

Southern Health NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RW1	Trust Headquarters	Hewat Centre	PO12 3PW
RW1	Trust Headquarters	Petersfield CMHT	GU32 3LB
RW1	Trust Headquarters	West Community Mental Health Team	SO15 5PQ
RW1	Trust Headquarters	Andover CMHT	SP10 3QX
RW1	Trust Headquarters	Eastleigh CMHT	SO50 5NY
RW1	Trust Headquarters	Romsey CMHT	SO51 8JB

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

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

Summary of findings

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 this service on this inspection.

We found the following issues that need to improve:

- The previous inspection found that there was inconsistent use of risk assessment and crisis planning for patients accessing the service. In addition, the investigation following a serious incident involving the death of a patient identified incomplete risk assessments as a learning point. On this inspection, we found that that assessing and recording of patient risks was not consistent. Staff did not always update risk assessments with new information, and there was poor and inconsistent use of the different crisis plans that the trust had provided staff to use.
- There was variation in caseloads across the teams. There were particularly high caseloads at the Andover team. Although the trust had undertaken a review of the demand and capacity of the teams, some staff reported that caseloads were not manageable and that they had extra duties that were not taken into consideration.
- We found that staff morale had been affected by the ongoing public scrutiny and coverage in the media, and the pressures from a recent split with adult social care.

- There was a lack of recording of the next of kin information in patients electronic care records. This had implications for the duty of candour where staff needed to be able to contact family members in the event of an incident.

However:

- There was positive use of the trust's risk register to escalate risks, such as those with the environment and staffing. This ensured that there were both long and short-term plans for the mitigation of risks. Incidents were reported and investigated, and learning was cascaded through to front line staff.
- There was a positive change in the oversight of the teams' performance with the continued implementation of the trust's electronic governance system. This allowed managers to check on key areas of performance within their teams to ensure completion of essential areas of practice.
- Staff spoke positively of the mutual peer support within the teams; they felt supported through their immediate leadership teams.
- The recent change to the trust's executive board had improved top down communication; however, staff felt it was too early for the change in the board to have had a noticeable impact.

Summary of findings

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

Are services safe?

We did not rate this area on this inspection.

- There was variation in caseload sizes across the trust, and some staff had much higher caseloads and work commitments. We found examples of staff needing to take work home with them to ensure it was completed.
- On this inspection, we found that that staff were not always assessing and recording risk consistently. Risk assessments were not consistently updated with new information and staff made poor and inconsistent use of the different crisis plans that the trust had provided staff to use.

However:

- Despite staffing pressures creating higher workloads, there had been positive steps taken to mitigate the risks.
- Staff had access to a clinic room to store medicines and to provide physical health care treatments to patients. The environments were assessed for safety and there was good adherence to infection control procedures. Equipment was well maintained.
- Medical cover was provided at each site. There was a buddy system in place for when a member of staff was not able to work; and this ensured that patients always had a staff member to contact for support.
- Staff provided a 'shared care' service for patients at risk of deterioration in their mental health. This ensured that there was increased support available to patients who were at risk due to their mental health crisis. Staff were able to refer patients on to more intense support when needed, through the trust's acute mental health teams.
- Staff were trained in safeguarding procedures. Incidents were reported and recorded appropriately by staff, and learning from serious incidents was cascaded down through the teams.

Are services well-led?

We did not rate this area on this inspection.

- The trust's electronic governance programme gave staff and managers oversight of essential areas of practice such as risk assessment completion and adherence to mandatory training.
- There was positive use of the risk register to escalate risks within the trust.

Summary of findings

- Although staff were positive about the local leadership, they said that it was too early to see any noticeable change from the new executive team, but felt that communication had improved.

However:

- Morale varied across the teams, and some staff felt under pressure within their role.

Summary of findings

Information about the service

There are ten community mental health teams for adults of working age in the trust. The service provides community based care to people in Hampshire who experience moderate and/or severe mental health problems. The teams accept both self-referrals and referrals from GPs. They provide patients with an assessment of their needs, and then signpost them to relevant psychological therapies, care coordination or to their acute mental health team and inpatient units.

The service is primarily, but not exclusively, for adults between the ages of 18 and 65..

On this inspection, we visited the Romsey, Andover, Southampton, Eastleigh, Bordon and Fareham & Gosport teams.

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 two CQC inspectors, one inspection manager, one Mental Health Act reviewer, an assistant inspector and a specialist advisor with specific experience in working with community mental health teams.

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 looked in detail at how safe and well led the community based mental health services for working aged adults were.

We inspected the community-based mental health services for adults of working age as part of a comprehensive inspection in October 2014. We undertook a further, focused inspection of the Southampton community mental health service in January 2016 in order to review the trusts governance arrangements and to follow up on their action plan following the Mazars report.

Following the January 2016 inspection, we told the provider that they must take the following action to improve:

- The trust must ensure that staff undertake risk assessments for all patients that use the service and that patients' care plans include the risks that have been identified and the actions required to manage these.
- The trust must ensure that staff follow a consistent procedure for following up on patients who do not attend their appointments, especially those identified as posing a high risk of harm to themselves and/or to others.

We also told the provider that it should consider taking the following action:

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

We issued the provider with requirement notices following the January 2016 inspection. These related to Regulation 12 – Safe Care And Treatment --under the Health and Social Care Act (Regulated Activities) 2014.

Summary of findings

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

- Visited six of the trust's community mental health teams and did a check of the environments
- Spoke with 24 members of staff including managers, doctors, nurses, support workers and psychologists
- Spoke with nine service users accessing the service
- Conducted a focus group with four members of staff
- Checked 68 sets of care records.

What people who use the provider's services say

We spoke with nine patients who use the service, and the feedback we received was positive from each of them.

Patients thought the service was responsive to their needs, that their views were taken into account and that they were empowered to make informed choices, for example, over their choice of medication.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure there are sufficient members of staff to meet the numbers of patients on the caseload.
- The provider must ensure that relevant care records are fully updated in a timely manner when changes to a patient's risk are identified.
- The provider must ensure that there are crisis plans in place for patients accessing the service, where risk assessments indicate this is required.

- The provider must ensure that next of kin details are accurately recorded in patient records.

Action the provider **SHOULD** take to improve

- The provider should complete their review to ensure that the CPA framework is consistently applied and ensure that caseloads are allocated equally

Southern Health NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Hewat Centre	Trust Headquarters
Petersfield CMHT	Trust Headquarters
West Community Mental Health Team	Trust Headquarters
Andover CMHT	Trust Headquarters
Eastleigh CMHT	Trust Headquarters
Romsey CMHT	Trust Headquarters

Mental Health Act responsibilities

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

Are services safe?

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

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

Our findings

Safe and clean environment

- Each community mental health team worked from an office base, where they could also see patients. Staff used alarms at the bases in order to call for assistance if needed when seeing patients. Where alarms were not fitted into the rooms, staff used personal alarms. Managers at the Eastleigh and Southampton sites were working with the estates department on the suitability of the building as a base for the community teams. Steps were taken towards reviewing the current environments in order to maximise the use rather than moving sites all together.
- Staff used on-site clinic rooms to store, dispense and administer medication and monitor physical health. There were well-stocked clinic rooms with equipment, for example, to administer a depot injection or take blood. Staff did not have use of an electrocardiogram machine at all sites but there were scales and tools to monitor blood pressures. Emergency medical equipment was not available at all of the sites with only the Hewat Centre having use of a defibrillator that was not stored within the community base but elsewhere in the hospital. Staff would use regular emergency services if required.
- All sites appeared clean and well maintained and there were arrangements in place to ensure regular cleaning.
- Staff completed environmental assessments at each of the sites; this included a full assessment of ligature risk. Staff were able to demonstrate improvements in the safety in the environment as a result of the assessments. For example, improvement in the safety of the toilets at the Southampton site.
- Staff adhered to infection control principles such as handwashing and disposal of clinic waste. Infection prevention and control information was displayed within the clinic rooms. Staff demonstrated how they safely disposed of sharps and which clinical waste bags they used according to what needed to be disposed of.

There were arrangements in place for sharps bins and clinical waste bags to be collected when full. Staff monitored fridge temperatures to ensure that medicines were stored at the correct temperature.

- There were arrangements in place to ensure that equipment at each site was well maintained and clean. For example, staff showed us that there was regular calibration of blood pressure monitoring equipment and scales. We saw that regular electrical safety testing of portable appliances and work place electronic equipment such as computers was carried out.

Safe staffing

- Managers had set staffing levels according to the budget available to them. Following a review of the demand and capacity of the teams staffing levels had been adjusted accordingly. For example, the manager at the Hewat Centre had negotiated an extra band 6 registered nurse post and the manager at the Southampton site had kept a 0.6 vacancy as flex in the budget to allow extra staff to be brought in if there was increased pressure on the service.
- Staffing levels and vacancies varied considerably between the teams according to size and demand on the service. For example, due to the larger caseload size of at the Hewat Centre, managers recruited more staff within their set budget than the Bordon and Petersfield team. The Bordon and Petersfield and the Romsey teams had no staff vacancies at the time of the inspection. The Andover team had one vacancy for a psychologist and had struggled to recruit into this post. The Southampton team had one vacancy for a band five qualified nurse. The Hewat Centre had four vacancies altogether, with two band six qualified nurses appointed but waiting to start leaving one band five and band six vacancies to fill. The Eastleigh team had seen a high turnover of staff. This had affected the team's caseload and ability to provide a service without the support of other teams. As a result, two nurses from the Romsey team were helping the Eastleigh team with the management of patients on the caseload, while a band seven nurse from the acute mental health team helped with them with assessments. Eastleigh's vacancies comprised two band six nurses, one band five nurse and

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one band three support worker. The manager for the service told us that they had offered jobs to one band five nurse and one band six nurse. The high vacancy rate at Eastleigh, which had been a problem since November 2016, was on the risk register in order to escalate the issue.

- The Hewat Centre, providing services to the Fareham and Gosport region, held the largest caseload within the community mental health teams at 1143 patients. The Bordon and Petersfield and the Romsey teams held the smallest caseload of 298 patients and 102. Staff held individual caseloads for patients and we found that these varied across the teams. Staff told us that the aim was for full time staff to have between 20-30 patients on their caseload and this was generally being met across teams. However, Andover held a total caseload of 381 patients, and staff told us that their caseloads were very high, at between 60-80 patients per whole time equivalent worker. The manager at Andover acknowledged that this was too high and that ideally caseloads should be two-thirds the size. Staff at Eastleigh, where there were significant challenges due to vacancies, had caseloads of up to 44 patients. Extra duties and commitments, such as administering depot injections, monitoring patients on the medication clozapine and attending team meetings, affected staff's ability to see patients regularly. Staff at other sites echoed this and we found examples where, due to the pressures on workloads, staff had taken work home with them. Staff felt that extra responsibilities were not factored into their caseloads.
- There were no patients on a waiting list for a care coordinator at the time of the inspection. Referrals were allocated to staff following assessment. We found that it was not always possible to keep caseloads down and that if a patient needed allocating then they would be given to the person with the least pressure on their caseload as well as the best skill match to support. We noted that there were low numbers of patients allocated to the CPA framework across the whole service. The CPA (Care Programme Approach) is a way that care is assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. The trust told us that they were reviewing this to ensure patients were allocated to the framework appropriately.

- Managers recruited temporary bank and agency staff to cover for long-term sickness and vacancies. We found examples of block contracts being offered to temporary workers to ensure that risks due to staffing issues were mitigated. At the Hewat Centre, there were two bank staff to support with caseloads and assessments while the Eastleigh team had cover for administration staff and one band six nurse.
- Staff used a buddy system to cover for each other when they took annual leave or time off work for shorter periods. The buddy system provided each patient with an alternative point of contact and allowed for risks on a member of staff's caseload to be managed in their absence.
- Psychiatrists provided medical cover at each of the sites, and staff told us that they were able to call on the support of a psychiatrist when needed.
- Staff received mandatory training relevant to their role. This was around the 95% completion target set by the trust.

Assessing and managing risk to patients and staff

- Staff triaged referrals and prioritised according to the risk presented at assessment. For example, staff saw urgent referrals within 24 hours, soon referrals within two weeks and then routine referrals within seven weeks. For patients who were more acutely unwell and needed an urgent assessment, teams were able to refer to the Acute Mental Health Team for assessment and intense support.
- We reviewed 68 sets of care records, including progress notes, care plans and risk assessments, across the six teams we visited. The patients varied from those that had been in contact with the service for some time and those newly referred and assessed. This gave us a broad range of patients to review from a variety of backgrounds and with different diagnoses, treatments and needs. The trust held a policy on the management of clinical risk. This policy guided staff on risk formulation, how to identify and when to update risk information. For example, to update the electronic record when there were risk incidents and what actions to take in the event of a crisis.
- Of the 68 risk assessments reviewed, we found that risk assessments were completed for all of the patients. Staff stated that they updated risk assessments annually or

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when there was a change in risk. However, we found there was inconsistency around the updating of risk information within the assessments. For example, a patient who had taken an overdose that resulted in an admission to hospital had not had an updated risk assessment despite the progress notes documenting the overdose. There was inconsistency in the recording of risk, which differed across the teams. While there was information in each risk assessment, it was not always up to date and reflective of the change of risks in the progress notes and in the letters to external healthcare providers. We found out of date risk information in one in five of the risk assessments we reviewed across the six teams. This had been identified as an issue in the previous inspection, and so remains a breach of regulation that has resulted in a requirement notice.

- There was no consistent place to record crisis plan information and this meant that there were continued to be clear risks that important patient information was not easily available to staff, particularly in the event that patients presented in crisis outside of working hours. There were three crisis plan templates available on the electronic records system for staff to complete with patients. These were the 'my crisis plan', 'my safety plan' and then a combination of the two. An older style crisis plan was also still in place in many of the care records viewed. Staff were not consistently completing the new crisis or safety plans or the older style crisis plans with patients. Staff stated that they previously completed a risk assessment and a crisis plan for patients, but since the new plans had only recently been brought in they were yet to be completed with all patients. Managers told us prior to the inspection that the new crisis and safety plans had not been rolled out across the whole trust. For example, while Southampton teams were using 'my crisis' and 'my safety plans', the north of the county were yet to start using them and the Andover team were using the 'my crisis plan' but not the 'my safety plan'. The low use of the crisis and safety plans was reflected in figures submitted by the trust that showed low numbers of patients with these plans. On reviewing the records, we found that crisis planning information was not always in the expected area of the electronic record, and there were examples that were several years out of date. There were examples of crisis plans completed in only three of the 12 records reviewed in the Romsey team. Of

the 14 sets of notes reviewed in the Hewat Centre, only seven contained some form of crisis planning.

Altogether, across the teams there were specific crisis plans in place in 28 out of the 68 sets of notes we reviewed, meaning only 41% of those patients had completed crisis plans. We found that some staff had included details about who to contact in a crisis within letters to the patients but this was not consistent.

- The trust provided a shared care service for patients who were in need of more intense input but were not meeting the criteria for the acute mental health team. Shared care staff were able to offer increased regularity of appointments and input to patients whose mental health was deteriorating in order to avoid a full relapse.
- Staff were trained in safeguarding and there were clear procedures for raising safeguarding alerts with the local authority. Staff demonstrated good links with the multi-agency safeguarding hub and we saw logs of safeguarding issues that the teams had dealt with. A safeguarding lead at the city council was available for staff at the Southampton team to contact to discuss safeguarding concerns. Similar arrangements with local authority safeguarding teams were in place at the other teams. The local authority and the trust were no longer providing an integrated service and this meant that social workers working in safeguarding had been removed from the teams recently. The split of the social work element had meant that the team managers were meeting monthly in order to discuss safeguarding issues and ensure that the split of the teams worked well with consistent and effective communication. Social workers joined the weekly multidisciplinary team meetings.
- Staff followed the trust's lone working protocol for working on their own with patients in the community. Staff were able to describe the process for lone working and explained when they had to provide visits with more than one staff member. For example, if a patient posed a risk of physical violence towards others.
- Staff were provided with safe boxes to transport medicines to patients' houses. There were safe arrangements in place for the storage of medicines on the sites.

Track record on safety

Are services safe?

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- Information provided by the trust prior to inspection showed that there had been 75 serious incidents attributed to the community mental health teams in 2016.
- Underlying factors in serious incident reviews have consistently identified poor risk assessments and/or crisis plans. The trust has developed new risk assessment training and tools. In addition, a trust-wide care records working group was focusing on the on-going issues with consistency in quality of risk assessments and crisis plans. At a local level, managers within the service cascaded learning from serious incidents. For example, staff showed us from learning shared with them how they had been prompted to ensure that all patients under their care had an up to date risk assessment. This was after the finding from an investigation of a serious incident that there had been issues with documentation.

Reporting incidents and learning from when things go wrong

Staff recorded incidents on an electronic incident record. This ensured that incidents were escalated in a timely manner through to managers.

- Staff demonstrated understanding of what incidents needed to be reported on the system. Staff gave examples of learning from incidents and changes that had been made within their teams as a result. Staff received de-brief from their managers following an incident when necessary. We found several examples of staff being prompted to complete next of kin information in the electronic care records. There was a 44% completion of next of kin information in the care records and the trust were aware that they need to ensure this is improved to comply with the duty of candour requirement to notify the relevant person when something goes wrong.
- Managers cascaded information of incidents and learning through the team meetings. This ensured that staff were aware of changes within the trust and learning could be shared between teams.

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 were aware of the new executive team in the trust. However, the consensus was that while communication from the board had improved, it was too early to see any noticeable positive change.

Good governance

- The trust electronic governance system allowed managers to monitor the performance of the teams. For example, the completion of risk assessments, staff training compliance and the completion of next of kin information in the electronic records system. Managers demonstrated how they ensured that staff within their teams kept up to date with key performance indicators by using the tableau information in team meetings and in supervision sessions. Staff felt that tableau was a positive change in the oversight of performance of the team, and not just a reporting tool. Time was spent within the teams translating the information available on tableau into positive change.
- The trust had a risk register in place for each of the community mental health teams. Staff and managers were able to submit items to the risk register in order to escalate concerns. We found examples of good use of the risk register in order to monitor and track risks, as well as actions taken to improve safety for the service. For example, in the Eastleigh mental health team staffing issues had been placed on the register. This had resulted in a short-term solution to mitigate the risk of staffing issues as well as providing a long-term plan. Ligature risks at the Hewat Centre had been placed on the risk register and, as a result, there was a plan in place to mitigate the risks.

Leadership, morale and staff engagement

- Staff spoke positively of the local leadership within their teams. They had regular supervision and team meetings, and told us that the peer support was positive within the teams.
- However, we also found examples of staff feeling under pressure to get work completed within normal working

hours. At two of the sites visited, staff showed us examples of when they had to take work home. This was due to staffing issues and having to take on additional responsibilities such as covering a depot clinic.

- High sickness levels also affected normal workload at some of the teams. The highest sickness rate within the mental health teams we visited was at the Hewat Centre, where sickness stood at 13%.
- We identified no issues with bullying and harassment.
- Managers demonstrated situations where staff performance needed addressing. The steps taken had ensured that patient safety and risk was managed effectively, while ensuring positive staff development.
- Morale varied across the teams according to the pressures with workloads and staffing issues. Staff told us that the image of the trust in the news had affected them and the patients that they worked with. For example, staff had to reassure some patients that despite the trust receiving negative coverage in the news, they were still going to get a good service.
- Staff had an opportunity for leadership development within the trust. We found examples of plans to upskill staff within the team by chairing multidisciplinary team meetings and care programme approach meetings as well as putting staff forward for formal leadership modules. There were opportunities for secondment to leadership roles.
- Staff were open with patients if something went wrong with their care. Managers held a record of incidents and outcomes that required them to fulfil their duty of candour. We saw several examples of staff being prompted to complete appropriate next of kin information in the electronic care records as this was an area that the trust continues to need to improve.
- There were regular team meetings for staff to give feedback to managers on the development of the service.

Commitment to quality improvement and innovation

- Staff showed that they were committed to quality improvement and recognised the need to review and improve patient care. We found examples of

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participation in research and the need for staff to be supported to concentrate on patient focussed activity. There were team based quality improvement plans which staff were able to contribute to.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

There was poor and inconsistent completion of crisis plans and that there was risk information missing from care records we reviewed for people accessing the service.

This is a breach of regulation 12(2)(a)

Safe care and treatment

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

There was inconsistent completion of next of kin details in care records

This is a breach of regulation 17(2) (c)

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider had not ensured there were sufficient members of staff to meet the numbers of patients on the caseload.

This was a breach of regulation 18(1).