Care Quality Commission

Southern Health NHS Foundation Trust

Community-based mental health services for older people

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)
RW146	Trust Headquarters	Andover OPMH CMHT	SP10 3LB
RW146	Trust Headquarters	New Forest East OPMH CMHT	SO40 9LA
RW146	Trust Headquarters	Winchester ICT	SO23 0HU
RW146	Trust Headquarters	Chase/Petersfield OPMH CMHT	GU35 0YZ
RW146	Trust Headquarters	Fareham & Gosport OPMH CMHT	PO13 0GY
RW146	Trust Headquarters	Southampton West OPMH CMHT	SO16 4XE

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 did not rate the service on this inspection.

- We found that all six services we visited had a sufficient number of staff and that the staff received training, supervision and appraisal. Staff morale was good, apart from the Gosport team, and staff felt supported by their managers. Staff knew about the organisation's vision and values. Staff had been involved in developing improvement actions for their individual teams. However, staff caseloads in the Gosport team were not equitable.

- The teams we visited had systems in place to assess and manage risk. There was clear learning from incidents and measures had been put in place as a result of learning. Each team had good communication systems, a local risk register and understanding of safeguarding procedures. Managers were able to monitor the completion of risk assessments using an electronic dashboard. Patient notes were comprehensive and structured across all six services. There were processes in place to assess risks within team meetings and psychiatrists were available at short notice.

- Patients and carers told us they were satisfied with the services they received and were complimentary about staff.

Summary of findings

Are services safe?

We did not rate this area on this inspection.

- All of the services we visited were fully staffed to the trust's staffing requirements. Vacancies were in the process of being recruited to and all staff had undertaken mandatory training. Sickness levels were low. All six services had effective systems in place to cover sickness and annual leave. Staff had regular supervision and appraisal. In most teams, staff had reflective practice groups that were facilitated by a psychologist.

- Staff carried out a risk assessment of patients and updated this as needed. Staff had access to information about historical as well as current risk. Patients' records were of good quality with clear recording of risks and risk management plans. There were clear plans on how to respond to a crisis. Each team had a local risk register which contained information on patients who were in crisis, at risk of crisis or were vulnerable.

- The service as a whole had implemented learning from incidents. Communication had been identified as an issue from a serious incident and we saw clear systems in place that ensured good communication. Teams had a duty system in place and a clear process to pass on important information at morning handovers.

- All staff knew how to report incidents and were able to clearly describe the safeguarding process. Patients who were identified as at risk of abuse were placed on the local risk register and a safeguarding referral made if appropriate.

However:

- Caseload sizes varied across all the teams. Some staff in Gosport had caseloads of 80 to 90 patients whilst other staff had lower caseloads of 35 to 55. Staff with higher caseloads stated that they were very busy and they felt these numbers were not manageable. We raised this issue with the trust at our previous inspection in October 2014. The trust were continuing to work with teams to address caseload size and improve caseload management.

- In the Gosport and Petersfield team, staff did not always record multi-disciplinary discussions in patient notes.

- There was no psychology input available at Petersfield that potentially reduced the range of interventions staff could deliver to patients.

Summary of findings

Are services well-led?

We did not rate this area on this inspection.

- Morale across teams was good. Staff spoke positively about the leadership within teams. Staff told us they were supported by both their colleagues and team managers and were confident they delivered a good service.

- Staff knew the organisation's vision and values, who the senior team were, and said they had been visited by the interim chief executive. Staff had been involved in developing individual team quality improvement plans.

- Southern Health had continued to roll out an electronic governance system called Tableau that had been well received by both staff and managers. All staff we spoke with told us that it was very helpful in helping them to manage safety and quality in service delivery.

- Staff were supervised, appraised and received mandatory training. Staff adhered to the Mental Capacity and Mental Health Acts.

Summary of findings

Information about the service

There are nine Community Mental Health Teams for Older People within Southern Health NHS Foundation Trust. They provide care to people with both an organic and functional mental health disorder. Community-based mental health services for older people provided by the trust are not commissioned to provide out of hours crisis services. Therefore services were available Monday to Friday during working hours. We visited six of these services Andover, New Forest East, Winchester, Chase/Petersfield, Gosport and Fareham, and Southampton West.

Our inspection team

Team Leader: Karen Bennett-Wilson, Head of Hospital Inspection, for the Care Quality Commission

The team that inspected this core service comprised four CQC inspectors.

Why we carried out this inspection

We carried out this short notice inspection of Southern Health Foundation NHS Trust to follow up on some areas that we had previously identified as requiring improvement or where we had questions and concerns that we had identified from our ongoing monitoring of the service. During this inspection we wanted to look in detail at how safe and well led the older people's community teams were.

At the comprehensive inspection in October 2014, we rated the community-based mental health services for older people as good. We told the provider that it should::

- Improve the systems in place to monitor the caseloads of staff in the Fareham and Gosport OP to ensure the well-being of patients and staff who work in the service.
- Work with local authorities in the area to ensure that social services input is flexible, responsive and that teams are facilitated to work closely to ensure the best outcomes for patients and their relatives.
- Ensure that patients have sufficient access to clinical psychology input if their needs for talking therapies are too complex to be managed by Improving Access to Psychological Therapies team.

How we carried out this inspection

This inspection was focussed on specific areas. During this inspection, we focused mainly on whether the service was safe and well led.

During the inspection visit, the inspection team:

- visited six community services
- spoke with nine patients who were using the service and 16 carers
- accompanied staff on a home visit
- spoke with the modern matrons, managers or acting managers for each of the services

- spoke with 24 other staff members; including doctors, nurses and social workers
- attended and observed two hand-over meetings and two multi-disciplinary meetings
- Looked at 46 electronic patient records of patients
- Looked at 12 sets of staff supervision records
- carried out a specific check of the service dashboards used to manage performance in services.

Summary of findings

What people who use the provider's services say

All of the patients and carers we spoke with were satisfied with the service they received and were complimentary about the staff. We were told of good examples of crisis support and out of hours support at Andover, New Forest and Southampton. Most patients and carers we spoke with had not needed crisis services. Everybody we spoke with told us staff responded quickly and were very caring. Carers told us they had been helped to find additional support and had been able to attend a psycho education course that they found beneficial. We had one issue raised about medication which we escalated to the trust and they took action.

Areas for improvement

Action the provider MUST take to improve

- The provider must assess staff caseloads in the Gosport team and ensure there is sufficient staff capacity to manage allocated caseloads.

Action the provider SHOULD take to improve

- The trust should review the provision of psychology in Chase/Petersfield. There was no psychologist at Chase/Petersfield.

- Staff should record all MDT discussions in patient records at Chase/Petersfield and Gosport.

Southern Health NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Andover OPMH CMHT	Trust Headquarters
New Forest East OPMH CMHT	Trust Headquarters
Winchester ICT	Trust Headquarters
Chase/Petersfield OPMH CMHT	Trust Headquarters
Fareham & Gosport OPMH CMHT	Trust Headquarters
Southampton West OPMH CMHT	Trust Headquarters

Are services safe?

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

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

Our findings

Safe staffing

Andover

Establishment levels: qualified nurses (WTE): 8.8

Establishment levels: nursing assistants (WTE): 3

Number of vacancies: qualified nurses (WTE): 0

Number of vacancies: nursing assistants (WTE): 0

New Forest East

Establishment levels: qualified nurses (WTE): 5.4

Establishment levels: nursing assistants (WTE): 2

Number of vacancies: qualified nurses (WTE): 0.6 (post recruited to)

Number of vacancies: nursing assistants (WTE): 0

Winchester

Establishment levels: qualified nurses (WTE): 7

Establishment levels: nursing assistants (WTE): 2

Number of vacancies: qualified nurses (WTE): 0

Number of vacancies: nursing assistants (WTE): 0

Chase/Petersfield

Establishment levels: qualified nurses (WTE): 5

Establishment levels: nursing assistants (WTE): 1.5

Number of vacancies: qualified nurses (WTE): 0

Number of vacancies: nursing assistants (WTE): 0

Fareham & Gosport

Establishment levels: qualified nurses (WTE): 12.3 FTE

Establishment levels: nursing assistants (WTE): 5.2 FTE

Number of vacancies: qualified nurses (WTE): 0

Number of vacancies: nursing assistants (WTE): 0

Southampton

- Establishment levels: qualified nurses (WTE) 7

- Establishment levels: nursing assistants (WTE) 2.4

(Also 2 memory nurses Band 3, totalling 67.5 hours not included in the above figure)

- Number of vacancies: qualified nurses (WTE): 1 (however, the nurse this position is replacing has not left yet).

- Number of vacancies: nursing assistants (WTE) 0

- Each of the six teams we visited met the staffing requirements determined by the trust.

- Caseloads varied between teams. Across all teams in the older adults' community mental health service the average caseload was 63. Caseloads were mixed, with staff caseloads containing a proportion of memory clinic patients who were reviewed annually. Staff told us they could discuss their capacity for new referrals at the MDT based on current caseload and number of complex patients. Andover had the highest average caseload of the teams we visited with 106. Fareham and Gosport were slightly above average overall at 70. However, staff in this team reported unequal caseloads. Some staff had caseloads of 35 to 55 whilst others had 80 to 90. The majority of staff we spoke with, apart from some staff in the Gosport team, said they were busy but were able to carry out their role. Information received from the trust demonstrated that across all teams over 50% of all patients had mild or moderate dementia.

- Gosport had used the trust capacity and resource audit tool to establish there were not sufficient hours for staff to complete the current workload. The manager told us they had not yet escalated this to the trust or placed it on the trust risk register as they felt they needed more information. Staffing had been on the risk register until February 2017 but following the recruitment of two new staff it was removed. Memory clinic patients were not included in staff caseloads at Gosport where staff reported difficulty managing. We raised the caseload size and staff capacity in respect of this team at our last inspection and told the trust they should review this.

- Staff used the duty system and the team diary to ensure continuity of care for patients in the event of staff sickness or annual leave. Staff ensured that the date of

Are services safe?

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

any patient medication due was in the diary before going on leave. The duty nurse checked the team diary in the event of staff sickness and was responsible for contacting patients to either re-arrange appointments or ensure a patient at risk received a visit. The provider did not use agency nursing staff.

- Five of the six services had access to a psychologist but there was no psychology input at Petersfield. This meant that there was no access to psychological formulation by the team when developing risk management plans. In addition, there was a lack of supervision for nursing staff that meant they were unable to deliver some therapeutic interventions aimed at reducing risk and increasing well-being.

- All patients had been allocated to a care co-ordinator. Staff caseloads were assessed regularly in supervision. New patients were allocated at the referrals meeting where staff were able to discuss their current caseloads and any capacity for new patients. In all teams, managers monitored caseloads regularly at their weekly meetings. Members of the team discussed patient discharges at the MDT meeting to ensure discharges were appropriate. In addition each team had a meeting three monthly with their consultant to review caseloads. All staff we spoke with told us risk assessments were monitored in supervision and information was available on Tableau to ensure patients had risk assessments in place.

- All of the services we visited had rapid access to a psychiatrist during business hours. The trust had vacant posts in Petersfield and Gosport for consultant old age psychiatrists; which were covered by locums. The provider had this on their risk register.

- Compliance with mandatory training for all staff across the services was above 90%. There were no teams with less than 75% compliance for any training. The trust had a system in place to monitor completion of training which sent out reminders when training was due for renewal.

Assessing and managing risk to patients and staff

- We looked at 46 care records across the six services. Care records were overall of good quality. Staff recorded

care plans within structured progress notes. It was evident from these progress notes that staff had discussed patients' care with them and worked in an individual way.

- Staff had ensured that all patients had a care plan in place that was intended to manage identified risks. Staff only used the care plan form within the electronic records system to develop an overall brief care plan which was sent to both patients and their GP.

- Staff undertook a risk assessment of all patients at assessment. We looked at 46 records across six community services and found that staff had updated patients' risk assessments when their clinical risk increased or decreased. Patients' records contained historical risk information which enabled staff to be aware of potential risks should the patient's health deteriorate.

- A significant proportion of patients using the service had dementia and records showed staff worked closely with carers to keep patients safe.

- Records showed that transfers of care from ward to community were managed safely. We reviewed records for patients currently in hospital and those recently discharged. Staff had maintained regular contact with the ward and had attended discharge planning meetings. Patients received follow up visits from community staff after discharge with 48 hours or seven days dependent on their risk assessment. There was a system in place for inpatient wards to refer patients to community services if follow up support was needed.

- Records showed that staff responded promptly to crisis and had a clear system in place across all teams. Staff used the morning handover and the duty system to monitor patients in crisis and those deemed to be at high risk. Each team had a risk register where all staff in the team could be aware of those patients who were currently at high risk. None of the services were commissioned for out of hours crisis support. Patients and carers we spoke with were not always able to describe potential out of hours or crisis support. Carers told us about patients receiving good crisis and out of hours support from Andover, New Forest and Southampton teams. One carer told us staff stayed with

Are services safe?

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their relative until respite care had been arranged. Staff told us that they would make sure that there were measures in place to support patients and carers in crisis before they finished their shift.

- All six of the teams we visited were able to respond promptly to a sudden deterioration in patients' health, using the team risk register and the duty system in place. Staff were able to discuss any patients they were concerned about at the weekly multi-disciplinary team (MDT) meeting.

- Staff attended multidisciplinary meetings once a week and handovers on the other four days of their working week. Following learning from incidents, the trust had put in place a standardised meeting format for these meetings. This standard agenda helped ensure that staff discussed patient risks, including any safeguarding concerns. Care programme approach meetings that were due were also a standardised item on this agenda. We attended three MDT meetings across the six services we visited. MDT meetings were well structured and decisions were taken about patients' care. In four services, the electronic patient record was 'live' and during the MDT meeting and records were updated immediately with any decisions. We found that Petersfield multi-disciplinary discussions and decisions were not recorded consistently within patient records.

- None of the services operated a waiting list. Patients assessed as urgent could be seen quickly. Community-based mental health services for older people provided by the trust were not commissioned to provide out of hours crisis services. Therefore services were available Monday to Friday during working hours.

- All of the staff we spoke with had received training in safeguarding. Staff were able to explain how to identify a patient at risk of abuse and the procedure to follow to report this. Patient records demonstrated that any patient identified as at risk was discussed at the MDT meeting, however Petersfield and Gosport did not always record this consistently. This meant there was a risk that information could get lost or that planned actions would not be recorded and subsequently followed up. Staff were aware of patients who had been identified as at risk of abuse and these patients were on each teams' risk register. We saw that patients who met

the safeguarding referral criteria had been referred to the local authority vulnerable adults safeguarding team and the community teams had care plans in place to provide appropriate support.

Track record on safety

- There were 11 serious incidents reported between March 2016 and January 2017.

- The trust had introduced a number of improvements in team communication following a serious incident in November 2015. As a direct result of learning from this incident all teams now had a duty system and a risk register. This meant that all staff were aware of the patients identified as most at risk and potentially needing additional intervention. Each team had a duty system with a member of the nursing staff undertaking duty on a rota system. Duty staff were made aware of any staff on sick leave to ensure any visits were undertaken and that patients were not 'missed'.

Reporting incidents and learning from when things go wrong

- All of the staff we spoke with knew what incidents to report and how to report them using the trust's electronic incident reporting system. Team managers reviewed incidents and cascaded any learning from these to staff in team meetings and at the morning handover. Team managers told us they were confident that staff reported all incidents. Staff we spoke with across all six teams understood their responsibilities with regard to duty of candour and were able to give examples of having been open and transparent when mistakes had occurred. However, there were on-going issues with the recording of next of kin details in the care records. This was part of the trust's improvement plan which was being monitor through performance reports.
- Staff we spoke with at all levels of the services were able to tell us about serious incidents that had occurred and learning that had been implemented as a result. In particular, there had been significant improvements in team communication with standardised and effective systems to discuss patients at risk implemented.

- Staff told us they had been offered a debrief and supported following incidents. We looked at records in respect of one incident that confirmed this.

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

Vision and values

- Staff we spoke with were able to tell us about the organisation's vision and values and we saw these displayed in the sites we visited.

- Staff told us about their team objectives and said they had been involved in the development of these. Staff knew who the most senior managers were in the trust and told us the services had been visited by the interim chief executive.

Good governance

- Southern Health had continued with the development of their electronic governance system called Tableau that incorporated data directly from the electronic patient records system and the electronic incident reporting system. All of the staff across the six services we visited were positive about the system and told us they found it helpful in managing their caseloads. Senior managers and team leaders used the Tableau system to monitor team key performance indicators. Managers were able to monitor the number of patients with outstanding risk assessments and, for example, those patients due a CPA meeting. Team managers were able to show us live statistics using Tableau. Staff we spoke with told us they used Tableau regularly, one member of staff told us they received a regular report which helped them plan CPA meetings.

- Staff received mandatory training, annual appraisal and regular supervision. Staff we spoke with told us they were busy but usually had time to provide the planned care for their patients.

- Individual care records and governance records showed that correct procedures were followed in respect of the Mental Capacity Act, Mental Health Act and adult safeguarding. There was clear monitoring of patients on care programme approach (CPA) which ensured staff followed the required procedures, although we noted that there were low numbers of patients allocated to the CPA framework. The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated

and reviewed for someone with mental health problems or a range of related complex needs. We have asked the trust to review this to ensure patients are being allocated to the framework appropriately.

- The team managers told us they had sufficient authority and administration support. Team managers told us they felt supported by senior managers to deliver services.

- While individual staff could not submit items to the trust risk register, there was a system in place to escalate risks via managers. Staff could submit items to the local risk register held by each individual local service. We were able to see that incidents were reported and that learning took place. There were daily discussions of the team risk register and all teams had this system in place.

Leadership, morale and staff engagement

- Staff we spoke with across all teams were positive about the local leadership of the teams. Staff discussed the integration with physical healthcare and overall they thought it was a good thing for patients. All of the staff we spoke with said that they enjoyed working in the teams they were based in. Staff reported morale being good and they said it was a supportive place to work and said there were no cases of bullying or harassment in the teams. Staff told us they felt supported by both managers and colleagues.

- Staff we spoke with told us they knew about the whistle-blowing policy and that they were able to raise any concerns in their teams.

- All of the services we visited had procedures in place to support staff to be open when things went wrong and to explain to patients and carers.

Commitment to quality improvement and innovation

- Each of the six services we visited had their own quality improvement plan. Staff we spoke with told us this was not only in respect of learning from incidents but that ideas for improvement were welcomed by managers. Actions were scored on a red, amber and green system and tracked electronically. We looked at plans and saw they were updated regularly with target dates and notes on progress.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured there were sufficient members of staff at Gosport to meet the numbers of patients on the caseload. This was a breach of regulation 18(1).