Care Quality Commission

Solent NHS Trust

Quality Report

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

Summary of findings

Contents

Summary of findings

Overall summary

Solent NHS Trust is a specialist provider of community and mental health services. The Trust formed in April 2011 a year after the merger of two PCTs. It serves a population of over a million people living in Southampton, Portsmouth, South East and South West Hampshire and provides community and mental health services from over 120 locations.

Overall we judged that community and mental health services were safe. Staff were confident and willing to raise concerns, we found high reporting levels. The Trust had systems for collating and investigating incidents and there was evidence of improvements made to services through sharing of lessons learned. However the environment of Kite Unit needs to be improved to protect people against the risks of receiving treatment that is inappropriate or unsafe. Most people working at the service said that they felt there were enough staff and the Trust was taking a proactive approach to check that there were enough staff to keep people safe and meet people's needs. However we found some community teams were finding it hard to meet demand. We found the leadership and sharing of productive ways of working across the Trust could be improved.

Staff used pathways of care to treat patients, based on nationally agreed best practice. There was evidence of very good multi-disciplinary team work taking place across the Trust, in both inpatient and community services. We found examples of innovative practice and excellent care.The Solent recovery college and the day treatment centre were innovative developments in supporting and in maintaining people's mental health recovery in the community.The Children's Outreach Assessment and Support Team ("COAST"), and the Portsmouth specialist palliative care services were also notable as exceptional services.

We found a highly committed and caring workforce and there was evidence that the Trust strategy and values were embedded in the organisation. Patients commented on the caring and compassionate approach of staff across the organisation. We saw staff treating patients with kindness, compassion, dignity and respect. Services sought patient feedback, which was generally positive, and feedback was used to make changes and improve services where possible. But the environment of the Kite Unit does not reflect the requirements of published expert guidance to ensure privacy and dignity.

Generally services we reviewed were accessible and responsive to the needs of the patients. Multi-disciplinary teams were working to make sure patients avoided unnecessary admission to either mental health wards or acute hospitals and that patients were discharged effectively. An excellent service was provided to homeless people in Southampton, and the special care dental service provided exceptional care to patients, children and young people with special needs. The children care services were centred on the needs of families. However, in some geographical areas sexual health services were struggling to meet demand and patients did not always receive treatment as the clinics were full. There was a risk that some patients may not receive thesexual health treatment they needed.

Overall we found that services were well-led both locally and at trust level. The Trust has a clear vision and objectives which focused on the delivery of high quality, patient centred care. The reorganisation into eight divisions, over the past year, had strengthened clinical leadership and accountability at all levels of the Trust. There were developing governance and risk management structures in place. The recently formed Assurance Committee had strengthened communication of quality and risk issues to the Trust Board.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We judged that overall services were safe. There were systems to identify, investigate and learn from incidents. Staff across all services said there was an open culture that supported them to report and learn from incidents. The Trust's Board had a focus on quality and this was reflected across the organisation.

There were safe systems, processes and practices and the Trust had systems in place for monitoring actions to mitigate risks to safety. But comprehensive risk assessments were not always carried out in some mental health services and improvements are needed to ensure these are always completed and acted upon.

Generally we found that there were safe staffing levels but the capacity of some community teams were stretched. Staffing shortages in adult community services present compromises to safety for people needing services in a timely way.

We found that improvements need to be made in respect of safety at the Kite Unit where there were a lack of specific male and female areas which contravenes the Mental Health Act cod of practice and some fixtures and fittings could present increased risks.

Are services effective?

In general we found services were effectively meeting the needs of patients, families and carers through evidence based practice, guidance and care pathways. There was excellent multi-disciplinary working and initiatives to support people at home and avoid admission to hospital.

The Trust was actively involved in working nationally to identify key performance and quality indicators for community services. Some services were measuring their performance and effectiveness but this was not well established in all services such as community nursing teams. More work was needed to ensure that teams were always making the most effective use of resources across localities and the Trust as a whole.

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

We found that patients were lawfully detained and that overall care and treatment was provided within the framework of the Mental Health Act and the Code of Practice.

Are services caring?

Patients were overwhelmingly positive about the quality of service that they received. We saw care being delivered across a wide range of services, and staff treated patients compassion, kindness, dignity and respect. Patients told us that they were involved in planning their care and that they were provided with enough information to make informed decisions.

Staff were passionate about the care they delivered. This was reflected in the comments made by patients and their relatives across all services.

Summary of findings

Are services responsive to people's needs?

Generally services were accessible and responsive to people's differing needs. We saw good examples of person-centred care and services that were adapted to meet specific needs. Staff provided a range of evidence as to how they had developed or enhanced their services to respond to feedback to patients.

However there was insufficient capacity at some busy sexual health clinics which meant that some patients could not access receive timely treatment.

We saw that people received care, treatment and support to meet their needs in a timely way on mental health wards. Complaints were few, but were dealt with in a positive way with an emphasis on resolution and learning.

Are services well-led?

We found that generally services across the Trust were well led, and there was strong leadership from the executive team. We found that executive level mental health experience was lacking, however, and we did not judge that this had been considered sufficiently.

Staff felt well supported and displayed a commitment to the values and objectives of the organisation. Local and senior leadership helped to motivate staff and reward patient-centred practice.

There were organisational, governance and risk management structures in place which were working well. Staff said that they felt supported to raise any concern and that the culture of the trust encouraged them to do so. Staff were provided with opportunities for training and professional development. Managers were supported to attend leadership development programmes.

Summary of findings

What people who use the trust's services say

We spoke with a range of patients and relatives during the inspection and with patient representative groups before the inspection. We also held listening events and spoke with patient representative groups before the inspection. We gathered comment cards from patients and relatives prior to and during the week of the inspection.

The feedback on services was overwhelmingly positive. People told us that staff were caring, that care and treatment met their needs and they felt listened to by staff and involved in decisions about their care. There was some negative feedback from patients attending sexual health clinics about long waiting times, lack of clarity about clinic availability and the risk of being turned away.

Most, but not all, community services carried out regular patient surveys and these showed that the majority of patients were satisfied with their care. For example, overall patient satisfaction for the community stroke service was 98 per cent positive for the year to March

2013. In the cardiac rehabilitation service a patient experience questionnaire was given to every patient on completion of their course of rehabilitation. February 2014 results showed 98 per cent satisfaction.

The trust has recognised a need for improving levels of patient feedback across all services and commissioned an internal review 2013-14. The draft report November 2013 cited the range of trust wide mechanisms used to gain feedback including the Family and Friends test. The results collected by the Trust between the period of April 2013 to September 2013 showed that from 1,738 responses collected, 1,332 patients 'were extremely likely' to recommend and 320 patients 'were likely' to recommend the Trust services to family and friends. Under 5% of patients provided a negative response.

The higher the Friends and Family test score, the more likely people are to recommend the trust's services. With the exception of August, the Trust consistently scored above 75 from April 2013 and scored 80 in January and February 2014. The response rate for January and February was low at under 5%, but the findings were consistent with what people told us during inspection in March.

Areas for improvement

Action the provider MUST take to improve

- The Trust must review access to sexual health services as waiting times were sometimes long for walk-in clinics and people were at risk of being turned away. Clinics were sometimes cut or cancelled if the required number of trained staff with the appropriate skill mix were not available.
- The Trust must reconsider the environment of the Kite Unit as it does not provide adequate protection to people and does not reflect the requirements of published expert guidance.
- The Trust must ensure the case loads of each mental health community team are supported by adequate numbers of skilled and experienced staff including consultant psychiatrist input.

Action the provider SHOULD take to improve

- The Trust should review the effectiveness of Information Technology ("IT") systems, in the short term as well as long term, to ensure that staff have efficient access to and use of computerised records.
- The Trust should ensure that collaborative working, information sharing and learning takes place across all service areas, in particular community teams, at both locality level and trust wide.
- The Trust should continue to review the staffing levels, skill mix and case loads of all community teams to ensure delivery of safe and effective care and to release staff for training and development.

Summary of findings

- The lack of capacity for physicians in the Looked After Children's ("LAC") service meant not all new assessments and reviews of care needs were carried out within the target timescales and is an area the Trust should consider as a priority to action.
- The Trust should review current arrangements to ensure information is gathered and accurate records kept of safeguarding children training in order to provide assurance that all staff are suitably trained.
- The Trust should review the mandatory staff training programme to ensure adequate dementia training for all staff.
- The Trust should review services in Southampton locality to ensure they meet National Institute for Health and Care Excellence (NICE) guidelines for falls prevention.
- The Trust should review the arrangements for audits of all medication stores to ensure expired medications are removed. Community staff should be reminded to check that medication is within date at the point of use.
- The Trust should review the arrangments for peer review of practice for independent prescriber nursing staff.
- The Trust should ensure risk assessment and management is embedded in practice in all services.
- The Trust should ensure that all clinical decisions in mental health services are based upon a robust and documented assessment process that includes multi-disciplinary involvement.
- The Trust should ensure analysis of outcome measures across CAMHS to inform service development.

- The Trust should ensure a high standard of record keeping across all CAMHS sites and ensure consistency.
- The Trust should ensure the environment and location of the Section 136 suite (Place of Safety) are reviewed to promote fully the safety and dignity of patients.
- The Trust should ensure that coordinated working arrangements were in place with Hampshire Police around Section 135 and 136 of the Mental Health Act.

Action the provider COULD take to improve

- The Trust could consult with commissioners to assess the local need for some services not currently commissioned, for example, a children's continence advisory service.
- The Trust could consider the staffing capacity of the health visitor service against demand in order to deliver the "Healthy Child Programme" outcomes effectively.
- The Trust could review the service provided the 'single point of access' telephone call centre, to ensure people receive accurate information about sexual health services.
- The Trust could review caseload turnover of community matrons to ensure effective use of their skills and timely delegation of the care of patients to other community nurse teams.
- The Trust could review the turnover of patients in cardiac rehabilitation clinics to ensure effective use of the specialist assessment clinics and progress of patients onto longer term maintenance support.
- The Trust could demonstrate further that it listened to all staff at the organisational level.

Good practice

Our inspection team highlighted the following areas of good practice:

- Across the Trust's services, staff demonstrated excellent commitment to providing the best care they could and putting the patient at the centre of their care.
- There was a positive working culture, demonstrated by staff talking with pride in working for the Trust and patients praising staff for their caring, compassion and dedication.

- We found many examples of very good integrated rehabilitation, supported by efficient multi-disciplinary teams working closely together to ensure the best outcomes for patients.
- The Children's Outreach Assessment and Support Team ("COAST") provides an excellent level of care and support to babies and young children at home with acute illnesses, and their families. We found this service to be both innovative and responsive to meet the needs of the local population, as well as supporting children through a short period of illness in

Summary of findings

their own home without the need for hospital admission. In addition members of the COAST team were working with the local acute trust to support the discharge process and enabling babies and young children to return home as soon as practicably possible.

- Special Care Dental Services provide an excellent service to patients, children and young people with special needs.
- The Homeless Healthcare Team provides excellent multi-disciplinary services to homeless people in Southampton. This service is designed to be accessible to this vulnerable group of patients and gives care and treatment to enable management of their health needs. The service works collaboratively in partnership with a number of other providers including GPs. It enables people without an address to arrange appointments for secondary health care.
- The Specialist Community Pallative Care Team run an innovative clinic called "Key Transitions". This enables patients to attend through GP identification or by self referral. The service promotes early intervention on to the palliative care pathway.
- People who used the learning disability service received care and treatment in line with the current best clinical practice guidance and this had resulted in very few admissions to inpatient units
- In community mental health services we saw two examples of positive recovery care models as

evidenced by the Solent recovery college and the day treatment centre. Both were an innovative development in recovery and in maintaining people's recovery in the community.

- The customer recovery outcome scores (CROS) had been introduced in community mental health services following extensive consultation and the subsequent audits showed that clinical outcomes were being monitored effectively.
- There were positive examples of collaborative working and active engagement with local black minority and ethnic (BME) groups through the community development workers employed by the trust in partnership with Portsmouth City Council. This had led to an increase in service engagement of these specific groups and demonstrated a pro-active approach to community engagement by the trust.
- In the Psychiatric Intensive Care Unit any identified risks had a clear and relevant care plan in place that showed the involvement of the person themselves. Practices consistently reflect the principle of least restriction, including when people were admitted to the service. All use of these interventions complied with national guidelines, the Mental Health Act Code of Practice and local policies and their use was recorded and monitored.
- Staff across the Trust demonstrated a clear understanding of the organisation's vision and values, and these were well-embedded in practice.

Solent NHS Trust

Detailed Findings

> **Registered locations we looked at:**
> Adelaide Health Centre - Trust HQ; St James' Hospital; St Mary's Hospital; Western Community Hospital; Royal South Hants Hospital; Jubilee House

Our inspection team

Our inspection team was led by:

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

Heads of Inspection:

Anne Davis, Care Quality Commission (Community Health services)

Julie Meikle, Care Quality Commission (Mental Health services)

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

Specialists in the community health inspection team included: School Nurse, Health Visitor, Specialist Dentist, GP, Sexual Health Manager, Children's Nurse, Older People's Nurse, Occupational Therapist, Speech and Language Therapists (adults and children), Physiotherapist, Palliative Care Doctor and Community Matron.

Specialists in the mental health inspection team included: consultant psychiatrists, mental health nurses, social workers, approved mental health practitioners and a general practitioner.

Background to Solent NHS Trust

Solent NHS Trust is a specialist provider of community and mental health services. The trust formed in April 2011 a year after the merger of two PCTs.

The trust employs over 4000 staff and services are provided to a population of over a million people living in Southampton, Portsmouth, South East and South West Hampshire. Some services extend across the whole of Hampshire, including specialist dentists and sexual health services. The trust delivers over 1.5 million service user contacts per annum.

Southampton and Portsmouth each cover a relatively small urban geographic area and have a population of around 200,000 people with significant health inequalities. Hampshire covers a wider geographical area which is predominantly more rural and affluent and the health profile indicates in general a level of deprivation which is significantly better than the England average. There are three areas where deprivation is significantly worse than

Detailed Findings

the England average: Havant County District, Portsmouth Unitary Authority and Southampton Unitary Authority. In Portsmouth twenty of the thirty two health indicators are significantly worse than the England average and in Southampton fifteen are significantly worse.

The trust provides a wide range of community health services, including community nursing, specialist community teams, specialist nurses and GPs, physiotherapy, speech and language, health visiting, school nursing and community paediatrics. Many services are provided through integrated multi disciplinary teams providing care and treatment in community settings rather than in acute hospital. These include rehabilitation and re-ablement teams for or those supporting patients with specific conditions such as stroke and neurological conditions. Community health services are provided from over 120 different locations including community and day hospitals, as well as outpatient and other settings within the community such as health centres, children's centres and service users homes.The trust provides mental health and learning disability services to all ages in Portsmouth and to children and adolescents in Southamptoin. Adult Mental Health inpatient services are provided at St James' Hospital, Southsea and in community teams across Portsmouth. Older people's mental health services are part of the older people's service line and are provided out of St James' Hospital and across Portsmouth. Children and adolescent mental health services and specialist eating disorder services are based at St James' Hospital and in community settings across Portsmouth and Southampton.

The models of delivery of services varies across the the two cities as a result of historical and commissioning differences. For example specialist services for long term conditions are directly provided by the trust in the Southampton area but not in Portsmouth, where provided by the NHS acute trust. The trust provides specialist inpatient and community end of life care in Portsmouth whereas in Southampton the NHS acute trust provides a specialist service. Inpatient stroke rehabilitation services are provided in Southampton, and older people rehabilitation wards are provided in both Southampton and Portsmouth. Adult mental health inpatient and community services are provided in Portsmouth, but not in Southampton where services are provided by a neighbouring NHS Trust. Community based children and adolescent mental health services (CAMHS)are provided across both Southampton and Portsmouth.

Solent NHS Trust has been inspected by CQC compliance teams on eight occasions prior to this inspection, the reports were published between August 2011 and October 2013. Of the three active locations which have been inspected, Royal South Hants Hospital has been inspected once for one outcome, St Mary's Hospital (Ella Gordon Unit) has been inspected twice and St James Hospital has been inspected four times.The three active locations inspected are currently compliant. Non compliance has been found in the past in Care and welfare of people who use services at St James Hospital.The outcome was found to be compliant at St James Hospital at a later inspection.

During 2013 we reviewed the operation of the Mental Health Act on five wards at St James Hospital. We found that overall there was adherence to the Mental Health Act however some improvement was needed to meet aspects of the Code of Practice. Issues included a lack of patients' involvement in care planning or decisions about the ward and more robust systems for determining and recording patient's capacity and consent to treatment. In June 2013 we visited the Kite unit and found that the environment did not meet the Code of Practice in respect of a lack of gender separation within bedrooms and bathrooms.

Why we carried out this inspection

This provider and locations were inspected as part of the first pilot phase of the new inspection process we are introducing for community health and mental health services. One reason for choosing this provider is because they are a trust that has applied to Monitor to have Foundation Trust status. Our assessment of the quality and safety of their services will inform this process.

The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

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

Detailed Findings

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

The inspection team always looks at the following core service areas at each inspection of community health services:

- Community health services for children, young people and families – this includes universal services such as health visiting and school nursing, and more specialist community childrens services.
- Community health services for adults – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
- Services for adults requiring community inpatient services
- Community health services for people receiving end-of-life care.

In addition we looked at:

- Sexual Health Services
- Special Care Dentists

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

- Mental Health Act responsibilities
- Acute admission wards
- Psychiatric intensive care units and health-based places of safety
- Child and adolescent mental health services
- Services for older people

- Services for people with learning disabilities or autism
- Adult community-based services
- Community-based crisis services
- Specialist eating disorder services
- Other specialist services inspected (a neuro-psychiatric ward)

Before visiting, we reviewed a range of information we hold about the community and mental health services health service and asked other organisations to share what they knew about the provider. The week prior to our visit we held listening events where patients and members of the public shared their views and experiences of services.

We carried out announced visits on 18, 19 and 20 March 2014. During our visit we held focus groups with a range of staff at the location (these included nurses, doctors, managers, support staff, allied health professionals, mental health act managers and clinical governance staff). We talked with people who use services and staff from all areas of the location. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences.

We visited mental health wards, community hospital wards, health centres, community clinics and accompanied the provider's staff on patient home visits.

We carried out unannounced visits on the evening of 21 March 2014 to Portsmouth district nursing out of hours team; Southampton rapid response team; community wards at Royal South Hants Hospital and the acute admissions ward at St James Hospital.

Are services safe?

Summary of findings

We judged that overall most services were safe. There were systems to identify, investigate and learn from incidents. Staff across all services said there was an open culture that supported them to report and learn from incidents. The Trust's Board had a focus on quality and this was reflected across the organisation.

There were safe systems, processes and practices and the Trust had systems in place for monitoring actions to mitigate risks to safety. But comprehensive risk assessments were not always carried out in some mental health services and improvements are needed to ensure these are always completed and acted upon.

Generally we found that there were safe staffing levels but the capacity of some community teams were stretched. Staffing shortages in adult mental health community services present compromises to safety for people needing services in a timely way.

We found that improvements need to be made in respect of safety at the Kite Unit where there were a lack of specific male and female areas and some fixtures and fittings could present increased risks.

Our findings

Safety in the past
Overall we found that care had been safe in the past. This was generally supported in all areas we inspected where we found that systems were in place that: protected people from abuse and avoidable harm; supported staff out of hours; and provided guidance in cases of emergency, including individual staff responsibilities.

The trust's rate for new pressure ulcers was typically above the national average in the past but there was a trend of a general decrease. The rate for falls was slightly above England's average for most of the previous 12 months, but these were reducing. There had been some serious incidents requiring investigation and action had been taken to identify root causes to mitigate the risk of repeated incidents.

There were no concerns relating to transmission of hospital associated infections in the last year. The trust had implemented a system to screen for MRSA pre admission to all of its in-patient units. There were no reported never events and most reported incidents were lower level of concern. However, there had been a high number of reported infromation governance incidents relating to confidential patient information, which were being investigated.

Staff had a good understanding of and confidence in systems for escalating concerns or reporting serious incidents and adverse events. They were able to give examples of issues that had been reported as serious incidents and tell us about how these had been managed. We found general awareness of key risks at all levels of the organisation board and front line staff.

The Mental Health Act commissioners alerted the trust in June 2013 due to a failing of practice in the Kite Unit around the lack of gender separated areas, and this had not been addressed by the time of this inspection.

Learning and improvement
We found there a commitment to learning from incidents and improving safety, throughout the organisation. The trust had set clear safety goals for example the reduction of pressure ulcers by 35%. This had not yet been acheived but the development of a pressure ulcer panel to review 'avoidable' and 'unavoidable' pressure ulcers and oversee the investigations was contributing to service wide learning and improvements.

Most staff were aware of the process for investigating when things had gone wrong, including the use of root cause analysis to investigate serious untoward incidents. Medicines incidents were reviewed and learning from those incidents was disseminated.

The trust SIRI panel (serious incident requiring investigation) included representation from the executive team, and reviewed investigation of incidents learning arising. Lessons learned from incidents and complaints were referred to divisional or service line clinical goverance meetings for further dissemination.

The trust disseminated high level learning through the trust wide publication 'RISQY Business'. We saw that services were learning at a local level and some were learning from incidents across the trust. But this was not always the case, for example there needed to be better sharing of learning across Portsmouth and Southampton teams.

Are services safe?

The Adult Mental Health (AMH) directorate disseminates a monthly quality and risk report. Included also was information on complaints, incidents, feedback from the patients' experience desk and feedback about staff experience.

Systems, processes and practices

There were appropriate policies and standard operating procedures, relevant to different services in place to support staff to deliver safe care and treatment and these were followed.

Medicines were handled safely within the trust. Medicines were stored safely, and prescriptions were reviewed in a timely manner by pharmacy staff. We found some out of date emergency medicines at the rapid response team base, this was immediately rectified, but we have recommended that the trust undertake a trust wide audit.

There were procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infections. There was a programme of audit to regularly check adherence to safety related policies and procedures, such as infection control, and administration of medicines.

Premises run by the trust were clean and well maintained and generally well designed to meet the needs of patients and promote their safety. However the Kite unit does not meet Department of Health guidance or the Mental Health Act Code of Practice as it does not provide separate bedroom and bathroom areas for men and women. The Kite Unit also has ligature points that cannot be fully mitigated and due to the layout of the unit it has areas where there is no line of sight. We found risk assessments in place to make it as safe as possible for the patients at the unit at the time of inspection.

Staff had received mandatory training in key areas such as medication, health and safety, fire safety, infection prevention and control, safeguarding children and adults. But staff told us that accurate safeguarding training records were not kept updated at trust level.The trust was undertaking a review of training on information governance as there had been such a high level of breaches.

Staff showed a good understanding of the different types of abuse and how to detect these. Staff were aware of the process for reporting safeguarding concerns and allegations of abuse within the trust and to external

organisations such as the local authority safeguarding teams. There were a trust-wide safeguarding leads for adults and children and staff were aware of how to contact them.

Staff were familiar with the process for reporting incidents, near misses and accidents, and were confident to do so citing an open culture in the organisation which supported them to report concerns and incidents.

Monitoring safety and responding to risk

There are systems in place to monitor safety and respond to risks at all levels of the organisation. There was daily monitoring of safe staffing levels which worked particularly well on inpatient units. There are no nationally recognised staffing levels for community nursing teams and the Trust had recognised the significant demands on capacity of some teams. A clear understanding and the establishment of safe staffing for these services presented a challenge for the Trust. We found that the safe care, provided by community teams teams, was supported by staff willingness to work additional hours. Although there were some reported improvement in staffing of district nursing teams this was identified as high risk by the Trust and subjected to regular scrutiny. Staffing shortages in adult mental health community teams posed a risk to people obtaining services in crisis and this also caused a failure to respond quickly to referrals from GPs.

Divisional risk registers were reviewed at monthly clinical governance subcommittees. The trust Assurance Committee has responsibility for regular monitoring and interrogation of safety and actions to mitigate risks. Membership includes trust executives along with the clinical and operational directors of the eight divisions/service lines. Significant risks featured on the corporate risk register for review and monitoring by the by the Board.

Monthly quality assurance reports with a range of safety related, RAG rated, data were produced for service level/divisional clinical governance groups.This included feedback from an internal staff survey on staff perception of how safe their service was. The board was provided with similar reports with trust wide and service level safety related data, which included narrative on incidents and trends.

Thresholds for RAG ratings were quite high in some cases but were based on achieving year on year improvements or

Are services safe?

related to targets set by commissioners and Monitor. Work to improve quality of data, integration of different types of data and appropriate thresholds for RAG rating was ongoing.

Anticipation and planning

The trust had a proactive approach to anticipating potential safety risks and we saw that this happened at all levels of the organisation. There was good use of individual patient risk assessments and an early warning system for the deteriorating patient was used on inpatient units.

The trust was developing RAG rated 'dashboards' of a range of data related to safety that could be interrogated at all levels of the organisation and provide real time information about emerging risks. This was in the process of being implemented at the time of inspection.

Each service line division, led by clinical and operation directors and non-medical clinical governance lead had devolved responsibility and accountability for managing safety and risks. This included anticipating any risks associated with budget setting and in identifying the cost improvements required each year. The trust had implemented comprehensive quality impact assessments (QIAs) for any service and budget changes. These were detailed and required consideration of potential impacts quality and patient safety. All QIAs were reviewed at a panel and signed off by medical director and director or nursing. The trust undertook audits to check the efficacy of QIAs over time.

Are services effective?
(for example, treatment is effective)

Summary of findings

In general we found services were effectively meeting the needs of patients, families and carers through evidence based practice, guidance and care pathways. There was excellent multi-disciplinary working and initiatives to support people at home and avoid admission to hospital.

The Trust was actively involved in working nationally to identify key performance and quality indicators for community services. Some services were measuring their performance and effectiveness but this was not well established in all services such as community nursing teams. More work was needed to ensure that teams were always making the most effective use of resources across localities and the Trust as a whole.

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

We found that patients were lawfully detained and that overall care and treatment was provided within the framework of the Mental Health Act and the Code of Practice.

Our findings

Evidence-based guidance
Overall we found that the care and treatment provided was evidence based and followed recognisable and approved national guidance. We saw examples of care plans in mental health services that referenced NICE (National Institute for Health and Care Excellence) guidelines. This was generally supported in all areas we inspected where we found staff were clear of their roles in care pathways and worked well with multi-disciplinary colleagues to ensure optimum health and well-being of patients.

Patients were involved in planning their own care, including consent. The Mental Capacity Act was followed, with evidence of capacity assessments and best interest meetings for those patients who lacked capacity.

There were some differences in the models of care provided in community health services across the trust geography, due in part to different commissioning arrangements. Generally this did not impact on the effectiveness of the service delivered but the lack of falls exercise groups in Southampton did not follow NICE guidance.

Monitoring and improvement of outcomes
The trust was involved in developing national indicators and external benchmarks for community services and had undertaken benchmarking of mental health services with neighbouring trusts.There was participation in local and national clinical audit and peer review.

The trust had identified quality improvement goals and service lines had identified clinical outcomes linked to national guidance that were used to monitor performance and identify areas for improvement in patient outcomes.We found that most services were undertaking audits and were monitoring performance and outcomes.

Information provided to the Board included: quality and safety reports; outcomes of clinical audit activity; and patient experience information, including trends identified following review of such information.

The trust had made a commitment to improving productivity, whilst also assuring quality and safety across all services and functions. The 'releasing time to care' productivity initiatives had started in 60% of services but further work was needed to see the benefits and the programme would take several years to implement. The trust had identified the importance of good quality data and staff trained to to input access and accurately interpret the information. An example of this is when seeking to quantify expected benefits from new mobile working schemes.

There were examples of the trust encouraging staff involvement inbringing fresh and innovative ideas to the organisation such as 'Dragons Den' initiative, and there were plans to develop a wider staff participation programme.

Are services effective?

(for example, treatment is effective)

Staffing, equipment and facilities

The majority of staff told us they had their full staffing complement and we found there were enough suitably trained staff to meet the needs of patients. However we noted some teams had experienced delays to recruit to vacant posts which in some cases had impacted negatively on performance. We also found different ways of working across Southampton and Portsmouth and it was not clear that staff resources and systems were being deployed effectively. The overlap and lack of clarity over roles across district nursing and community matron teams may be reducing the effectiveness of the use of resources.

Training is delivered across the Trust, to fulfil both mandatory and statutory requirements, although staff would prefer more face to face training rather than eLearning. Overall we found that staff valued the trust appraisal system and opportunities for regular supervision, training and professional development. The trust had processes in place for managing poor or variable staff performance and local managers were supported by Human Resources support officers.

Equipment and facilities were generally fit for purpose and in good supply. The inpatient units were designed for purpose and well equipped. Some delays in the provision of individually adapted mobility equipment were identified and this was in part due to the change in commissioning arrangements for this service.

The trust had inherited several IT systems across its geography, these were not interlinked and a need for major investment had been identified and agreed by the Board. Staff across most services told us about IT issues that impacted on their work. Some interim actions had been taken to address problems and the trust were introducing improved mobile technology, but more needed to be done. There were examples of duplicate information across hard copies and electronic records risking information being lost. In some cases a lack of mobile IT or connectivity issues left patients without clear up to date records in their home for other visiting professionals to refer to.

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

We found that patients were lawfully detained however there was room for improvement in the recording of procedures required under the Mental Health Act and Code of Practice.

Generally people's rights were being upheld and they were involved in thier care. Advocacy support was available and community meetings took place.

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

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

Are services caring?

Summary of findings

Patients were overwhelmingly positive about the quality of service that they received. We saw care being delivered across a wide range of services, and staff treated patients compassion, kindness, dignity and respect. Patients told us that they were involved in planning their care and that they were provided with enough information to make informed decisions.

Staff were passionate about the care they delivered. This was reflected in the comments made by patients and their relatives.

Our findings

Compassion, kindness, dignity and respect

There was an emphasis on providing care with compassion, kindness and respect, across all the services we visited. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner.

Each person's culture, beliefs and values had been taken into account in the planning and delivery of care; staff ensured patient confidentiality when attending to care needs; and trusting relationships between staff and patients, focused on maintenance of or improvement in patient independence.

Generally inpatient environments supported the maintenance of privacy and dignity.

Informed decisions

Patients and their families told us they were involved in and understood their care and treatment. Observation of practice and review of records showed action taken by staff to ensure patients understood what was going to happen to them and why, at each stage of their treatment and care. This included adapting style and approach to meet the needs of children and involving relatives, and those close to patients, where patients lacked capacity.

Emotional support

Patients and their families told us that they were supported by staff who were sensitive to their needs and preferences. We saw examples of patients, children and young people and their families receiving sensitive emotional support from staff.

Staff in palliative care teams had extensive training in communication skills and how to handle "difficult" conversations in a pro-active and compassionate manner. People told us how they felt emotionally supported by the staff and how they built warm and trusting relationships. They told us they felt able to have emotional and distressing conversations, knowing that they would be helped and supported in a warm, confidential and compassionate manner.

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

Are services responsive to people's needs?
(for example, to feedback?)

Summary of findings

Generally services were accessible and responsive to people's differing needs. We saw good examples of person centred care and services that were adapted to meet specific needs. Staff provided a range of evidence as to how they had developed or enhanced their services to respond to feedback to patients.

However there was insufficient capacity at some busy sexual health clinics which meant that some patients could not access timely treatment to meet their needs.

Our findings

Meeting people's needs

Overall we found that services across the trust delivered individualised and person centred care. We found multi-disciplinary professionals worked flexibly in integrated teams to ensure joint approaches to care delivery to meet individual needs and provide care close to home. Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care.

We saw excellent examples of the trust promoting and managing the services that encouraged attendance and take up of treatment and care. For example the multi-disciplinary drop in clinic for homeless people in Southampton.

There were different models of service delivery based on historical commissioning arrangements. The recent organisation of the trust into autonomous service line divisions meant that contract negotiations could be more focused on specific needs of people using those services.

Some services such as sexual health clinics had attempted to make adjustments to meet needs of patients by adjusting times or triaging where there was excess demand. But we found that at some clinics people presenting at the service were at risk of not having their needs met.

There were regular Care Programme Approach (CPA), (an individualised approach to giving care and treatment within mental health services), meetings. These included attendance from other professionals to discuss the person`s treatment, progress and discharge planning.

Access to services

In general we found that services were accessible and tailored by front line professionals to meet patient individual needs, at the times and in the places to best suit their needs. This included those patients that lacked capacity or that presented with disabilities.

The trust had set up a 'single point of access' (SPA) telephone reception service for people telephoning sexual health services or podiatry for advice or appointments. Staff in the Southampton rapid response team had robust systems in place to triage and prioritise the referrals and were able to respond within two hours if there was an urgent need. Dental services had developed an innovative clinician led single point of access referral system which meant that patients with special needs were able to access the service.

We saw examples of arrangements were in place to support people from different ethnicities and cultures accessing the services. For example the health visitor drop in clinics for children and families from ethnic groups led to increased attendance and engagement. The trust provided a translation service; its staff would visit services to provide interpretation and cultural support to patients. Staff in sexual health teams had been trained specifically to provide services for the lesbian, gay, bisexual, and transgender communities and those from black and minority ethnic groups.

Most services waiting times were shorter that the national guidelines. However, we found cancellation of sexual health clinics was impacting on access to services.

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

Are services responsive to people's needs?

(for example, to feedback?)

where the trust worked as advocates for people where changing needs had been identified. An example was supporting people with access to housing, employment and other benefits.

Care co-ordination

We found effective communication between multi-disciplinary teams and partner organisations to focus care and treatment on the needs of patients and promote continuity of care. Discharge arrangements from community services and inpatient wards were robust. Patient and families were involved and there was good communication with GPs, and other relevant services. Numbers of delayed transfers from inpatient units were low and occurred where patients were awaiting funding for a move to a care home.

Learning from experiences, concerns and complaints

Staff told us that there was an open culture at the trust in which staff were supported to report where care had gone wrong to improve quality in the future. The trust monitored formal complaints and we saw that complaints were discussed at governance meetings and action was taken.

We found that services actively sought feedback from patients and told us of improvements they had made. For example we saw that access hours to some children and family clinics had been changed to reflect feedback from parents. The majority of staff we spoke with considered that the trust did listen to and respond to their feedback.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

We found that generally services across the Trust were well led, and there was strong leadership from the executive team. We found that executive level mental health experience was lacking, however, and we did not judge that this had been considered sufficiently.

Staff felt well supported and displayed a commitment to the values and objectives of the organisation. Local and senior leadership helped to motivate staff and reward patient-centred practice.

There were organisational, governance and risk management structures in place which were working well. Staff said that they felt supported to raise any concern and that the culture of the trust encouraged them to do so. Staff were provided with opportunities for training and professional development. Managers were supported to attend leadership development programmes.

Our findings

Vision and strategy

There is a clear vision for the organisation to lead the way in delivering local care. Strategic objectives focus on improving outcomes for people; working with partners; and ensuring sustainability. The corporate objectives include placing people at the centre of services; and valuing rewarding and developing staff.

The expected outcomes of corporate objectives are communicated throughout the organisation through the 'Solent Wheel'. The trust quality objectives are described in the Solent Quality Wheel under the headings: services are safe; people have a good experience of services; best practice is used to ensure better outcomes: and national standards are met. We found that throughout the organisation staff knew about, and identified with, the trust vision and strategy. The objectives in the Solent wheels underpinned staff appraisal and supervision.

As part of the process of application for Foundation Trust status the organisation had recruited shadow governors and a large number of members, public and patients, and had involved them in developing the vision and strategy.

Quality and risk were high on the board's agenda, with detailed discussion at each board meeting.The board regularly reviewed progress against strategic and quality objectives and were provided with performance reports linked to these objectives.

Governance arrangements

There is a clear governance structure and clarity re roles and responsibilities. The organisation had a Quality Governance Assurance Framework and Risk Management Framework.

Over the past year the trust has implemented a new organisational structure of eight divisions/service lines which work autonomously with the aim of improving clinical leadership and focus on quality outcomes for patients. Each division is led by a clinical director, an operations director and a non-medical governance lead. There are monthly divisional sub governance meetings to review specific performance, quality and risk issues and to prepare a report for the Assurance Committee. The trust Assurance Committee is a relatively new initiative intended to provide a more robust assurance on all aspects of quality and risk and performance to the trust Board. It is chaired by a non-executive director with membership of senior trust executives, including Medical Director, Director of Nursing (Governance Lead) and directors from all eight divisions.

We found that risks were identified at team, division/ service line and corporate level, for example community nursing staffing levels and the clinical implications of IT issues. Front line staff were generally confident that quality issues and risks they had identified were known and that action would be taken.

Finance, corporate and clinical governance information is provided to the divisions and to the board, but is not yet fully integrated. The trust has identified the need to improve data quality and this should be aided by the large investment in IT. Going forward the use of RAG rated 'dashboards' with a range of data that can be interrogated at all levels of the organisation will provide real time information about quality, performance and emerging risks

Leadership and culture

The trust recognised the importance of culture and values and good leadership as underpinning quality care. The reorganisation into eight service line divisions was designed to enhance clinical leadership. Managers and

Are services well-led?
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

clinical leads at all levels of the organisation were supported to attend learning and development leadership programmes. We found many examples of excellent leadership of local services and teams.

We found a culture of candour, openness and honesty across the organisation and staff felt confident to raise concerns. Generally staff reported good support and communication at times of change and restructure.There were cooperative and supportive relationships amongst staff and multi-disciplinary teams. Some work was needed to ensure unified culture and ways of working across some community teams and the whole geography of the trust, east and west.

Board members regularly visited all parts of the organisation and feedback was presented at board meetings. The majority of staff told us that the board and senior managers were visible and approachable and felt that senior leaders heard, understood and took action when concerns had been raised.

The trust was accredited with the Investors in People, Health and Wellbeing Award in January 2014. We found that staff were committed to high quality care and were proud to work for the organisation. The recent staff survey placed the trust as above average in the criterion: staff recommended the trust as a place to work or receive treatment.

Acting on feedback
Most, but not all, services actively and regularly sought feedback from patients. This was undertaken in different ways and the inconsistencies in the extent of feedback sought and received meant not all patients were able to provide their views.

Patient experience data, plaudits and complaints, formed part of performance reports provided to the eight service divisions and to the board, for monthly discussion. Board members conducted regular walkabouts which included seeking feedback from patients and staff and providing verbal feedback at trust board every 6 months. Patient stories were also discussed at board meetings

Performance reports also included the update and results from the monthly internal staff survey on their view of safety and quality of the service and whether they would recommend o friends and family. There was low uptake of

the survey and so it was promoted through staff publications RISKy Business and the Staff News email. Staff also told us about 'staff surgeries' where they could raise issues and they said they felt listened to.

The trust has recognised a need for improving levels of patient feedback across all services and commissioned an internal review 2013-14. The draft report November 2013 cited the range of trust wide mechanisms used to gain feedback including kiosks, comments boxes and the Family and Friends test. The trust was committed to increasing patient feedback from a range of sources and was piloting innovative methods of real time feedback on electronic tablets, to increase participation. A new post, Head of Patient Insight and Professional Leadership had been created with the role of triangulating patient insight on patient experience. Thiswould also take into consideration complaints, SUIs, Healthwatch and 'Board to Floor' walkabouts. The aim was to provide the service line divisions with an external perception of their services.

Continuous improvement and innovation
There were systems for identifying and investigating safety incidents and an emphasis in the organisation to reduce harm. We saw consistent systems in regards to safeguarding practices, including prioritisation of training and awareness of appropriate escalation process for those working alone in the community who may observe safeguarding concerns. There was appropriate monitoring, reporting and learning from incidents and we saw examples of improvements arising from incidents and complaints.

The trust uses national staff survey results to drive improvement and 2013 results showed there had been progress made from the previous year. Appraisal for staff at all levels of the organisation was linked to trust objectives, values and behaviours and staff reported that these were well structured. The trust had not met its target for numbers of appraisals undertaken to date but had plans to address this. There was a mandatory training programme and a lot ofthis was delivered through eLearning and many staff told us they preferred face to face training. Dementia training was not mandatory. The majority of staff we spoke with told us they had good access to training, including specialist external courses and they were supported by their line managers to access training.

The reorganisation into eight divisions/service lines has given clinicians and local teams more accountability for

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

performance improvement and innovation. Their responsibilities include quality monitoring, contract negotiations, and budget management, including cost improvement plans (CIPs). Safeguards were in place to ensure all cost improvements were underpinned by quality impact assessments and final sign off for these was the responsibility of executive team. At the time of inspection the children and families division were still to finalise CIPs.

We found several examples of service led innovation, for example the COAST service. Staff were actively encouraged to contribute to improving and innovating high quality care. For example, the trust's "Dragon's Den" scheme encouraged innovation and the Southampton school nursing team had recently won the award. The recent VIP awards recognised a number of staff across the organisation for their outstanding contribution to patient focused, high quality care.

The organisation has started to implement the Solent Transformation strategy 2014-17. Its aims are to ensure clinical staff are supported and empowered to maximise the time they spend in direct clinical care of patients. The trust recognises that in order to do this, clinicians need the right tools, procedures, training, systems, estate and management.

Data quality is a key issue and a work programme has been started to address the problems. There is a big dependency with the rest of the organisation buying into the benefits of improved data quality and that has not happened yet. IT challenges are widely acknowledged and major investment has been secured to unify systems across the trust and address connectivity issues for staff working in the community.

Functioning Governance Framework for Mental Health Act duties

We spoke with the manager with lead responsibility for Mental Health Act administration at the trust and met with the Mental Health Act administration team and the hospital managers. We found that there were robust processes in place for the receipt of statutory documentation and medical scrutiny. We found that there was a programme of audit in place to consider how well the Mental Health Act is being implemented at the trust.

We found that the trust has a governance process in place for looking at the use of the Mental Health Act. Inpatient audits undertaken at hospital level are aggregated and presented at the hospital managers meeting along with information about how frequently different sections of the Mental Health Act are used. Through this meeting the hospital managers also look at any findings from CQC and other external reviews about how the Mental Health Act is operated. Any areas of concern found are referred to the trust's assurance committee for taking forward at hospital level.

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

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	The environment of Kite Unit does not provide adequate protection to people against the risks of receiving treatment that is inappropriate or unsafe and does not reflect the requirements of published expert guidance: • There is not clear gender separation within bedroom and bathroom areas as required by the Mental Health Act Code of Practice and Department of Health Guidance. Regulation 9 (1) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	The Kite Unit is not of a suitable design and layout: • There are areas of the ward that do not provide clear lines of sight to staff observing patients. • There are fixtures and fittings that pose a risk to patients who wish to self-harm that have not been reviewed, removed or mitigated. Regulation 15 (1) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Staff shortages were identified within the access to intervention and the intensive engagement community adult mental health teams. • These shortages had an adverse impact on individual case load size and subsequently on direct patient care interventions. • Delays were identified in responding to some referrals received from General Practitioners (GP). This had led to the trust not meeting the agreed time scales for the completion of some community based assessments. Regulation 22

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	People were not always able to access sexual health services as waiting times were sometimes long for walk-in clinics and people were at risk of being turned away. Actions taken by the Trust to improve access to the service have not been sufficient.
	• This meant people were not always provided with services that protected their sexual health or treated their sexual health illnesses.The provider had not ensured the planning and delivery of care and treatment to meet people's needs, and to protect their safety and welfare.
	Regulation 9 (1) (b)(i)(ii)(iii)