?

We found the following areas of good practice:

- The training staff received to help them to manage challenging behaviour; Proactively Reducing Incidents for Safer Services (PRISS) highlights the need to use de-escalation first and staff were very positive about this approach.
- Staff undertake a risk assessment of every patient on admission and update this regularly and after every incident.
- Staff created an environment care plan for each patient in the hospital, this care plan reflected the environmental hazards to inform the patient of how an acute ward may feel for example if it became unsettled and noisy. Staff were then able to use the care plan to support patients appropriately.

However, we also found the following issues that the service provider needs to improve:

- There was confusion on the wards with regard to the numbers of PRISS trained staff allocated to the wards per shift. This had led to anxiety and uncertainty re safe staffing on the wards.
- Seclusion records were not recorded in a clear and consistent manner on Elmleigh.

Are services effective?

At the last inspection in January 2016 we did not find any concerns relating to the effective key question. Since that inspection, we have not received any information that would cause us to re-inspect this key question.

Are services caring?

At the last inspection in January 2016 we did not find any concerns relating to the caring key question. Since that inspection, we have not received any information that would cause us to re-inspect this key question.

Are services responsive to people's needs?

At the last inspection in January 2016 we did not find any concerns relating to the responsive key question. Since that inspection, we have not received any information that would cause us to re-inspect this key question.

Are services well-led?

We found the following issues that the service provider needs to improve:

Summary of findings

- We were told by ward staff and managers that the re-opening of Hamtun ward had been poorly managed. Staff and the public had been told that the ward would re-open with restricted numbers of patients to enable the staff team to re-orientate themselves to the ward. This plan was changed at the last minute and the ward admitted its full complement of patients. Staff felt that the re-opening was unsafe and that they didn't feel listened to by senior managers when they raised their concerns about this. Staff on Hamtun ward described feeling supported by the local management team but not by the senior management team. None of the staff on Hamtun ward knew why the decision for a phased re-opening of the ward had been changed as senior managers had not explained this to them.
- Incident reports submitted by staff had not been reviewed by managers, so they had not been aware that staff had an incorrect view of the numbers of PRISS trained staff required on the wards. This issue could have been resolved by managers clearly communicating the policy to staff.

However, we also found the following good practice:

- We saw that on Elmleigh reports were being presented to the safer staffing board with regard to low staffing numbers and reviews of assaults of staff were occurring to identify any increases and trends to allow the trust to make changes as required based on the evidence presented.

Summary of findings

Information about the service

The trust provides acute mental health care inpatient units for adults of working age from four sites, Antelope House (in Southampton), Elmleigh (in Havant), Melbury Lodge (in Winchester), and Parklands Hospital (in Basingstoke). It also provides psychiatric intensive care (PICU) from Antelope House and Parklands Hospital.

We visited two of these sites:

- Antelope House has two acute mental health inpatient wards. These are Trinity, a 21-bed female ward, and Saxon, a 21-bed male ward. It also has a 10-bedded mixed sex psychiatric intensive care unit (PICU) (Hamton). Hamton Ward has three beds for female patients, and seven beds for male patients. Hamton ward had been closed for eight months due to low

staffing levels. During this closure the trust had completed a targeted recruitment exercise and had also refurbished the seclusion room on Hamton ward; the ward had re-opened in March 2017.

- Elmleigh has four wards. These include Red bay (11 bedded female ward), Blue bay (11 bedded male ward), Yellow bay (six bedded ward is located between Red and Blue bay to allow either male or female patients to occupy those beds) and Green bay (a six bedded, mixed sex, high dependency unit). Staff move patients between green bay and the rest of the bays dependent on their needs.

Because this was a focused inspection we did not re-rate the service. The ratings remain the same as those awarded at the comprehensive inspection in 2014.

Our inspection team

The inspection was led by Michelle Mcleavy, Inspection Manager.

The team was comprised of two inspectors and two inspection managers and a Mental Health Act reviewer.

Why we carried out this inspection

We carried out this unannounced, focused inspection as we had received concerns about low staffing levels, high use of bank and agency staff and not enough suitably trained staff on the psychiatric intensive care unit (PICU) and acute wards at Antelope House. We had also received concerns that seclusion of patients at Elmleigh was not being carried out in line with the Mental Health Act Code of Practice.

We visited Elmleigh on the 25th and 27th April 2017 and Antelope House on the 5th and 6th June 2017.

When we last inspected Antelope House and Elmleigh in January 2016 we identified the following areas where the trust needed to improve at Antelope House and Elmleigh;

- The trust must ensure the safety of their premises and the equipment within it.
- The trust must identify and prioritise action required to address environmental risks on the

wards, such as management of ligature points.

- The trust must ensure that the works on the seclusion room on Hamton psychiatric intensive care unit are completed so that the room is fit for purpose.
- The trust must ensure that staff check and record medicine fridge temperatures, at Elmleigh and on Kingsley ward at Melbury Lodge to ensure medicines are stored at the correct temperature.

We also identified the following areas where the trust needed to improve in its other acute wards for adults of working age:

- The trust must ensure that action is taken to reduce the environmental risks of patients absconding from Kingsley ward at Melbury Lodge via the roof and garden. We asked the trust to take urgent interim action while estate work is assessed and undertaken.

Summary of findings

- The trust must ensure that patients' privacy and dignity is protected on Kingsley ward while allowing staff to maintain adequate visual observations.

Following this inspection we were able to remove the requirement notice at Antelope House as the seclusion room on Hamtun psychiatric intensive care unit was fit for purpose following extensive renovation work being completed.

How we carried out this inspection

During our comprehensive inspections we always ask the following five questions of every service:

- Is it safe?
- Is it effective
- Is it caring
- Is it responsive
- Is it well-led?

As this was a focussed inspection we looked specifically at issues relating to the key questions:

- Is it safe?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about this service, we also asked a range of other organisations for information. We also reviewed information provided by the trust and conducted a review of seclusion records at Elmleigh.

During the inspection visits, the inspection team:

- visited all three of the wards at Antelope House, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients at Antelope House who were using the service
- spoke with the managers for each of the wards at both locations
- spoke with 28 other staff members; including doctors, nurses, healthcare assistants, counsellors assistants and senior managers at Antelope House and Elmleigh
- interviewed the area manager with responsibility for these services.
- at Elmleigh we reviewed nine seclusion records and inspected the seclusion room
- looked at 14 treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Patients at Antelope House were on the whole positive about the service that they were receiving and we heard that staff were empathetic, compassionate and knowledgeable. Staff knocked on the door prior to entering bedrooms and were respectful of patient wishes. Patients said the wards were always clean and they were spacious. However, we also heard that patients did not always feel safe on the ward and one patient experienced

an assault whilst in the canteen. We spoke to two patients that had been restrained and they understood why it needed to happen, staff treated them with respect and provided support following the incidents. We heard that a patient on Hamtun ward did not know his allocated nurse for the day as they were used to seeing it written on a board on Saxon and Trinity.

Summary of findings

Areas for improvement

Action the provider **SHOULD** take to improve

- The trust should consider its processes for sharing information with staff with regard to policies to avoid staff becoming confused or misinformed about what is or isn't expected practice.
- The trust should consider the feedback from the staff on Hamtun ward with regard to feeling disconnected from the senior management team.
- The trust should review all incident reports to identify themes and trends as they arise.
- The trust should ensure that the use of the Elmleigh 136 suite is in line with the Mental Health Act code of practice.
- The trust should assess the safety of the door between Abbey ward and Saxon ward.

Southern Health NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Saxon Ward	Antelope House
Trinity Ward	Antelope House
Hamtun Psychiatric Intensive Care Unit	Antelope House
Blue Bay	Elmleigh
Green Bay	Elmleigh
Red Bay	Elmleigh
Yellow Bay	Elmleigh

Mental Health Act responsibilities

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

Are services safe?

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

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

Our findings

Safe and clean environment

- All wards were clean and furnishings were in good repair. The recent refurbishment of the seclusion room and high care area on Hamtun ward had been completed to a high standard and the furnishings and colour scheme that had been chosen for the area created a pleasant environment. We saw significant improvements in the layout of the seclusion room; it complied with the Mental Health Act code of practice guidance in all areas apart from having externally controlled heating. Access to the seclusion room was through the high care area. The seclusion room and high care area were not used at the same time for different patients.
- Staff showed us a door which linked Abbey ward to Saxon Ward, the staff member was worried that the door was not anti-barricade so did not open two ways. There was a risk that a patient would be able to block themselves or a staff member in. Staff would then need to go off the ward and round onto Abbey ward in order to gain access to the barricaded area.
- All staff used personal alarms. They used these to summon assistance. The response was co-ordinated each day, all wards allocated responders that carried bleeps so they could go to areas where alarms had sounded, all responders were PRISS trained. We saw the bleeps in use across the hospital during our inspection and staff responded quickly when bleeps sounded.
- Elmleigh was regularly using the place of safety 136 suite for seclusion of patients; this was against the MHA code of practice and also contravened the trust policy. If the section 136 suite was being used for seclusion staff notify the ambulance service so no new patients are brought to Elmleigh requiring a section 136 place of safety environment. The data shows that the Elmleigh 136 suite has the lowest level of use for patients detained under section 136 MHA as of September 2016, it was not clear at this time if this was

due to lack of availability due to its use as a seclusion facility by the trust. We raised this with the trust who took immediate action to ensure the use of the 136 suite was in line with the MHA code of practice.

Safe staffing

- Information provided by the trust ahead of the inspection showed that there was a variance between the establishment numbers of staff and the actual numbers of staff employed at Antelope House. In some instances this variance was positive, the establishment levels for band 7 nurses was six and the number in post was ten. The variance was negative for Band 5 and 6 posts with 20 combined vacancies. The trust had recruited seven long term agency placements to support the staffing levels. Overall the wards were working with 80% of the required nursing complement and 77% of the health care assistant staff complement.
- Antelope House had employed seven agency nurses on long-term placements that they had selected following an interview process. These nurses received supervision, the full trust induction and mandatory training. The service was moving to a revised staffing model, with the creation of new Band 4 roles and a more senior administration role, taking over some of the non-clinical tasks. The revised model was being finalised, and would be taken to the Trust Executive Group (TEG) in early July 2017.
- At Elmleigh staffing levels had been identified as low, the associate director of nursing told us in April that it is an ongoing challenge and they had become aware of more significant issues at the end of 2016. The staffing issues had been exacerbated by a number of Band 5 nurses leaving at the same time. Steps taken to address the low staffing levels included over-recruiting to Band 2,3 and 4 posts and asking occupational therapists and counsellors to be included in the numbers on the wards as they were usually considered to be supernumerary on the ward. Since March 2017 new admissions to Elmleigh ward had ceased as a result of concerns re low staffing levels.
- Staff told us that a lot of agency staff were used on the wards. They tried to use agency staff that knew the

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wards. We spoke to agency staff on Saxon, Trinity and Hamtun wards and they told us that they were inducted onto the ward and that substantive staff were very helpful when they came for their first shift. They were shown how to do observations, introduced to ward processes and to the patients.

- Staff did not feel that there was any friction between agency staff and substantive staff. However due to agency staff not having a card to access the electronic care records and not always being able to restrain patients if required, substantive staff were often required to do more. Staff did not feel that there were more incidents on the days that there were more agency nurses. Staff said there were not always enough staff to do restraint and that there were often not enough staff to provide 1:1 time or escorted leave. We heard from one patient that had waited many hours for 1:1 time after requesting it earlier in the day. This issue was resolved at the time of the inspection.
- On Saxon ward there had been an issue with staff becoming out of date with their PRISS training, and this was now on the Trust's risk register. Managers felt that ideally all staff should be PRISS trained, but as a minimum they needed three PRISS trained staff on the ward per shift to be confident that they could respond effectively to incidents. At Elmleigh 41 of 50 staff were PRISS trained as of April 2017. The trust had scheduled additional PRISS training for staff, this was scheduled for a weekend and the trust had agreed to pay staff overtime if it fell outside of their working hours.
- Managers at Antelope house told us that they could adjust staffing levels according to the assessed needs of the patients on the ward; however, they had to absorb the first enhanced observation staff member. If more than one patient needed enhanced observations, staff could then request increased staffing levels. We were also told that there was a floating member of staff, covering the three wards, who was available to provide additional support if patients needed one-to-one time or escorted leave.
- At Elmleigh they used a system of red flags regarding staffing numbers; a red flag would trigger an escalation to higher management for support to address the issue. Red flag triggers were: eight staff or under working on a shift, below PRISS trained staff agreed numbers on shift, insufficient qualified staff on a shift to administer medicines, and a lack of an immediate life support trained staff member on duty. The team secretary looked at the staffing roster on a daily basis, if there were any red flag warnings, then they alert a ward manager, who will take action as required including but not limited to negotiating staff shift changes, cancel non-essential training, cancel Band 6 management days etc. We saw that the night before our visit in April that this system had been used to address a staffing deficit when three agency staff cancelled their shift at short notice, Two members of staff remained on shift to provide cover and a member of staff was used from a neighbouring ward to staff the shift.
- Staff on Hamtun Ward had to deal with an incident on the morning of our inspection which involved four patients. One staff member was hurt in the incident and was sent home. The staff said that while there were enough PRISS trained staff across the hospital site they had only three PRISS trained staff on the ward and following the staff member being sent home they went down to two. Staff stated that they did not feel safe with less than five PRISS trained staff on the ward. They stated that there was the potential to need many more PRISS trained staff with four patients involved in an incident.
- Trinity and Saxon had allocated junior doctors, Hamtun ward did not. Staff stated that this caused problems but there was no evidence of any negative impact. Doctors covered Hamtun ward on a rota basis. The doctor we spoke with stated that they prioritised work on Hamtun due to the level of illness and needs of the patients on the ward. The service had an on call rota for out of hours cover. This covered a number of different hospitals so doctors may be attending in another location before getting to Antelope house. The expectation was that a doctor is on site within an hour of the call or has arranged to be there as soon as possible if they are already attending to another call or patient. We did not see any evidence that this was not happening.

Assessing and managing risk to patients and staff

- On Saxon ward the ward manager was clear about what they could or could not do with regards to searching patients. If there was not a search trained member of staff on the ward they would request one from Trinity or Hamtun. Informal patients that staff had concerns about bringing items on the ward signed a contract to agree to

Are services safe?

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searches of their room and person. If they withdrew consent or breached the contract, staff had the option to discharge them. If a patient was suspected of bringing unauthorised items onto the ward their access to the ward was restricted to the waiting area, until the patient agreed to a search or handed in contraband items. Staff told us that they searched patients at the discretion of the named nurse. There were few nurses trained in search procedures so staff often just asked patients to empty out their pockets following leave. This was to ensure that risk items were not brought onto the ward. Staff said that if they suspected someone of bringing drugs onto the ward they would put the patient on 1:1 observations to mitigate the risk.

- Staff expressed confusion at the levels of PRISS trained staff that were supposed to be on the wards, we found that some staff believed there was supposed to be a minimum of five on each ward rather than five across the hospital. We found that staff did not always feel safe when there were less than five PRISS trained staff on the ward. This had negatively affected morale. Staff felt confident in dealing with aggression and stressed that the use of PRISS restraint techniques was always a last resort. The restraint training staff received highlights the need to use de-escalation first and staff were very positive about this.

Reporting incidents and learning from when things go wrong

- Between 1st - 29th May 2017 there had been nine separate incidents raised by staff where they had said there were insufficient PRISS trained staff working. On investigation during our inspection, it was found that in only three of the nine logged incidents were there actually insufficient PRISS staff working. There were four instead of the minimum five. We asked a senior manager what the impact of this would be, and she said that it meant there wouldn't be a member of staff to

hold a person's head if they were required to carry out restraint. The trust had not analysed these reports prior to our inspection and had not identified that staff had not understood the policy with regard to the numbers of PRISS trained staff on the wards.

- On Elmleigh, seclusion interventions by team and reason for seclusion data showed that there had been 45 recorded seclusion incidents in the year to the end of March 2017. Only 25 of these were recorded on Ulysses as 'Risk of harm to other' which is the valid reason for the use of seclusion; 14 were recorded as 'not known', two as 'damage to property' and four as 'risk of harm to self.' No analysis had been done by the trust of these results. Therefore the trust could not identify why all of these incidents of seclusion had occurred or if they were or were not in accordance with the MHA Code of Practice. The modern matron told us that initial analysis highlighted that there were disproportionate incidences of seclusion on weekends when there were no dedicated managers, occupational therapists and only junior doctors on duty. This was however only an initial look at the data and further detailed analysis was required to identify any patterns or trends.
- A Quality Governance Business Partner had just been recruited and will commence in post in July 2017. The post holder will be responsible for analysis of the data and incident report and devising remedial plans to rectify any areas of underperformance or non-compliance with legislation. The trust acknowledged that this had been a gap, but were hopeful this would be addressed once the governance business partner was in post.
- The associate director of nursing told us that they would also be reviewing all seclusion incidents in the future to ensure that there was oversight and scrutiny of seclusion activity.

Are services effective?

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

Our findings

At the last inspection in January 2016 we did not find any concerns relating to the effective key question. Since that inspection, we have not received any information that would cause us to re-inspect this key question.

Are services caring?

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

Our findings

At the last inspection in January 2016 we did not find any concerns relating to the caring key question. Since that inspection, we have not received any information that would cause us to re-inspect this key question.

Are services responsive to people's needs?

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

Our findings

At the last inspection in January 2016 we did not find any concerns relating to the responsive key question. Since that inspection, we have not received any information that would cause us to re-inspect this key question.

Are services well-led?

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

Our findings

Good governance

- We received a whistle blowing concern prior to the inspection that detailed that staff felt at risk on the wards at Antelope House due to low levels of PRISS trained staff and low staffing levels in general which had led to high use of agency staff. We saw during the inspection that the PRISS policy had not been communicated effectively to staff and the concerns and anxieties around PRISS trained staffing levels had been exacerbated by the poor communication. Staff had been completing incident reports when they felt that the numbers of PRISS trained staff had fallen below the required levels. A lot of these reports would have been erroneous as the levels were in line with the policy of having 5 trained staff across the hospital not per ward. This had not been picked up in incident reviews and information re the correct levels as per policy was not relayed to staff. A lack of oversight of the incident reporting system and feedback to staff had created unnecessary anxiety at ward level. We did not see any evidence that the use of agency staff was having a detrimental impact on the running of the wards. For example, it was not documented that there were more incidents. However, staff told us that they had to take more responsibility when there were non- PRISS trained agency staff working.
- The trust told us it was planning to introduce a weekly safer staffing call chaired by the associate director of nursing to review staffing levels for the following 24 hours, with a view to identifying immediate risks and providing resources or actions to reduce the risks. The trust board already received a report on safer staffing levels each month, which includes the availability of a full PRISS team across the unit.
- We reviewed the minutes of the Elmleigh safer staffing project board and we saw that on the 5th April 2017 a review of shift cover (including red flag shifts and tasks that staff had not been able to complete) had been presented, in the minutes there was an item where further information had been requested with regard to the number and frequency of assaults on staff. The

board were reviewing the information to inform the decisions and actions required to ensure the safety of patients and staff. A similar report had been presented to the board on the 18th April 2017.

Leadership, morale and staff engagement

- We received mixed information about the management of the service from the staff we spoke with. Some staff said they felt confident in raising concerns to their line managers and that they did not fear victimisation. They enjoyed the job although they acknowledged that it can become stressful. Staff supported each other and we heard universally that the teams stuck together but morale was variable. A number of staff said that while there was a good atmosphere between staff there was little appreciation for their efforts from the management above them, some staff felt that the management team were quick to criticise any errors made, but were slow to praise hard work. Other staff told us that they had felt bullied in their role and when they had spoken out about this the management team had not addressed this.
- All of the substantive staff we spoke with on Hamtun ward told us that they had felt let down by the senior management team when the ward had re-opened. They had been told that the ward would re-open with restricted patient numbers to enable staff to re-orientate themselves to the new environment. However; this was not the case and all beds were operational immediately on re-opening. Staff did not feel that their views and concerns for staff and patient safety were listened to.
- Staff on Hamtun ward consistently described feeling supported by the local management team, but they did not feel supported by the senior management team at the trust. This was a concern raised at the previous inspection in January 2016.
- Staff nurses were offered the opportunity to train as advanced nurse practitioners and support workers were encouraged to apply for training to work as band 4 mental health practitioners.
- At Antelope house staff at every level spoke positively of the modern matron and the positive impact she had on the running of the service.

Are services well-led?

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

- The trust had created an improvement lead role to address some specific issues within the hospital, these included: staffing levels, PRISS training, restrictive practice and a review of some concerning staff dynamics. The staffing levels review has resulted in the upcoming proposal to the TEG of the revised staffing model and a review of PRISS trained staff has led to further training being provided. The rest of the work was ongoing.