Solent NHS Trust

Quality Report

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Date of inspection visit: 27 - 30 June 2016
Date of publication: 15/11/2016

Core services inspected	CQC registered location	CQC location ID
Sexual Health Services	Royal South Hants Hospital St Mary's Hospital Crown Heights	R1C34 R1C17 R1CH3
Community Health Inpatient Services	Jubilee House St James Hospital St Mary's Hospital Western Community Hospital	R1CF5 R1CF2 R1C17 R1C03 R1C34
Community Health Services for Adults	St James Hospital St Mary's Hospital Western Community Hospital Royal South Hants Hospital Adelaide Health Centre	R1CF2 R1C17 R1C03 R1C34 R1CD1
Community Health Services for Children, Young People and Families	Solent NHS Trust Adelaide Health Centre	R1C R1CD1
Community End of Life	Western Community Hospital Jubilee House Jubilee Ward, Jubilee House	R1C03 R1CF5 R1CF5
Wards for older people with mental health problems	St James Hospital	R1CF2
Community-based mental health service for older people	St James Hospital	R1CF2
Community-based mental health services for adults of working age	St Mary's Hospital	R1C17

Summary of findings

Long stay/rehabilitation mental health wards for working age adults	St James Hospital	R1CF2
Mental health crisis services and health-based places of safety	St James Hospital	R1CF2
Specialist community mental health services for children and young people	St James Hospital Adelaide Health Centre	R1CF2 R1CD1
Community mental health services for people with learning disabilities	St James Hospital	R1CF2
Acute wards for adults of working age and psychiatric intensive care units (Acute wards or PICU)	St James Hospital	R1CF2
Substance misuse services	St James Hospital	R1CF2

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

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

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

Summary of findings

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Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

Letter from the Chief Inspector of Hospitals

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 3,400 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. Solent NHS Trust is the main provider of community services to people living in Portsmouth, Southampton and to parts of Hampshire. The trust is also the main provider of mental health services to people living in Portsmouth

Our inspection took place on 27-30 June 2016 and unannounced visits up until the 14 July 2016. We inspected the trust as part comprehensive inspection of community NHS trusts. We inspected 17 core services. This included five community services and nine mental health services and three primary medical services.

The community core services inspected were: community inpatients, adult services, end of life care services, sexual health services, and care of the child and young person services. We did not at this time inspect the dental core service.

The mental health core services inspected were: substance misuse services, acute wards for adults of working age and psychiatric intensive care units, community mental health services for people with learning disabilities, specialist community mental health services for children and young people, long stay/ rehabilitation mental health wards for working age adults, mental health crisis services and health-based places of safety, wards for older people with mental health problems, and community-based mental health services for older people.

The primary medical services (PMS) were general practice and health centres. Please review the specific reports on Portswood Solent GP, Adelaide Health Centre and Royal South Hants – Nicholstown. For information on the PMS inspection please review the specific location reports.

Overall, we rated the trust as 'requires improvement'. We rated the trust's services as 'requires improvement' for safe, effective and well led services. The trust was 'good' for providing caring and responsive services.

Community based services for adults were good overall but needed to improve safety, community based services for children and young people and families required improvement.

Mental health services for adults were good overall but needed to improve safety. Services for older people, children and young people, and substance misuse services required improvement.

Learning disability services were outstanding.

Our key findings were as follows:

- Staff were reporting incidents. The trust had a strong culture for reporting incidents and there was evidence of learning and action taken to improve services. However, the process was inconsistent and some community and mental health teams did not recognise what should be reported or take actions on incidents.
- Staff followed the Duty of Candour although staff understanding of the regulation, for example, the requirement to formally write to patients, needed to improve.
- Some staff were working with children and vulnerable adults without the appropriate level of training, including safeguarding training. Risks were not always managed or recognised to safeguard patients.
- Staff did not always store, prescribe or administer medicines appropriately or monitor their use.
- The trust had completed a ligature audit programme although it had not identified all ligature points,

including assessments of outside areas. Identified risks were not always mitigated. However, the trust responded quickly to concerns we raised at the time of the inspection. .

- Staff did not always check equipment before use.
- There were delays in the wheelchair provision and repair service commissioned by the Clinical Commissioning Group and provided by an external provider. This affected the safety and well-being of some patients who received adult community services.
- Staff completed risk assessments for patients but these were not always appropriately completed for children and young people in community and mental health services.
- Some services had staff shortages and had difficulty coping with demand. There were some missed and shortened appointment times in community and bed closures on mental health acute inpatient wards. Staffing levels did not meet planned levels in some services and there was an impact on patient care and outcome. In Portsmouth, community nursing staff had high workloads and there were missed patient visits. Children's health visitors had higher than recommended caseloads In the Southampton CAMHS, children's needs were not being fully met, and patients were not always appropriately monitored in Southampton substance misuse service
- In some instances, care was not fully delivered or took account of national and evidence based guidelines.
- The trust did participate in national and local audits, and nationally was identified as the top community trust involved in research.
- Patient outcomes varied. Some were similar to the England average for long term conditions; some indicators and performance targets were not being met, such as the Healthy Child Programme.
- Staff had appraisal and supervision. In one team, they reported that they did not always have training specific to their role.
- There was limited evidence in several mental health services that patients were involved in care planning and the standard of care planned varied.
- There were many examples of integrated multidisciplinary teams working well together particularly for patients with long-term chronic conditions. These often included team members from other organisations such as the local acute trusts, the local authority and a neighbouring community trust. The teams worked well together for the benefit of the patients.
- Staff were caring and compassionate and treated patients with dignity and respect.
- There was an outstanding patient centred culture in the learning disability services.
- Patients were involved in their care and treatment, although the CAMHS service did not have appropriate advocacy support to involve children and young people. Not all patients had care plans for older people in community mental health services and care was inconsistent because staff did not communicate with other agencies involved in their family member's care.
- Many services were focused on bringing care closer to people's homes, supporting early interventions, avoiding hospital admission and promoting self-management. There was evidence of integrated and collaborative working although this varied across geographical areas based on commissioning and strategic planning arrangements.
- Waiting times varied but overall were being met. For example, patients were being seen for cardiac and stroke care following discharge and patients had early intervention for psychosis. However, some services had long waiting times (over 18 weeks) for treatment, such as cognitive behaviour therapy for CAMHS. There was some variation in waiting times across Portsmouth, Southampton and Hampshire for the same type of services.
- The trust had considerable and ongoing IT connectivity problems and this sometimes directly impacted on patient care. Some staff could not access systems, some staff could not update systems in a timely way, and staff reported electronic information was sometimes missing.
- The operations model of two chief operating officers was developing. The model was based on the different strategic and commissioning approaches for the cities

Summary of findings

of Portsmouth and Southampton. However, the operational teams described feeling quite separate across the two cities, with different working practices across Portsmouth and Southampton. There was less evidence of shared learning, resources and staffing across the two cities. This had resulted in staff working under pressure in places and having varying impact on patient care delivery for the equivalent services across the two cities. Substance misuse services in Southampton and community nursing services in Portsmouth identified more risks to patients.

- The trust was developing a five year strategy, and was working with an operational plan to focus on prevention and early intervention to promote healthy lifestyles and reduce the risk of ill-health through better management of long-term conditions and an increasing emphasis on self-management, choice and personalisation of care.
- The trust has identified equal priority for physical and mental health and to work with partners across social care, primary care and other services to deliver more joined up services and care closer to home and avoid acute hospital admissions.
- The leadership team was relatively new and showed commitment, enthusiasm and pragmatism to develop and continuously improve services. There had been rapid pace of change to transform and sustain services, and this had meant uncertainty and some confusion with staff about local leadership and support. Some staff expressed feelings of isolation and an inability to contribute to changes and quality improvement at work.
- Governance arrangements were inconsistently developed and needed to improve to properly provide assurance around quality and risks. Services had quality dashboards but the quality of clinical and performance information needed to improve. Risks needed to be appropriately escalated to the board through the care group structure. Some risks were not known and some mitigating actions were not well developed or timely or had not led to improvements.
- There was insufficient quality monitoring oversight of contracts with external providers. This included an independent ambulance provider transporting mental health and s136 patients to a place of safety. This put patients at risk.
- Staff were positive about working for the trust and recognised the value of their service. However, morale was low across some areas due the uncertainty of reorganisation. The trust was worse than other similar trusts for its level of staff engagement. However, many staff reported the open and accessible culture that the new CEO was working to promote. Many service lines had action plans in response to the staff survey.
- Public engagement took place through a variety of means, such as surveys, patient forums community groups.
- There were many examples of innovation and improvement within the trust and staff were involved in quality improvement projects, new models of care, research and audit. The trust was developing a programme approach to ensure quality improvement was being managed effectively based on national models of best practice.
- The trust was in a position of financial deficit, and was working towards a financial recovery plan. Cost improvement programmes were challenging, and focused on the transformation of services and improving efficiency and management costs. Cost improvement programmes needed to have better monitoring information to determine the impact on service delivery.

We saw several areas of outstanding practice including:

- The trust was listed as the most research active trust in 2015/16 in the National Institute for Health Research National League Tables. There were many examples across community services of integrated working, new models of care, therapy based initiatives and early intervention projects to promote public health
- The trust had developed innovative processes for learning from mortality in community and mental health settings. A range of appropriate approaches had been developed which enabled a review or investigation into deaths across high priority settings (mental health, learning disability, children services & community services), as well as in primary care, dental and sexual health – areas that are often 'hard to reach' in terms of investigating mortality in the NHS. Learning was shared within the trust and with its commissioners and stakeholders. The trust was developing its approach across Hampshire and Isle of Wight and was working with national organisations to further develop the process.

Summary of findings

- We observed areas of good and innovative practices in some community services. This included 'The Trache' bus' within the children and young people's community service and COAST, the paediatric specialist care service.
- Tulip Clinic in particular for sex industry workers and exploited children was noted for its very good practice.
- Community mental health services for people with a learning disability were an excellent inclusive service; service users were at the centre of the service and were very involved in their care.

However, there were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider must take action to improve the following services:

The main actions identified are to ensure:

Community services

- There are sufficient numbers of suitably qualified staff in all **community adult teams** to ensure consistently safe and timely care is given as planned to meet patient's needs.
- Patients are protected against the risks of unsafe or inappropriate care and treatment arising from incomplete patient records or an inability to access electronic patient records when required by staff, including bank staff.
- The trusts works with the external provider of wheelchairs and commissioners to provide wheelchairs in a more responsive and timely way. The safety and well-being of patients was currently at risk because of the long waiting times for wheelchairs.
- Medicines are safely managed in **community children, young people and families services**, specifically the school services, staff receive appropriate training, supervision and competency assessments, and staffing levels are as planned to deliver appropriate levels of care.
- The quality of mental capacity assessments in community wards improves and patient records and care plans are completed fully, in a timely manner and used appropriately in **community end of life care services**

Mental Health

- Patients with potential safeguarding issues are managed safely on the **acute ward, Hawthorn ward, and the psychiatric intensive care unit Maple ward.** There was no clear segregation of male and female bedrooms in one corridor on Maple Ward (PICU) which was in breach of Department of Health guidance on mixed sex accommodation.
- **Long stay/rehabilitation mental health wards for working age adults,** the Oakdene unit: remove non-collapsible curtain rails, and ensure other anti-ligature work identified in its audit is completed
- **The ward for older people with mental health problems,** Brooker Unit , will assess, monitor and manage risks appropriately, including staff competence and training, resuscitation procedures, safeguarding procedures, managing mixed sex environments and the administration of medicines.
- **Community-based mental health services for older people** take reasonable steps to provide opportunities to involve people in making decisions about their care and treatment, and support them to do this, and ensure that physical health checks are carried out in line with the national guidelines.
- Staff have appropriate training, and there are appropriate governance systems to monitor **mental health crisis services and the health-based places of safety.** This includes appropriate governance of the private ambulance provider for the health-based place of safety.
- Risks assessments are completed for all **children and young people in specialist community mental health services**, and there is an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment. Crisis plans are completed for all young people who are assessed as requiring them to keep them safe. Staffing levels are as planned and staff have appropriate training.
- There is appropriate monitoring of prescribing, and staffing levels are as planned to be able to manage caseloads in **Southampton substance misuse services.**

The trust MUST also ensure

Summary of findings

- The trust is to work with NHS England to agree a formal escalation policy for patients who require mental health forensic services.
- All serious incidents are investigated so that wider lessons are learnt and human factors understood.
- Complaints are handled in a timely manner.
- Governance arrangements are effective and identify, assess, monitor and manage risk and quality issues appropriately.
- Staff engagement continues to improve.
- Cost improvement programmes are effectively monitored and managed in terms of impact on staff and patients.

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

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

We always ask the following five questions of services.

Are services safe?

Requires improvement 

Overall we rated the trust as 'requires improvement' for safe. For specific information, please refer to the core service reports for community health services and mental health services at Solent NHS Trust

We rated the trust as requires improvement for safe because

- Staff were not consistently reporting incidents across some community and mental health teams and did not always recognise what should be reported as an incident.
- Not all staff we spoke to understood the full requirements of the Duty of Candour and the trust policy needed to be updated to comply with the NHS contract standard.
- Incidents and patients' records were not always recorded and updated in a timely way due to IT connectivity issues and pressure on staff's time. This posed a risk to patient care.
- Most bank nurses did not have password access to electronic patient record systems, and were dependent on access via substantive staff. This contravened information governance principles and nursing and midwifery code of practice.
- Compliance with safeguarding training was below the trust target: the relevant staff had not all completed level 3 training as needed when working with children and young adults. Risks were not always managed or recognised to safeguard vulnerable adults on mental health inpatient wards.
- Medicines were not always stored, prescribed or administered or monitored appropriately in children's and young people (school) services, substance misuse services, mental health long stay rehabilitation services, older peoples mental health wards or on the Jubilee Ward.
- Ligature points were assessed. However, potential ligature points had been not fully identified on the mental health inpatient wards. Action had not been taken to remove ligature points on the mental health long stay rehabilitation ward
- Risks associated with mixed sex wards on older people mental health ward were not being managed in line with current DH guidelines.
- The environment and cleanliness at Bitterne Health Centre did not fully support safe care.
- The delays in wheelchair provision and repair service through an external provider affected the safety and well-being of some patients who received adult community services.

Summary of findings

- Some equipment was not checked and tested to ensure it was safe to use and fit for purpose. Not all staff were aware of the process to order and obtain essential patient safety equipment, particularly out of hours and weekends.
- Staff did not always have appropriate levels of mandatory training, and staff on the older people mental health wards did not have access to appropriate training in medication management and violence and aggression.
- Staffing levels did not meet planned levels in some services and there was an impact on patient care and outcome. In Portsmouth, community nursing staff had high workloads and there were missed patient visits. In children's and young people's services there were higher than recommended health visitor caseloads in deprived areas. In the Southampton CAMHS service children needs were not always being fully met.
- There was unequal care delivery across Southampton and Portsmouth when staff shortages affected teams offering the same type of trust service. For example, patients were at higher risks in Southampton substance misuse service than in Portsmouth, and in community nursing in Portsmouth than in Southampton. Staff were not shared across teams.
- Risks assessments were not always appropriately completed for children and young people in community and mental health services.

However,

- Overall, the trust was a consistent reporter of incidents nationally and was in the top 25% compared with other similar trusts. Many staff reported incidents and there was evidence of lessons learnt.
- The trust had commissioned a review of serious incidents and mortality management and recommendations were being used to ensure a more consistent approach.
- The trust followed the Duty of Candour where appropriate.
- Relational security in the mental health ward environments was good.
- Across the trust most environments were visibly clean.
- Most medicines were secured and stored safety.
- Risk assessments were holistic and comprehensive for most adult patients both in community and mental health services.
- Staffing levels met planned levels in some areas, including community and mental health inpatient areas. Recruitment was ongoing and vacancy levels were decreasing.
- In the learning disability service, service users were actively encouraged to manage their own risks.

Summary of findings

Are services effective?

Requires improvement 

Overall we rated the trust as 'requires improvement' for effective. For specific information, please refer to the core service reports for community health services and mental health services at Solent NHS Trust

We rated the trust as requires improvement for effective because

- Some mental health services did not use nationally recognised standards or good practice including HoNOS and National Institute for Health and Care Excellence (NICE) guidelines. For example, psychological therapies were not provided in long stay rehabilitation or CAMHS services as recommended by NICE. National guidelines were not followed in substance misuse services.
- Some mental health services could not demonstrate that patients were involved in care planning and the standard of care planned varied.
- Some audits had not led to the development of local action plans and improvements.
- Some staff could not access training because of workload and some staff were not always provided with training specific for their role, for example, dementia training in older people's service and training in dealing with younger people in CAMHS.
- Clinical supervision was ineffectual in some of the school services of the children and young people community services where clinical practice was not always up to date.
- Some performance targets in children and young people services and sexual health services were not achieved.
- Staff in some mental health services did not have training or did not appropriately assess patient's mental capacity.

However,

- In community services, most care was delivered that took account of national guidance. There was participation in national and local audits and patient outcomes, where known, were broadly similar to other trusts.
- Patients had their pain assessed and monitored depending on their needs. There were processes for obtaining pain relief for patients out of hours in the community and for end of life care patients.
- Patients had their nutritional needs assessed and there were appropriate referrals to specialists.
- The trust had an innovative approach to review the learning from unexpected deaths across services. Over the last six months, all unexpected deaths had had a mortality review or serious incident/ high risk investigation.

Summary of findings

- Most staff had appraisal and supervision and access to training and development
- There were many examples of integrated multidisciplinary teams working well together particularly for patients with long-term chronic conditions. These often included team members from other organisations such as the local acute trusts, the local authority and a neighbouring community trust. These teams worked well together for the benefit of the patients.
- Patient consent was appropriately obtained and most staff understood their roles and responsibilities regarding the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- Portsmouth CAMHS service had achieved accreditation and CAMHS learning disability services accreditation for excellence by the quality network for community CAMHS.

Are services caring?

Good

Overall we rated the trust as 'good' for caring. For specific information, please refer to the core service reports for community health services and mental health services at Solent NHS Trust

We rated the trust as good for caring because

- Staff provided compassionate care and treated patients with dignity and respect. Feedback from patients, carers and family members was consistently positive.
- Patients were involved in their care and treatment and staff took time to explain care and treatment and services in ways patients could understand.
- We observed staff supporting patients with care and kindness, including ancillary and non-clinical staff, within busy service environments. For example, this was evidenced in Jubilee Ward at Jubilee House, Portsmouth, and Fanshawe Ward, Southampton.
- Caring in the Mental Health Learning Disability unit was outstanding. All staff had a focus on enabling and empowering service users to achieve their goals. Service users had an active voice in how the service was delivered through a well-run participation group, seeking of service user's views, and service users working in the service as volunteer trainers.
- Patients told us staff met their emotional needs by listening to them, by providing advice when required, and responding appropriately to their concerns. There were many examples where staff were working to support patients' and their carers' wellbeing, spiritual and psychological needs. This included setting up support groups and working with the voluntary sector.

Summary of findings

However:

- Some clinic receptionist staff did not always display compassion, respect and consideration to patients.
- In the specialist MH children's and young people's service, there was no evidence of patient advocacy, and no evidence of the young person's involvement in their care and treatment.
- In community mental health services for older people, not all patients had care plans and these were not routinely given to patients. The patients did not know how to get involved in their care, and carers said care was inconsistent because staff did not communicate with other agencies involved in their family member's care.
- There was variation in the provision of spiritual and pastoral support for community inpatients and teams. Some wards and teams did not have direct access to a chaplaincy service although a spiritual strategy was being developed.

Are services responsive to people's needs?

Good

Overall we rated the trust as 'good' for responding to people's needs. For specific information, please refer to the core service reports for community health services and mental health services at Solent NHS Trust

We rated the trust as good for responding to people's needs because

- The learning disability service was outstandingly responsive to the needs of its' patient group
- Many services were focused on bringing care closer to people's homes, supporting early interventions, avoiding hospital admission and promoting self-management. There was evidence of integrated and collaborative working, although this varied across geographical areas based on commissioning and strategic planning arrangements.
- Many services were responsive and waiting times were being met. For example, patients were being seen for cardiac and stroke care following discharge, and patients had early intervention for psychosis. The CAMHS service met targets to assess children for mental health conditions.
- Staff had good awareness of equality and diversity and action was taken to improve access to services and people's understanding about their care.
- Action was being taken to support vulnerable people using the service.
- Access to sexual health services had improved since the inspection in 2014

Summary of findings

- There was good access for the acute mental health inpatient wards to transfer patients quickly to the psychiatric intensive care unit

However:

- Some services had staff shortages and had difficulty coping with demand. There were missed and shortened appointment times in community services, and bed closures on mental health acute inpatient wards.
- Patients had long waiting times of over 18 week's treatment in some services. There was variation in waiting times across Portsmouth, Southampton and Hampshire for the same type of services.
- The Healthy Child Programme was not meeting its targets. Waiting times for some CAMHS services such as cognitive behaviour and autism were lengthy.
- Patients had limited access to therapy service in rehabilitation services and to psychology services.
- Some services could not be sustained, and the trust had made the decision to withdraw contracts. However, patients had not been adequately informed of service changes in podiatric surgical services, and patients still travelled to clinic appointments with surgical expectations.
- There were long delays in wheelchair provision which affected the ability of community staff's responsiveness; some patients had waited up to two years for a suitable wheelchair. The demand for the service was greater than the level of commissioning. However, the monitoring arrangements and actions that trust had taken had yet to improve the responsiveness of the service or the risk to patient safety and well-being.
- There was evidence of learning and improvement as a result of responding to complaints. However, the trust was not always meeting national and local trust target response times.
- On the mental health long stay rehabilitation ward, the use of the bathroom was supervised to ensure safety but this impacted on patient's privacy and dignity.

Are services well-led?

Requires improvement 

Overall we rated the trust as 'requires improvement' for well-led. For specific information, please refer to the core service reports for community health services and mental health services at Solent NHS Trust

We rated the trust as requires improvement for well-led because

Summary of findings

- Governance arrangements were not well developed and needed to improve to properly provide assurance around quality and risks. Services had quality dashboards but the quality of clinical and performance information needed to improve. Risks needed to be appropriately escalated to the board through the care group structure. Some risks were not known to senior staff, and some mitigating actions were not well developed or timely or had not led to improvements.
- There had been rapid pace of change to transform and sustain trust services, and this has meant uncertainty and some confusion with staff about local leadership and support. Some staff expressed feelings of isolation and an inability to contribute to changes and quality improvement at work.
- Staff were positive about working for the trust and recognised the value of their service. However, morale was low across some areas due to the uncertainty of re-organisation and some staff groups working under pressure. The trust was worse than other trust for staff engagement based on the NHS staff survey 2015. However, many staff reported the open and accessible culture that the new CEO was working to promote.
- Cost-improvement programmes needed better monitoring information to determine the impact on services.

However,

- The trust was developing a five year strategy and was working with an operational plan to focus on prevention and early intervention to promote healthy lifestyles, and reduce the risk of ill-health through better management of long-term conditions and an increasing emphasis on self-management, choice and personalisation of care.
- The trust has identified equal priority for physical and mental health, and works with partners across social care, primary care and other services to deliver more joined up services and care closer to home and avoid acute hospital admissions.
- The leadership team showed commitment, enthusiasm and pragmatism to develop and continuously improve services.
- Public engagement took place through a variety of means, such as surveys, patient forums and community groups.
- There were many examples of innovation and improvement within the trust, and staff were involved in quality improvement projects, new models of care, research and audit. The trust was developing a programme approach to ensure quality improvement was being managed effectively based on national models of best practice.

Summary of findings

- The trust had a historical financial deficit and was working towards a financial recovery plan. Cost improvement programmes were challenging and focused on the transformation of services and improving efficiency and management costs.

Summary of findings

Our inspection team

Our inspection team was led by:

Team Leader: Joyce Frederick, Head of Hospital Inspection, CQC.

Inspection Managers: Moira Black, Inspection Manager of acute and community hospitals, CQC: Gary Risdale, Inspection Manager of mental health hospitals, CQC.

The team comprised 33 CQC staff including four inspection managers, inspectors, an assistant inspector and support staff. We were assisted by 28 specialist advisors, including doctors, community nurses, board level clinicians and managers, a governance lead, safeguarding lead and other health professionals. We were also joined by four experts by experience who are people who have used services.

Why we carried out this inspection

We inspected Solent NHS Trust as part of our planned, comprehensive inspection programme.

How we carried out this inspection

When we inspect, we always ask the following five questions of every service and provider:

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

Before the inspection visit the inspection team:

- Requested information from the trust and reviewed the information we received.
- Asked a range of other organisations for information they held; this included NHS Improvement, NHS England, clinical commissioning groups, local councils, Healthwatch, Royal College of Nursing, other professional bodies, user and care groups.
- Sought feedback from patients and carers.
- Conducted 40 focus groups, and spoke with a range of staff in the trust, at many locations, including nurses, medical staff, allied healthcare professionals, governors, clerical, administrative and portering staff, catering and domestic staff, and pharmacists.

During the announced inspection visit from 27-30 June 2016 and unannounced visits up until the 14 July 2016, the inspection team:

- spoke with 598 staff and 110 managers
- reviewed 341 clinical records
- interviewed directorate and service managers, and the trust senior management team
- conducted 10 focus groups, and spoke with a range of staff in the trust, at many locations, including nurses, medical staff, allied healthcare professionals, governors, clerical, administrative and portering staff, catering and domestic staff, and pharmacists.
- spoke with 139 patients and 56 carers of people using services
- spoke with 37 external stakeholders
- attended 46 clinical meetings
- observed 42 clinical appointments
- observed care on the wards and in clinics
- visited 11 wards and 87 locations
- joined healthcare professionals for home visits
- looked at a range of policies, procedures and other documents relating to the running of the trust.
- requested and analysed further information from the trust to clarify what was found during the inspection visits.
- had a tour of the premises at each location.

Summary of findings

We visited all of the trusts' mental health locations and a large sample of the community health services. We inspected 17 core services. This included five community services and nine mental health services and three primary medical services.

The community core services inspected were: community inpatients, adult services, end of life care services, sexual health services, and care of the child and young person services. We did not at this time inspect the dental core service.

The mental health core services inspected were: substance misuse services, acute wards for adults of working age and psychiatric intensive care units, community mental health services for people with learning disabilities, specialist community mental health services for children and young people (also referred to as child and adolescent mental health services or CAMHS), long stay/rehabilitation mental health wards for working age adults, mental health crisis services and health-based places of safety, wards for older people with mental health problems, and community-based mental health services for older people.

The primary medical services (PMS) were general practice and health centres. Please review the specific reports on Portswood Solent GP, Adelaide Health Centre and Royal South Hants – Nicholstown. For information on the PMS inspections please review the specific location reports.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality and treatment at Solent NHS Trust

Information about the provider

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 3,400 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. Solent NHS Trust is the main provider of community services to people living in Portsmouth, Southampton and to parts of Hampshire. The trust is also the main provider of mental health services to people living in Portsmouth. The trust delivers over 1.25 million patient contacts each year.

Southampton and Portsmouth each cover a relatively small urban geographic area and have a population of around 200,000 people with significant health inequalities and areas of deprivation significantly worse than the England average. 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.

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 an acute hospital. These include rehabilitation and reablement teams and 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 models of delivery of services varies across 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 this is provided by the local NHS acute trust. The trust provides specialist inpatient and community end of life care in Portsmouth, whereas in Southampton the local 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.

Summary of findings

The trust provides adult mental health and learning disability services to all ages in Portsmouth.

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.

Solent NHS Trust had a comprehensive inspection in March 2014, although it was not rated at this time. The trust had four compliance actions to improve the environment of the Kite Unit to comply with the Mental Health Act, to improve access to sexual health service and to improve staffing levels in community and mental health teams to meet the needs of patients.

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.

- Mental Health Act (MHA) training was not part of the mandatory training which meant the trust was unable to monitor compliance with this. However, the trust identified in the preparation of data for the inspection that MHA training was a deficit in their training programme and commenced increased MHA training opportunities for staff. We were concerned that none of the crisis team had received training.
- Despite the lack of mandatory training, staff in both inpatient and community settings displayed a good knowledge of the Act, the code of practice and its guiding principles.
- On inpatient wards, detention paperwork was of a high standard and patients' rights under section 132 were read and repeated appropriately. Staff adhered to the code of practice. Ward managers undertook regular audits of the paperwork.
- Where patients lacked capacity, automatic referrals were made to an independent Mental Health Act advocate (IMHA).
- Staff in both inpatient wards and community teams were aware that legal advice could be sought from a centralised MHA team. Staff found the advice and support offered by the team to be helpful and appropriate.
- Six patients with a learning disability from the area were detained under the Mental Health Act in hospitals outside of the region. The learning disability service had an identified clinician who acted as care coordinator for all of them and was actively involved in their reviews with an aim of returning them to the Portsmouth area if possible.
- Patients in the community who were subject to community treatment orders (CTO) had regular reviews and the paperwork was completed to a good standard.

However,

- The health-based place of safety was managed and staff by a private ambulance service. The service transports patient who might need to be detained by the police for their own safety under Section 136 of the Mental Health Act 1983. The trust provided the premises and was responsible for the oversight of the service. However, the trust had no day-to-day oversight of activity in the health-based place of safety, it was possible for patients to be admitted and discharged under the Mental Health Act without coming to the attention of the hospital managers. The information provided by the ambulance service to the trust was not comprehensive; it did not provide information around how long patients waited for assessment.

Summary of findings

What people who use the provider's services say

- Many patients we spoke with were complimentary about the staff, and told us staff were caring, friendly and sensitive to their needs. Some patients also acknowledged the high degree of professional knowledge shown by specialist staff in the trust.
- Relatives said they were regularly updated about progress, kept informed of arrangements to be made, and asked for their input into their loved ones' care and treatment planning.
- Staff from outside organisations told us that clinical staff were empathetic, kind and often "went the extra mile" to deliver a caring service, even when working under considerable operational pressure.
- The NHS Friends and Family test results (March 2016) for community patients demonstrated the percentage of patients that would recommend the trust as a place to receive care was 96%. This was above the English national average (95%). The response rate was below the England national average at 2.2% compared to 3.4%. Figures had been similar from October 2015 – March 2016.
- The Friends and Family test results (March 2016) for mental health patients demonstrated the percentage of patients that would recommend the trust as a place to receive care was 94%. This was above the English national average (87%). The response rate was also above the England national average at 4.1% compared to 2.5%. Figures had been similar from October 2015 – March 2016.
- The trust scored about the same as other trusts in the CQC community mental health survey (2015). The survey asks service users about staff, their care and treatment and experience of the service.
- Patient-led assessment of the care environment (PLACE) were self-assessments undertaken by teams of NHS and independent healthcare staff, and also by the public and patients. They focused on the environment. In 2015, the trust scored higher than the national average for cleanliness (98%, compared to 97% nationally), food (93%, compared to 88%), facilities (93%, compared to 90%) and privacy, dignity and well-being (91%, compared to 87%).

Good practice

- The trust was listed as the most research active trust in 2015/16 in the National Institute for Health Research National League Tables. There were many examples across community services of integrated working, new models of care, therapy based initiatives and early intervention projects to promote public health.
- The trust had developed innovative processes for learning from mortality in community and mental health settings. A range of appropriate approaches had been developed which enabled a review or investigation into deaths across high priority settings (mental health, learning disability, children services & community services), as well as in primary care, dental and sexual health – areas that are often 'hard to reach' in terms of investigating mortality in the NHS. Learning was shared within the trust and with its commissioners and stakeholders. The trust was developing its approach across Hampshire and Isle of Wight and was working with national organisaitons to further develop the process.
- We observed areas of good and innovative practices in some community services. This included 'The Trache' bus' within the children and young people's community service and COAST, the paediatric specialist care service.
- Tulip Clinic in particular for sex industry workers and exploited children was noted for its very good practice.
- Community mental health services for people with a learning disability were an excellent inclusive service; service users were at centre of the service and were very involved in their care.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Actions the provider MUST take.

Community Health Inpatient Services

The provider must ensure:

- Medicines are stored at recommended temperatures, through daily monitoring of storage areas and fridges, with clear processes for action if outside recommended range of temperatures.
- Interpretation services are available.

Community Services for Adults

The provider must ensure:

- There are sufficient numbers of suitably qualified staff in all community teams to ensure consistently safe and timely care is given as planned to meet patient's needs.
- Patients are protected against the risks of unsafe or inappropriate care and treatment arising from incomplete patient records or an inability to access electronic patient records when required by staff, including bank staff.
- They work with the external provider of wheelchairs to provide wheelchairs in a more responsive and timely way.
- Staff are aware and understand the full requirements of the duty of candour, to be correctly carried out.
- All facilities used for patient care are provided with emergency alarms.
- Appropriate standards of cleanliness are maintained in all clinical environments to provide safe patient care.

Community Health Services for Children, Young People and Families

The provider must ensure:

- Urgent equipment such as suction machines must be available in schools in order to meet the needs of children and young people.
- Medicines within school settings are administered safely and must include a valid prescription and protocol for "as required" medicines.
- Medicines within school settings are administered from the original labelled container ensuring medicines are given to the correct patient, correct dose, appropriate information and advice.
- Medicines within school settings are stored safely and securely and in-line with current legislations, trust policies and standard operating procedures.
- Staffing is reviewed and there are adequate staff to deliver the healthy child programme, health visiting and school nursing services.
- Robust processes are developed for identifying risk and monitoring quality across all services particularly school nursing.
- Staff receive training and appropriate supervision of their practices and their competencies are assessed when they are undertaking extended roles.

Community End of Life

The provider must ensure:

- Review the quality of mental capacity assessments in community wards.
- Ensure that patient records and care plans are completed fully, in a timely manner and used appropriately.

Community Sexual Health Services

The provider must ensure:

- Staff leading specialist clinics receive level 3 safeguarding children training.

Substance misuse services

The provider must ensure:

- Staff in the prescribing services review prescriptions regularly and policies are in place clearly outlining staff responsibilities in this.
- Staff are supported effectively to monitor and manage caseloads.
- Staff complete all safe storage visits for clients with children, and embed a system to identify which new clients starting treatment need a home visit.
- All clients have a prescribing care plan in place.
- There are sufficient staffing levels to safely manage and review clients who are in receipt of prescriptions.

Summary of findings

- Services have signed patient group direction forms (PGD).
- There is clear discharge planning for all clients accessing the prescribing service. This includes those clients who routinely do not attend appointments or who disengage.
- Managers add all risk items to the service risk register on an ongoing basis.
- Staff attend mandatory training.

Specialist community mental health services for children and young people

The provider must ensure:

- Risks assessments are completed for all young people and there is an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment.
- Crisis plans are completed for all young people who are assessed as requiring them to keep them safe.
- Care records contain up- to- date care plans to support staff to care for and treat young people safely.
- All staff receive training specific to their role. In Southampton, assessments were being completed by clinicians who did not have sufficient training to do so.
- Children and young people do not have access to knives in the unlocked kitchen in Southampton CAMHS and access to the photocopying cupboard and doctor's interview room in Portsmouth CAMHS.
- Governance systems are effective. Systems should ensure consistency in standards and work processes across the different community CAMHS teams; manage the waiting lists; ensure there are sufficient staff to care and treat young people; ensure recommendations from serious incidents are met and systems are in place to assess the risks to young people whilst they were waiting for assessment or treatment.

Mental health crisis services and health-based places of safety

The provider must ensure:

- All staff received their mandatory training and that they have all received appropriate training for their work place.
- The review of the health-based places of safety standard operating procedure takes place. It must receive the appropriate level of scrutiny and address every deviation from the multi-agency policy that covers the other health-based places of safety suites in Hampshire.
- The governance systems in place to monitor care in the health-based places of safety are comprehensive and allow for effective monitoring of safety and quality.
- All incidents that occur within the health-based places of safety are recorded effectively on the trust`s incident system and that relevant risk information is passed on as appropriate.
- The safety of all staff working in the premises.

Long stay/rehabilitation mental health wards for working age adults

The provider must ensure:

- Non-collapsible curtain rails are removed and other anti-ligature work identified in its audit is completed.

Wards for older people with mental health problems

The provider must ensure:

- Staff are aware how to use ligature cutters and where to find them. It also must ensure that all information relating to the management of ligature risks is documented clearly.
- Incidents of patient on patient assaults are reviewed and that safeguarding referrals are made appropriately.
- The resuscitation status is known for all patients and there are systems in place to avoid error.
- Procedures are in place to maintain the safety of individual patients within a mixed sex environment, in line with national guidance.
- All confidential information is stored securely.
- There are systems and processes in place to monitor, assess and evaluate procedures and practices, including staff competence and training, resuscitation procedures, safeguarding procedures and managing mixed sex environments.

Community-based mental health service for older people

The provider must ensure:

- Physical health checks are carried out in line with the national guidelines.

Summary of findings

- Staff review their caseloads in the memory assessment service to ensure staff are able to review patient's medication six monthly in line with national guidance.
- Policies and procedures are followed about managing medicines in line with current legislation and guidance, including those related to storage and transportation
- The leaders and manager of the service have access to appropriate policies, procedures and documentation in order to be assured of the effective management of the service.

Acute wards for adults of working age and psychiatric intensive care units (Acute wards or PICU)

The provider must ensure:

- Potential ligature points in garden areas are on the ligature risk audit and mitigated safely.
- Patients with potential safeguarding issues are managed safely. There must be clear cohesive care plans reflecting these risks.
- Wards do not breach the Department of Health guidance on mixed sex accommodation.

The trust MUST ensure

- Serious incidents are investigated so that wider lessons are learnt and human factors understood
- Complaints are handled in a timely manner.
- Governance arrangements are effective and identify, assess, monitor and manage risk and quality issues appropriately
- Staff engagement continues to improve
- Cost-improvement programmes are effectively monitored and managed in terms of impact on staff and patients.

There are further actions the provider SHOULD take to improve. These are detailed in each specific core service reports.

Solent NHS Trust

Detailed findings

Requires improvement

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

Summary of findings

We rated the trust as requires improvement for safe because,

- Staff were not reporting incidents across some community and mental health teams and did not always recognise what should be reported as an incident.
- Not all staff we spoke to understood the full requirements of the Duty of Candour and the trust policy needed to be updated to comply with the NHS contract standard.
- Incidents and patients' records were not always recorded and updated in a timely way due to IT connectivity issue and pressure on staff time. This posed a risk to patient care.
- Most bank nurses did not have password access to electronic patient record systems, and were dependent on access via substantive staff. This contravened information governance principles and the nursing and midwifery code of practice.
- Compliance with safeguarding training was below trust target because the relevant staff had not completed level 3 training as required when working with children and young adults. Risks were not always managed or recognised to safeguarding vulnerable adults on mental health inpatient wards.
- Medicines were not always stored, prescribed, administered or monitored appropriately in some of the children's and young people services, substance misuse services, mental health long stay rehabilitation services or older peoples mental health wards.
- Staff had not identified and assessed some potential ligature points on the mental health inpatient wards. Action had not been taken to remove ligature points on the mental health long stay rehabilitation ward.
- Risks associated with mixed sex wards on the older people mental health ward were not being managed in line with current DH guidelines.
- The environment and cleanliness at Bitterne Health Centre did not always support safe care
- The delays in wheelchair provision and repair service through an external provider affected the safety and well-being of many patients who received adult community services.
- Some equipment was not checked and tested to ensure it was safe to use and fit for purpose. Not all staff were aware of the process to order and obtain essential patient safety equipment, particularly out of hours and weekends.

Requires improvement

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- Staff did not always have appropriate levels of mandatory training, and staff on the older people mental health wards did not have access to appropriate training in medication management and violence and aggression.
- Staffing levels did not meet planned levels in some services and there was an impact on patient care and outcomes. In Portsmouth, community nursing staff had high workloads and there were missed patient visits. In children's and young people's services, there were higher than recommended health visitor caseloads in deprived areas. In the Southampton CAMHS service, children needs were not always being met.
- There was unequal care delivery across Southampton and Portsmouth when staff shortages affected teams offering the same type of trust service. For example, patients were at higher risk in Southampton substance misuse service than in Portsmouth, and in community nursing in Portsmouth than in Southampton. Staff were not shared across teams.
- Risk assessments were not always appropriately completed for children and young people in community and mental health services.

However,

- Many staff reported incidents and there was evidence of lessons learnt.
- The trust was a consistent reporter of incidents nationally and was in the top 25% compared with other similar trusts
- The trust had followed the Duty of Candour where appropriate.
- Relational security in the mental health ward environments was good.
- Across the trust most environments were visibly clean.
- Most medicines were secured and stored safety.
- Risk assessments were holistic and comprehensive for most adult patients both in community and mental health services.
- Staffing levels met planned levels in some areas, including community and mental health inpatient areas.
- In the learning disability service, service users were actively encouraged to manage their own risks.

Our findings

Safety performance

- The trust reports all patient safety incidents of any severity to the National Reporting and learning service at least once a month. The trust was considered to be a consistent reporter as 50% of incidents were submitted more than 24 days after the incident occurred compared to 27 days nationally. The trust reported 2,564 incidents to the NRLS between 1 January 2015 and 31 December 2015. When benchmarked, the trust were in the top 25% of reporters of incidents when compared with similar trusts.
- The NRLS considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture. The majority of incidents reported were no harm (48.6%) or low harm (43.5%), 5.4% were moderate harm, 0.4% severe harms and 2.1% resulted in death. Of the incidents reported to NRLS the majority related to 'Patient Accident' Implementation of Care and Ongoing Review and 14.4% to 'Medication'.
- In the period 1 January 2015 – 31 December 2015, the trust reported 151 serious incidents to the Strategic Executive Information System (STEIS). The majority of these were in community nursing (57.6%) and concerned pressure ulcers. None of these were Never Events. Never events are serious, largely preventable patient safety incidents that should not happen if the available preventative measures have been used.
- In the period 3 January 2015 to 12 February 2016, the trust reported 168 serious incidents that require an investigation. The majority of these related to adult community health services and 86% related to an unexpected or avoidable death or severe harm; this was 8% in mental health services.
- The trust monitored NHS safety thermometer data about the care provided by the community services for adults. The NHS safety thermometer was a monthly snapshot audit of progress in providing harm- free care for patients. The types of harm monitored included falls, new pressure ulcers, urinary tract infections and venous

thromboembolism (blood clots). For the months of April, May and June 2016 the average percentage numbers of patients that received harm free care was between 94.2% and 97.7%, an overall average of 96.2%.

- Individual localities within community and mental health services had quality dashboards. These monitored safety information, such as healthcare associated infections, avoidable pressure ulcers acquired in the community, information governance breaches as well as information related to workforce and patient experience feedback.

Incident reporting, learning and improvement

- The trust had systems to report and record safety incidents, near misses and allegations of abuse. Many staff we spoke with knew how to recognise and report incidents on the trusts electronic recording system. Staff could describe examples of reportable incidents such as accidents, pressure ulcers, medication errors, slips, trips and falls. However, staff in community children and young people's services had not reported incidents due to staffing shortages and high workload, and some did not recognise what incidents should be reported. Staff in older people's mental health services and Southampton substance misuse teams were not reporting incidents.
- There were some areas of significant concern. Due to lack of equipment or IT connectivity issues, community staff reported they could not always access on-line reporting in the community but had to return to a hub office to do so and this caused delays. The recording of incidents at the health-based place of safety suite did not record ligature incidents for a patient and this put patients at risk because of recurrence.
- The trust identified itself as a high reporter of incidents across community and mental health services. Incidents were appropriately investigated by trained staff and this was now being done in a timely way. There was evidence of shared learning across learning locality teams although this was inconsistent. Southampton community nurses team reported shared learning from newsletters and through team meetings. However, some Portsmouth community nursing team reported they did not always receive feedback from incidents or learning about actions or changes.
- Serious incidents were investigated and reported and there was some evidence of learning following these in services. In Southampton CAMHS there had been action planning but limited improvements or learning had been made following the serious incident involving the suicide of a young person in July 2015.
- The trust collated monthly data on expected and unexpected deaths, and there were mortality and morbidity review service meetings for unexpected deaths. There was a standard operating procedure for unexpected deaths. Service lines use specific criteria and mortality review and reporting forms and information was reviewed monthly by the serious incident and review panel.
- We reviewed six serious incidents. Three unexpected deaths, one emergency treatment, one clinical delay and one pressure ulcer. The quality of these investigations varied and the root cause of an incident was often not explored and actioned. It was not always clear what mitigations or actions had occurred and if these actions were completed.
- The trust commissioned an independent review of its incident and serious incident process as part of its ongoing quality improvement and development. The review took place in April and May 2016 and identified improvements in the culture for reporting incidents. The serious incidents requiring investigations panel were timely (74% within 45 days but there were delays in completing investigations (only 21% completed within target times). Investigations were also not focussed on the systemic causes of incidents but on individuals such as how the illness of a patient may have contributed to the incident and the specific actions of individual staff. Resultant actions were therefore too narrow and there were missed opportunities to look at wider system changes and improvements which could prevent incidents occurring elsewhere. There were recommendations for staff training, improved procedures, and updates to the Duty of Candour policy to improve capture around safeguarding and improvements in the use of data.

Duty of candour

- The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or

Requires improvement

Are services safe?

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other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The Duty of Candour regulation came into effect in the NHS on 27 November 2014.

- The trust Duty of Candour policy (November 2015) which detailed the background, responsibilities, reporting arrangements, communications and key performance indicators. The chief nurse was the nominated executive lead for championing and implementing the principles of Being Open and Duty of Candour. An external review (May 2016) identified the trust Duty of Candour policy needed to be updated to meet the contract requirements of the NHS standard. Meetings with patients or the relevant person should be followed up in writing and all correspondence retained. It was found that this happened in practice. However, the policy states that conversations with patients and/or their family need only be recorded in the patient's notes, which does not comply with requirements.
- Staff were aware of the Duty of Candour regulation and the importance of being open and transparent with patients and families. However, some staff were not aware that there should be a written apology to patients and their families and still considered informal verbal feedback as being trust policy. They noted that written feedback did not always happen in practice.
- We reviewed five serious incidents; all had appropriately identified the Duty of Candour and patients and/or their families had been contacted although the mode of feedback was not always indicated.

Safeguarding

- Trust had safeguarding policies for vulnerable adults and children. The chief nurse was the executive lead. There were safeguarding leads in each of the locality teams for adults and children and a named nurse. There was not a named doctor in the trust. However, the Trust have told us that there are two doctors who support the safeguarding children team. Safeguarding training had been redesigned to take account of national and other guidance and included child sexual exploitation, health and domestic violence and female genital mutilation and learning from serious case reviews.
- Staff were aware of safeguarding and how to recognise and report abuse or neglect and were referring concerns to the local authority for action. However, some areas did not manage risks around safeguarding vulnerable adult's issues consistently or safely. The older people mental health wards did not identify 'patient on patient' assaults as safeguarding events. Staff on Maple ward were not care planning and managing risks around safeguarding vulnerable adults consistently or safely. Shortages in staff numbers and high caseloads in some areas of children and young people services had impacted on number of staff able to attend local safeguarding conferences. The staff were able to go to the first safeguarding conference. However, they had stated their preference was to attend other safeguarding conferences which they considered would also be relevant as this may impact on staff having care information in a timely way.
- The trust was not meeting its training targets for either adults or children's safeguarding. Compliance with training varied with some teams having only 33% of staff trained in adult safeguarding against a trust target of 95%. Compliance with safeguarding level 3 training was not effectively monitored. Not all staff working with vulnerable children and young adults, for example, in the children and young people's service and sexual health service had completed the appropriate level (level 3) of safeguarding training.
- Data was collected on referrals but was not used to compare trends. Since April 2014, the trust had reported 11 serious incidents dating back to April 2014 as part of a Serious and Partnership Case Review. There were seven incidents assigned to Southampton Safeguarding Children Board and three are in relation to Portsmouth Safeguarding Children Board. There is one incident recorded for the Hampshire Safeguarding Children Board. Four of the incidents involve school nursing services, three involve Health Visitors and two incidents are in relation to CAMHS. There was one incident of physical and sexual abuse involving looked after children.

Medicines management

- The trust had appropriate medicines policies, and a controlled drug policy that detailed specific arrangements for medication administration in people's homes. Most medicines were being stored securely and safely. This included FP10 prescription pads (a hand written prescription form). There were some examples where medicines were not appropriately locked away.

Requires improvement

Are services safe?

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- Some teams used competency-based assessments, to support safe medication administration practice. However, there were risks in some teams and medicines were not managed safely. In Mary Rose school service, staff had not consistently followed practice guidelines for the safe administration of medicines, and medicines were not stored safely and securely at all times. The trust now had an action plan to improve this.
- In community end of life care anticipatory medicines (just in case medicines) were prescribed and obtained in a timely way. These are medicines that patients may require near the end of their life to relieve symptoms such as pain and restlessness. However, in Jubilee ward inpatient ward there was not a clear protocol for out of hours prescribing and there could be delays to respond to requests to review patients to change their medication.
- In the Southampton Substance misuse service staff in the prescribing teams did not review prescriptions consistently, thoroughly or regularly. Staff had not ensured all clients with children living at or visiting their home had safe storage facilities for their medication. The trust had produced an immediate action plan in response to concerns.

Safety of equipment and facilities

- The trust has a large number of locations, many of which were in a good state of repair. With the exception of a few community service bases in need of refurbishment, the accommodation was generally well maintained across the trust sites. However, some significant risks were noted in some locations. In mental health inpatient services there were risks associated with mixed sex wards that were not always managed in line with current DH guidelines, such as no female lounge. The mental health inpatient wards had ligature points that had not been risk assessed consistently. Several ligature points had been identified on Hawthorn ward and Maple ward in acute mental health. In the older people's mental health ward, Brooker unit, ligature points were identified and staff were not aware where ligature cutters were kept. The mental health long stay rehabilitation ward had patient bedrooms and communal areas with ligature risks such as fixed curtain rails. These has been risk assessed in February 2016 but were waiting to be replaced. It has been a requirement for all NHS organisations to identify and remove all non-collapsible rails, and replace them with collapsible rails since 2004. Access to unsafe areas within the Southampton CAMHS allowed vulnerable patient's access to objects such as knifes and scissors. The trust had responded quickly to address this concern. In community adult services the environment and cleanliness at Bitterne Health Centre did not always support safe care
- Relational security in the mental health ward environments was good.
- Some service had problems accessing important equipment. In community services, not all staff were aware of the process or were ordering and obtaining essential patient safety equipment, particularly out of hours and weekends. There were also delays in the wheelchair provision and repair service through an external provider. This affected the safety and well-being of many patients who received adult community services. Some patients had waited up to two years and these patients were at risk of pressure ulcers and had breathing and swallowing difficulties because they did not have appropriate seating. There had been an increase in referrals to the psychology service for those patients waiting because of low mood as they were confined to their homes and unable to live independently.
- The maintenance of essential equipment was not always effective and there were examples of equipment that did not have appropriate safety tests or recalibration. Bitterne Health Centre for long-term conditions had weighing scales that had not been calibrated for three years and medications were prescribed according to weight. A bladder scanner and the portable suction were found to be out of date for safety testing. In the children and young people's service weighing scales had also not been serviced for several years.
- The system for equipment ordering was not entirely robust in the adult community team; the staff had 24 hour access, but they were unaware of the locations of emergency equipment for some people to use at home. At Mary Rose school, resuscitation equipment had been loaned outside of the school and not returned, and was unavailable in the school.
- Staff on the community sexual health team did not all wear the recommended alarms when working alone in the community; these were not always accessible. Staff in adult community teams did not have emergency alarms in consulting rooms.

Requires improvement

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Records management

- The quality of records varied with a combination of paper and electronic patient record keeping systems used. Patients having home visits had paper records held in their homes.
- There were connectivity problems with the trust IT systems and this directly impacted upon the safe and effective response to patient care. Staff in community teams found difficulties in reading or updating patient records in a timely way. There was the potential for missed safety risks as there was duplication of records in paper and electronic format. The trust had not issued all staff with laptops at the time of the inspection and some records were only updated when staff returned to an office and this had caused delays. GP based staff could not access the electronic patient record.
- Community nursing records contained all appropriate risk assessments, screening tools, care plans, mental test scores, therapy outcome measures, falls histories, contact notes, and consent advice leaflets. The trust audited the patient care records regularly to ensure staff met and maintained standards.

Cleanliness, infection control and hygiene

- Most locations were visibly clean. Bitterne Health Centre was an exception and had dirty carpets and curtains that were six months out of date for changing. There was surface dust on portable suction equipment and the environment.
- Staff followed infection prevention and control procedures. This included hand hygiene, isolation procedures and the correct use by community nurses of personal protective equipment (PPE), such as gloves and aprons. Staff adhered to the trust 'bare below the elbows' policy in clinics and home environments.
- Generally, in community and mental health locations, there were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps in clinic and home environments.
- Patient led assessment of the care environment **(**PLACE) survey published in August 2015 showed the trust had achieved 97% which was similar to the national average of 97%. Only one location, Royal South Hants Hospital, scored below the national average (94%).

Mandatory training

- Mandatory training covered a range of topics, which included fire safety, health and safety, basic life support, safeguarding, manual handling, hand hygiene, communication, consent, complaints handling and information governance training.
- The trust compliance target was 85% and trust data showed the compliance with mandatory training was generally high across the community and mental health services although there was some variation in the level of compliance and type of training. On the mental health older peoples wards and long stay rehabilitation wards staff did not have training in medication management or violence and aggression. Staff in community children and young people's services told us it was difficult to attend training due to a shortage of places and having to prioritise work.
- Many staff we spoke with preferred face-to-face training and some felt that on line training was not ideal, or even appropriate, for some types of training.

Assessing and responding to patient risk

- Staff used comprehensive holistic patient risk and care assessments, and most teams had broad multi-disciplinary reviews to identify and respond to risks to the safety, health and wellbeing of patients in the community within their care. There were daily discussions, including virtual meetings, of complex patients and their comprehensive risk assessments. Any changing risks, any end of life issues including falls risk assessments although this could vary due to staff shortage in some community teams.
- In inpatient units, staff assessed and monitored risks to patients. They used the national early warning score to identify patients whose condition might deteriorate. There were appropriate arrangements in place to access medical advice and support when required although there was some concern about out of hours medical support on Jubilee ward, particularly for end of life care patients.
- Several mental health service areas had robust patient-centred risk assessments which were reviewed regularly.
- The single point of access team reported that call handlers risk assessed calls using templates, but also used a variable approach. For example, they accessed professional advice when needed and police support for dealing with frequent aggressive callers.
- Risks assessments were not always completed for children and young people. In the community team, not

all nutritional risks were correctly identified, particularly in children requiring tube feeding in the school services. This had resulted in some untrained education support workers administering liquids through intragastric tubes. The trust had taken action on this immediate concern. In the Child and Adolescent Mental Health Services in Southampton, appropriate risk assessments had not been done for all children using the service. This was despite a specific recommendation for risk assessment identified in a serious case review. Ther risks to young people whilst they were waiting for assessment or treatment had not been assessed. Staff in community and mental health teams did not always review risk assessments regularly and care records did not contain crisis and contingency plans.

- In learning disability services, service users were actively involved in managing their own risks with engagement with carers and other organisations such as supported living.

Staffing levels and caseload.

- There were staffing issues across many staff groups and localities and this had meant some service delivery was fragmented in places. Many community teams were working with high caseloads. Bank and agency staff were being used wherever possible and trust staff worked flexibly across teams as needed. The trust had introduced rotational posts with the acute trust to improve the recruitment of therapy staff and there was an ongoing recruitment campaign across all staff groups. Services were reviewing capacity and demand but in some areas appointment times were shorter than planned or community visits were missed.
- There were significant registered nurse vacancies in community nursing teams particularly in Portsmouth (19% on inspection but with previously much higher vacancies) and although bank and agency staff were requested, not all shifts were covered. This affected the safety of patients waiting for visits, and staff who were concerned that their workload was too high to care for patients properly. There was an overflow of unmet visits from shift to shift and rescheduling visits, often several times. There was an impact on patients. For example, increased medication errors and pressure ulcers rates in Southampton were improving but were worsening in Portsmouth. The trust had ongoing recruitment plans and aimed to reduce vacancies in the Portsmouth team to 3% in the next three months.
- In community children and young people's services, vacancies and the use of an outdated assessment tool resulted in higher than recommended health visitor caseloads in deprived areas. There were high caseloads for therapist, school nursing and public health staff. Staff were providing a limited range of service and this had impacted on the level of care they could deliver. They were prioritising and targeting those children who were deemed to be most at risk.
- There were not always sufficient staffing levels to safely manage and review clients who are in receipt of prescriptions in the substance misuse service and to meet Southampton CAMHS patients' needs. Not all patients were able to be seen in the necessary and safe timeframe. The high caseloads for the specialist MH team for children and young people in Southampton impacted upon the delivery of the service. This differed to the service in Portsmouth where staffing levels were better.
- Staffing levels were low in the Southampton substance misuse and had been consistently lower than planned over the previous 18 months. The overall caseload in the Southampton service was high and there were risks to the service around medication, monitoring and prescribing. Staffing levels were as planned in the Portsmouth team.
- Staffing levels in Community in-patients were being maintained as planned to provide safe care. The trust employed regular agency and bank staff to mitigate risks to patients when wards were short of staff. Risks to patients were monitored and arrangements were in place and followed to access medical advice and support when needed. Staffing sexual health services was as planned and this had improved access to patients. The long stay rehabilitation unit was well-staffed as was the learning disability service in Portsmouth.
- Mental health recovery teams were piloting a case load tool to manage workload. Risks were reviewed and care coordinated. Patients had regular monitoring to ensure therapeutic and appropriate levels of medication.

Managing anticipated risks

- The trust had identified an increased acuity for mental health patients to the acute inpatient wards. Staffing had been increased to accommodate this and there was

Requires improvement

Are services safe?

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

now stable locum medical staff in post. However, the wards were under pressure when forensic beds across the county were unavailable. A formal escalation policy was being agreed by NHS England.

- Risks that could be anticipated were not always well managed. In community services there were risk on the risk register that had not been responded to in a timely way: Bitterne Health Centre (BHC) did not have resuscitation equipment for eight months between October 2015 and June 2016. Staff had not had training in the use of the equipment. In mental health services, ligature risk assessments were done but this was inconsistent and several ligature points had been identified but not actioned.
- There were significant delays in the provision of wheelchairs and repair service through an external provider, which affected the safety and well-being of many patients.
- There was insufficient oversight of a mental health contract with an external independent ambulance provider. The trust did not have satisfactory access to records, incident forms or staffing records for this contract. This did not provide the high level of assurance required by the trust to assure the service delivery was safe, responsive or effective.
- Business continuity plans were used for IT and staff followed these.

Major incident awareness and training.

- There were policies and procedures in place for dealing with major incidents, including the Major Incident policy (2014) due for review in 2017 and business continuity policy (July 2015) which provided detailed guidance on levels of incidents and delivering on critical activities. The plan was not service specific and did not include a response to staffing issues.
- The trust held a routine practice of a "virtual" major incident procedure to practice staff responses in Southampton, a few months before our inspection.

Are services effective?

Requires improvement

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

Summary of findings

We rated the trust as requires improvement for effective because

- Many mental health services did not use nationally recognised standards or good practice including HoNOS and National Institute for Health and Care Excellence (NICE) guidelines. The community memory clinic did not follow NICE national guidance for assessing and starting anti dementia medication
- There was limited evidence in several mental health services that patients were involved in care planning and the standard of care planned varied.
- Some non-clinical staff were undertaking clinical tasks in schools and their competence was not assessed.
- Some audits had not led to the development of local action plans and improvements.
- Some patients did not have good access to appropriate specialist and therapists.
- Some staff could not access training because of workload and some staff were not always provided with training specific for their role, for example, dementia training in older people's service and training in dealing with younger people in CAMHS.
- Clinical supervision was ineffectual in children and young people community (school) services where clinical practice was not always up to date.
- Systems to support medical revalidation required improvement. The trust, however, had an action plan to develop this.
- Some performance targets in children and young people services and sexual health services were not achieved.
- Staff in some mental health services did not appropriately assess patient's mental capacity.

However,

- In community services most care delivered took account of national guidance. There was participation in national and local audits and patient outcomes, where known, were broadly similar to other trusts.
- Patients had their pain assessed and monitored depending on their needs. There were processes for obtaining pain relief for patients out of hours in the community and for end of life care patients.
- Patients had their nutrition needs assessed and there were appropriate referrals to specialists.
- Most staff had appraisal and supervision and access to training and development
- There were many examples of integrated multidisciplinary teams working well together particularly for patients with long-term chronic conditions. These often included team members from other organisations such as the local acute trusts, the local authority and a neighbouring community trust. The teams worked well together for the benefit of the patients.
- Patient consent was appropriately obtained. Some staff understood their roles and responsibilities regarding the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- Portsmouth CAMHS service had achieved accreditation and CAMHS learning disability services accreditation for excellence by the quality network for community CAMHS.

Our findings

Evidence-based care and treatment

- In community health services, care being delivered took account of national guidance, such as National Institute for Clinical Excellence (NICE) guidelines. Care pathways were used for long term conditions, for example, in pulmonary, neurological, stroke and orthopaedic rehabilitation and diabetes care, to deliver care and ensure access to specialist advice. The Healthy Child Programme for children and Unicef Baby Friendly accreditation had been gained. Staff were aware of recent changes in guidance.
- Child and Adolescent Mental Health Services in Portsmouth has been a member of the Quality Network for Community CAMHS (QNCC) since 2006 and achieved CAMHS Accreditation for 2014 to 2017. The CAMHS Learning Disability service achieved 'excellence' for the

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Requires improvement

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accreditation for 2015 to 2018.The accreditation is awarded by the Royal College of Psychiatrist for the high standards in practice, the quality of care, working with partners and service user experience.

- Patients who were in the last days of life or in a rapidly deteriorating state were identified in a timely way and their care was reviewed. They had their needs met at appropriate intervals, with escalation of their needs to the 'out of hours' services. Patients who were in the last days of life had a comprehensive plan of care in place, including a communicated DNACPR status.
- Some mental health services did not use nationally recognised standards or good practice including HoNOS and National Institute for Health and Care Excellence (NICE) guidelines. Within the long stay rehabilitation service and substance misuse service there was evidence that national prescribing guidelines were not being followed. The community memory clinic did not follow NICE national guidance for assessing and starting anti dementia medication
- Services took part in national and local audits. There was evidence of improved practice although some local audits had not led to the development of local action plans and improvements.

Assessment of needs and planning of care (mental health)

- There was limited evidence in several mental health services that patients were involved in care planning and the standard of care planned varied. Many care plans in Southampton CAMHS services were not up to date, staff had not recorded if patients in the Place of Safety had their rights under the Mental Health Act explained to them, and records in the crisis teams did not include MCA assessments.

Pain relief

- Patients in mental health and community services had their pain assessed and monitored depending on their needs. For end of life care, pain relief was prescribed as necessary to meet individual's need. There were processes for obtaining pain relief for patients out of hours for community and end of life care patients. However, within the school service, medicines were not always signed for, and some children were non-verbal. This meant staff could not fully ascertain if analgesia had been given at the appropriate time, or was effective.
- Pain management was discussed within multi-disciplinary teams, and the aim was to reduce pain that could be limiting the patient's mobility and mood.
- The trust multi-disciplinary pain team accepted referrals for patients with long term and intractable pain issues, and were available for advice and support for individual patients. The pain team used pain management programmes including the 'acceptance and commitment therapy model', developed as best practice nationally. The pain team gave effectiveness questionnaires to the patients before and after the programme, and at six month follow up.

Nutrition and hydration (if relevant)

- Patients' nutrition and hydration status was assessed using the 'Malnutrition Universal Screening Tool' (MUST) by the community and in-patient teams. Action was taken for patients identified as nutritionally at risk.
- Community dietitians were available for at risk in-patients and out-patients and responded to urgent and routine requests. In the in-patient units, attention was paid to patients receiving regular and appropriate nutrition and hydration.
- The speech and language team assessed and supported patients with swallowing difficulties. However, this support was not in place within the school service. Not all children with swallowing difficulties had appropriate care plans to clearly delineate their highly specific needs. Health care support workers who had not yet been fully trained or competence-assessed administered fluid through intra-gastric tubes. This was a potentially hazardous procedure, so we immediately flagged our concerns to the trust.
- The older peoples' support team based in the local acute trust emergency department focussed on ensuring patients had adequate food and fluid intake in order to avoid potential admissions

Patient outcomes

- The adult community service had participated in all national audits for which they were eligible. These included the British Heart Foundation National Cardiac Rehabilitation, Chronic Obstructive Pulmonary Disease National Audit, English National Memory Clinics, National Diabetes, Sentinel Stroke National Audit Programme (SSNAP). The bladder and bowel service

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used the national outcome tools to monitor its' patient's outcomes. Performance overall was similar to the England average although areas for improvement were identified.
- Community independence and community rehabilitation teams demonstrated improved physical outcomes based on patient feedback and 'global impression of change' measures for patients who had participated in programmes.
- In children's community services the new birth visit and child development assessments targets for new parent and children as part of the Healthy Child Programme were not met and were below the England average. Immunisation rates were above expected targets and the baby friendly breast feeding accreditation (level 3) had been achieved.
- Sexual Health services had met or exceeded many performance targets. However, the service needed to improve its performance in the time taken to test children of HIV parents and chlamydia diagnostic rates.
- The trust had participated in the national care of the dying audit and had scored similar to other trusts.

Mortality

- The trust had developed innovative processes for learning from mortality in community and mental health settings. A range of appropriate approaches had been developed which enabled a review or investigation into deaths across high priority settings (mental health, learning disability, children services & community services), as well as in primary care, dental and sexual health – areas that are often 'hard to reach' in terms of investigating mortality in the NHS.
- The aim of the approach was to improve care and have an effective and efficient process which minimised the impact on frontline staff, provided electronic reporting and where there was learning and respect of families/ carers.
- The process had started in 2014 and the trust had seen an increasing number of deaths investigated via mortality reviews and serious or high risk investigations. In January to June 2016 all unexpected deaths and all had been reviewed or investigated.
- All learning from mortality was discussed and subjected to challenge at monthly serious incident forum. Learning summaries were escalated up to board level, across service lines, and to commissioners.
- The Trust had taken on the role of lead provider together with the lead clinical commissioning group for developing system-wide process for learning from mortality. The trust was in the final stages of developing a system-wide process encompassing a wide alliance of providers, commissioners, local authorities, public health
- The trust also had national support for its work and had activity engaged and collaborated on its work to develop a proportionate, and appropriate system for learning from mortality. Its innovative approach to learning from mortality was part of the CQC national-level mortality work group.

Competent staff

- New staff were given both a trust and local induction, some of which was electronic via the electronic staff record (ESR) system.
- The majority of staff had received an annual appraisal. There were exceptions where some small teams had had no appraisals, for example, the out of hour's twilight service in Portsmouth.
- Most staff had supervision with the exception of some small specialist teams and in children and young people' services, clinical supervision was ineffectual as clinical practice had been discussed but not observed and some practices were out of date.
- Staff had opportunities for their personal development and could access training and development courses. Some training had been on hold previously, however this was no longer the case for most. Some services had not had appropriate training specific to their role: staff working in older people mental health services had not had dementia training, and not all staff in CAMHS had training in dealing with younger patients. In the community CYP service, some support workers had not been given the correct training nor had competence assessments to deliver medicines safely. Some staff reported finding time and a location to do their mandatory training was difficult.
- The trust was supportive of higher-level study, with funding obtained for a masters in clinical research, which was a shared programme of work and study.
- Medical staff revalidation processes were assessed in February 2016. The review identified the system needed to improve in terms of support, governance, information, appraisal levels and the quality assurance of appraisal. The trust did not have an appraisal lead. An

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external review was undertaken in May 2016 and an appraisal lead was appointed. System to support national best practice in revalidation were being developed and projected to be in place by December 2016.

Multi-disciplinary working and co-ordination of care pathways

- There was strong evidence of well-coordinated and effective multi-disciplinary working. Many teams were multi-disciplinary from a range of disciplines, medical, nursing, therapies and psychology. There were regular multidisciplinary (MDT) meetings and virtual ward meetings, which included social care, to identify the best options for holistic care and treatment, particularly for patients with complex needs.
- The recent co-location of community specialist services in long-term conditions, to Bitterne Health Centre (BHC), provided opportunity for interaction and cross working; it was felt there was now a platform for all different long-term services.
- Specialist nurses worked closely with GPs, colleagues in the acute trust, the third sector, and other community services to support patients along their clinical pathway.
- Some patients did not have good access to appropriate specialist and therapists. Therapists were not present in some rehabilitation services. Psychology input was lower than the service requirement in the CAMHS service.

Referral, transfer, discharge and transition

- The trust used single point of access (SPA) arrangements to screen referrals into the service or to forward patients to appropriate services. Referrals came from community teams, from GPs, other healthcare professionals and self-referrals from patients themselves. Community adult teams were co-located in Southampton with social care to provide a more streamlined service. .
- There were clear pathways to refer patients. There were a range of services with clear referral criteria designed to meet the needs of patients and these criteria worked across community and acute care, for example, in end of life care. Some services worked within acute trusts, for example, the Frailty Intervention Team (FIT) in a local emergency department and early supported stroke discharge with the acute stroke team and palliative care team. .
- Trust staff told us that the workflows in the community nursing teams in Portsmouth were at times ineffective. Some community nursing teams reported confusion on the overlap of visits with the community matrons. They stated it was not a clear pathway when the patients were discharged to community matron as this did not provide seven-day services. Staff felt that patients may be confused who to call at weekends which may result in a visit to ED or even an admission.
- In Community Inpatients, admission criteria supported patients to be admitted the ward that met their individual needs.
- In children and young people's services community nursing team in Portsmouth had good links with acute care for transition of children. However, these were not as well developed across Southampton. The CAMHS service did not always accept referrals from the public health nurses. There was a pathway for when children transferred from the health visiting service to the school nursing service and for when children moved out of the area.

Availability of information

- The trust was developing an electronic records system to improve access to information. Staff including doctors told us the scanned records were not easy to find as they did not follow any format similar to the paper records. Some staff had problems accessing records, including discharge information. Sometimes records were missing on the electronic system and there were delays in getting them added which could impact on care.
- Staff access to IT systems was currently variable and sharing information was difficult in places. Staff told us the IT system worked well at base locations, but there was limited access out in the community. Teams had different levels of access to acute hospital or adult social care (ASC) records and trust's electronic system was unable to connect to the GP's electronic system.
- IT connectivity problems and pressures on staff time meant there were risks of delayed recording and a possibility for incomplete records.
- Many bank nurses working in community settings did not have access to the electronic patient record system, and were dependent on access via substantive staff

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colleagues to record patient information. This is against information governance regulations and the Nursing and Midwifery code of practice (NMC) as a risk to the security of records.
- Information was available to GPs in a timely way when patients were discharged from inpatient units.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff followed consent procedures and overall there was a good understanding of the Mental Capacity Act (2005). However, staff training on the Mental Capacity Act varied and overall compliance did not meet trust targets. The trust provided guidance and templates for staff on 'big decisions' for patients on the intranet.
- Staff across most services discussed patient capacity, for example, at virtual ward and multi-disciplinary meetings. Mental capacity assessments were done, these were decision specific and best interest decision meetings were documented. In the learning disability service staff had recorded how patients with non-verbal or physical difficulties could communicate their decisions.
- However, some staff did not have a clear understanding of the Mental Health Act. Some of the lowest training figures 46% were in community mental health services. Mental capacity was assessed and best interest meetings were held but mental capacity assessments were not done for specific decisions, for example, living arrangements, driving assessments and managing finances and there were no references in care plans.
- The older people's mental health ward had four patients subject to Deprivation of Liberty (DoLs) safeguard applications. The applications were all made appropriately.

Good

Are services caring?

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

Summary of findings

We rated the trust as good for caring because

- Staff provided compassionate care and treated patients with dignity and respect. Feedback from patients, carers and family members was consistently positive.
- Patients were involved in their care and treatment and staff took time to explain care and treatment and services in way patients could understand.
- We observed staff supporting patients with care and kindness, including ancillary and non-clinical staff, within busy service environments, for example in Jubilee Ward at Jubilee House, Portsmouth, and Fanshawe Ward, Southampton.
- Caring in the Mental Health Learning Disability unit was outstanding. All staff had a focus on enabling and empowering service users to achieve their goals. Service users had an active voice in how the service was delivered through a well-run participation group, seeking of service user's views, and service users working in the service as volunteer trainers.
- Patients told us said staff met their emotional needs by listening to them, by providing advice when required, and responding to their concerns. There were many examples where staff were working to support patients' and their carers wellbeing, spiritual and psychological needs. This included setting up support groups and working with the voluntary sector.

However:

- Some clinic receptionist staff did not always display compassion, respect and consideration to patients.
- In the specialist MH children's and young people's service, there was no evidence of patient advocacy, and no evidence of the young person's involvement in their care and treatment.
- In community mental health services for older people not all patients had care plans and these were not routinely given to patients. The patients did not know how to get involved in their care, and carers said care was inconsistent because staff did not communicate with other agencies involved in their family member's care.
- There was variation in the provision of spiritual and pastoral support for community inpatients and teams. Some wards and team did not have direct access to a chaplaincy service although a spiritual strategy was being developed

Our findings

Dignity, respect and compassionate care

- Staff across the trust used a respectful, compassionate and kind approach to their patients and clients. Staff were caring, compassionate and patient centred in their approach. We observed staff maintained patient's respect and dignity at all times and referred back to patients to support their individual choices.
- Many patients gave positive feedback about the care they had received and the manner and attitude of the staff. There is consistently positive feedback from patients, carers and family members.
- We saw many examples of kindness towards patients and their relatives, from well-motivated and highly - committed staff.
- Caring in the Mental Health Learning Disability unit was outstanding. All staff had a focus on enabling and empowering service users to achieve their goals. Staff worked with service users and had detailed knowledge of their care and needs. Service users had an active voice in how the service was delivered through a well-run participation group, seeking of service user's views, and service users working in the service as volunteer trainers.
- We also observed staff supporting patients, including ancillary and non-clinical staff, within busy service environments, for example in Jubilee Ward at Jubilee House, Portsmouth, and Fanshawe Ward, Southampton.
- Some clinic receptionist staff did not always display compassion, respect and consideration to patients and distress and anxiety was reported from a few patients.
- The Friends and Family test results (March 2016) for community patients demonstrated the percentage of patients that would recommend the trust as a place to receive care was 96%, which was above the English

Are services caring?

Good

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

national average (95%). The response rate was below the England national average at 2.2% compared to 3.4%. Figures had been similar from October 2015 – March 2016.

- The Friends and Family test results (March 2016) for mental health patients demonstrated the percentage of patients that would recommend the trust as a place to receive care was 94%, which was above the English national average (87%). The response rate was also above the England national average at 4.1% compared to 2.5%. Figures had been similar from October 2015 – March 2016.
- The trust scored about the same as other trusts in the CQC community mental health survey (2015).
- PLACE assessments are self-assessments undertaken by NHS and private/ independent health care providers, and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services. In relation to privacy, dignity and wellbeing, the 2015 PLACE score for Solent NHS Foundation Trust is 91%, which is above the England average of 87%.

Patient understanding and involvement

- Patients were involved in making decisions about their care and treatment.
- Patients and relatives we spoke with confirmed that they felt involved in their care. Patients told us the staff had explained their treatment options to them, and they were fully aware of their care plans.
- The involvement of service users in the Mental Health Learning Disability unit was outstanding. Staff always empowered service users to have a voice and to realise their potential. There was determination and creativity to overcome obstacles to delivering care for service users with communication difficulties and keep them involved in their care. Service user's individual preferences and needs were always reflected in how care is delivered.
- In community mental health services for older people, however, not all patients had care plans and these were not routinely given to patients. The patients did not know how to get involved in their care and carers said care was inconsistent because staff did not communicate with other agencies involved in their family members care. In the specialist MH children's and young people's service, there was no evidence of patient advocacy, and no evidence of the young person's involvement in their care and treatment.

Emotional support

- Patients we spoke with said staff met their emotional needs by listening to them, by providing advice when required, and responding to their concerns.
- Throughout the inspection, we witnessed many examples of kindness towards patients and their relatives, from well-motivated committed staff. We observed, for example, community nurses treated their patients with sensitivity, kindness, dignity and respect. Patients and carers felt emotionally supported and reassured by the community nursing visits. Patients told us they were very happy with the Portsmouth out of hour's team caring approach.
- There were many examples where staff provided emotional support to their patients: The Snowdon at home team considered patients spiritual needs throughout all aspects of care planning for patients and carers and the FIT team accessed spiritual support for patients 7 days a week. The MS support group assisted with patients' anxiety. There was psychological support for colorectal patients and psychosexual counselling services were available in sexual health services to address sexual concerns.
- The speech and language team ran groups in association with the voluntary sector to support patients and public health nurses and worked with no limits workers to support emotional well-being. Some community inpatient wards arranged for representatives from support organisations such as the Multiple Sclerosis Society to visit the wards to provide emotional and practice support for patients.
- There was, however, variance in the provision of spiritual and pastoral support for patients. Fanshawe and Lower Brambles inpatient wards and the end of life care team did not have direct access to a chaplaincy service for patients.

Promotion of self-care

- Staff in community services showed commitment and motivation to ensuring patients understood and were

Good

Are services caring?

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

involved in long-term treatment programmes. They supported the view that this positive engagement led to better outcomes and a higher likelihood of longer-term improvements for patients.

- Staff in the Mental Health Learning Disability unit worked with service users and had detailed knowledge of their care and needs. Service users had an active voice in how the service was delivered through a well-run participation group, seeking of service user's views, and service users working in the service as volunteer trainers.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated the trust as good for responding to people's needs because

- Many services were focused on bringing care closer to people's homes, supporting early interventions, avoiding hospital admission and promoting self-management. There was evidence of integrated and collaborative working although this varied across geographical areas based on commissioning and strategic planning arrangements.
- Many services were responsive and waiting times were being met. For example, patients were being seen for cardiac and stroke care following discharge and patients had early intervention for psychosis. CAMHS service met targets to assess children for mental health conditions.
- Staff had good awareness of equality and diversity and action was taken to improve access to services and people's understating about their care.
- Action was being taken to vulnerable people using the service. The learning disability service was outstanding.
- Access to sexual health services had improved.
- There was good access for the acute mental health inpatient wards to transfer patients quickly to the psychiatric intensive care unit.

However:

- Many services had staff shortages and had difficulty coping with demand. There were missed and shortened appointment times in community and bed closures on mental health acute inpatient wards.
- Patients had long waited over 18 weeks treatment in some services. There was variation in waiting times across Portsmouth, Southampton and Hampshire for the same type of services. The Healthy Child Programme was not meeting its targets. Waiting times for some CAMHS services such as cognitive behaviour and autism were lengthy.
- Patients had limited access to therapy service in community rehabilitation services and to psychological services as recommended by NICE in long stay mental health rehabilitation services.
- Some services could not be sustained and the trust had made the decision to withdraw contracts. However, despite the trusts plans to inform patients we found patients had not been adequately informed of service changes in podiatry and patients still travelled to clinic appointments unaware of the changes to surgical pathways.
- There were long delays in wheelchair provision affected the ability of community staff's responsiveness; some patients had waited up to two years for a suitable wheelchair. The demand for the service was greater than the level of commissioning. However, the monitoring arrangements and actions that trust had taken had yet to improve the responsiveness of the service or the risk to patient safety and well-being.
- Access to interpreter services was improved on community inpatient wards.
- There was evidence of learning and improvement as a result of responding to complaints. However, the trust was not meeting national and local trust target response times.

Our findings

Planning and delivering services which meet people's needs:

- The trust delivered services across Southampton, Portsmouth and Hampshire and there were Joint strategic needs assessments (JSNA) in each of these areas. Overall the JSNAs identified the rising prevalence of chronic conditions with older age, and increased need for chronic disease management and falls prevention. The increasing number of people of all ages who lived longer with one or more long-term conditions increased the need for better co-ordinated, integrated services to keep people safe and well at home.
- The specific differences in the JSNA meant commissioning intentions and service planning and delivery differed across the two cities and the pace of developments differed. Southampton had developed more integrated working than Portsmouth, for example. However, services were mainly planned in a way that met the needs of the local population. Service planning had focused on supported self-management and early diagnosis or interventions that minimised risks and impacts of exacerbations.

Good

Are services responsive to people's needs?

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

- The trust held regular commissioner meetings with service leads to consider local health needs and planned services and aimed to work with all health and social care partners to provide responsive services to maintain health and wellbeing, avoid inappropriate hospital admissions, and support early discharges. There were new service models to support integrated reablement and rehabilitation, services bringing care close to patients home and work with the voluntary sector, such as the Parkinson's Society and Age UK, to develop maintenance and self-help services. Community nursing and therapy teams, for example, were co-located with adult social care across Portsmouth and Southampton
- Service were developed with input from doctors, nurses and people who used the service, to understand their impact on the quality of patient care. Information and data were used proactively to identify opportunities to drive improvements. Many services were targeting those who were most vulnerable.
- The importance of flexibility, choice and continuity of care was reflected in the services. The needs of people were taken into account when planning and delivering services. For example, the trust provided clinics for young people at locations and times when they could access them. The sexual health clinic started a monthly learning specialist disability clinic following an outbreak of syphilis. Community inpatient wards had its own admission criteria to ensure only patients who were appropriate and would benefit from the assessment and rehabilitation services. The trust had developed an early palliative care clinic for those patients identified as being in their last year of life, rather than just last days or weeks of life.
- There was a single point of access (SPA) service in Portsmouth to deal with referrals. This was opened from 7am -10pm seven days a week and helped patients and healthcare professionals arrange appointments and deal with queries or questions about services. The service also signposted patients to alternative services. The trust was expanding the single point of access across both cities.
- Southampton community teams had joined a national vanguard programme to develop new models of care. The trust was working with GPs, partner organisations and the voluntary sector to pilot the 'multi-speciality community provider organisational model of care'.
- Many services were experiencing difficulties in coping with demand, mainly because of staff shortages although some identified the reorganisation of services had extended waiting times as care pathways were not clear. The community adult team, for example, described an extending the wait for physiotherapy treatment following the mergers of services. Community nursing teams for children and adults were not responsive due to a lack of capacity to cope with demand, particularly in Portsmouth. Patients were being prioritised according to risk but there were shorter appointments and some community visits not delivered as planned. In children's services there was also a decreased focus on preventative public health care. The community MH team described long waits for psychology appointments and for the memory clinic in the OPMH service. The mental health inpatient wards had closed beds due to staff shortages.
- Sustainability reviews had identified there were not sufficient resources to maintain the current level of service provision. Speech and language service could not provide a full service for patients in the West Hampshire area and the trust had withdrawn from the contract. The trust had also withdrawn the podiatry service contract this year. However, despite the trusts plans to inform patients, we found they had not been appropriately informed and patients still travelled to clinic appointments unaware of the changes in the surgical pathways.
- Patients had good access to therapies and activities in the majority of services with the exception of the some rehabilitation and therapy services. Patients had limited access to therapy service in community rehabilitation services and to psychological services as recommended by NICE in long stay mental health rehabilitation services.
- The trust contracted some services from external providers. However, there was limited evidence that these contacts were being monitored appropriately or action appropriately.
- The wheelchair service was commissioned by a private provider. Currently demand was greater than the level of service commissioned and there were long waiting times. The trust was in discussion with the provider and commissioners. However, the actions by the trust had not yet resulted in an improved and more responsive service. The trust had a service contract with an independent ambulance provider to transport mental

Good

Are services responsive to people's needs?

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health and s136 patients. There was insufficient oversight of a mental health contract and the trust did not have satisfactory access to records, incident forms or staffing records for this contract. There was no assurance that the service delivered was safe, responsive or effective.

Equality and diversity:

- Mandatory training for all staff included equality and diversity issues. The majority of staff had completed this and could demonstrate an understanding of equality and diversity.
- All of the services we visited, bar one, a sexual health clinic, were accessible to patients using mobility aids by use of ramps and or lifts. Disabled parking was available at all the hospital and clinic sites we visited. We heard of one service changing its location to enable easier access for wheelchair users.
- Patient information leaflets were available in different languages and staff knew how to access this. However, information leaflets were not available in different languages for children and young people.
- Translation services and interpretation services were available and well-advertised although in on Jubilee Ward interpreter were only available for hearing and vocally impaired patients. This had had an impact on patient care. The sexual health service was planning to introduce a web based translation tool within the service.

Meeting the needs of people in vulnerable circumstances:

- There was support for vulnerable patients, for example, people with a learning disability and people living with dementia, and children and young people. Staff had training and good awareness of meeting the needs of vulnerable patients. There were many examples in community services were adjustments were made to support people. This included developing services specific to vulnerable patient groups and tailoring care to meet individual needs.
- The learning disability service in Portsmouth had introduced a named worker which allowed issues to be addressed quickly before they reached crisis. Service users, carers and external stakeholders all said the service responded quickly. Appointment times were flexible to meet the needs of people. Crisis support was available seven days a week through the intensive support team. The Kestrel Centre environment was fully adapted to service user's needs with written, visual and braille signage. The service had consulted with people on the reception area and acted on that response, reducing the stimulus for people with autism and providing a distraction box.
- On the mental health long stay rehabilitation ward patients were supervised at bath times which did impact on their privacy and dignity.

Access to the right care at the right time:

- Community advisory service met response times for initial contact and 99% of routine referrals (within two working days) and 98% of urgent referrals (within one working day). Many community services were meeting target times, for example stroke and cardiac patient were seen by rehabilitation teams following discharge. Specialist clinical services such as cardiology, diabetes and pain management achieved referral to treatment targets. However, demand and staff shortages were limiting rehabilitation, speech and language therapy and psychology services and waiting times within 18 weeks were not being met for some services. There was also variation across Portsmouth and Southampton for some services. People who required a wheelchair were waiting up to 2 years and this had meant clinical risks and a loss of independence.
- The community end of life care services supported 81% of patients to die in their preferred place of care against the trust target of 100%. Staff made every effort to ensure that people's needs were met, which included medicines being delivered, equipment being provided and support for relatives being put in place. However, the fast track rapid discharge process of those patients expressing a wish to die at home was not monitored and there was no assurance that this happened in a timely way. Some delays were identified as patients waited for a care package.
- The trust was not consistently delivering the healthy child and the education and healthcare programmes such as new birth visits and child development assessments. There was a decline in the percentage of parent and babies who were receiving the new birth visits within 14 days. Trust was significantly below the target of 90% and this was due to staff shortages. The referral to treatment time of 18 weeks was not consistently achieved in therapy and child development centres due to unfilled posts which impacted on care

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delivery. Children also had long waiting times for wheelchairs which impacted on their safety and well - being. There had been an improvement in the assessments of looked after children who came into care, for example, 87% of children now received immunisation although this was still below the trust's target of 95%.

- Waiting times for CAMHS services were met and over 85% of children were seen within 18 weeks. However, waiting times for children on the autism pathway, cognitive behaviour therapy and neuro development was long. For example, in Southampton it was currently 56 weeks from initial assessment from a general team to seeing the specialist clinician for autism. Referral systems in Portsmouth via the single point of access were more organised and waiting times were decreasing from this and new initiatives, for example on neurodevelopment waiting list.
- In sexual health services patients were offered an appointment within 48 hours for contraception and sexually transmitted infections services were offered an appointment within 48 hours. The psychosexual service met the 18 week referral to treatment target. However, a number of clinics in the localities had been closed because of staffing issues and the need to allocate education and training time for staff. Patients were being offered subsequent appointments within 48 hours.
- Bed occupancy between August and January 2016 was 80% on Maple ward (the psychiatric intensive care unit or PICU) and 72% on Hawthorn ward (the acute admission ward). However, over the previous three months this had increased to an average of 95% occupancy for both wards. The trust had closed four beds to admissions due to the increased acuity of patients being admitted and staff recruitment problems. However increased pressure on bed had resulted in the need to reopen two more bed. Medical cover was improved on the mental health impatient ward (Hawthorn Ward) and this has improved discharge procedures. There was good access to transfer patients quickly to the psychiatric intensive care unit.
- The target for early intervention psychosis was being met and 80% of new patients were assessed and allocated within two weeks.
- Substance misuse services did not meet all waiting time targets set by the commissioners of assessing 95% of clients within a two-week period although figures were improving. There was not a clear discharge pathway in Southampton service.
- Bed occupancy in community inpatient wards was high (84% to 90%) but was lower (71%) for neuro-psychiatric rehabilitation patients because appropriate admission criteria was followed. Snowden ward kept beds opened for 48 hours if patients had to be admitted to an acute hospital for short periods of treatment; this meant they had immediate access to continuation of their rehabilitation treatment once they were discharged from the acute hospital. Between 1 August 2015 and 31 January 2016, there were a total of 172 delayed discharges across the inpatient wards. These were related to delays in residential care placements and care packages in the patient's own home.

Learning from complaints and concerns:

- Staff understood how to handle complaints and there was evidence of learning from concerns and complaints and improvements to services. Service team leads responded to complaints. Patients received a written response to formal complaints. The CEO signs off all serious complaints. There were monthly reports to the directorate quarterly reports to the board and relevant committees, and an annual report to the trust board.
- In 2015/16 the trust received a total of 289 written complaints, a decrease of 26 from the previous year. Approximately half were upheld. Most complaints were received from community services and concerned clinical treatment, appointment cancellation or delays, the attitude of staff and communication or information given to patients. 11 cases have been to the Parliamentary and Health Services Ombudsman, four were closed, one was partially upheld and the trust was required to improve its discharge arrangements. Six are currently open. .
- The trust acknowledged 93% of complaints within the Department of Health three working days expected timeframe. Only 40% of complaints were responded to within the trust target of 30 working days. The trust was reviewing its arrangements, including across

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organisations, to improve this. The trust was developing training, support for complaints handling and methods to improve patient feedback. Complaints data was being used to support board walkabouts.

- We reviewed a small sample of six recent complaints letters. Response letters identified the concerns of the complainant and included an apology and full response including details of any organisational learning because of their complaint.
- The trust could demonstrate learning from complaints across its services. For example, there were new systems to contact patients for missed appointments in community health services across Portsmouth and Southampton, same day access clinics had been introduced in sexual health services, there was work to increase access to activities and therapies on mental health wards, actions had been taken to reduce breach of confidential information in children and families services.

Are services well-led?

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Summary of findings

We rated the trust as requires improvement for well-led because

- Governance arrangements were not well developed and needed to improve to properly provide assurance around quality and risks. Services had quality dashboards but the quality of clinical and performance information needed to improve. Risk needed to be appropriately escalated to the board through the care group structure. Some risks were not known and some mitigating actions were not well developed or timely or had not led to improvements.
- There was insufficient quality monitoring oversight of contracts with external providers. This included an independent ambulance provider transporting mental health and s136 patients to a place of safety. This put patients at risk.
- The operations model for the two cities of Portsmouth and Southampton was developing. However, the 'bridge' whereby there should be equity of services across the trust was a challenge. The operational teams described feeling quite separate across the two cities, with different working practices across Portsmouth and Southampton. There was less evidence of shared learning, resources and staffing across the two cities. This had resulted in staff working under pressure in places and the same service types having different impact on patient can delivery. There risks in some service areas that were not being appropriately managed, for example, Portsmouth community nursing services, Southampton CAMHS and Southampton substance misuse services. The corresponding services across the trust did not have similar risks.
- There had been rapid pace of change to transform and sustain services and this has meant uncertainly and some confusion with staff about local leadership and support. Some staff expressed feelings of isolation and an inability to contribute to changes and quality improvement at work.
- Staff were positive about working for the trust and recognised the value of their service. However, morale was low across some areas due the uncertainty of reorganisation and some staff groups working under pressure. The trust was worse than other trust for staff engagement. However, many staff reported the open and accessible culture that the new CEO was working to promote.
- Cost improvement programmes needed to have better monitoring information to determine the impact on services.

However,

- The trust was developing a five year strategy and was working with an operational plan to focus on prevention and early intervention to promote healthy lifestyles and reduce the risk of ill-health through better management of long-term conditions and an increasing emphasis on self-management, choice and personalisation of care. The trust has identified equal priority for physical and mental health and to work with partners across social care, primary care and other services to deliver more joined up services and care closer to home and avoid acute hospital admissions.
- The leadership team showed commitment, enthusiasm and pragmatism to develop and continuously improve services.
- Public engagement took place through a variety of means, such as surveys, patient forums community groups.
- There were many examples of innovation and improvement within trust and staff were involved in quality improvement projects, new models of care, research and audit. The trust was developing a programme approach to ensure quality improvement was being managed effectively based on national models of best practice.
- The trust had a historical financial deficit and was working towards a financial recovery plan. Cost improvement programmes were challenging and focused on the transformation of services and improving efficiency and management costs.

Our findings

Vision and strategy for this service

- The trust vision had three goals: Great care, Great place to work and Great value for money. The trust was

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developing its five year strategy and was working to an operational plan for 2015/16. The objectives within this plan identified the focus on prevention and early intervention to promote healthy lifestyles and reduce the risk of ill-health through better management of long-term conditions and an increasing emphasis on self-management, choice and personalisation of care. The trust had identified:

- equal priority for physical and mental health;
- working with partners across social care, primary care and other services to deliver more joined up services and care closer to home and to avoid acute hospital admissions;
- objectives for staff to develop leadership and strong clinical business teams;
- to develop change programmes and deliver on financial cost improvement and recovery plans;
- to listen to users and improve access and patient outcomes;
- to develop infrastructure, including IT systems.
- The trust had made the decision not to continue to work towards foundation trust status but to focus on delivering their change programme. This including aligning themselves with new models of care and reorganising and integrating their services. The focus was not to retain the sovereignty of Solent NHS Trust but to deliver services that worked for the populations.
- The trust had identified the potential risks to the organisation if they were unable to position themselves to deliver city based integration. This included the future viability of services and ability to deliver cost effective quality care. The board needed to agree an organisational strategy and implementation plan to work across both cities, and needed to work on a comprehensive transformation plan with multi-agency accountability.
- Most staff we spoke with were aware of the trust's overall vision and strategy although were not always clear about the strategy for their own services. The reorganisation and integration of some services was challenging for some staff teams.
- The trust had actively engaged staff in developing new values to support the organisation and trust vision. The values covered Honesty, Everyone counts, Accountable, Respectful and Teamwork (HEART). All staff was aware of the trusts' values and these had been incorporated into everyday practice, including recruitment and appraisal.

Governance, risk management and quality measurement

- The trust had two main board committees: the audit & risk committee and the assurance committee. These met bimonthly and monthly respectively. There were committees beneath for finance, remuneration, governance and the Mental Health Act. A quality improvement and risk group reported to the assurance committee and oversaw various groups, for example, on medicines management, search and development, clinical audit and effectiveness, serious incidents requiring investigation and quality improvement.
- The operational governance structure was led by the trust management team and this reported to the board. Care groups reported monthly on services (the service lines) through care group boards and performance sub committees which started in 2015.
- Each service line reported using CQC's five key questions. Quality dashboards were used and these indicated serious incidents, complaints, workforce, and operational performance, including waiting times. The quality metrics were reviewed by the quality improvement and risk group but currently were not presented to the assurance committee. This meant that some data, for example, training data on safeguarding was not always known by board members.
- The quality dashboards were underdeveloped in terms of clinical and risk indicators. It was not always clear what specific action was being taken in response to identified concerns. Information from the different service lines was not always joined up to focus on specific risk issues across services. The absence of good quality clinical information in some services was a concern. Sometimes there was an abundance of data at different levels but there needed to be a stronger focus on metrics that denoted quality and risk.
- There was better information on finance and activity to the service lines to take ownership of financial decisions and to describe service pressures, such as the increase acuity of patients on the mental health acute inpatient wards as a result of demographic needs and pressures in the acute service.
- A trust wide dashboard was being developed as currently there was a lack of sufficient oversight across services that span Portsmouth and Southampton. This had led to unequal service delivery and risks to patients,

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and unequal workloads for staff in similar services for example in substance misuse and CAMHS services. The trust was planning an independent review of service line management of the quality governance process.

- Each service line had a governance and quality lead who had become integral to service delivery. However, they did identify their roles as too reactive and required more time to streamline data driven approaches and to concentrate on developing staff and embedding changes in practice.
- Care group registers included identified risks and these were monitored and shared with staff. However, in some areas risks were not known and mitigating actions on identified risks were not effective. Review dates were not always clearly stated or timely. High level risks were escalated but the process was inconsistent. Some risks were being monitored in terms of operational staffing issues rather than risks to patient care.
- The corporate risk register defined its highest risks as the Portsmouth community nursing, sexual health services and West Hampshire Speech and Language Therapy. Risks are scored in terms of severity (1 – 20) and based on the trust scoring system all risks over 15 would be on the corporate risk register. However, not all high risks were on the corporate risk register as either they were not appropriately identified or the risks were not known. Mitigation actions and controls varied and were not always reviewed to ensure risks were being appropriately managed.
- There was a lack of effective governance in mental health services and some community services. For example, a lack of effective quality assurance of an independent ambulance provider transporting mental health and s136 patients, and lack of governance oversight in CAMHS services, Southampton substance misuse services and children and young people and families community services. Where serious concerns were highlighted to the trust following inspection, the trust had responded quickly with immediate actions plans. However, systems were not mature enough to identify and escalate concerns within the trust own processes.
- The trust had a service contract with an independent ambulance provider to transport mental health and s136 patients. There was insufficient oversight of a mental health contract and the trust did not have satisfactory access to records, incident forms or staffing records for this contract. There was no assurance that the service delivered was safe, responsive or effective.
- Since the last CQC inspection (March 2014) the trust had made progress on the service developments that had been identified at this time. This included improving the environment on the Kite Unit and improving access to sexual health services. Some improvements were ongoing in terms of staffing challenges in community and mental health teams.
- The trust board monitored progress against the trust's strategy and quality improvement through the board assurance framework (BAF). The BAF identified strategic and operational risks and the assurance around these. The BAF did identify assurance and controls. There was however, a degree of variation in the level and type of assurance sought and how sources of assurance were defined. There was sometimes reassurance instead of assurance identified from board and committee minutes.
- Clinical audit programmes were developed and there was good participation in national and local audits. More attention needed to be paid to change practice following audit and re-audit. Internal audit and external reviews had been used to check assurance systems. The findings of the independent review into serious incidents processes identified the need for a more coordinated approach with clinical and internal audit to provide assurance around governance processes and clinical effectiveness.

Leadership of service

- The trust leadership team was relatively new with many members of the trust board having been in post for less than two years. The Chair had been in post since April 2011 as has the director of HR and organisational development. However, the chief executive was appointed in September 2014, the Chief Medical Officer in January 2016, the Chief Nurse in September 2014,and the director of finance in August 2015. The trust has two chief operating officers (COO). The role of COO for Portsmouth was developed in 2015 with the Director of Strategy taking up the post in July 2015. The COO for Southampton COO joined the trust in July 2012, and

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commenced the revised arrangement in July 2015. The five non –executive directors had been in post between one and five years. The trust was appointing to the remaining two NED posts.

- The trust leadership team demonstrated commitment, passion and pragmatism. There had been many recent changes within this relatively new team, and there were efforts to build and develop understanding as a platform to challenge and support more effectively. The board had established board development days and seminars and alternated board meetings to every two months. The leadership team identified improving relationships and understanding and cohesion as a team.
- There was openness about the trust position and an understanding of the present environment. The trust was working to offer the best services for patients and this could be through new models of care and working with collaboration with primary care and adult social care. There was less emphasis on retaining services because of need to protect the trusts' service profile.
- The non- executive directors told us they were supported to fulfil their role. They considered the trust worked well as a board and were they were able to provide support and challenge to executive directors. However, there was a reliance on specific members to lead and the scrutiny and challenge was not always effective or driven objectively by data and information. There was not a named NED responsible for whistle-blowing or a nominated independent NED. The trust had decided to wait until the appointment of the remaining NEDs. The trust considered staff were aware that they could raise concern with any NED. However, some staff were unaware of this.
- Although not a foundation trust, the trust had a council of governors and was committed to engaging with governors. The governors were involved in board to ward visit, planning and strategy, and board appointments. There was engagement with local communities. The governors identified being well supported and well informed. They were now receiving better quality information than in the past.
- The NHS Staff Survey 2015 identified that the trust was similar to other trusts for the percentage of staff reporting good communication between senior management and staff.
- The trust operational management was divided into two care groups: Southampton and Portsmouth care groups with county services within the Southampton care group. There were differences across the two cities based on strategic and commissioning decisions. Southampton services, for example, were integrated and Portsmouth integration was slower. The commissioning models across Southampton and Portsmouth had certain similarities and the two COOs identified the interchangeability of their posts and a 'bridge' whereby there should be equity of services across the trust. However, staffing issues in the nursing management team in Portsmouth had resulted in the Portsmouth COO having a role with a more operational focus and Southampton more strategic.
- Some community service teams identified the new nursing management structure within care groups and service lines had meant the removal of some senior posts. This extensive reorganisation had led to uncertainty and with some staff reporting a team loss of skills and experience. Changes in shift patterns in 2014 had not been consulted on and staff had left the organisation. Teams in the Portsmouth care group described being told what would happen rather than being active participants. Some staff described feeling isolated and not knowing their manager or leadership team. Managers identified the need to regain staff "trust" and identified initiatives as ongoing but improving. For example, skill mix changes had stopped and support was in place to rebuild management teams. Changes in the Southampton care group were similar and some staff had left the organisation because of this uncertainty.
- The service line management within the care group structure was a new process. Service lines had governance and performance meetings. Clinical Directors and operational directors were appointed to service lines. Each team had a team leader who provided day-to-day operational leadership; locality managers managed these. The trust was supporting leadership development through specific courses and programmes.
- Most trust staff described their managers as approachable and supportive. Most staff felt respected and valued their immediate and senior managers.
- The CEO was recognised by staff as approachable and pro-active. Her leadership style was described as "highly facilitative, appropriately challenging, patient focussed and supportive of staff".

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Culture within the service

- Most staff were very positive about the service they provided and described supportive and caring culture within teams. However, many staff were not positive about the rapidity of changes that had happened to improve team leadership and expressed a concern about changing roles and a loss of skilled and experience managers.
- The locality model of two chief operating officers was described as developing. The operational teams described feeling quite separate across the two cities, with different working practices across Portsmouth and Southampton. There was less evidence of shared learning, resources and staffing across the two cities. This had resulted in staff working under pressure in places and the same service types having different impact on patient can delivery. There risks in some service areas that were not being appropriately managed, for example, Portsmouth community nursing services, Southampton CAMHS and Southampton substance misuse services. The corresponding services across the trust did not have similar risks.
- The trust had undertaken a safety culture survey based on the Manchester Patient Safety Framework (MaPSaF), which is a tool to help NHS organisations assess their progress in developing a safety culture. Most staff, however, reported a strong safety culture and had confidence in raising concerns.
- The trust had a whistleblowing policy (May 2015) and the process to escalate concerns was appropriately identified through service leads. There was not a named independent NED and the trust had not undertaken a formal, systematic review and benchmarking against the recommendations in the Francis review under 'freedom to speak up'. The trust was in the process of adapting NHS 'freedom to speak up' guidance and launching the 'guardian' role for the trust.
- As a community trust, there were numerous stakeholders including commissioners, acute hospitals, GPs, local authorities and local Healthwatch groups. These stakeholders identified the trust as an open and transparent organisation that had worked well in partnership and was responsive to concerns. There were concerns about the trust's performance in some areas and the financial sustainability of some services.

Fit and Proper Persons Requirement

- The trust was had met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014) to ensure that directors of NHS providers are fit and proper to carry out this important role.
- The trust had agreed its Fit and Proper Persons Policy at a board paper in January 2015. All executive and non-executive directors were included under this policy. The trust had introduced a recruitment checklist, self-declaration form and pre-employment checks. There had been relevant checks and due diligence in the appointment of new directors, ongoing compliance of existing director and monitoring of compliance. All directors all board members were requested to, and had all signed, an annual declaration.
- We reviewed four executive and non-executive appointments. There was evidence that the appropriate checks had been carried out with regard to Disclosure and Barring Scheme (DBS), professional registration, recruitment, insolvency and bankruptcy. There has also been psychometric testing on the capacity to lead. There was also a six monthly check of social media and public sources of information.

Staff engagement

- The leadership team undertook board to floor walkabouts to engage with staff and understand potential safety issues. Areas for action were reported to the trust board.
- All policies and procedures were signed off with the joint consultative committee and staff groups. The staff side told us that there were good relationships with senior staff and considered the focus of the CEO was now on the quality agenda. However, the transformation of services was rapid and many staff were feeling uncertain and there was low morale in some teams. Staff side had not always received information in advance to be able to support staff. Information was more forthcoming recently and though the pace of change was slowing in comparison, they did not always have the capacity to support staff effectively.
- The NHS Staff survey 2015 demonstrated the trust was below (worse than) other similar trusts for staff engagement overall. There was a slight decline in the

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engagement score compared to 2014. Of 28 questions, the trust was worse than other trusts for 14 and better than other trusts for 5 questions. Action plans were being developed in teams following the staff survey.

- The trust had the lowest scores for, staff satisfaction with their level of responsibility and involvement, staff satisfaction with the quality of work and patient care they are able to deliver, percentage of staff able to contribute to improvements at work, the percentage of staff agreeing that their role makes a difference to patients / service users, and staff satisfaction with resourcing and support.
- The trust had the highest scores for: a lower percentage of staff experiencing physical violence or bullying, harassment or abuse from patients or relatives, confidence and security in reporting unsafe clinical practice, Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month and percentage of appraisals.
- The Staff Friends and Family Test was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff whether they would recommend their service as a place to receive care, and whether they would recommend their service as a place of work. The trust has a higher staff response rate (20.84% compared to the England average of 11.43%) from 1 July to 31 September 2015.
- The percentage of staff that would recommend the trust as a place to receive care is 6% lower that the England average (73% compared to 79%). The percentage of staff that would not recommend the trust as a place to receive care is 2% higher that the England average (9% compared to 7%).
- Medical engagement needed to improve. There had not been sufficient clinical line management, supervision or job planning for medical staff. The Chief Medical Officer had identified a road map for improvement and the Doctors and Dentists Negotiating Committee had restarted in March 2016. The improvement plan was to be implemented by October 2016. Processes for appraisal and revalidation had been well developed. The Medical Revalidation Annual Organisational Audit demonstrated a continually upward trend for the implementation of medical revalidation (the Responsible Officer Regulations). This included the systems in place within the organisation and the rate for doctor appraisals. The trust completed annual appraisal rate for all doctors was 97.9% and 2.1% had an approved incomplete or missed appraisal. The appraisal rate was higher than similar trusts and trusts across all other sectors.
- 15% of staff within the trust were BME and 3.7% were in senior roles. The Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2) became mandatory in April 2015 for NHS providers. Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality. The workforce race equality indicators (May 2016) identified there were significant differences for BME staff in the trust reporting on appraisals, training and development, support from managers, harassment, bullying or abuse from patients or staff in the last 12 months, career progression or promotion, and discrimination at work from managers/ team leaders or other colleagues than white staff. However, the trust was similar or below (better than) other trust in terms of scores. The equality and diversity group had a work plan to address concerns.
- The trust was the only community trust nationally to undertake the equality delivery system assessment and was working to incorporate this evaluation with work ongoing within their communities. A baseline assessment had been done on patient access and experience and the challenges were identified for those working in deprived areas where health literacy was a problem. The trust was identifying different forms to improve communication.
- The trust used a variety of means to support good staff communication (for example, the Chief Executive's blogs, newsletters and video messaging). Staff recognised the efforts of the CEO to improve communication and promote an open access culture. Many staff reported the senior management to be visible and there were opportunities to contact them and discuss issues. However, some staff told us they thought the trust senior management team were focused on Southampton services and some Portsmouth services were not well understood.

Public engagement

- The trust patient experience group met quarterly, led by the Chief Nurse. The group included trust representatives from the care group service lines, as well as external organisations such as Health watch and carer organisations. The venues were altered across the

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Requires improvement

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.

two cities to encourage attendance. The trust produced a quarterly patient experience report which included data on the Friends and Family Test, complaints, and surveys. There was work ongoing to triangulate this data to identify areas of good practice and areas to focus improvement. A carer's report was also produced annually for the clinical commissioning groups.

- Public engagement happened through a number of initiatives, such as open days, health promotion events, patient forums, meetings with local community groups. Social media was also used to deliver key messages and updates of interest to the general public
- The trust patient experience framework aimed to improve the level of patient/service user feedback. Patient feedback through surveys, interviews and complaints was being used to improve the service and the 'You Said – We Did' approach was visible in many clinical areas.

Innovation, improvement and sustainability

- The trust encouraged innovation and improvement and staff were involved in research. quality improvement projects and audits. The trust was listed as the most research active care trust in 2015/16 in the National Institute for Health Research National League Tables. There were many examples across community services of integrated working, new models of care, therapy based initiatives and early intervention projects to promote public health.
- The trust had a historical financial deficit and was working towards a financial improvement plan. In 2014/15 the deficit had been £6.3m and the trust planned to reduce the deficit to £5.1m in 2015/16 a slight reduction because of investment in replacing the IT and clinical records system and planned £4.5m in 16/17. The finance director had presented the financial review for the trust structured around the trust values.
- Cost improvement was being delivered though transformation schemes across the Trust, rationalising estate, increasing staff productivity through better IT and workforce redesign, and working with partners to deliver care more cost effectively. The trust was also going to buy in services to reduce management costs. The trust cost improvement programme this year was £14m and £10m had currently been identified.
- Cost improvement plans underwent quality impact assessments and were monitored monthly by the finance committee and the board. Monitoring the impact on quality needed to improve in terms of the metrics reviewed at monthly governance and performance meetings with care groups. The board were introducing more 'deep dive' reports with more meaningful information for service lines. For example, there would be further savings from integration of services in Portsmouth but skill mix changes in nursing had stopped.
- The trust was developing a quality improvement programme to manage quality and innovation in a more effective way. The programme was being modelled on the Institute for Healthcare Improvement (IHI) Breakthrough Series and the Health Foundation approach to quality improvement. The programme would focus on leadership, development of skills and knowledge of the model for improvement, understanding the impact of human factors on sustainable change, and measurement for improvement. The programme would support the service teams as part of the clinical audit schedule for 2016/2017 and quality priorities for the trust and would be monitored quarterly.
- A trust organisational development strategy was required. The development was delayed because of the responding to priority issues of staffing, financial stability, IT infrastructure and responding to increased activity.

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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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA 2008 (Regulated activities) Regulations 2014: Person centred care** How the regulation was not being met: • We found that the provider did not take every reasonable step to provide opportunities to involve people in making decisions about their care and treatment and support them to do this. This includes physical, psychological or emotional support to get information in an accessible format or to understand the content. 9 (1) (3) (d) • Prescribers were not ensuring clients had clear prescribing care plans outlining treatment aims and goals. Staff from the prescribing service were not routinely discussing or identifying discharge plans. Clients could 'remain' in the system for many years. There was no systematic procedure to follow up clients who routinely failed to attend appointments. 9 (1b) (1c)

Regulated activity	Regulation
	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services • The trust did not ensure that all young people had care plans. 9

Regulated activity	Regulation

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Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010: Dignity and respect.** How the regulation was not being met: • There were no interpreting services for community health inpatient services for patients who did not speak English. 10 (1) (f) • If a service user at Oakdene wanted a bath there was a blanket ruling that a member of staff had to be present due to the potential risk to service users of the mechanical features of the assisted bath. Service users had expressed their concern regarding this lack of privacy in the service user feedback survey. 10 (1) and (2) • On Maple ward there was no clear segregation of male and female bedrooms in one corridor. This was in breach of Department of Health guidance on mixed sex accommodation. This is a breach of regulation 10 (2) (a)
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (Regulated Activities) Regulations 2014 :Safe care and treatment** How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe care or treatment. • Medicines management in school services were not in line with current legislation. Medicines were not always kept safe for children and young people. Medicines management in school services were not in line with current legislation in relation to administration, prescription and their safe storage. Staff transported medicines in unlocked cases to patients' homes.12 (g)

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- Risks relating to medicines were not assessed, monitored and action taken to mitigate these in order to safeguard the welfare and safety of children and young people using the service. 17(2) (b)
- Systems were not in place to ensure equipment (wheelchairs) were supplied by the service provider, ensuring that there was sufficient quantities to ensure the safety of the service user and to meet their needs. 12 (2) (f)
- Staff did not know where the ligature cutters were or what ligature cutters were used for on Brooker Unit. 12 (1) and (2c)
- The Brooker Unit had not adequately assessed the risk to patients within a mixed sex environment. 12 (1) (2a) and (2b)
- In the Southampton CAMHS, we found that there was not an effective system in place to assess the risks to young people. The trust did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. Staff were not trained to complete assessments of young people and children. The trust did not ensure that young people and children did not have access to dangerous items in the unlocked kitchen and interview rooms. The trust did not ensure crisis plans were completed for all young people who were assessed as requiring them to keep them safe. 12 (1a) (1b) (1d) and (2b) (2c).
- The trust was not ensuring staffing levels were consistently safe to manage clients receiving prescriptions. The trust was not ensuring staff in the Southampton team reviewed prescriptions regularly, or that managers supported staff with robust protocols with regard to monitoring responsibilities. Caseloads were high and staff were not able to adequately monitor or manage them well. Staff had not carried out all home visits to clients who had children living in the house, or where children visited. This meant they could not be assured medication was safely stored in the home. Staff could not produce a signed copy of patient group directions form (PGD) in the Portsmouth service. 12 (1) (2b) (2c)
- Potential ligature points in the outside area of both Maple ward and Hawthorn ward had not been identified or acted upon. Staff were not ensuring

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patients with potential or actual safeguarding issues were managed safely in the ward environment. Care plans around these risks were not cohesive. 12 (1) (2b) (2d)

- Potential ligature points which had been identified by the trust on the mental health long stay rehabilitation ward had not been effectively mitigated. This is a breach of regulation 12 (1) (2) (d)
- Children, young people and families using community services did not have their needs met in a consistent manner. Staff receive such appropriate support, training, professional development, supervision as is necessary to enable them to carry out the duties they are employed to perform. 18 (2) (a)
- Children, young people and families using community services sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the needs of people using the service. 18 (1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment** How the regulation was not being met: • We found that patient on patient assaults were not being considered or reported as safeguarding events at Brooker Unit. 13 (1) and (2)

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

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How the regulation was not being met: All premises and equipment used by the service provider was not clean.

- The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used. 15(2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Good governance** How the regulation was not being met: • Systems were not in place community health services for adults to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the acre and treatment provided to the service user and of decision taken in relation to the care and treatment provided. 17 (2c) • The provider did not have an up to date environmental risk assessment. Staff could not identify where quality and safety was being compromised. 17 (1) (2b) • There was a lack of oversight by ward management on Brooker Unit with regards to resuscitation procedures, safeguard reporting, managing mixed sex environments, knowledge of trained staff in restraint procedures and staffs knowledge of how to respond to an incident involving the use of ligature cutters. 17 (1) and (2a) (2b) (2c) • Information relating to ligature risks was missing from the annual audit tool. 17 (1) and (2a) (2b) • We found that confidential patient records had not been secured properly due to open office doors, allowing easy access to unauthorized persons. 17 (1) and (2c) • The health-based place of safety had deviated from the multiagency agreed policy, used throughout Hampshire

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and had adopted a standard operating procedure. The standard operating procedure had not under gone the same level of scrutiny as recommended in the Mental Health Act code of practice. 17 (1) and (2a) (2b)

- The provider must ensure there is an effective system in place to ensure consistency in standards and work processes across the different community CAMHS teams to manage the waiting lists, to ensure there were sufficient staff, to ensure recommendations from serious incidents are met and assess the risks to young people whilst they were waiting for assessment or treatment. 17 (2a) (2b)
- Managers did not have good oversight across the Southampton service. There was a primary focus on staffing resulting in a failure in ensuring monitoring reviews and safety in the service. Staff morale was low due to long-term staffing issues. Managers had not added to and updated the service risk register sufficiently. Staff had not completed all mandatory training. 17 (1) (2) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA (RA) Regulations 2014 Staffing** How the regulation was not being met: • Staffing levels were not as planned by the trust in some community teams and the requirements set out in the fundamental standards were not met. 18 (1) • The provider operated the memory assessment service at very high capacity. The staff member leading the clinic had a caseload in excess of 600 patients. We saw that staff had missed patients' six-month reviews. 18 (1) • There was no established agreement between the trust and the ambulance service to agree a process when and if ward staff should respond to an alarm in the health-based place of safety. This places staff at risk. 18 (1) and (2a) • No staff had been trained in the Mental Health Act at the crisis team. Seventy percent of staff had completed fire and safety, seventy three percent of staff had

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completed safeguarding children and health and safety training, Mental Capacity Act training had been completed by sixty three percent of staff and fifty seven percent of staff had completed safeguarding adult training. 18 (1) and (2a)